Involvement of Nurses in the Euthanasia Care Process in Flanders (Belgium):
An exploration of two perspectives

Yvonne Denier, Bernadette Dierckx de Casterlé, Nele De Bal, and Chris Gastmans

INTRODUCTION

Worldwide, nurses fulfill a specific and crucial role in terminal care. This is due to their patient-centred practice, their provision of continuous 24-hour care, and their experience and expertise in caring for dying patients and their families, especially in day-to-day symptom control, pain and comfort management, and emotional support (1-4). As such, nurses are also often the first caregivers to receive a euthanasia request and are intimately involved in the entire care process (1, 5-7).

Since May 2002, Belgium has legally permitted euthanasia if performed by a physician under strict due-care conditions. Euthanasia is legally defined as an act, undertaken by a third party (the physician), which intentionally ends a person’s life (by administration of lethal drugs) at his or her request (8). Though nurses are obviously intimately involved in the euthanasia care process, the Belgian legislation makes little mention of it. Because euthanasia belongs to the medical sphere, it is mainly the responsibility and involvement of physicians that is emphasized in the law. With regard to nurses, the law only stipulates that the euthanasia request must be discussed with the nursing team having regular contact with the patient. Nothing is said about the nature, content, and frequency of this consultation.

Flemish health care institutions (hospitals and nursing homes) have addressed this flaw by paying explicit attention to the role of nurses in the euthanasia care process in their written institutional ethics policies on euthanasia (9, 10). Nevertheless, the meaning and definition of the role of nurses, as indicated in these policies, continue to be an issue.

The same goes for professional organizations. Though the need for professional guidelines is generally acknowledged (11, 12), they have not...
yet been developed. We are presently at a middle stage in addressing this problem; to develop sound and practical guidelines for nursing practice in euthanasia care, more empirical research is needed on the actual involvement of nurses in such care.

Nurses are left with many questions about their professional and legal role in the euthanasia care process. Because they represent the largest group of caregivers for the terminally ill and have a crucial role in end-of-life care, a better understanding of their specific role in the care process for a patient requesting euthanasia could promote optimal end-of-life care.

Attention to the role of nurses in euthanasia care is growing internationally. Existing research gives us insight into the fact that nurses across diverse geographical and clinical settings are often closely involved in the euthanasia care process, regardless of the legal status of euthanasia in the country being studied (1, 5-7). The research offers us an interesting overview of the various attitudes nurses have about euthanasia (12-18); of the variety of tasks they undertake during the euthanasia care process (such as listening actively, providing information, determining the cause of the request, providing emotional support, maximizing pain and symptom control, reporting the request to physicians and colleagues, discussing the request, participating in decision making, being present and assisting during the life-terminating act, providing after-care) (1, 5-7, 15, 19-27); and of specific aspects of their involvement at the time of the patient’s request for euthanasia (providing relevant information to the patient), during the decision-making process (consulting with physicians), and during the administration of the drugs (attending, assisting, or even carrying out the euthanasia) (1, 6, 20, 22).

Although these studies help us to understand the actual role of nurses in euthanasia care, they are limited in two ways. First, they provide us with many pieces of the puzzle in the form of specific examples of aspects of euthanasia care; but, although these examples are highly important, we still lack a basic organizing structure for them. We require a general storyline that will allow us to grasp the essence of euthanasia care from a nurse’s perspective. Without such a structure, it will be very difficult to hold a steady course through this highly complex and dynamic care process.

Second, the majority of the existing studies are quantitative. These offer us a broad perspective on existing euthanasia care practices, but they do not resolve the question “What does participation in the euthanasia care process actually mean for the nurse involved?” In order to describe nurses’ involvement in euthanasia care from the perspective of the nurses themselves, we need to employ a qualitative approach. However, existing qualitative research is scarce and small-scale (24, 27, 28), and it is limited to the period before the Belgian Act on Euthanasia (May 2002) (19). Since the act came into effect, Flemish nurses have been increasingly confronted with and involved in euthanasia care.

A thorough understanding of the specific role and contribution of nurses in the care for a patient requesting euthanasia could promote optimal interdisciplinary end-of-life care. An important first step in reaching this understanding is to listen to nurses’ descriptions of their experiences in caring for patients requesting euthanasia. This study is the first large-scale qualitative study exploring nurses’ involvement in euthanasia care in Flanders (Belgium), in the legal context.

METHOD
Design
As our study aimed to explore nurses’ involvement in caring for patients requesting euthanasia, a qualitative interview design seemed most appropriate. We selected a grounded theory approach (29) to guide our data collection and analysis.

Sample
Participants were recruited from general hospitals in Flanders, Belgium (n=82). Initially, we collected data using purposive sampling with the aim of achieving maximum variety with regard to hospital characteristics (size, geography, religious affiliation [Catholic or non-denominational], ownership [public or private], and type [academic or non-academic]; as well as existence of a palliative support team and an ethics policy) and nurse characteristics (demographic, work experience, setting and unit, position, level of education, additional training, and attitude toward euthanasia). This approach was superseded by theoretical sampling as initial data directed us as to how additional sampling should proceed. New information relevant to theoretical concepts continued to emerge. To evaluate our hypotheses, we enrolled new participants from a palliative care setting. Again new information emerged, indicating that we needed to enrol more bedside nurses, nurses working in Catholic hospitals, and nurses having conscientious objections.

This resulted in 18 individual in-depth interviews with nurses from nine different hospitals, geographically spread over the five provinces of Flanders. Of these hospitals, four were Catholic and five were non-denominational. The sample
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Data Collection

Data were collected in one-on-one interviews conducted between March 2005 and November 2006. Interviewees were asked to recall a recent case of caring for a patient requesting euthanasia and to describe their experience of the entire process. Open-ended questions were used, and the interview format was guided by a literature review (5, 30), a pilot study (19), and a systematic review by the supervisors (BDdC and CG). Interviews were all conducted and transcribed verbatim by the same researcher (NdB). They lasted on average an hour and a half. To ensure the quality of the questions, regular meetings with the research supervisors were held. Comments were integrated into the interview guide, which evolved over time.

Data Analysis

All interviews were recorded on MiniDisc and transcribed verbatim. Data analysis was performed, in accordance with the conditions of grounded theory methodology (29), by a multidisciplinary research team (YD, BDdC, NdB, and CG). Interview transcripts were systematically examined and re-examined to identify themes and patterns in the nurses’ responses; significant sections of the data were compared and checked for similarities, differences, and connections. All the data were coded and categorized, and through this process major concepts and the relationships between them were identified. Coding was supported by the QSR NVivo7 software program.

Rigour

We ensured that the findings were trustworthy by means of various strategies (31). We ensured credibility by maintaining meticulous records of the interviews; by having the researcher list personal impressions in a reflexive journal; by documenting the details of data analysis using thick description, which allowed an independent researcher (YD) to come to analogous conclusions about the data; and by triangulating data collection (aiming for a maximum variety of participants) and data analysis (using field notes, interviews, literature, and meeting reports). Interviews were coded and recoded several times. We ensured neutrality by holding frequent meetings with the research supervisors (BDdC and CG) to compare and modify results, to establish uniformity of wording and of category and concept definitions, and to identify the relationships between categories and concepts. We also attempted to ensure neutrality by arranging for independent assessment and interpretation of transcripts by a multidisciplinary team of experts in a formal peer debriefing. Their comments were integrated into the results.

Ethical Considerations

The research protocol was approved by the ethics committee of the Faculty of Medicine of the Catholic University of Leuven. Participation was entirely voluntary, with informed consent obtained on several occasions, in various forms, and on various levels. We presented the protocol to the contact people in the form of a detailed brochure containing information on the aim and protocol of the study and confirmed that any participant could withdraw his or her consent at any point in the study. This process of informed consent was repeated prior to every participant interview. We maintained the anonymity of the institutions and the participants in reporting on the study, and we treated all data confidentially.

RESULTS

The Two Perspectives

We found an important, twofold variation in the way in which nurses recounted their involvement in the process of care for patients requesting euthanasia. This variation was determined by the specific perspective taken by the nurse involved: the procedural, action-focused perspective; or the existential-interpretative perspective. The perspective determines the nurses’ view of the process and, consequently, their judgment of what is most important in providing good care.

Nurses who adopted a predominantly procedural, action-focused perspective reported that they found a good, practical organization of the process to be important. Their involvement was guided by the question “What should I do to make this care process successful?” Their main focus was respecting the patient’s euthanasia request. The right way to do this, they reported,
was to make absolutely certain that this was what the patient wanted. It was important to them to achieve full certainty in an organized way; they ensured that all the procedural steps were taken by means of a checklist. The existence of a clear protocol was highly valued by these nurses because the protocol itself served as the checklist. They also stressed the importance of maintaining a strict division between their professional role and their personal views or feelings. Accordingly, they reported that their involvement in the euthanasia care process was considered successful when everything went well on a practical and organizational level.

Nurses who adopted a predominantly existential-interpretative perspective said that it was important for them to be able to understand the patient’s request. Consequently, their involvement was guided by the question “What is the right attitude for me to have in guiding and supporting the patient and the patient’s family through this process?” These nurses’ primary focus was on showing respect for the patient as a person in the broad sense — that is, as someone with a unique life story, with his or her own wishes, fears, and sources of distress. The right way to do this, they reported, was to create a communicational atmosphere and to enter into personal relationships with patients and their family members. Nurses who adopted this perspective stressed the importance of allowing personal and emotional involvement to affect the caring relationship while maintaining a professional involvement. In order to reach a true understanding of the euthanasia request, they said, it is important (when appropriate) to show one’s emotions. For them, the euthanasia care process was successful when it was existentially right — that is, when all involved were able to make their peace with the situation. Both perspectives are summarized in Table 1.

Based on the nurses’ accounts, we have determined that the two perspectives are not mutually exclusive. Rather, they are mutually enriching and complementary dimensions of care. Both perspectives were always present in the nurses’ accounts of the euthanasia care process, but we found that one perspective or the other would predominate in these accounts. Related to this, we found an important connection between the predominant perspective and the nurse’s position. All the bedside nurses emphasized the importance of understanding, communication, and dialogue. For them, the existential-interpretative perspective determined their involvement in the care process. We also found that the procedural, action-focused perspective was primary in the experiences of all the senior nurses we interviewed.

We are able to describe the two perspectives more clearly when we take a close look at the nature, content, purpose, range, and development of involvement.

### The Nature of Involvement

How are nurses involved in the euthanasia care process? When seen from a procedural, action-focused perspective, their involvement is predominantly practical and organizational. They organize and direct the care process.

“I make sure that everything is well arranged for everyone involved: for the family, for the patient, for the physicians; for everyone at the bedside. It’s a bit of, well, yes — sort of coordinating everything. Making sure that everything proceeds well.”

It is important, the nurses reported, to reach full certainty on various levels and to use a checklist. It must be established that this is what the patient wants, that the patient has received all the necessary information to make a good decision, that the team is well informed, that all the steps of the procedure are followed, and that all the practical arrangements have been made — in short, nothing must be overlooked.

“You cannot make any mistakes or overlook something. [Ahum,] with every euthanasia you must pay attention to everything and everyone: family, patient, grandchildren, children, [ahum,] bystanders, staff, [ahum,] visitors who pass through the corridor. All your staff — everyone from the lowest to the highest branch. I mean, the cleaning ladies, physicians, students.”
When the procedural, action-focused perspective was dominant, most nurses also stressed the importance of keeping their personal views, feelings, and emotions to themselves.

"[The moment in which the euthanasia is carried out] is a very emotional moment for ourselves, too. But then you must remain calm and be strong because you cannot, well, allow yourself to, well, yeah, to burst out into tears, so to speak."

From the existential-interpretative perspective, the nurse’s involvement is predominantly dialogue focused. Nurses who gravitated toward this perspective reported that their professional involvement could not be separated from their personal and emotional involvement. They said that they show their emotions and share their views and experiences with the patient and the family and that this is an essential aspect of the care process.

"I always express my feelings...I am not the so-called professional who listens to everyone but at the same time hides his own feelings...and it is by your attitude as care provider that you will receive things in return. When you are cool, clean, and distant in your manner, you cannot expect the family or other people involved to talk about their emotions. But when you show your own emotions, and show that you were touched, well, then, you can take it from me, you will receive a lot in return."

The nurse guides, counsels, and supports the patient and the family rather than organizing the care process. His or her focus is on showing respect for patients as people in the broad sense, on entering into personal relationships with them and their families by creating a communicational atmosphere — by talking and listening, by getting to know each other, by learning about life stories, experiences, expectations, wishes, and fears.

"I join them, take a chair, and sit down next to them. And then I listen and go along with the things they tell me. Also with things that are not directly or immediately related to euthanasia or to their disease, but that do have to be expressed. People can be stuck with questions, sometimes during their whole life, or be stuck with something that has never been expressed. And you have to let them express these things...And this is always very personal."

From this perspective, it is important to reach understanding within the personal relationship rather than certainty. The nurse tries to understand why the patient’s request is reasonable. Nurses who adopted this perspective reported that it is crucial to find the right attitude. "How should I be?" is an important question to them.

The fact that both perspectives are always present but that one is always predominant is illustrated by the next two quotes. The first illustrates the procedural, action-focused perspective. Here, it is important for the nurse to provide the patient with all of the information necessary to make the right euthanasia decision before discussing non-euthanasia subjects with the patient:

"When a patient is really asking for euthanasia, we provide information and make sure that the patient knows what it is all about...Usually, providing information on euthanasia, it’s done within an hour. The day after, I go in and ask, ‘Are there any questions? Did you understand everything? Do you want me to repeat certain things?’ Of course, there are people who like to talk and like to get attention...They usually tell other things: anecdotes about the children, the grandchildren, travelling, and so on. When this happens, I always say, ‘For now, I would like to stick to your euthanasia request first, because I find it very important to explain everything clearly and to make sure that you are well informed about the legislation and what we expect from you.’ And then I try to guide the conversation in that direction. Of course, I do make sure, once everything is cleared up...to make time to listen to the other things."

The second quote illustrates the importance of providing emotional and psychological support in the broad sense. The more technical aspects of care also deserve attention, but this attention can easily be given by someone else:

"I interpret the involvement [in the euthanasia care process] in a very broad way — emotionally, psychologically, also in relation to the relatives, and in the contact with them afterwards — because I find that the involvement in or guidance of a euthanasia care process, it is something that requires a broad view...I always try to do this during the whole process. And this is sometimes difficult, because there are also a lot of other things to be done. When these other things are practical things, you can always ask someone else: ‘Could you do this?’ ‘Could you make sure that that is done?’ ‘Please make sure that that person is being called.’ Or, ‘Could you change the cassette, please?’; or, ‘Change the pain pump?’ These are things you can easily pass on. But the guidance of a euthanasia care process isn’t something that you can easily hand over.”

The Content of Involvement
What happens during the euthanasia care process? We found that the care process for patients requesting euthanasia is complex and dynamic,
and that it can be seen as consisting of seven stages: the period preceding the euthanasia request, the stage of confronting the request, the decision-making stage, the period preceding the euthanasia moment, the moment when the euthanasia is carried out, the immediate after-care stage, and the later after-care stage. Two factors have to be taken into account here. First, the process does not always consist of these seven stages; the euthanasia request may disappear at some point in the process. Second, although in summarizing the stages we give the impression that they are distinct, they are not strictly separable in practice. We present them in this way in order to more clearly illustrate the involvement of nurses in the euthanasia care process as seen from the two perspectives.

With regard to the procedural, action-focused perspective, the nurses reported that it was important to follow the steps of the euthanasia care protocol using a checklist approach. Having a care protocol is important, because it offers a clear overview of the different stages in the process and thus helps to ensure that nothing is overlooked. Nurses also reported that from this perspective it is not so important to have a face-to-face relationship with patients and their relatives from the beginning of the euthanasia care process to the end. They said that it is not difficult to delegate the personal aspects of care to their colleagues; the procedural aspects of care are more important to the nurse involved. This description of the immediate after-care stage provides an example:

“Especially, yes, at the first moment, there is a lot of grief, of course. They lose someone. Some people want to be left alone, so then you respect that. [Ahum,] other people want to talk, so then you try to find a nurse to do this, because you also have to arrange all the administrative formalities. So, when the general practitioner was involved, you have to make sure that everything is completed before he leaves. You have to draw up the death certificate.”

Seen from the existential-interpretative perspective, the nurses’ role is to take part in the full care process and give good care in the broad sense. Euthanasia care is a flowing, rather than a step-by-step process. Here, the importance of a care protocol is less evident, because such a protocol alone does not necessarily facilitate good euthanasia care, which is much more than merely following a legally required and procedurally determined process. A care protocol could also detract from the nurses’ ability to rely on their professional expertise when it comes to deciding on the appropriate course of action to take at a particular moment in a particular care process.

“The purpose of involvement

What is the essential purpose of nurses’ involvement in the euthanasia care process? Our interviewees stated unanimously that they believe that they make an important contribution to a good euthanasia care process. The answer to the question “What is a good euthanasia care process?” varied, however, between the two perspectives.

A similar comparison can be made when it comes to the way in which communication is conducted between the parties involved. From the procedural, action-focused perspective, nurses stressed the importance of providing patients with the necessary information on euthanasia and palliative care, of explaining the procedure, of reporting to colleagues, and of making the necessary practical arrangements. From the existential-interpretative perspective, nurses maintained that it is important to take the time to speak to patients and their family members about what is going on and to understand how everyone concerned is experiencing the process. These nurses focus on what people are going through as individuals with a unique life story.

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From a procedural, action-focused perspective, nurses found it most important to respect the
patient’s request for euthanasia. They reported that this has significant practical and organizational implications: the practical organization of the euthanasia care process must be strong; and all the steps of the procedure must be taken (for instance, the patient must receive and understand all of the necessary information and have an opportunity to speak with a physician about the euthanasia request, the request must be discussed by the health care team, and all of the appropriate pain-relief and comfort measures must be employed).

From the existential-interpretative perspective, a good euthanasia care process is one that works well on an existential level. The patient’s life should end in a good way. Nurses reported that it is important for all parties involved to make their peace with what is happening.

The Range of Involvement (in Time and Space)

How far does the involvement go? Where and when does it stop? From the procedural, action-focused perspective, the nurses reported that it was important for them to consciously and explicitly create closure in time and space (for example, by going home, by phoning the family one month after the death, or by organizing the annual memorial service at the hospital).

From an existential-interpretative perspective, the nurses explained that their involvement does not stop at a particular moment in time (for example, they continue to be available to the patient’s family, as mourning care is not limited in time or space). Closure for these nurses is a very personal process; it happens in its own time and may involve continuous contact with the patient’s family.

“‘Stopping’ is a big term. An important part of coming to terms with it was the funeral: attending the funeral, talking to people...seeing his wife, who had not expected to see me there, [ahum,] the warm-heartedness that you receive from those people at that moment...I actually have spoken to this woman several times afterwards...I had to convince her, though, to call me when times became hard. And that is also very important for people — to have someone they can fall back on. And it is also important for me, for coming to terms with it, and for knowing ‘Did I do this right?’”

The Development of Involvement

Does the nature of the nurses’ involvement in the euthanasia care process evolve? Indeed, all of the nurses reported that their involvement in caring for patients requesting euthanasia develops over time.

“I have to say that you grow into your role. So your first euthanasia is very different, with regard to your view, your way of dealing with people, with bystanders, than your last euthanasia. From every euthanasia you learn something.”

The way in which their involvement developed depended on which perspective was predominant. From the procedural, action-focused perspective, this development is a learning process. One evolves as an organizer, gradually improving the practical organization of the euthanasia care process. From the existential-interpretative perspective, this development is a personal growth process. Nurses reported that being involved in caring for patients requesting euthanasia has had an impact on their own identities, on who they are and how they view life.

DISCUSSION

This study shows that viewing the euthanasia care process from both the procedural, action-focused perspective and the existential-interpretative perspective reveals important aspects of that process as experienced by nurses. How should we understand the relationship between the perspectives?

First of all, it is essential to avoid polarizing the perspectives to the point that each excludes the other; and it is important to avoid making moral judgments — identifying one perspective as more worthy than the other. Analogous to the model of skilled companionship that defines nursing care as a harmonious integration of skills (medical-technical competence) and companionship (caring attitude) (32, 33), the relationship between the two perspectives should be a model of well-balanced integration. According to this model, the procedural, action-focused perspective functions as the substructure, the framework within which the existential-interpretative perspective can come into existence. In order for nurses to enter into an existential-interpretative relationship with patients and their families, all of the practical, technical, and organizational aspects of nursing must be addressed. This is also in keeping with the ethics of care approach, in which, according to some authors, care is considered an ethical practice that blends expert activity with a caring attitude (34, 35). Within this approach, a distinction is made between care as an activity (“caring for,” or “taking care of”) and care as an attitude (“caring about”) (36-38). Care is an activity engaged in by one person that meets the needs of another person (39); this is strongly related to the procedural, action-focused perspective. Care is also an attitude related to the mentality, feelings, and awareness of the caregiver (40, 41); as such, it resembles the...
existential-interpretative perspective. According to the care ethicists, both aspects of care — activity and attitude — are strongly linked within the concept of care as a practice (34). This supports the argument for a well-balanced integration of the two perspectives.

However, this study also shows that in reality there is no perfect balance. Although both perspectives were always present in the nurses’ accounts of their experiences, we found that one or the other was predominant. Why is this so? There are various determining factors. In the case of the procedural, action-focused perspective, one explanation may be related to the Belgian Act on Euthanasia (2002). When we conducted our research, in 2005-06, the act had been in effect for a relatively short time. Consequently, its implementation in clinical practice was still in the embryonic stage. For this reason, it may have been logical for nurses to favour the procedural, action-focused perspective; they would tend to adhere to the new law, which is itself procedural and action focused. Making sure that all legal requirements are fulfilled is a logical first step in the implementation process.

A second explanation may be found in the connection between the predominant perspective and the nurse’s position. The procedural, action-focused perspective was dominant among all the senior nurses we interviewed, and this likely reflects the fact that as team coordinators, they have a professional responsibility to ensure that their team functions well and provides well-organized care. As such, they are not involved — or are much less involved — in direct patient care, which is mostly provided by bedside nurses. The close contact between bedside nurses and patients and their relatives might explain the fact that the existential-interpretative perspective determined the involvement of all the bedside nurses we interviewed.

A third explanation is related to the individual characteristics of the nurses — their age, personal strengths, professional self-image, work experience, and personal experience. After all, the existential-interpretative perspective presupposes a capacity to enter into a personal relationship with patients and their relatives and to be comfortable with it. The nurses reported that dealing with requests for euthanasia creates an emotional burden. This is consistent with the findings of Georges and colleagues (42), who investigated the experience of general practitioners who deal with euthanasia requests. Health care providers find dealing with such requests very demanding. In light of this, it might be a sensible coping strategy for the nurses to let the procedural, action-focused perspective dominate their practice, because, as a substructure and framework, it can support them in formulating an organized approach to an existentially difficult matter. This perspective can strengthen their capacity to deal with patients’ requests for euthanasia and give them something to hold on to. This is consistent with the findings of an international study exploring nurses’ responses to ethical dilemmas in daily nursing practice (43). The study noted that nurses tend to be conformist (following existing conventions rather than using critical reflection) when faced with ethical dilemmas.

A final explanatory factor might be the work environment. When staff numbers are insufficient, management support is lacking, and the hospital’s stance on euthanasia has not been clearly stated, it might again be a sensible coping strategy to let the procedural, action-focused perspective dominate. This is in line with two studies conducted by the BELIMAGE Group (44, 45), which investigated hospital nurses’ professional self-image and their perceptions of their work environment, concluding that nurses encountered many barriers in the work environment (time limitations, insufficient staff, ineffective teamwork, lack of management support, lack of recognition for what they do) that prevented them from becoming skilled companions. The work environment is therefore an important factor in the effort to achieve a well-balanced integration of the two perspectives.

Despite our reference to the care ethics approach at the beginning of this section, it is important to bear in mind that the two perspectives do not provide a full ethical framework for good euthanasia care in the broad sense. They are best understood as a means of looking at general reports of nurses’ experiences. As such, they do not have a normative quality: good euthanasia care as described by the nurses is more a matter of empirical experience than normative viewpoint. Our examination of the two perspectives does not provide us with an answer to the question “What is good euthanasia care?” in a broad ethical sense; instead, it gives us insight into the ways in which nurses — within a particular working context and with a particular patient — seek to provide good euthanasia care. With regard to the existential-interpretative perspective, we have seen that nurses try to join a patient on his or her path and determine the best course of action by spending time and talking with the patient. With regard to the procedural, action-focused perspective, we have seen that there is a strong focus on the patient’s autonomy. But, of course, merely trying to understand the patient’s situation (the existential-interpretative perspective) or respect the
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The involvement of nurses in the care process for patients requesting euthanasia in general hospitals in Flanders since the Belgian Act on Euthanasia came into force in 2002. Unlike those who conducted research in the period before legalization (19), we found that a great many hospitals and nurses were willing to participate in our efforts. This enabled us to achieve a large heterogeneity in our sample. This willingness of nurses to cooperate in our research also had a positive effect on the quality of the interviews, which were all of long duration and great depth.

Adding to existing quantitative (1, 6, 7, 12, 13, 20, 21, 26) and small-scale qualitative research (24, 27, 28), our large-scale qualitative study provides general insight into what involvement in the euthanasia care process actually means for nurses, given that euthanasia has been legal since 2002 and that nurses have been increasingly involved in euthanasia care. Also adding to existing research, which makes important but fragmented contributions to the study of euthanasia care, our work offers insight into the basic structure of such care by showing that it consists of two perspectives. Together these perspectives create a storyline that we can use in our effort to achieve a general understanding of the essence of nursing care for patients requesting euthanasia. This storyline gives us a framework for critical reflection on nursing practices in euthanasia care.

As for the limitations of the study, we did not manage to attain a great variation in attitude toward euthanasia. We found that all of the nurses had a positive attitude except one, who had conscientious objections and did not believe it to be a good option. Accordingly, we have insufficient data on the involvement of nurses who have conscientious objections to euthanasia. This lack of variation might contribute to bias. On the one hand, it is possible that the nurses who have conscientious objections are not involved in the euthanasia care process; if this is the case, then there is no bias on the level of attitude. On the other hand, it is also possible that the nurses who have conscientious objections are involved in the euthanasia care process but were unwilling to participate in the research; if this is the case, then we do have bias on the level of attitude. Another possible bias is related to the fact that this study was carried out by a research team with a particular view of euthanasia (46, 47) and good nursing care (35). However, despite this possible methodological bias, our results remain valid because built-in guarantees, such as peer debriefings with external experts, ensured the trustworthiness of the data.

STRENGTHS AND LIMITATIONS OF THE STUDY

This is the first qualitative study of the involvement of nurses in the care process for patients requesting euthanasia in general hospitals in Flanders since the Belgian Act on Euthanasia came into force in 2002. Unlike those who conducted research in the period before legalization (19), we found that a great many hospitals and nurses were willing to participate in our efforts. This enabled us to achieve a large heterogeneity in our sample. This willingness of nurses to cooperate in our research also had a positive effect on the quality of the interviews, which were all of long duration and great depth.

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As for the limitations of the study, we did not manage to attain a great variation in attitude toward euthanasia. We found that all of the nurses had a positive attitude except one, who had conscientious objections and did not believe it to be a good option. Accordingly, we have insufficient data on the involvement of nurses who have conscientious objections to euthanasia. This lack of variation might contribute to bias. On the one hand, it is possible that the nurses who have conscientious objections are not involved in the euthanasia care process; if this is the case, then there is no bias on the level of attitude. On the other hand, it is also possible that the nurses who have conscientious objections are involved in the euthanasia care process but were unwilling to participate in the research; if this is the case, then we do have bias on the level of attitude. Another possible bias is related to the fact that this study was carried out by a research team with a particular view of euthanasia (46, 47) and good nursing care (35). However, despite this possible methodological bias, our results remain valid because built-in guarantees, such as peer debriefings with external experts, ensured the trustworthiness of the data.

CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

This study shows that the involvement of nurses in the euthanasia care process is influenced by the predominant perspective they take on it — that is, the procedural, action-focused perspective or the existential-interpretative perspective. We believe that, analogous to the model of skilled companionship (32, 33), the model of the complementary perspectives is an important contributor to the euthanasia care process and provides insight into the essence of nursing care for patients requesting euthanasia. Our study thus offers a baseline for further research (quantitative and qualitative) on euthanasia care.

For instance, it is of primary importance that nurses are sufficiently supported in reaching a well-balanced integration of both perspectives, as this will enable them to be skilled companions. It would be interesting to gather more information on the factors that determine the predominance of one perspective over the other. Our study offers the basis for developing a list by means of which the various aspects of nurses’ experiences in euthanasia care can be examined in a large-scale quantitative research setting.

Furthermore, with nurses’ involvement in euthanasia care as its focus, our research says nothing about the role of physicians. It would be interesting to examine whether the two perspectives on euthanasia care are also present among physicians. The next step in the process could be to study physicians’ involvement in the euthanasia care process via qualitative methodology.

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