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Involvement of Nurses in Euthanasia

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Abstract

Nurses in this study formed their personal opinions on euthanasia largely from situational experiences. The role of nurses in euthanasia is also important as nurses spent most of the time with the patient. At present, there is no clear guidance for nurses on euthanasia. Their role can be categorized into three phases namely, pre-euthanasia, intra-euthanasia and post-euthanasia stage. The discussion in this paper provides a more concrete and clear description of nurses' role and responsibilities.

Keywords: Euthanasia, Nurses involvement, Physicians, mercy killing,

In moral debates about mercy killing, the focus is often solely on the concern and responsibilities of physicians; the involvement of nurses is hardly ever accorded much attention. Although euthanasia or mercy killing may be one of the so called medical decisions surrounding the end of life, it is still an issue that greatly affects nurses. They are the ones who are also concerned on a daily basis in the care of dying patients. In hospitals they are at patient's bedsides 24 hours a day. This permanent, caring involvement with terminally ill patients demonstrates nurses a great deal about patient's anxieties, questions, fears and needs. Accordingly, a nurse being confronted with a patient's request for euthanasia would not be such an unlikely occurrence (Beer et al., 2004).

In 2002 May 16th, the Belgian parliament definitively permitted the legislative bill on mercy killing. The law came into force on 23 September 2002. Belgium was the second country (after the Netherlands) to have approved law on euthanasia. Even though there is currently legal regulation of euthanasia in Belgium and the Netherlands, very little is known about the involvement of Belgian and Dutch nurses in euthanasia and physician assisted suicide. Some insight into their actual involvement in the process of euthanasia would nevertheless be beneficial when drawing up guide lines for clinical practice (Beer et al., 2004).

Occasionally there are some cases that come into light in which nurses have administered a lethal injection at the request of a patient, without the knowledge of the physician or the patient's family. Such practices usually acquire extensive media attention and some have alleged that this kind of nursing practice is more widespread than is generally in consideration. Disturbing messages like this cause confusion about the position of nurses in mercy killing.

"Involvement of nurses in euthanasia", means the role played by the nurse in cases where a patient

request for euthanasia. This involvement is not at all limited to aiding in administering the lethal medication but comprises the nurse's role throughout the entire process of euthanasia. This process encompasses registering the request for euthanasia, participation in decision making, actually per forming the euthanasia, and aftercare. The nurse's involvement in euthanasia does not refer to the attitudes and ideas of nurses regarding euthanasia or their own involvement in it (Beer et al., 2004).

The literature studied demonstrates that around one nurse in four have at some point been confronted with a request for euthanasia from at least one patient. Twenty five percent of American nurses working with adult cancer patients have been confronted with a euthanasia request. In this study, the no of requests received by a nurse can vary from 0 to 20 in the year preceding the study. Of the nurses in a different American study (oncology and non-oncology nurses), 22% had at some point received a euthanasia request from a patient, and the number of requests varied from 0 to 30 in the year preceding the study. In a study carried out in the Australian state of Victoria, 36% of nurses had at some times received a euthanasia request from a patient. It should be pointed out that, in addition to a request from a legally competent patient, a request by a way of an advance directive also belongs to their definition of euthanasia (Young et al., 1993, p.445).

Another Australian study from the same period reveals that 30% of nurses in South Australia had at some point received a request from a patient for active termination of life. In this study more men than women reported having received a request from a patient. However, the number of men in the sample was rather small, so it is unclear whether this sex discrepancy is valid for the total population of South Australian nurses (Young et al., 1993, p.446). Studies of American intensive care nurses provide a smaller number; 13% of nurses have at some point been confronted with a patient request for euthanasia or assisted suicide.

Research from the Netherlands discloses that half of the patients use the word "euthanasia" to express their request. The other half employ the vague or indistinct terms. In this regard, it is referred that nurses play important role in registering and correctly interpreting the request for euthanasia or assisted suicide. Because of their specific expertise and daily involvement in the care of terminal patients, nurses are the most appropriate people to determine, together with other caregivers (including doctors), whether the request is genuinely a euthanasia request and whether the request originates from the patient himself (Asch & Dekay, 1997). Precisely as a result of their immense personal involvement and long-standing relationship with the patient, in some cases nurses are driven by their feelings regarding the request, without fully examining those feelings.

Australian nurses almost always inform the other nurses (92%) and the physicians (90%) about the patient's request to accelerate death. In 68% of cases, the family is informed. A study in which Japanese palliative care nurses were compared with the Australian nurses, from the study it is revealed, as for as informing other nurses and the physician's the statistics is comparable. On the other hand, the family is more frequently informed by Japanese than by Australian nurses (Young et al., 1993, p.47).

The results of the Dutch qualitative research illustrate that informing the physician, and especially informing other nurses, about the request usually takes place without the patient's consent even though, in the Netherlands, requesting consent was one of the guidelines put forward by the Royal Dutch Medical Association and the National Nurses Association (Young et al., 1993, p.448). The

authors indicate that a possible explanation for this is the fact that nurses act out of habit and are insufficiently aware of the need for extreme care in dealing with information regarding ethically sensitive issues like euthanasia.

Participation by nurses in decision making is usually constrained to taking part in discussions; nurses appear to have very little to deliver in the actual decision making process. In the Dutch qualitative research, nurses thought that a formal vote in decision making was not a necessity, but they did think it was important that they be heard, precisely because of their everyday involvement in terminal care and their specific expertise in the field (Matzo & Emanual, 1997).

The medical literature shows, however, that participation by nurses in discussions about a euthanasia request or assisted suicide is absent in about half of the cases. Differences can be noted in the extent to which physicians consult with nurses. In the first place, the physician's specialty plays a role: Dutch specialists (in internal medicine, pulmonology, cardiology, neurology, or surgery) and nursing home physicians consult more frequently with nurses than Dutch general practitioners (GPs) in cases of euthanasia or assisted suicide. Among Dutch specialists and nursing home physicians, consultations take place in 95% of cases. On the other hand, Dutch general practitioners have consultations with the nurses involved in 55% of cases. One possible explanation for this discrepancy put forward by the authors is the work environment. Compared with nursing home physicians or specialists, general practitioners usually have a more personal relationship with their patients, one in which nurses play no part. The disparities in the extent to which physicians consult based on their specialty is illustrated by another Dutch study. As far as general practitioners are concerned, there were consultations in 17-40% of reported cases of euthanasia. If one only considers at the cases in which nurses are involved in patient care, the consultation rate is 64%. Among Dutch specialists (in various disciplines), this percentage is notably higher: nurses were consulted in 75-86% of cases (Matzo & Emanual, 1997, p.725).

The extent of consultation between physician and nurses also varies according to the topic of consultation. In 52% of cases, Dutch general practitioners consulted nurses about the patient's request for euthanasia or assisted suicide when professional nurses were engaged in treating the patient. Consultations were carried out to a lesser extent about the physician’s intention to perform euthanasia or assisted suicide (40%) and the physician’s actually carrying it out (36%) (Matzo & Emanual, 1997, p.726).

Respect for the patient’s wishes was the primary reason given by Dutch general practitioners for not consulting nurses. Some of the other reasons cited were: the physician not considering it necessary to consult, lack of time, the limited involvement of nurses in care, and the physician’s wish to safeguard confidentiality.

The role performed by the nurse in carrying out euthanasia can fluctuate from simple presence in person to the actual administration of the lethal medication. In general, the nurse has a role that consists primarily in assisting the patient and family. This implies good patient oriented care not only in the days and hours leading up to, but also during the administration of the lethal medication. One surprising discovery is that Dutch homecare nurses are absent at the moment the lethal medication is administered in 90% of cases. In 3% of cases, the nurse is present in the house but not at the patient's bedside. This means that in 7% of cases, homecare nurses are present at the patient's bedside during

administration of the lethal medication. In a nursing home, this percentage is 60% (Matzo & Emanual, 1997, p.727).

Although the administration of the lethal medication is usually carried out by a physician, it is sometimes delegated to a nurse. For instance, 21% of Dutch specialists asserted that nurses sometimes administer the lethal medication under their supervision. In the same study, Dutch general practitioners stated that the lethal medication was administered by a nurse in 4% of the cases, and in 3% of cases for Dutch hospital physicians. An Australian study revealed that 23% of nurses had at some point been asked by the physician to administer the lethal medication, and of these, 85% had complied with the request. One study revealed that the percentage of nurses in South Australia who ended the life of a patient in an active manner at the request of a physician was 5.4%. An American study of the association between the self reported participation of intensive care nurses and their social and professional characteristics displayed that older nurses, more religious nurses, nurses working in a cardiology unit, and nurses with less positive attitudes towards euthanasia are less likely to report having cooperated in performing euthanasia (Matzo & Emanual, 1997, p.728). It is observed that the effect of the sex and religion of the nurses is probably mitigated by attitudes.

Among the reasons for physicians delegating the administration of a lethal medication, reference is often made to the nurse's technical expertise with medical drip devices (intra venous drip), the means by which a lethal medication is most often administered. Other reasons mentioned include habit, a wish to discover the easiest solution, and the hierarchical relationship between the physician and nurse. Although the percentages are low, it cannot be denied that nurses sometimes carry out euthanasia without a physician having prescribed it. An Australian study demonstrated, for instance, that 5% of nurses working with terminal patients over 12 years of age, and who receive a euthanasia request from a patient, sometimes abide by with the patient's request without authorization from a physician. This figure is almost identical to the 4.5% rate among oncology nurses in an American study, and the 2% rate among nurses (mixed sample of oncology and non oncology nurses) from a separate American study. In the two latter studies, however, it is not evident to what extent the attending physician was involved (Kuhse & Singer, 1993, p.311).

Reasons cited by the nurses for performing euthanasia without a physician's authorization include: a feeling of responsibility for the patient's wellbeing, the wish to alleviate the patient of his or her suffering, and the wish to prevent therapeutic obstinacy on the part of physicians.

Nurses generally practice their involvement in carrying out euthanasia as being quite demanding. This is primarily because of the planned nature of the patient's death, and the quick transition from life to death, which encounter the nurses with a sense of unreality. This does not diminish the fact that nurses demonstrate a relatively high degree of willingness to participate in carrying out euthanasia. This willingness is high for the personal presence of a supporting nurse when the lethal medication is being administered (Matzo & Emanual, 1997, p.729). Very few nurses, on the other hand, are trained to administer the lethal injection themselves.

The fact that the participation of nurses in euthanasia is situation dependent contributes to an extreme lack of clarity regarding nurse's involvement, and this is somewhat troubling. Particularly when it comes to performing euthanasia, there is hardly any lucidity regarding the actual role and responsibility of nurses. In spite of the fact that responsibility lies in principle with the physicians,

and nurses are granted a supporting role as assistants, the nursing practice in this phase turns out to be less transparent (Stevens & Hassan, 1994). The atmosphere of illegality in which euthanasia was positioned at the moment the studies were carried out can be a significant contributing factor to this: only in the Dutch studies was there an official policy of toleration regarding euthanasia, where the euthanasia procedure was structured by concrete guidelines with respect to the division of labor between physician and nurses. The discovery that in some cases nurses administered the lethal medication themselves; whether or not this was delegated by the physician and in the presence of the physician; is a finding that should be taken quite seriously. It goes without saying that the lack of clarity regarding the nurse's involvement in euthanasia, as demonstrated by this study, does nothing to help care for the patients. This is even more disturbing when one understands that nurses; compared with other healthcare professionals, are best positioned to provide care for dying patients (Asch DA, 1996).

The continuity of care and the closeness with the patient place nurses in a privileged position for listening to and registering the patient's euthanasia request, for determining what the reasons may be for the request, for reporting the request to the attending physician, for participating in discussions about the request, and for assisting and supporting the patient and family. The strong personal involvement in caring for these patients and the specific expertise in this area permit nurses to be a "skilled companion" for these patients, a companion who is willing and competent to encounter the other as a person, to ascertain his or her needs and, together with the patient, to seek the most dignified answer in an interdisciplinary context (Beer et al., pp.494-497).

Conclusion

In this study were all from a background in palliative care. It might have been expected that nurses working in palliative care would de facto argue against euthanasia, as palliative care is on the whole better equipped to deal with suffering of whatever kind. It is therefore all the more important to hear these nurses' reflections and consider them seriously. There may be important studies possible in the future on the effects of mental suffering in terminal illness. The effects of living longer, and therefore of finding meaning in extended life, have profound effects on society and hence on health care.

References

1. Asch, D.A. (1996). The role of critical care nurses in euthanasia and assisted suicide. *N Eng J Med.* pp.374.
2. Asch, D.A., & Dekay, M.L. (1997). Euthanasia among US critical care nurses: practices, attitudes and social and professional correlates. *Meal Care.* pp.890-900.
3. Beer, T.De., Gastmans, C., Dierckx, de, & Casterle, B. (2004). Involvement of Nurses in Euthanasia: A Review of the Literature. *Journal of Medical Ethics.* pp.494-497.
4. Chinn, P.L. & Kramer M.K. (2004). Theory and nursing: Integrated knowledge development, 6th edn. Mosby, St. Louis, MO.
5. Ferrell, B., Virani R. & Grant M. (1999) Analysis of end-of-line content in nursing textbooks. Oncology Nursing Forum 26(5), 869–876.
6. Field, M.J. & Cassell C.K. (1997) Approaching death: Improving care at the end of life. (Report of the Institute of Medicine Task Force). National Academy Press, Washington, D.C.

7. Sheehan, D. & Ferrell B. (2001) Nursing education. In Textbook of palliative nursing (Ferrell B. & Coyle N. eds), Oxford University Press, New York, NY, pp. 690–700