CLINICAL ETHICS

Nurses' views on their involvement in euthanasia: a qualitative study in Flanders (Belgium)

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Background: Although nurses worldwide are confronted with euthanasia requests from patients, the views of palliative care nurses on their involvement in euthanasia remain unclear.

Objectives: In depth exploration of the views of palliative care nurses on their involvement in the entire care process surrounding euthanasia.

Design: A qualitative Grounded Theory strategy was used.

Setting and participants: In anticipation of new Belgian legislation on euthanasia, we conducted semistructured interviews with 12 nurses working in a palliative care setting in the province of Vlaams-Brabant (Belgium).

Results: Palliative care nurses believed unanimously that they have an important role in the process of caring for a patient who requests euthanasia, a role that is not limited to assisting the physician when he is administering life terminating drugs. Nurses' involvement starts when the patient requests euthanasia and ends with supporting the patient's relatives and healthcare colleagues after the potential life terminating act. Nurses stressed the importance of having an open mind and of using palliative techniques, also offering a contextual understanding of the patient's request in the decision making process. Concerning the actual act of performing euthanasia, palliative care nurses saw their role primarily as assisting the patient, the patient's family, and the physician by being present, even if they could not reconcile themselves with actually performing euthanasia.

Conclusions: Based on their professional nursing expertise and unique relationship with the patient, nurses participating as full members of the interdisciplinary expert team are in a key position to provide valuable care to patients requesting euthanasia.

Nurses care for terminally ill patients and deal with patients' families longer and more intensely compared to other health professionals.^{1–4} Various studies, as well as anecdotal experiences, show that nurses are involved in the care process surrounding euthanasia—that is, the administration of lethal drugs with the explicit intention of ending a patient's life at the explicit request of the patient, whether euthanasia is legal or illegal in the country being studied.^{1 2 4–9} Although the nature of the nurses' involvement in euthanasia was not described, studies of nurses from various disciplines have shown that the percentage of nurses willing to be involved in euthanasia, when legal, varies widely from 14%^{10 11} and 23%¹² to 65%.¹³ Remarkably, the percentage of nurses willing to be involved in euthanasia is lower than the percentage of nurses believing that euthanasia is ethically acceptable (23%,^{10 11} 31%,¹² and 62%¹⁴ to 78%¹³), pointing to a gap between the idea of euthanasia and actively taking part in the execution of euthanasia. The percentage of nurses willing to administer lethal drugs ranged from 14%,¹¹ 16%,¹⁵ and 17%¹⁶ to 36%.¹⁷ The myriad of differing percentages given when investigating attitudes of nurses toward euthanasia indicates the difficulty of trying to give a nuanced picture of a complex reality. In the review of pertinent literature published between 1990 and 2002—that is, the period before the legalisation of euthanasia in Belgium and the most recent act in the Netherlands⁴—we identified several statistically significant characteristics, such as age, religion, and nursing specialty, that influence a nurse's opinion on participation in euthanasia. Older nurses found it more difficult to reconcile their involvement in euthanasia. In addition, the more religious nurses were, the more they tended to oppose euthanasia. Moreover, this literature review

found that nurses who dealt primarily with terminally ill patients—that is, palliative care nurses—tended to possess more conservative views on euthanasia.⁴ Parallel to this literature review by Verpoort *et al*,⁴ we undertook a thorough philosophical/ethical analysis of the data in the empirical literature concerning nurses' attitudes toward euthanasia.¹⁸ Emphasis is laid on the complexity of nurses' attitudes and on the contextual complexity nurses are confronted with in the formation of their attitudes. Positive correlates for euthanasia such as age, nursing specialty, and religion appeared.

The Belgian Act on Euthanasia¹⁹ came into force on 23 September 2002, making Belgium the second country—after the Netherlands—to decriminalise euthanasia under certain conditions. Nevertheless, the Belgian legislation has little to say about nurses' involvement in euthanasia, only stipulating that the patient's euthanasia request must be discussed with the nursing team having regular contact with the patient (Ministry of Justice,¹⁹ art 3, §2, 4°). This short reference leaves nurses with many questions regarding their specific role in euthanasia. If the aim of nurses is to guarantee expert care for these patients, then the professional role of nurses in euthanasia must be clarified. This is especially the case for palliative care nurses.

Although nurses worldwide are confronted with euthanasia requests from patients under their care, rarely are their opinions considered in the decision making process. To develop clear guidelines on the role of nurses in euthanasia, it is essential to consider fully the viewpoint of palliative care nurses, given their daily interactions with dying patients and their expertise in palliative care. Research strongly suggests that being confronted with terminally ill patients ensures

that one forms an opinion about (nurses' involvement in) euthanasia. Despite this expertise and experience, their views on this timely and critical topic have yet to be studied in depth. In anticipation of new Belgian legislation, we interviewed palliative care nurses about their views on euthanasia⁵ and their role in the care process surrounding euthanasia, whether or not it is actually carried out. This research is limited to euthanasia requests in terminal (those who will die as a result of the illness within the foreseeable future), mentally competent (capable of expressing their wishes) adult (older than 18 years or emancipated minor) patients. This paper focuses on nurses' views on their involvement in euthanasia.

METHOD

Design

In depth exploration of palliative care nurses' views on their involvement in the care process surrounding euthanasia requires a qualitative research design. Although the primary aim of this study did not include theory development, we selected a Grounded Theory approach to guide our data collection and analysis because it has the potential to develop and refine theoretically relevant concepts leading to a better understanding of nurses' involvement in euthanasia.²⁰

Procedure and sample

We presented the study protocol to the head nurse of a palliative care unit, a palliative home care team, and a palliative support team in the province of Vlaams-Brabant (Belgium). After being granted permission, we distributed information leaflets to nurses who fulfilled the following inclusion criteria: (a) Dutch speaking, (b) working at least one year in a palliative care setting, and (c) willing to volunteer for an interview. The leaflets explained the study aim, stated the definition of euthanasia, and provided information on potential participants' rights. Those nurses eligible and interested in participating in our study gave written and informed consent. Initially, we attempted to obtain as much heterogeneity as possible with regard to the participants' age, gender, religious beliefs, work experience, education, and function by employing purposeful, selective sampling. Data collection using this approach was then superseded by theoretical sampling based on emerging findings as the study progressed, to ensure adequate representation of the important themes. We enrolled new participants until a certain saturation level was reached. After 12 interviews, data collection was suspended because no new information emerged relevant to the theoretical concepts concerning nurses' involvement in euthanasia. Because theory development was not our aim, we did not explicate and validate the links between categories. Our sample comprised five palliative care unit nurses, four palliative home care team nurses, and three palliative support team nurses. All but one were female. The mean age was 40.3 years (range from 29–53 years). Their nursing experience ranged from 2.5–30 years, 1.5–10 years of which were in a palliative care setting. The sample included one licensed nurse, eight undergraduate nurses, and three nurses with a master's degree. Eight Roman Catholic nurses, two liberal Humanists, and two atheists participated. All the nurses had been confronted with euthanasia requests from their patients.

Data collection

We performed one on one, semistructured interviews between December 2001 and April 2002. These interviews were guided by open ended questions that served as an interview guide, as well as a standard by which to assess the information obtained.²¹ The interviews lasted an average of one hour and were all conducted in a private area at the

participant's workplace. All interviews were tape recorded with permission of the participants. To ensure the quality of the questions, regular meetings with the research supervisors were held. Their valuable comments were integrated into the interview guide that evolved over time. Following each interview, feedback from participants was sought about items that were unclear.

Data analysis

The applied Grounded Theory approach consisted of isolating, investigating, comparing, conceptualising, categorising, and relating the data to each other.²⁰ Initially, the interview transcripts and the accompanying field notes were read several times, significant passages were marked, and concepts were assigned to words, sentences, or paragraphs. We coded these concepts initially using the participants' phrasing and terms. We grouped these concepts into categories using the constant comparison method, and then we compared iteratively each section of the data with every other section throughout the study, looking for similarities, differences, and relationships. These early conceptualisations were recorded in analytic memos. Finally, the data were organised into a framework by making first degree connections between the categories. The coding process was supported by the QRS NUD*IST N4 software program.²² Continued refinement, including rereading the transcripts, rediagramming the concepts and categories, and reviewing the literature completed the process of analysis. Trustworthiness of data was ensured by maintaining meticulous records of the interviews and of the investigator's personal impressions and by documenting the details of data analysis (decision and audit trail). Frequent meetings with the research supervisors were also held, and an independent assessment and interpretation of transcripts by additional skilled qualitative researchers was carried out.²³

Ethical considerations

The study protocol was approved by two members of the ethics committee of the Faculty of Medicine of the Catholic University of Leuven.

We respectfully maintained the anonymity of both the institution and the participants, and we treated all collected data confidentially. Participants received an identification number as indicated on the audiotape and the transcript of the interview; these were stored in a location separate from the list containing the nurses' identification numbers. All references to names or places were omitted from the transcript. The recorded interviews were listened to and transcribed exclusively by the researcher. After the study was finished, the recordings were destroyed.

RESULTS

The palliative care nurses we interviewed believed unanimously that they had an important role in caring for patients seeking euthanasia. This role was by no means believed to be limited to assisting the physician during administration of life terminating drugs. The participants felt that a nurse's involvement began at the moment their patient formulated a euthanasia request (implicitly or explicitly) and ended after the potential life terminating act, a time when they felt a need to offer support to the patient's relatives.

We will present, in sequential order, the way participating palliative care nurses viewed their roles in the different phases of euthanasia: hearing the euthanasia request; participating in the decision making process; participating in the execution of euthanasia, and supporting family members and colleagues, regardless of whether the death occurred naturally or by euthanasia.

Hearing the request for euthanasia

Interviewed nurses reported that the caregivers' role in euthanasia involved more than simply administering a lethal medication. The care process began when the patient formulated a euthanasia request. Palliative care nurses felt they played an important role during this phase, as their experiences taught them that a nurse's professional attitude could dissuade the patient from pursuing euthanasia. This professional attitude entailed nurses accepting the euthanasia request with "active openness", thus taking the request seriously rather than passing it over as unimportant. It also required that nurses took the time to listen carefully to patients, with the aim of uncovering their reasons for requesting euthanasia. Identifying these reasons is critical to formulating an adequate palliative response to deal with the specific issues of suffering that underlie the euthanasia request. According to palliative care nurses, improper euthanasia requests often originate from suffering that can be alleviated by alternative courses. Palliative care nurses observed that, by offering palliative care alternatives, many improper requests for euthanasia were withdrawn and undignified deaths were avoided.

A request is often made out of ignorance, fear, and things that are not open to discussion...especially fear of what will come. Openness often provides some relief, making it possible to speak about things...often a cry for help, a cry for reassurance, the unknown.

Nevertheless, the nurses stated that active openness or adequate palliative care did not always succeed in alleviating patients' suffering. A persistent euthanasia request could be attributed to a number of factors: intractable pain and symptoms, fundamental spiritual or existential suffering, and at times the limitations inherent in human beings, as is expressed in the following excerpt.

Sometimes it "clicks" with someone in the team, and that person will make all the difference in caring for that patient and his request accordingly. Nevertheless, when the patient does not feel comfortable with the team and he feels that no caregiver is able to smooth his way...it happens [that a euthanasia request persists].

Participating in the decision making process

Nurses stated that every persistent request for euthanasia must be addressed and discussed openly. The palliative care nurses we interviewed argued in favour of an interdisciplinary decision making process, requiring nurses' input. The participation of nurses in this process was deemed crucial because of the nurses' expertise in dealing with terminally ill patients and their unique, close relationship with these patients. A fundamental element of the patient/nurse relationship is continuity: daily follow up gives the nurse insight into the patient's experiences and how these experiences may develop and contribute to the patient's request for euthanasia. Because a nurse's viewpoints are not based on momentary impressions, euthanasia requests deemed impulsive can be largely excluded. As mentioned, nurses are uniquely positioned to gauge the validity of euthanasia requests.

As a nurse you have a very special relationship with your patient. There is 24 hour follow up, constant interaction with team members, enabling me to get a broad picture of what my patient is thinking and of how he is functioning. I

think that the nurse plays an important role in the interdisciplinary team.

Palliative care nurses indicated that their close and often physical dealings with their patients foster a trusting environment in which in depth discussions can safely take place. Through this intimacy, nurses can communicate the significance of the patients' suffering to other caregivers. In addition, because of their holistic training, nurses can gain insight into the physical, psychological, social, and spiritual dimensions of the patient's suffering. This ensures that the euthanasia decision making process is not based on a one sided interpretation of the situation.

Often we know a lot about the patient, because we are so close to them. We are on quite intimate terms with patients, both physically and psychologically. Often, it is during physical care that intimate issues come up; thus, we get to know a lot of minute details about our patients. We are with them much longer [than other healthcare givers], so that these little things come to our attention.

Our view is different from that of the physicians. We see problems differently. Difficulty arises sometimes because we are too involved; we can't distance ourselves [from our patients]. The benefit is that we are able to express how difficult it really is for the patient with a [euthanasia] request. Sometimes the physician isn't in touch enough [with the patient] to really express the patient's problem.

In addition, our study nurses believed that consensus among the healthcare team members was essential to uphold the conscience of individual caregivers, as well as for good team functioning.

I feel the backing and support of my team. I am not doing something that only I or the patient wants. No, I have the entire team backing me up with moral support.

Participating in the execution of euthanasia

Concerning the actual act of performing euthanasia, palliative care nurses saw their role primarily as assisting the patient, the patient's family, and the physician by being present, even if they could not reconcile their morals with actually carrying out a request for euthanasia. Nurses were willing to set personal convictions aside in order to meet their patients' needs in a professional manner, especially since they viewed dying as a significant event during which the patient could not be left alone. Nevertheless, the nurses also felt that their presence during the administration of the lethal drug was justified only when in compliance with the patient's wishes.

Whatever your opinion about euthanasia might be, you can't leave people alone at such an important moment. The process of dying is too emotional, too significant in our lives.

Most nurses we interviewed believed that administering the lethal medication was a medical act that was beyond their competence. The expertise and accountability of the physician, his position within the team, and his societal recognition seem to support this belief. Some of the reasons stated for why they were unwilling to personally perform euthanasia included an emotional resistance to killing; the irrevocable nature of the act; doubts they had about the right course of action, and concerns they had about the possible

impact on a person's own self understanding. Some nurses, however, thought they should be permitted to administer the lethal drug, as long as a physician was present to guarantee that administration proceeded smoothly. Still, the nurses emphasised that performing euthanasia could not be casually delegated to a nurse who did not take part in the decision making process surrounding the euthanasia request. Furthermore, the participants stressed that every nurse must always have an opportunity to decline participating in euthanasia on conscientious grounds.

I think it is important that physicians—who make the final decision in the matter of euthanasia—should also be the executors. In my opinion, you cannot ask a nurse uninvolved in the decision making process concerning euthanasia to give the lethal injection.

I am a little hypocrite. In fact you [the nurse] support the idea of euthanasia, but someone else has to do it. But I think to have the right to...myself not to...I think it is analogous to a nurse participating in abortion: it's essential to have a choice whether or not to cooperate.

Supporting family members and colleagues

The palliative care nurses we interviewed believed they had an important role in supporting the patient's family once their loved one had passed away. Euthanasia can give rise to questions, doubts, and feelings of guilt in family members, possibly resulting in a pathological mourning process. Relatives might need reassurance about making the right decision. These nurses also indicated that family members might need someone who would listen to their thoughts and feelings.

They sometimes wonder: "Shouldn't I have tried to stop him? Shouldn't we have let the natural process of dying run its course? Didn't we do enough to help him? Maybe this is why he arrived at his [euthanasia] decision? Maybe it was to relieve me of the burden?"

Having good communication with the patient's relatives also served as a great relief for our participant nurses.

...maybe having contact with the relatives as much as possible. To know that they are okay more or less, to ask how they are doing and how they feel about their experiencing the euthanasia event. These aspects are vital to be able to have a positive experience yourself.

All the nurses we interviewed were convinced that euthanasia could also have a major impact on the healthcare professionals involved in the end of life process. The ethical aspects of the event can give rise to deep, complicated feelings, questions, and doubts. Thorough emotional support for healthcare practitioners was deemed indispensable.

There are emotions involved. You cannot be passive. It [euthanasia] does not leave you unaffected. If you care for your patients with heart and soul, you will go through hard times. And sometimes your heart and soul will be trampled on. Healthcare practitioners have to be taken care of otherwise they will go under [or collapse emotionally and psychologically].

Nurses stressed that it was essential to discuss the events surrounding euthanasia with other team members after

performing euthanasia. During this discussion, they felt attention had to be paid to the palliative nurses' feelings and experiences, to the aspects of the event that went well, and to how the quality of patient care could be improved. The nurses also indicated that, in order to successfully reconcile their experiences with their beliefs, it was fundamentally important to feel that they were supported and encouraged by their colleagues. Although they all agreed that team support was essential, they felt that such support alone was insufficient. Many nurses desired debriefing with a psychologist. Because euthanasia is a morally traumatic and significant event, the nurses feared that they might collapse without psychological aid.

DISCUSSION

Although the results of this study are limited to the situation in Belgium prior to euthanasia legalisation, our research showed that the involvement of nurses ideally extends throughout the entire care process surrounding euthanasia. This process begins as soon as the patient formulates a euthanasia request, which often originates in the nurse/patient dyad. From a palliative care perspective, one could expect that for nurses the process begins even earlier; by their caring attitude nurses create an atmosphere in which the patients feel free to put forward their request. Nevertheless, the research design of this study was unable to pronounce on this phase. Taking into account that not every request to die ends in euthanasia, nurses considered the care process to be complete after they finished counselling and supporting relatives following the patient's death, regardless of whether the death occurred naturally or by euthanasia. The different phases of the care process surrounding euthanasia are also described by Van de Scheur and Van der Arend.⁹ Although presented artificially in our study as four different stages, the phases in the process are not strictly separate. We chose to present it this way to illustrate the special role of nurses in each stage of the euthanasia process.

The nurse's professional expertise can fully manifest itself the moment euthanasia is first requested. During this initial phase, the nurse's specific task is to be alert and receptive to signals that might convey a wish to die. By addressing this request with "active openness" the nurse considers the request seriously. The importance of this attitude is also described by Coyle,²⁴ who emphasised that, instead of dismissing the request, nurses need to listen to the patient and to recognise the factors underlying the patient's suffering. Once these factors are identified, a concrete management plan addressing each factor and area of distress can be formulated using interdisciplinary resources. According to Verpoort *et al*,⁵ a patient's suffering and the remaining alternatives for alleviating this suffering were decisive factors in the acceptability of euthanasia in a particular situation.

Based on their expertise in palliative care and their unique relationship with the patient, nurses saw themselves as professional partners in the shared decision making process surrounding euthanasia, a process that involves at the very least the patient, family, physician, and other nurses. The ideas contributed by the various parties during this process were considered as areas of communal exploration and discussion, rather than fixed facts leading to immediate action. Consistent with the findings of the literature reviews of De Beer, Gastmans, and Dierckx de Casterlé,^{1,2} and Verpoort *et al*,⁴ our study nurses perceived their role in offering a contextual understanding of euthanasia and requests to die to be one based on their real life experience with people facing life and death decisions. By providing constant care, and by their mere presence, nurses often form close relationships with patients and their families, developing

an intimate appreciation of their circumstances, their anxieties, their concerns, and their reasons for requesting to die. Although nurses are uniquely positioned to act as essential informants, intermediaries, and consultants in the decision making process, the ultimate responsibility for euthanasia and other end of life decisions rests with the physician, as stated in the Belgian Act on Euthanasia.¹⁹

Palliative care nurses considered that performing the actual act of euthanasia was the physician's task. They saw their role during the administration of the lethal drug as primarily supportive (for the patient, family, and physician). They also felt that such support is justified only if it complies with the patient's wishes and if the nurse is willing. The palliative care nurses in our study stated that they were willing to set aside their personal convictions in order to meet the patient's needs in a professional manner. This sentiment is in keeping with the findings of Young *et al.*¹⁶ Nurses in our study also interpreted dying to be a crucial moment at the end of life during which the patient cannot be left alone.

Palliative care nurses believed that the execution of euthanasia was a medical act. The dominance of doctors in our healthcare system could undoubtedly have contributed to this belief. However, nurses also gave several reasons why they were unwilling to carry out euthanasia. Among their ethical reasons for such unwillingness were the irrevocable nature of the act and doubts about the right course of action. Concerns about the possible impact on one's self understanding, and an emotional resistance to killing were personal, emotional reasons that nurses gave for their unwillingness. Musgrave *et al.*,¹⁵ and Young *et al.*,¹⁶ attempted to explain the nurses' unwillingness to administer the lethal medication. They surmised that nurses believed that philosophically agreeing with euthanasia is very different from actively performing it. Another possible reason for nurses' unwillingness to administer the lethal medication is that they may feel that doing so could change the nature of the nurse/patient relationship.¹⁶ Tanida *et al.*¹¹ found the illegal status of euthanasia greatly affected the attitudes of Japanese nurses toward performing euthanasia. In that study, although a large percentage of palliative nurses surveyed were asked by patients to expedite their death, none actively sought to carry out these requests. Over 14% of the nurses indicated they would practice euthanasia if it were legalised. At the time of the present study, euthanasia was illegal in Belgium. Verpoort *et al.*⁵ reported positive as well as negative feelings among nurses about legalisation of euthanasia and its implications for practice.

The nurses we interviewed placed great importance on caring for the patient's relatives following the patient's death. This is consistent with the findings of Demarest and Bend,²⁵ suggesting that nurse practitioners contribute greatly to the care of family caregivers at the end of their loved one's life. Despite the important role nurses play in comforting family members after a patient's death, almost no empirical research data is available on their involvement during this time.^{1 2 4}

As stated by our nurses, the care of patients requesting euthanasia is neither restricted to the administration of a lethal drug nor a matter to be dealt with solely by physicians. Although physicians may have a close relationship with their patients, nurses are the ones that provide comfort and care to patients 24 hours a day. As a result, nurses are in a unique position to form close relationships with both patients and their families, thereby developing an intimate appreciation of the patients' circumstances. The willingness of nurses to personally and fully care for patients who request euthanasia, in addition to the specific palliative and terminal care expertise these nurses possess, allows them to be skilled companions of their patients.^{26 27} Such a companion willingly views the patient as a unique person and is competent to

ascertain the patient's needs. In addition, in an interdisciplinary context, this companion willingly works in concert with the patient to seek the most dignified answers to the patient's questions about euthanasia. Indeed, collaboration among the members of a healthcare team is necessary for good end of life care, which is consistent with the results of the present study, which demonstrates that good end of life care—both for patients who request euthanasia and those who do not—is based on close interdisciplinary collaboration. Cannaerts *et al.*²⁸ similarly described effective team collaboration, or “working together in diversity”, as being essential for good palliative care. While all interdisciplinary team members share a common goal with regard to patient care, individual differences among caregivers are accepted, and even encouraged, in order for the team to realise that goal. This is consistent with the findings of Cannaerts *et al.*'s survey of caregivers who felt that using their specific skills and knowledge are necessary for the wellbeing of their patients and the patients' families.²⁸

Strengths and limitations of the study

We sought as much heterogeneity as possible in the composition of our study sample by purposefully selecting candidate nurses. Nonetheless, our final study sample consisted largely of female, Roman Catholic nurses, a composition that might contribute to bias. Despite the potential for bias, our results remain valid and are useful because the research was carried out in three different palliative care settings, saturation was achieved, and built in guarantees were present to ensure the trustworthiness of the data. These mitigating factors ensured that our data would yield a balanced picture of the self perceived role of palliative care nurses in care processes surrounding euthanasia in this part of Flanders. Because this study was carried out in the months leading up to parliamentary approval of the Belgian Act on Euthanasia, the illegality of euthanasia was a potential source of distortion for our findings. One may question whether the study's guarantee of participant anonymity sufficiently allowed the participants to answer freely and truthfully. As euthanasia was still illegal at that time, the research team chose to pay special attention to the study's ethical implications for the participants instead of to getting accurate information on nurses' actual experiences with euthanasia.

Implications for clinical practice

Our findings indicate that each stage of the euthanasia process requires that the nurses involved possess specific skills and competencies with regard to care and support of their patients. These findings also underscore the importance of the interdisciplinary drafting of clear guidelines about the specific role of nurses, physicians, and other healthcare professionals involved in the end of life care process. Insight into the views of palliative care nurses in this regard—as explored in this study—will be useful when drawing up uniform clinical practice guidelines for euthanasia. Written guidelines will help caregivers avoid disagreements about patient care and will help promote consensus among caregivers during each step of the process. Such guidelines may also be helpful as a practical guide in the work environment and serve as a cornerstone for the foundation of quality end of life care. In the Netherlands, guidelines concerning the cooperation and task distribution between physicians and nurses in the euthanasia process were drawn up by the Royal Dutch Medical Association (KNMG) and the National Nurses Association (NU'91).²⁹ In Belgium, the ethics committee of Caritas Flanders (an organisation to which all Catholic healthcare institutions in Flanders belong) developed guidelines outlining the steps caregivers should take

when confronted with patients' requests for euthanasia.³⁰ These strategies can reduce the unjustified variation in patient care, and help to reduce the amount of uncertainty about the role of nurses in euthanasia, and thus they can promote high quality end of life nursing care.⁶

Need for further study

Because we carried out this study in the months prior to approval of the Belgian Act on Euthanasia, further research is recommended on the self perceived roles of nurses in patient care surrounding euthanasia, as well as their actual involvement in this process, in the context of current legalisation. The present study provides a baseline for future studies aimed at examining the changes over time of nurses' views on their roles in euthanasia. It will be interesting to see if viewpoints change as euthanasia becomes legalised. Research in various other national regions would add significantly to the present study, which was restricted to nurses in the Belgian province of Vlaams-Brabant. Future researchers would do well to choose a broader range of subjects, because our relatively narrow sample consisted largely of female, Roman Catholic, palliative care nurses. Future research will clarify the generalisability of our qualitative research findings.

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