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Palliative Care Experience and Attitudes Towards Euthanasia Among Healthcare Professionals

Abstract: On one hand, the development of medicine allows to prolong the life of patients who previously had no chance for survive, on the other hand, though, it condemns some of them and their loved ones to extreme suffering. Fear of suffering is the main reason for a possible wish for euthanasia. The research aimed at measuring the attitude towards euthanasia among doctors and nurses who come in professional contact with terminally ill patients or patients versus the medical personnel who do not come in such contact. The research included: age, profession and workplace as well as personal experience in providing care to the seriously ill. The Attitudes Towards Euthanasia Questionnaire by Głębocka and Gawor was used during the research. The method consists of three scales: Informational Support, Liberal Approach and Conservative Approach. Medical staff taking care of terminally ill patients were less conservative in their opinions than the participants from the comparative group. The intergroup differences in terms of Liberal Approach towards Euthanasia Scale were not obtained. It turned out that the age fostered the conservative approach, and working at the intensive care units or taking care of an ill relative fostered the reduction of such approach. All the respondents approve the idea of providing the patients and their families with informational support. Working in intensive care units or taking care of terminally ill relatives seems to reduce conservative attitudes towards euthanasia because persons with such experience have personally faced the multifaceted emotional and physical costs of suffering.

Keywords: euthanasia, attitudes, doctors and nurses, terminally ill

Introduction

In addition to improvement of living conditions, the rapid development of medical science has contributed to an increase in life expectancy, which has almost doubled over the last hundred years. The achievements of contemporary medicine enable recovery of people who until a few decades ago had no chance of survival, but simultaneously offer the possibility to sustain life of patients in a vegetative state for many years. Cases of Diane Pretty, Terry Schiavo or other patients fuelled a broad debate about euthanasia (cf. Głębocka, Gawor, & Ostrowski, 2013). Although the polemics has continued for some time and certain studies have indicated an increase in public support for active euthanasia, there is still much

controversy about this issue (Cohen, Van Landeghem, Carpentier, & Deliens, 2013; Danyliv & O'Neill, 2015). It requires twofold solutions: individual (people's right to decide to end their life) and institutional (legalisation of euthanasia). In Poland, there has been an intense debate about the issue, which has involved lawyers, doctors, representatives of the church and terminally ill persons. No clear consensus has been reached, however, under current legal regime in Poland, even at the informed request of a terminally ill and suffering patient a physician is forbidden to assist in their death by administering a lethal dose of drugs.

In the absence of clear regulations, some chronic terminally ill patients, living in unendurable pain, which is unimaginable for common people, don't have a chance

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to take informed decision about their future. Medicine can't improve their quality of life, so they have to face an escalation of suffering. The Public Opinion Research Centre (CBOS) conducted a study asking people to differentiate between withdrawing futile therapy/treatment (a term which in Poland appears only in the Code of Medical Ethics) and euthanasia. The study involved a representative random sample of 952 adult residents of Poland. They were asked about their associations with the terms 'withdrawing futile therapy/treatment' and 'euthanasia'. The respondents could freely formulate their answers rather than selecting them from a pre-defined list. Describing 'withdrawing futile therapy' proved the most problematic for people, as 36% had no associations with the term. Some of the respondents offered general associations with medicine, healthcare and medical treatment. Withdrawing futile therapy was typically associated with severe, chronic and incurable diseases. Some people, probably owing to the term 'therapy', believed it applied to treatment of addictions/mental diseases or psychotherapy. On the other hand, the term 'euthanasia' was associated exclusively with death (CBOS, 2013). It demonstrates that the Polish society lacks elementary knowledge about these concepts.

In each case, euthanasia is a medical procedure raising serious moral dilemmas. Most likely this is why so many studies on euthanasia and its potential legalisation have been conducted among medical students and doctors, who are brought into close contact with pain and suffering of terminally ill patients on a daily basis (cf. Cuttini et al., 2004; Beder, Pinar et al., 2010).

Opponents of euthanasia contend that this procedure is in disagreement with the physicians' fundamental duty to protect life and health. Until recently, the primary goal of medicine and medical progress was to save human life and delay death as long as possible. However, the opposite tendency can be observed lately, at least in some countries: to enable premature termination of life through an act of euthanasia (Kelleher, Chambers, Corcoran, Keeley, & Williamson, 1998; Kowalik, Ratajska, & Szmaus, 2002).

However, both the medical community and the general public are split on the issues of saving lives at all costs and euthanasia. Studies among physicians have demonstrated that the opinion on the matter depends on age, beliefs (mainly religious) and country (Broeckaert, Gielen, van Iersel, & Van den Branden, 2009; Roelands, Van den Block, Geurts, Deliens, & Cohen, 2015). Young Australian doctors proved to be more 'open' to euthanasia than their older counterparts (Kuhse & Singer, 1988; after: Kelleher et al., 1998), while in Holland young physicians were more eager to discuss euthanasia with their patients (Pijnenborg et al., 1994; after: Kelleher et al., 1998). Furthermore, a study conducted in 1977 by Carolyn Winget, Frederic Kapp and Rosalee Yeaworth demonstrated different attitudes towards euthanasia among students of medicine/nursing and practicing healthcare professionals. Students of medical science displayed an ambivalent and ambiguous attitude towards euthanasia, while working physicians and nurses were more committed to it and their attitude

was much clearer. Moreover, students in early years were more inclined to share an idealised vision of a healthcare professional as a person trying to keep their patients alive by all means and at all costs, while graduate students and physicians were more open to euthanasia (Winget et al., 1997). Another study, which was conducted among National Health Service (NHS) doctors in the United Kingdom, revealed that physicians with firm religious beliefs were less supportive of changes in the law banning euthanasia (Ward & Tate, 1994; after: Kelleher et al., 1998). Even though most studies confirm a negative association between religious beliefs and approval of euthanasia, there are some which indicate a moderate, though statistically significant, positive association between religiosity and acceptance of euthanasia (Hains & Hulbert-Williams, 2013).

In general, attitudes towards euthanasia among medical staff are more positive in countries where voluntary euthanasia is legal, such as Holland and Belgium. A study conducted among Belgian physicians revealed that, despite a broad spectrum of attitudes (advocates of voluntary euthanasia in special circumstances; moderate supporters; and people holding very liberal views), each of the three groups in fact supported assisted suicide (Broeckaert, Gielen, van Iersel, & Van den Branden, 2010). And a German study demonstrated that the degree of acceptance of euthanasia by physicians depended on the type of illness and was higher in case of the terminally ill than incurable patients whose life was not threatened.

All the aforementioned factors determining attitudes towards euthanasia are of sociocultural nature. Only few studies address psychological dimensions, such as locus of control or extraversion, correlating with negative attitudes towards euthanasia (Hains & Hulbert-Williams, 2013; Aghababaei, Wasserman, & Hatami, 2014). Certainly, social and cultural characteristics explicate, to a certain degree, the process of developing attitudes towards euthanasia, but they fail to describe it in its totality. The very use of a category of 'attitudes' supports introduction of some psychological factors into the model (cf. Rosenfeld, 2000).

In order to present a more complete theoretical basis for the study it seems reasonable to refer to the issue of fear of death. According to one of the most popular theories of fear of death, the Terror Management Theory (TMT) proposed by Solomon, Greenberg and Pyszczynski (1997), conservative attitudes tend to be fostered by death-related anxiety. People are looking for clear, simple and unambiguous solutions to satisfy their need to belong to a group, and thus reduce their anxiety. Therefore, it could be assumed that on an individual level, the higher death-related anxiety, the stronger conservative attitudes towards euthanasia will be. However, according to a study conducted in 2014 among various professions, the lowest levels of fear of death was found among priests, even though they totally oppose euthanasia. Naturally, this may result from their religious beliefs; or it may reflect their personal experience of regular exposure to death (for example, during funeral ceremonies). The highest death-related anxiety was observed in psychologists as well as non-medical professionals having no direct contact

with dying people (Zana et al., 2014). This would imply that the intensity of fear of death tends to be lower as individuals have more personal experience of death, and tends to be higher as they are exposed to dying and death less frequently. It is also plausible that personal experience of care of terminally ill patients results in fear of dying, which in the caregivers' perspective becomes stronger than fear of death, which in turn mitigates their conservative attitudes towards euthanasia. Fear of dying means exactly the fear of suffering: pain, medical procedure, disability, loneliness and dependence of others. This kind of fear connects also with one's image of suffering that dying involves (Jastrzębski, 2001). Fear of dying can be reflected from hopelessness which medical staff can experience observing suffering patients.

To better understand the mechanism of reduction in conservative attitudes towards euthanasia, it is worth referring to the conceptualisation of fear of death, which investigators often equate to fear of dying. However, based on an approach proposed by Collett and Lester, Joachim Wittkowski (2001) distinguishes fear of death from fear of dying. He observes that individuals can refer either form of fear to themselves (fear of own death) or other persons (fear of death of relatives). He further indicates that in order to understand various orientations towards dying and death it is important to consider not only one's fear, but also acceptance of both phenomena. A study conducted by Wittkowski in a group of 944 people demonstrated that fear of one's own death, fear of one's own dying, fear of another person's death and fear of another person's dying were only moderately correlated with one another. According to Wittkowski, all the specified dimensions are relatively independent of one another as well as stable, that is not susceptible to changes over time or due to situational stimuli. However, numerous experimental studies conducted within the TMT paradigm explicitly show that direct activation of dying- or death-related content enhances fear and triggers anxiety-reducing mechanisms (cf. Łukaszewski, 2010). Thus, it may be assumed that the frequent confrontation of an individual with death increases the level of anxiety, but simultaneously provides an opportunity to develop effective mechanisms to mitigate it. Personal exposure to the phenomenon might reduce uncertainty towards dying and death. A number of studies have demonstrated that a state of uncertainty promotes extreme views, cognitive closure and focus on clearly defined and indisputable ideas, which are contained in the conservative worldview. Kees van den Bos (2009) argues that the anxiety-reducing mechanisms described within TMT may be in fact related to coping with personal uncertainty.

Our study aimed to identify the attitudes towards euthanasia among physicians and nurses, encountering terminally ill patients or unconscious patients, sometimes in a vegetative state, versus those healthcare professionals who are not in contact with dying patients. We focused on the following factors: age, profession, workplace, and personal experience of caring for seriously ill people as predictors of attitudes toward euthanasia.

Methods

In the study, we used The Attitudes Towards Euthanasia Questionnaire by Alicja Głębocka and Agnieszka Gawor (cf. Głębocka, Gawor, & Ostrowski, 2013). It consists of 28 items over three scales: (i) Informational Support Scale (12 items), (ii) Liberal Attitude Scale (9 items), and (iii) Conservative Attitude Scale (7 items). The questionnaire reliability is acceptable (Cronbach's Alpha = .83).

Sample items of the questionnaire are as follows (respectively):

Scale I: 1. *Relatives of a patient should be provided with psychological support at each stage of treatment.*

2. *Relatives should have an opportunity to say goodbye to a dying patient;*

Scale II: 1. *Everyone has the right to decide whether they want to continue living or not.* 2. *When medicine is powerless and there is no hope of recovery, patient's death should be facilitated;*

Scale III: 1. *No one has the right to decide whether they want to continue living or not.* 2. *Patient's life should be supported at all costs and regardless of suffering involved.*

Participants were to indicate to what extent they agreed with the given statement on a five-point scale from 1 – "Definitely no" to 5 – "Definitely yes".

In addition, the respondents were asked to provide information about their age, gender, profession, workplace and personal experience of caring for terminally ill relatives.

Procedure

The study was anonymous. Respondents were reached by the authors in person. The participants filled out individually a paper form of the questionnaire. The data was collected in the hospitals of the south-west part of Poland.

STATISTICA 14 software was used for data analyses. There were three types of statistical analyses included to this study: between groups comparison, regression analysis and correlation.

The research project received a positive recommendation by the Research Project Committee of the Andrzej Frycz Modrzewski Cracow University Faculty of Psychology and Humanities.

Participants

In the study, there were 125 participants, including 57 physicians and 68 nurses. Half of them, 29 physicians and 34 nurses, worked in intensive care or oncology units, that is healthcare centres providing treatment to terminally ill patients or patients in a vegetative state. The remaining ones worked in healthcare facilities without daily exposure to terminally ill patients. This group included general practitioners, dermatologists, dentists and nurses working in outpatient clinics. The average age was 39.86 ± 8.77 years. Only outpatient clinic physicians differed in age from other participants in a statistically significant manner

($M = 47.53 \pm 8.2$; $p < .001$). The average age of hospital-based physicians and nurses was 37.43 ± 7.1 years and 38.12 ± 6.9 years, respectively, while the average age of nurses working in outpatient clinics was 38.55 ± 6.7 years.

There were 25 male and 32 female physicians, while the nurse group included almost exclusively women (66 persons). The latter reflects the employment profile of this occupation, which is still considered a typically female job and rarely chosen by men in Poland. 64% of the respondents lived in towns and the remaining ones lived in villages. 68% were in formal or informal relationships, 27% were single and 5% of the respondents did not answer this question.

The question: *Are you currently taking care of a seriously ill or disabled relative who needs support in their daily activities* was answered affirmatively by 14.40% of respondents, whereas 36% provided such care in the past. Overall, 41.6% of physicians and nurses had personal experience of taking care of relatives who were not able to satisfy their basic life needs themselves. The average duration of such care was 161 weeks, that is more than 3 years. These variables were used in the multiple regression analysis.

We assumed that: (1) Healthcare professionals taking care of terminally ill patients would have more liberal and less conservative attitudes towards euthanasia compared to those with no such experience. (2) Exposure to suffering, terminally ill patients reduces conservative attitudes towards euthanasia: workplace and personal experience of caring for seriously ill patients will be predictive of stronger attitudes permitting and weakest attitudes forbidding euthanasia. (3) The conservative attitudes toward euthanasia will positively correlate to age.

Results

The one-factor (physicians vs. nurses vs. workplace) multivariate (three scales of The Attitudes Towards Euthanasia Questionnaire: (i) Informational Support Scale, (ii) Liberal Attitude Scale, and (iii) Conservative Attitude Scale) analysis of variance (MANOVA) was conducted to verify the first hypothesis.

The results confirmed statistically significant differences between study groups (Wilks' lambda = .807, $F(9, 253) = 2.584$, $p < .05$). A post hoc analysis revealed no statistically significant differences with respect to the Informational Support Scale. All groups agreed on the positive significance of support for patients and their families through talking and providing information and guidance on how to cope with a traumatic situation caused by a terminal condition ($M = 4.52 \pm .37$). There were also no statistically significant differences between groups over the Liberal Attitude to Euthanasia Scale ($M = 3.44 \pm .73$). However, statistically significant differences occurred for the Conservative Attitude to Euthanasia Scale ($M = 2.51 \pm .54$). It was found that both physicians and nurses taking care of terminally ill patients had less conservative views than outpatient clinic doctors. The detailed results are shown in Table 1 below.

Table 1. The average results for the Attitudes Towards Euthanasia Questionnaire conducted on the group of doctors and nurses, including their workplace

Profession	Information Support Scale	Liberal Attitude towards Euthanasia Scale	Conservative Attitude towards Euthanasia Scale
Doctors from ICU	4.45	3.54	2.18*
Nurses from ICU	4.56	3.46	2.34 **
Doctors from health care centre	4.54	3.38	2.78* **
Nurses from the health care centre	4.51	3.48	2.57

Notes. * means $p < .001$; ** means $p < .05$.

The study results may indicate that exposure to suffering, terminally ill patients reduces conservative attitudes towards euthanasia. In order to further verify this hypothesis, we conducted a multiple regression analysis for independent variables: age, gender, profession, workplace and personal experience of caring for seriously ill relatives. It was found that none of the independent variables considered in the study was a predictor of two of the dependent variables: informational support and a liberal attitude to euthanasia. However, three variables: age ($\beta = .34$, $p < .001$), workplace ($\beta = .30$, $p < .001$) and personal experience of caring for seriously ill and disabled relatives ($\beta = .22$, $p < .05$) predicted a conservative attitude to euthanasia. It turns out that age fosters conservative attitudes, whereas working in intensive care units or taking care of an ill relative or friend contributes to reduction in such attitudes. The model explains 22% of variance ($R = .4795$, $R^2 = .2299$, $F(4, 103) = 7.6905$, $p < .001$).

Some interesting information about the relations between attitudes towards euthanasia and age were provided by the correlation analysis (see Table 2 below). It emerges that age of healthcare professionals is unrelated to scores on the Informational Support Scale, which was considered by all participants to be a highly important element of building proper doctor-patient relationships. Support for liberal attitudes diminished with age, while support for conservative attitudes increased, yet both trends were moderate.

Table 2. The indicators of correlation between the Attitude Towards Euthanasia Questionnaire and the age of respondents

	Information Support Scale	Liberal Attitude towards Euthanasia Scale	Conservative Attitude towards Euthanasia Scale
Age	.05	-.21*	.34*

Note. For all indicators $p < .05$.

It seems that the differences in attitudes forbidding euthanasia among study participants are very well reflected in scores for item 28 of the Questionnaire: *You should keep all patients alive at all costs, without giving any consideration to the financial or social burden involved*. Physicians working in intensive care and oncology units only slightly agree with this statement ($M = 1.4 \pm .2$). Nurses taking care of terminally ill patients have a similar opinion on the issue ($M = 2.16 \pm .41, p > .05$). Both groups differ in a statistically significant manner from outpatient clinic physicians ($M = 3.00 \pm .58, p < .001$) and nurses ($M = 2.76 \pm .52, p < .001$).

Discussion

We assumed that medical professionals working with terminally ill patients would present more liberal and less conservative attitudes towards euthanasia compared to those from the comparative group. The results confirmed the first hypothesis partially. Lower levels of conservative attitudes towards euthanasia were observed among physicians and nurses having personal experience of intensive and oncology care compared to those with no such experience. This means that medical staff who have contact with terminally ill patients are less categorical in their beliefs about inadmissibility of euthanasia.

The second and third hypotheses were also confirmed partially. Age, workplace, and personal experience of caring for seriously ill and disabled relatives predicted a conservative attitude to euthanasia, but not liberal beliefs. Age fosters conservative attitudes, whereas working in intensive care units or taking care of an ill patients contributes to reduction in such attitudes.

Support for liberal attitudes diminished with age, while support for conservative attitudes increased. These results confirmed the results from previous studies country (Broeckeaert, Gielen, van Iersel, & Van den Branden, 2009; Roelands, Van den Block, Geurts, Deliëns, & Cohen, 2015).

The notion that fear of death fosters conservative attitudes towards euthanasia, whereas fear of dying may weaken them (with reference to the Terror Management Theory assumptions and the relation between fear of death and fear of dying (Solomon, Greenberg, & Pyszczynski, 1997; Wittkowski, 2001) can explain the results of the study. Medical staff working on the intensive care and oncology wards have frequent contact with dying patients and death. Death can be perceived by them as liberation from a psychological strain caused by the process of dying, and fear of death can be assessed as inferior to fear of dying. The quality of life of terminally ill patients is diminished by pain, disability, dependence on others and reduced ability to decide for themselves. Fear of these factors is the main reason for a possible wish for euthanasia in the future, when the quality of life is reduced so drastically that further existence becomes unbearable (Johansen, Hølen, & Kaasa, 2005). It does not mean that each terminally ill patient is ready for euthanasia. It turns out that even a declared positive attitude of patients towards euthanasia does not lead to wanting it for themselves in

case of a terminal illness. The discrepancy between positive attitudes towards euthanasia and requests for euthanasia for oneself were pointed out by Johansen, Hølen, Kaasa, Loge and Materstvedt (2005). The authors investigated terminally ill patients and demonstrated that wishes for euthanasia were hypothetical, future oriented, dependent on lack of quality of life and, above all, fluctuating and ambivalent. It's also possible that less categorical resistance to euthanasia is a result of personal feelings of hopelessness experienced by physicians and nurses taking care of terminally ill patients and observing their suffering. This is a very interesting hypothesis, which should be examined in further studies. In particular, this is the case when considering the phenomenon of empathy reduction among medics who can be incapable of understanding and feeling the affective state of their patients. Empathy of pain and suffering usually involves two steps: emotional sharing and cognitive reappraisal. (Decety, 2011; Han, Fan, & Mao, 2008). Some research revealed that physicians didn't experience even the first stage of empathy (Capozza, Falvo, Boin, & Colledani, 2016). The relationship between fear of death, fear of dying and attitudes toward euthanasia can be related to personal experience of death and dying. These experiences can be more spiritual (uniquely human) and more biological (non-uniquely human, sharing with animals). As was mentioned above the lowest levels of fear of death was found among priests, even though they totally oppose euthanasia. They experience regular exposure to death – for example, during funeral ceremonies and dying – visiting and praying for sick people. Priests have mostly spiritual experiences, but medical staff are more likely to focus on biological aspects of illness (see: Haque, Waytz, 2012). It is possible that personal exposure to dying and death might reduce uncertainty towards them. The anxiety-reducing mechanisms may be in fact related to coping with personal uncertainty (van den Bos, 2009). The highest death-related anxiety was observed in psychologists as well as non-medical professionals having no direct contact with dying people (Zana et al., 2014). It's important to consider that according to the classification worked out by Wittkowski (2001) people can experience four different kinds of fear: fear of one's own death, fear of one's own dying, fear of another person's death and fear of another person's dying. Direct activation of dying- or death-related content (frequent contact with dying people) enhances fear and triggers anxiety-reducing mechanisms (cf. Łukaszewski, 2010). The frequent confrontation of an individual with death and dying increases the level of anxiety, but simultaneously provides an opportunity to develop effective mechanisms to mitigate it. One of these mechanisms can be patients' dehumanisation, including: empathy reduction, moral disengagement and mechanization. Medical caregivers try to cope with negative emotional states using dehumanization as one of the effective methods (Haque, Waytz, 2012). If the tendency to dehumanize really influences the attitudes to euthanasia should be explored in further studies.

As indicated by social psychology studies, the most effective way to alter attitudes towards a certain group

is direct contact and interaction with its members, which is the premise of the contact hypothesis (Allport, 1954). In particular, a friendly and informal atmosphere contributes to reducing prevailing attitudes, and thus prejudice and stereotypes (Aronson, 2011). It is possible that healthcare professionals taking care of terminally ill patients have such interpersonal contact, which appears to reduce their conservative attitudes. This contact may stimulate decategorisation, as the observer is provided with individualised information about another person, which minimises the salience of group categorisations (Brewer, 2000).

Furthermore, it is likely that healthcare professionals may attempt a rational assessment of the situation, balancing all the benefits and costs of potential treatment, as they encounter the physical suffering of patients and the emotional and social costs borne by their relatives on a daily basis.

To sum up, arguably, working in intensive care units or taking care of terminally ill relatives seems to reduce conservative attitudes towards euthanasia because persons with such experience have personally faced the multifaceted costs of such care.

The study demonstrated that, regardless of their position (physicians vs. nurses) or workplace (hospitals vs. outpatient clinics), all respondents were more supportive of liberal than conservative attitudes towards euthanasia. All study groups also agreed on the positive significance of support for patients and their families through talking and providing information and guidance on how to cope with a traumatic situation caused by a terminal condition. Interestingly, in Polish hospitals this idea seems to be followed only to a slight extent. Healthcare centres often do not employ psychologists, and physicians themselves are typically not trained in communicating difficult information to patients and their relatives. As a result, all too often they try to avoid directly confronting patients or their families, or they make serious mistakes when providing information about a patient's medical condition and prognosis. They try not to raise difficult issues for fear of failure to cope with the emotions of the patients and their relatives (Gawor, Gerber-Leszczyszyn, Nawrat, & Nowak, 2006). There is also a phenomenon of dehumanization, that is treating patients as non-human individuals. In practice, it manifests itself in, for example, refusing patients the right to decide. Healthcare professionals talk about patients in their presence yet without their participation, speaking about "them", that is in the third person. This phenomenon is common in hospitals in Poland. Consequently, patients are not considered partners (cf. Glebocka, 2017).

However, whether the declared attitudes correspond to the actual opinions of participants and to what extent they are dictated by conformism and fear of criticism or exclusion due to presenting socially unacceptable views is another matter. In numerous opinion polls Poles support openness and tolerance, but it does not directly translate into their behaviours. Nevertheless, openness and tolerance at a declarative level are certainly a good sign for changes on a behavioural level, as well.

The study was subject to certain limitations due to ethical constraints and difficulties in reaching the target group. The presented results cannot be held representative for the whole population of healthcare professionals in Poland. They are not conclusive as to the mechanisms of reducing or fostering certain attitudes towards euthanasia. At this point, it is impossible to determine whether the indicated mechanisms occur simultaneously or alternately, and whether any of them is dominant. Therefore, further exploration of the matter seems necessary and completely justified.

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