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**EXPLORING THE BELIEFS UNDERLYING ATTITUDES
TO ACTIVE VOLUNTARY EUTHANASIA IN A SAMPLE
OF AUSTRALIAN MEDICAL PRACTITIONERS
AND NURSES: A QUALITATIVE ANALYSIS**

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ABSTRACT

A qualitative study explored beliefs about active voluntary euthanasia (AVE) in a sample ($N = 18$) of medical practitioners and nurses from Australia, where AVE is not currently legal. Four behaviors relating to AVE emerged during the interviews: requesting euthanasia for oneself, legalizing AVE, administering AVE to patients if it were legalized, and discussing AVE with patients if they request it. Using thematic analysis, interviews were analyzed for beliefs related to advantages and disadvantages of performing these AVE behaviors. Medical practitioners and nurses identified a number of similar benefits for performing the AVE-related behaviors, both for themselves personally and as health professionals. Benefits also included a consideration of the positive impact for patients, their families, and the health care system. Disadvantages across behaviors focused on the potential conflict between those parties involved in the decision making process, as well as conflict between one's own personal and professional values.

INTRODUCTION

Active voluntary euthanasia (AVE), defined in this context as the act of taking life to relieve suffering at the request of the patient, achieved by active steps (usually the administration of a drug) (Martin, 2003; Sanson et al., 1998), is not currently legal in Australia. Nevertheless, the issue has contemporary social relevance, with the passing of the Northern Territory of Australia's *1995 Rights of the Terminally Ill Act*, which was subsequently overturned in 1997. It is reasonable to suggest that end-of-life legislation may again become an issue for the Australian public in the future (Kitchener, 1998; Sikora & Lewins, 2007). The introduction of any such legislation would impact on Australian health professionals who would become the first point of contact for any such requests and would act as the appropriate agents to perform AVE (Dickinson, Clark, Winslow, & Marples, 2005). In addition, previous literature has revealed that Australian doctors and nurses do receive requests from patients and their families to end the patient's life (Stevens & Hassan, 1994) and that AVE does occur in Australia regardless of its illegality (Douglas, Kerridge, Rainbird, McPhee, Hancock, & Spigelman, 2001; Kuhse & Singer, 1988; Kuhse, Singer, Baume, Clark, & Rickard, 1997). It is, therefore, important to understand attitudes toward AVE-related behaviors among health professionals in Australia.

BACKGROUND TO THE STUDY

Attitudes toward euthanasia among health professionals are elicited commonly using either quantitative or qualitative methods to assess levels of support for euthanasia practices. Quantitatively, two main approaches have been employed to examine these attitudes. First, the predominant approach is to examine demographic and individual difference variables, such as age, gender, and religious affiliation, as predictors of attitudes to euthanasia (e.g., Kitchener, 1998; Miccinesi et al., 2005; Richardson, 1994; Shuman, Fournet, Zelhart, & Roland, 1992; Sprung et al., 2007). Second, researchers have assessed attitudes to euthanasia as a response to medical scenarios varying factors related to the presence of terminal illness and level of pain experienced (e.g., Emanuel, Fairclough, Daniels, & Clarridge, 1996; Kitchener & Jorm, 1999; Matzo & Schwarz, 2001; Mitchell & Owens, 2004; Rynnänen, Myllykangas, Viren, & Heino, 2002; Teisseyre, Mullet, & Sorum, 2005).

These quantitative approaches typically examine general attitudes toward euthanasia and specific scenario-related attitudes rather than examining the actual beliefs that underlie and inform these overall attitudes. For instance, these approaches have focused on health professionals' favorability toward AVE and other forms of euthanasia (e.g., Emanuel et al., 1996; Rynnänen et al., 2002), the perceived acceptability of performing or legalizing euthanasia (Kitchener & Jorm, 1999; Teisseyre et al., 2005), and willingness to perform or be involved

in AVE (e.g., Dickinson, Lancaster, Clark, Ahmedzai, & Noble, 2002; Onwuteaka-Philipsen et al., 2006; Verpoort, Gastmans, De Bal, & Dierckx de Casterlé, 2004). In addition, in the case of physicians, studies have included self-reported performance of AVE (e.g., Dickinson et al., 2005; Douglas et al., 2001; Kuhse et al., 1997).

Overall, these studies have demonstrated low favorability toward AVE among nurses and medical practitioners (e.g., Ryyänen et al., 2002). Those health professionals favoring AVE tend to have only qualified support for performance of AVE, which is dependent upon factors such as the patient having a terminal, incurable illness (e.g., Dickinson et al., 2002; Hassan, 1996), the suffering as unbearable, intractable pain that cannot be alleviated by palliative care practices (e.g., Mitchell & Owens, 2004; Stevens & Hassan, 1994) and the patient requesting AVE (e.g., Teisseyre et al., 2005). Further, although some medical practitioners and nurses are in favor of AVE (e.g., Dickinson et al., 2005; Kitchener & Jorm, 1999) and would support the legalization of AVE, many health professionals do not wish to perform AVE themselves (e.g., Dickinson et al., 2005; Sanson et al., 1998; Verpoort et al., 2004).

There are a number of studies that have approached the investigation of medical practitioners' and nurses' attitudes toward euthanasia qualitatively. These studies have highlighted the ethical and moral complexities of end-of-life care, primarily from either an ethical decision making perspective (e.g., Kuuppelomäki, 2000; Matzo & Schwarz, 2001; Oberle & Hughes, 2001) or the perspective of caring as a moral ideal (e.g., Asch, Shea, Jedrzejewski, & Bosk, 1997; McInerney & Siebold, 1995). Themes that have emerged in these qualitative analyses include the potential for the abuse of euthanasia (Kuuppelomäki, 2000; Matzo & Schwarz, 2001; McInerney & Siebold, 1995), pain, suffering, and quality of life as ethical justifications for euthanasia (Asch et al., 1997; Kelly, Burnett, Badgers, Pelusi, Varghese, & Robertson, 2003; Kuuppelomäki, 2000), personal values and value conflicts in relation to euthanasia (Asch et al., 1997; Kuuppelomäki, 2000; McInerney & Siebold, 1995; Oberle & Hughes, 2001), and death with dignity and autonomy (Kuuppelomäki, 2000; McInerney & Siebold, 1995).

There are few qualitative comparisons of medical practitioners' and nurses' attitudes toward AVE (Verpoort et al., 2004). One study comparing the attitudes of medical practitioners and nurses found that medical practitioners have expressed less support of euthanasia practices than nurses (Kuuppelomäki, 2000). Oberle and Hughes' (2001) study, however, suggested that nurses and medical practitioners have similar views about the issue and any differences are a result of the different decision-making roles nurses and medical practitioners fulfill. In addition, existing studies that do compare nurses' and medical practitioners' attitudes toward euthanasia have examined global attitudes rather than attitudes related to specific AVE behaviors, such as administering AVE or discussing AVE with a patient who requests it.

The advantage of a qualitative approach within this context is that it allows an exploration of the salient beliefs contributing to people's attitudes toward a sensitive and often complex topic that is not often captured in quantitative surveys. Within this area, attitudes have been conceptualized in a multitude of ways with many studies adopting an atheoretical approach or focusing on the ethical and moral components of people's attitudes rather than drawing on established theoretical models of attitudes and attitude formation. The present study utilized a social psychological approach to understanding attitudes toward specific AVE-related behaviors. As a theoretical model of attitude formation from the social psychological literature, the expectancy-value model of attitude formation (Ajzen & Fishbein, 1980) was employed to investigate the beliefs that underlie attitudes toward AVE.

According to this expectancy-value model, an attitude toward a behavior is the degree to which performance of the behavior is positively or negatively valued. A person's attitude toward a behavior is determined by a set of salient behavioral beliefs, beliefs that are a result of a person's perception that performing the behavior will produce given outcomes (i.e., either advantageous or disadvantageous) and how negatively or positively these outcomes are evaluated (Ajzen, 2006). For discussing AVE if a patient requests it, a person's attitude would be determined by how likely the advantages (e.g., providing an opportunity to discuss current treatment options) and disadvantages (e.g., challenging my values as a health professional) would be to occur as a result of behavioral performance and an evaluation of how positive these outcomes would be. The benefit of examining attitudes from this perspective is that it provides a theoretical framework to understand the beliefs informing people's opinions and, as part of a full theory of planned behavior model including a consideration of norms and control factors (see Ajzen, 1991), can provide a conceptualization of how these beliefs ultimately impact on behavioral decision-making.

THE PRESENT STUDY

The present study was informed by a commonly utilized model of attitude formation within the social psychological literature to identify and compare the salient behavioral beliefs that medical practitioners and nurses hold about a range of AVE-related behaviors. Given the paucity of recent Australian qualitative research examining AVE beliefs of nurses and medical practitioners and the limited use of theoretical frameworks applied to studies examining these beliefs informing attitudes, the present study explored the AVE beliefs of these two groups to identify both commonalities and differences.

METHOD

Participants

The 18 participants were medical practitioners ($n = 9$) and nurses ($n = 9$) drawn from two Regional Health Care Districts in Australia. Medical practitioners (3 males and 6 females) were aged between 30 and 53 years ($M = 36.3$ years). The medical practitioners worked in varying divisions within the health care system and included general Resident Medical Officers ($n = 3$), an Oncologist ($n = 1$), a Palliative Care Specialist ($n = 1$), an Infectious Disease Specialist ($n = 1$), a Nuclear Medicine Specialist ($n = 1$), a Hematologist ($n = 1$), and an Anesthesiologist ($n = 1$). Nurses (1 male and 8 females) were aged between 30 and 54 years ($M = 39.8$ years) and also worked in varying divisions within the health care system including Oncology ($n = 4$), Gynecology/Oncology ($n = 2$), Neonatal/Maternity ($n = 1$), Drug and Alcohol Services ($n = 1$), and Infectious Diseases ($n = 1$). Four of the medical practitioners and three of the nurses reported that they had experience with a family member or close friend who had been, or was currently, terminally ill. In relation to religious beliefs, three medical practitioners and six of the nurses interviewed identified themselves as Christian, with the other interviewees either stating that their beliefs were not associated with a specific religion or that they did not hold any religious beliefs.

A snowball sampling technique was used, with initial participants recruited through the authors' contacts within the health care system. Participants were then asked to recommend participation to their colleagues. All participation in the study, and the recruitment role undertaken by participants, was voluntary.

Materials and Procedure

Prior to interviews, the university ethics committee and relevant health care district ethics committees approved the study. Based on the elicitation procedure recommended by Fishbein and Ajzen (1975) to explore the beliefs underlying attitudes, a semi-structured interview schedule was constructed (see Appendix 1). Initially, the participants were invited to generally discuss the things they had thought about, or discussed, in relation to euthanasia in the past. Part of this conversation involved defining AVE as a form of euthanasia and ensuring that each participant was comfortable with the definition of AVE that was utilized in the present study. From this general discussion about euthanasia, the interviewer identified behaviors that the participant had mentioned that relate to AVE (e.g., patients' requesting euthanasia), then explored the advantages and disadvantages that the participant associated with each self-generated behavior as well as other AVE-related behaviors identified commonly in the literature. To enable some comparability across participant beliefs, all participants discussed the advantages and disadvantages for the four AVE behaviors of:

1. requesting euthanasia for oneself,
2. legalizing AVE,
3. administering AVE to patients if it were legalized; and
4. discussing AVE with patients if they request it.

Interviews were conducted until theoretical saturation was reached and no new beliefs emerged (Mason, 1996) and the exception checking process did not produce additional beliefs (Miles & Huberman, 1994).

RESULTS

Data Analysis

All interviews were transcribed verbatim upon completion of each session and participant responses were identified by the abbreviations for medical practitioner (*MP*) or nurse (*N*). Transcripts were then analyzed and coded using thematic analysis (Braun & Clarke, 2006; Joffe & Yardley, 2004). The coding rules applied were both pre-determined, as a function of the semi-structured questionnaire, and evolving, in response to the interview process (Miles & Huberman, 1994).

Initially, participants generated behaviors that they associated with euthanasia. In addition to these generated behaviors, participants were also asked to consider other AVE behaviors commonly identified in the literature. Subsequently, using the expectancy-value model, the advantages and disadvantages of performing the four AVE-related behaviors (requesting euthanasia for oneself, legalizing AVE, administering AVE to patients if it were legalized, and discussing AVE with patients if they request it) were identified. The advantages and disadvantages for each behavior were further refined to incorporate the themes arising from patterns in the data (Hsieh & Shannon, 2005; Joffe & Yardley, 2004). For example, the broader concept of advantages of requesting AVE was further refined to incorporate specific themes related to these advantages, such as avoiding a painful death and having control over my own decisions. As new themes emerged from interviews, transcripts were recoded to incorporate these themes and this process continued until no new themes emerged. To ensure coding assignments for the belief themes were consistent, three of the authors initially independently coded beliefs with the corresponding themes, and resolved any inconsistencies in belief assignments before proceeding with further analysis of participant responses.

Behaviors Associated with Active Voluntary Euthanasia

Initially, in the general discussion about euthanasia all interviewees identified two behaviors associated with AVE. These behaviors were administering euthanasia to patients and legalizing euthanasia. Most interviewees also identified requesting euthanasia for oneself as another behavior related to AVE. In

addition, about half of the interviewees raised discussing euthanasia with others (including patients) as a relevant behavior. Irrespective of whether each AVE behavior was initially participant-generated, all interviewees were asked the advantages and disadvantages related to all four behaviors.

Advantages and Disadvantages of Requesting Active Voluntary Euthanasia If You Are Terminally Ill

Participants discussed both the advantages and disadvantages of personally requesting AVE under circumstances of terminal illness (see Table 1 for a list of emergent themes). Both doctors and nurses approached the advantages of requesting AVE from two perspectives, advantages for themselves and advantages for their family. Personal advantages that participants raised were control over their life and the relief from pain. Nurses also discussed the additional advantages of choosing when to die, who they would have present, and how they would like to be remembered, represented by the theme of a dignified death. Statements illustrating this theme included:

... and the dignity I suppose because dying can be an undignified process . . . if you become bed ridden and dependent on people to look after you, you might become incontinent, and that's pretty undignified (*N*).

The beliefs relating to positive consequences that participants perceived for their family centered on relieving their family from the psychological effects of witnessing suffering, the physical burden of caring for their loved one, and financial costs resulting from end of life care. For instance,

that the family doesn't have to deal with [that] whole sort of situation . . . they're helpless, they can't help the patient and they know that the patient is in pain, and they can only sit by and watch (*N*).

Statements from medical practitioners during the process of exception seeking reflect some medical practitioners' belief in the ability of available treatment/symptom control regimes to address the patients' discomfort, thereby reducing instances of distress. Examples of these statements include:

I think that people who don't work with terminal illness don't have an understanding about the whole issue and also the issue about what can be done to alleviate suffering, and so sometimes its kind of a knee-jerk reaction that if some one is very ill (*MP*).

... if they are in a lot of pain, say, they are likely to feel like "I can't cope with this, I don't want to cope with this anymore," but if you provide them with adequate analgesia, then they can say "that's not so bad, life's pretty good" (*MP*).

Table 1. Emergent Themes in Participants' Interviews of the Advantages and Disadvantages of Requesting Active Voluntary Euthanasia If You Are Terminally Ill

Consequence	Belief theme
Advantage	Control over my own decisions (<i>MP, N</i>) Relieving my family from watching me suffer (<i>MP, N</i>) Avoiding a painful death (<i>MP, N</i>) Relieving my family from having to physically care for me (<i>MP, N</i>) Removing the burden of the costs for end-of-life care for my family (<i>MP, N</i>) Allowing me to die with dignity (<i>N</i>) Relieving the medical staff from having to watch me suffer (<i>N</i>) Freeing up health resources for others in need (<i>N</i>)
Disadvantage	Family disagreements about my decision (<i>MP, N</i>) Loved ones' grief or guilt (<i>MP, N</i>) Decision making while feeling bad/vulnerable (<i>MP, N</i>) Missing out on a cure or longer life (<i>MP, N</i>) Decision making based on concern for others (<i>MP, N</i>) Disagreements with physician/medical staff about my decision (<i>MP</i>) Family missing out on potential personal growth due to end-of-life care (<i>MP</i>) Family thinking negatively about me because of my decision (<i>N</i>)

Additional beliefs raised by nurses involved the impact within the health care system. Advantages discussed included both the relief from suffering of attending medical staff and freeing up health resources for others in need.

For the disadvantages articulated by medical practitioners and nurses, discussion focused on the impact of the decision on others. Both doctors and nurses discussed the possibility of family conflict, guilt, and making decisions based on concern for others with one doctor raising the issue of potential conflict with treating physician/medical staff who may disagree with the AVE decision. Some nurses also discussed the disadvantage of their family thinking negatively about them as a consequence of their decision, whereas one of the doctors talked about families missing out on the personal growth opportunity associated with end of life care. Participants in both samples also expressed concern that a person might request AVE when they were feeling particularly low or vulnerable, or that they may choose AVE and miss out on a cure in the future.

Advantages and Disadvantages of Legalizing Active Voluntary Euthanasia

In addition to discussing the advantages and disadvantages of requesting AVE, nurses and doctors considered the costs and benefits of legalizing AVE (see Table 2). In both samples, discussions centered on issues of allowing people to choose medical assistance over suicide in the context of terminal illness, the belief that legalizing AVE would relieve health professionals from fear of legal repercussions and the patient’s right to choose in relation to their own death. The advantages that people expressed in relation to AVE in comparison to suicide encompassed the idea that AVE, under conditions of terminal illness, is distinct from suicide, and that AVE represented a more humane end to life than the potential use of violent or uncertain means. Examples of the expression of this belief included:

I think it’s really unfortunate that they don’t have an option except to be classified as a person that committed suicide (*N*).

. . . people might choose a method that isn’t going to work or is going to leave them worse off. . . they might take the wrong pills, pills that are going to make them really, really ill as well, on top of their terminal illness (*N*).

Table 2. Emergent Themes in Participants’ Interviews of the Advantages and Disadvantages of Legalizing Active Voluntary Euthanasia

Consequence	Belief theme
Advantage	Ending life with medical assistance and not suicide (<i>MP, N</i>) Acknowledging people’s right to choose (<i>MP, N</i>) More funds for research/care of those with non-terminal diseases (<i>MP, N</i>) Complying with end-of-life wishes without legal repercussions (<i>MP, N</i>) Giving an alternative to a painful death (<i>N</i>)
Disadvantage	Potential abuse of system for personal or financial gain (<i>MP, N</i>) Allows euthanasia for reasons other than terminal illness (<i>MP, N</i>) Patients perceiving a duty to die to prevent being a burden to family (<i>MP, N</i>) Loss of patient’s control for the end-of-life decision (<i>MP, N</i>) Reducing spending on terminally ill people (<i>MP, N</i>) Patients perceiving a duty to die to prevent being a burden to the health care system (<i>N</i>)

Nurses also discussed that legalizing AVE would give people an alternative to a painful death. The issue of the legalization of AVE allowing greater funding to be dedicated to research and the care of those with non-terminal diseases was also raised in both samples.

Participants' discussion of the disadvantages of legalizing AVE centered on beliefs that abuses of the system may lead to a person's life being ended without their permission, potentially for financial or personal gain of outside parties, and that legalizing AVE would introduce a health care system that actively encouraged AVE as a means of lowering health care costs. Both doctors and nurses thought that people may feel obliged to request AVE to prevent being a burden for others, with nurses also highlighting people's reluctance to be a burden on the health care system. A further disadvantage raised by both doctors and nurses was that legalization would take control away from the individual, and give numerous others a say in the person's end of life decision. Participants also expressed their belief that a disadvantage was that the system may become more liberal and that, over time, the system would encourage AVE for reasons other than terminal illness. One medical practitioner expressed this concern as

... if it was something that was openly practiced, I just don't know where it would stop. And that's, that's one of the dangers of it I think (*MP*).

Another medical practitioner believed that this potential for legalization had disadvantages that reached beyond the medical system, extending into society, stating:

... as a society that we'll sort of see that as [an] easy way of dealing with people who are very frail, or very ill. And I think that that would have a negative impact on us as a community and a society (*MP*).

Advantages and Disadvantages of Administering Active Voluntary Euthanasia, If It Were Legal

In the event that euthanasia were to become legalized in Australia, participants considered the advantages and disadvantages of being involved in the administration of AVE for people who were terminally ill and requested AVE (see Table 3). Both doctors and nurses believed that administering AVE for a person who was terminally ill and requested it would end that person's suffering. Nurses also expressed their relief that administration of AVE would reduce their discomfort from having to watch their patients' suffering, with both doctors and nurses endorsing the belief that administering AVE would give a more humane alternative to unnaturally prolonging life with medical intervention. Participants in both samples raised the advantage of being able to respect patients' wishes with one of the nurses discussing how administering AVE would relieve patients' families of the responsibility to assist their loved ones to die.

The disadvantages of administering AVE, in the event that euthanasia were to become legalized, expressed by medical practitioners and nurses focused on the belief that being responsible for administering AVE could be psychologically harmful to them as a health professional. Participants expressed a number of potentially damaging personal effects of administering AVE, including guilt over participating in this behavior, the responsibility of actually being the person to end a life, and the burden of coming to terms with the finality of the act. Examples of these psychological consequences of administering AVE included:

I would have to do a great deal of work to, what's the word for it, emotionally get myself to that point (*N*).

. . . if you don't believe in it and it's against your beliefs then obviously it would be detrimental to you to go and participate (*MP*).

Participants also expressed concern that administering AVE would be in conflict with their personal beliefs such as beliefs about taking a life, and beliefs about their responsibility as health care professionals to save lives. Statements illustrating this conflict included:

. . . [foreign] to the way I live my life and care for people and patients, caring for them not killing them, hopefully (*N*).

. . . but to actually kill someone, which is what euthanasia is, it's against our medical training and against what you've been taught is acceptable (*MP*).

Other disadvantages noted by nurses and medical practitioners included changing the nature of end of life care. For some medical practitioners, this reflected a concern for their personal experience working within a changed health care system. For instance, one medical practitioner stated that:

. . . it kind of would change the climate of care...at the moment we can practice knowing we can support people and do what we can about their suffering, and they can sort of work together with us, and understand that we are trying to care and support them but to bring euthanasia into the equation seems a very sort of final and negative way out of that, and sort of an end to that supportive relationship (*MP*).

Both nurses and doctors raised concerns about acting prematurely before the correct prognosis or cure is identified and causing conflict with the patient's family about the decision as further disadvantages. Other disadvantages discussed by medical practitioners were that a person may choose AVE as a function of direct or indirect coercion from family, or from confounding medical conditions such as depression. For some medical practitioners, this concern was related to informed consent issues, with some participants perceiving informed consent for AVE as problematic. Statements about this belief included:

. . . from the doctor's point of view, how can you ever be sure that that person's truly making an informed decision that's totally isolated from anybody else's judgment or coercion? (MP)

We [currently] don't accept people who we think are mentally impaired, depressed, as being able to give their informed consent, so can a patient who was in such a situation able to give consent which has become such an important part of medical practice? Does the very nature that they have symptoms which they consider intolerable or are in a situation that they consider intolerable, make them better or less able to give informed consent? (MP)

In addition to the disadvantage of causing conflict with the patient's family about the decision, medical practitioners also acknowledged conflict with the patient and that health care teams do not always agree over treatment decisions and, were AVE an option, these intra-team conflicts could be exacerbated. For example:

. . . even within the medical profession, between groups we already know that treatment decisions can invoke quite a range of divisive responses between medical staff and nursing staff and allied health, I think that the euthanasia decisions would be even more divisive as they cut closer to people's core beliefs. . . . (MP)

Some nurses identified the additional disadvantages that health professionals may miss out on personal growth opportunities resulting from involvement in end of life care. In addition, there were concerns expressed about the reduced level of health care once the decision to euthanize is made.

Advantages and Disadvantages of Discussing Active Voluntary Euthanasia

As seen in Table 4, both nurses and medical practitioners approached the advantages of discussing AVE with patients, if they request it, from two perspectives. Participants thought that discussing AVE with patients helped them to better understand their own beliefs about end of life issues. Statements supporting this belief include:

Patients might talk about it and I have to sort through my attitudes, I have to do some sort of correlating where I come from in my belief system with how I practice (MP).

. . . I guess you get exposed to people's ideas and opinions, and it gives you something to think about, make up your own mind I guess (MP).

A second belief about discussing AVE with a patient if they request it was that it presented an opportunity to discuss current health care, showing that, rather than discussion of an illegal behavior being detrimental, it opened dialogue

Table 3. Emergent Themes in Participants' Interviews of the Advantages and Disadvantages of Administering Active Voluntary Euthanasia, If It Were Legal

Consequence	Belief theme
Advantage	<p>Ending that person's suffering (<i>MP, N</i>)</p> <p>Given a more humane alternative to unnaturally prolonging life with medical intervention (<i>MP, N</i>)</p> <p>Being able to respect patients' wishes (<i>MP, N</i>)</p> <p>Relieving medical staff/other patients from watching patients' suffering (<i>N</i>)</p> <p>Alleviating family of their responsibility to assist their loved one to die (<i>N</i>)</p>
Disadvantage	<p>Difficulty in assuming responsibility as a health professional (<i>MP, N</i>)</p> <p>Being in conflict with my beliefs (<i>MP, N</i>)</p> <p>Acting on the wrong prognosis or before a cure is found (<i>MP, N</i>)</p> <p>Changing the nature of end-of-life care (<i>MP, N</i>)</p> <p>Causing conflict with the patient's family about the decision (<i>MP, N</i>)</p> <p>Causing conflict with patient about the decision (<i>MP</i>)</p> <p>Causing conflict among the treating physicians/other medical staff about the decision (<i>MP</i>)</p> <p>Uncertainty that patients' decisions were influenced by factors other than terminal illness (<i>MP</i>)</p> <p>Health professionals missing out on the personal growth associated with end-of-life care (<i>N</i>)</p> <p>Reduced levels of health care once the decision to euthanize is made (<i>N</i>)</p>

and gave health professionals insight into the patient's state of mind. Examples of expressions of this belief included:

I just explain that "no, that's not legal," so it's sort of directly confronted and I say "no we are not allowed to do that," and be up front about that and try to move positively to what we can do, to support them and deal with their symptoms (*MP*).

A lot of people just in those times, just will talk about anything, just to have their feelings validated, and . . . patients when they requested it, and you sat down and you spoke with them, and it was really more to just sit with them and talk with them and just re-assure them that yes . . . it's dreadful and it's horrible, but we'll keep you comfortable and stuff like that (*N*).

Table 4. Emergent Themes in Participants' Interviews of the Advantages and Disadvantages of Discussing Active Voluntary Euthanasia

Consequence	Belief theme
Advantage	<p>Allows a better understanding of my beliefs about end-of-life issues (<i>MP, N</i>)</p> <p>Provides an opportunity to discuss current treatment options end of life issues with patients and their family members (<i>MP, N</i>)</p>
Disadvantage	<p>Difficulty for me as a health professional given my commitment to promoting life (<i>MP, N</i>)</p> <p>Colleagues disapproving or misunderstanding my intentions if I discuss euthanasia with patients (<i>N</i>)</p>

For the disadvantages of discussing AVE with a patient if they request it, both medical practitioners and nurses identified the difficulty of discussing AVE, as a health professional, given their professional commitment to promoting life. Nurses also discussed the possibility that colleagues may disapprove of or misunderstand their intentions if they discussed euthanasia with patients.

DISCUSSION

The aim of the present study was to use the expectancy-value model of attitude formation (Ajzen & Fishbein, 1980) to identify and compare the beliefs that medical practitioners and nurses ascribe to a range of AVE-related behaviors. Most participants identified four common behaviors associated with AVE: requesting AVE if you are terminally ill, legalizing AVE, administering AVE if it were legalized, and discussing AVE if a patient requests it. During the interview process, participants considered and discussed the advantages and disadvantages for each of the four AVE behaviors.

Medical practitioners and nurses identified a number of similar benefits for performing AVE-related behaviors, both for themselves personally and as health professionals. For example, medical practitioners and nurses noted that, on a personal level, discussing AVE allowed them to gain a better understanding of their own beliefs about end-of-life issues and that, as a health professional, discussing AVE with a patient afforded them the opportunity to talk about treatment options and potentially provide better care for their patient.

Across all AVE-related behaviors, benefits that were raised also included a consideration of the positive impact for patients, their families, and the health care system. Benefits for patients focused on patient autonomy in the decision making

process, such as having control over their own end-of-life decisions and the acknowledgment of people's right to choose how to end their life. Another benefit for patients discussed by medical practitioners and nurses was allowing a more humane death, accomplished by ending suffering or avoiding a painful death, allowing a person to die with dignity, and the choice of ending life with medical assistance. Advantages for families discussed by some medical practitioners and nurses focused on relieving family from watching their loved one suffer, from the burden of having to care for their loved one, and from the responsibility of having to assist their loved one to die. For the health care system, benefits discussed included increased availability of health resources and funding for others in need.

Disadvantages across behaviors focused on the potential conflict between those parties involved in the decision making process, as well as conflict between one's own personal and professional values. For instance, some medical practitioners and nurses discussed the difficulty, as a health professional, of assuming the responsibility of administering AVE to patients if it were legal and the difficulty of discussing AVE given that AVE is in conflict with their commitment as a health professional to promote life. Other participants were concerned about disagreements with family and with other treating physicians and medical staff. In relation to the three AVE behaviors of requesting, legalizing, and administering AVE, both medical practitioners and nurses were concerned that patients' decision-making would occur for the wrong reasons, such as while they are feeling vulnerable or as a result of co-morbid conditions. Medical practitioners and nurses also discussed the possibility that the decision may be based on concern for others or a perceived duty to die to prevent being a burden on family or the health care system. Many nurses and medical practitioners also raised possible negative outcomes related to a change in health care as a result of legalizing and administering AVE. These negative outcomes included the potential abuse of the system for personal or financial gain, loss of patient's control over the end-of-life decision, reduced levels of health care for patients once the decision to euthanize is made, and reduced spending on terminally ill people.

As expected, the range of positive and negative beliefs raised by participants associated with the AVE behaviors reflected some of the themes identified in previous research. Beliefs including the idea that AVE could be a relief from suffering (e.g., Asch et al., 1997; Kelly et al., 2003; Kuuppelomäki, 2000) and that AVE was intrinsically related to autonomy (e.g., Kuuppelomäki, 2000; McInerney & Siebold, 1995) were reflected in the advantages elicited in this study for both nurses and medical practitioners. The fear of the abuses of AVE (e.g., Kuuppelomäki, 2000; McInerney & Siebold, 1995; Verpoort, Gastmans, & Dierckx de Casterlé, 2004) and expressed beliefs reflecting personal values and value conflicts (e.g., Asch et al., 1997; Kuuppelomäki, 2000) emerged in this study as perceived disadvantages related to AVE behaviors. Other novel disadvantages associated with AVE behaviors emerging in the current research

included family members and health professionals missing out on the opportunity for personal growth associated with end-of-life care as a result of requesting or administering AVE if it were legal. Some medical practitioners and nurses were also concerned that they may act prematurely on the wrong prognosis or before a cure is found resulting in the patient missing out on a cure and subsequent longer life as an outcome of requesting and administering AVE.

It is also interesting to note that different beliefs were associated with separate AVE related behaviors. For example, relieving suffering, family burden, and responsibility were associated with the AVE behaviors of requesting and administering AVE and not with legalizing or discussing AVE. In addition, the advantages of increasing understanding of health professionals' own end-of-life beliefs and providing an opportunity to discuss current treatment options were only associated with the behavior of discussing AVE. Similarly, disadvantages such as difficulty assuming responsibility as a health professional was only associated with the behaviors of administering AVE if it were legal and discussing AVE. Further, anticipated conflict was associated with all AVE behaviors except legalizing AVE. These findings highlight the importance of considering attitudes toward specific AVE related behaviors rather than more global considerations of AVE.

Overall, an examination of the beliefs elicited in this study suggests that both nurses and medical practitioners expressed beliefs concerning professional practice, and the personal consequences of involvement with AVE, should it become legalized. Nurses, however, appeared to consider more advantages across AVE behaviors, compared to medical practitioners; although these advantages can be grouped similarly around the themes of allowing a humane death and relieving suffering. For instance, nurses focused on the relief resulting from the performance of AVE behaviors, such as requesting and administering AVE, not only for family, but also for themselves as health professionals, other medical staff, and other patients.

While both nurses and medical practitioners raised a number of disadvantages, medical practitioners, in comparison to nurses, focused largely on the anticipated conflict resulting from the performance of AVE behaviors, namely requesting and administering AVE. Medical practitioners considered AVE being in conflict with their beliefs, causing conflict with patients, their families, and with other treating physicians and medical staff. As suggested by previous research (Oberle & Hughes, 2001), the differing focus of nurses and medical practitioners may reflect the different roles the members of each group fulfill. Medical practitioners may possess more of a tendency to anticipate conflict as they are the most likely to be required to administer AVE if it were legalized, whereas nurses focus more on relief for themselves, patients, and their family as an outcome of AVE since nurses often have more of an opportunity to become intimately involved with patients and their families and view their suffering on a daily basis.

Strengths and Limitations

Overall, this research has several strengths. First, recruitment of a sample of Australian medical practitioners and nurses provides a current depiction of beliefs about AVE behaviors in a context where little recent qualitative research comparing the beliefs of these two groups has been conducted. Second, this study adopted a theoretical framework, the expectancy-value model of attitude formation, to explore the beliefs underlying nurses' and medical practitioners' AVE attitudes. Third, nurses' and medical practitioners' attitudes toward four specific AVE behaviors were explored, rather than considering only global attitudes toward AVE, which allowed an examination of salient beliefs for each AVE behavior. An exploration of beliefs related to specific AVE behaviors is important given that the advantages and disadvantages raised by participants did not directly correspond with all AVE behaviors, indicating that a global assessment of attitudes toward euthanasia in general or AVE only may be misleading.

There are, however, some limitations warranting consideration. First, a larger sample size may have been beneficial; however, theoretical saturation of beliefs was reached in each group. Second, the use of snowball sampling for recruitment, whereby participants were referred via colleagues, may have resulted in a non-representative or biased sample of participants with similar attitudes and practices. A snowball sampling strategy, whereby a person known to the participants is involved in the recruitment process, was undertaken, however, given the anticipated difficulty of accessing the populations under investigation (due to availability and time constraints) and the potential reticence to participation given the current illegality of euthanasia in Australia. Despite the limitations of this sampling strategy, the range of beliefs elicited suggests that participants held a variety of views about the four identified AVE behaviors. In addition, some researchers have suggested that those who are opposed to AVE may express their negative attitude by refusal to participate (e.g., Achille & Ogloff, 1997). The process of seeking advantages and disadvantages from all participants partially addressed this non-respondent bias, producing a cross section of positive and negative behavioral beliefs. This study, however, does not quantify which beliefs were the most important to participants, rather it identifies the range of beliefs that participants hold about AVE, and generalization of these findings to a larger population should be treated cautiously. Finally, the attitudes elicited in this study are hypothetical for two of the behaviors as AVE is currently illegal in Australia and, as a consequence, these attitudes may change if AVE were legalized and if beliefs were elicited from medical practitioners or nurses responsible for administering AVE to a patient (Sanson et al., 1998).

CONCLUSION

This study, in identifying the behaviors most associated with AVE as requesting, legalizing, administering, and discussing AVE, suggests a future behavioral

focal point for studies aimed at understanding specific behavioral attitudes in relation to AVE. While the range and patterns of behavioral beliefs do not allow for strong conclusions about attitudes toward AVE, they do suggest that the attitudes held by each of the participants were most likely arrived at through a complex interplay of participants' positive and negative behavioral beliefs. Taken together, the results of this study indicate that utilizing the expectancy-value theory of attitude formation (Ajzen & Fishbein, 1980) to investigate attitude formation in relation to AVE may provide a useful perspective for understanding these attitudes. Specifically, future research should test the saliency and subjective value of these beliefs across a larger group of medical practitioners and nurses to determine the patterns of beliefs and belief saliency that discriminate between attitudes toward AVE across these groups. Given the expected relationship between attitudes and behavioral tendencies (Ajzen & Fishbein, 1980), examining the extent to which health professionals' beliefs and attitudes, in combination with other relevant factors, influence behavioral willingness in relation to AVE actions would also be a useful undertaking. Finally, future studies could also consider a comparison of the beliefs underlying attitudes toward AVE for other stakeholders potentially involved with decision making in relation to AVE, such as allied health professionals including psychologists, psychiatrists, and social workers.

Overall, the results of this study indicate that nurses appeared to consider more advantages across AVE behaviors that focused primarily on the idea of relief from suffering not only for patients and their families but also for themselves and other health professionals. In contrast, doctors focused largely on the disadvantage of conflict associated with performance of AVE, with patients, families, and other health professionals, as well as with their own personal beliefs and values. In particular, this study also flags the concerns of medical practitioners and nurses, expressed as disadvantages by these participants, about a health care system that institutionalizes AVE, and the concomitant effect that this may have on their professional performance and psychological well-being. Understanding the belief pattern of the health professionals is particularly important, as it suggests that, should AVE become a topic of legislation in Australia in the future, there may be potentially conflicting attitudinal positions from these varied stakeholders. Future research that allows insight into the attitudes of medical practitioners and nurses will contribute to informed discussion when euthanasia arises as the subject of public and professional debate.

APPENDIX 1

Semi-Structured Interview Questions

1. Icebreaker: Have you spent time in the past thinking about euthanasia or discussing euthanasia? When you have done so, what kind of things have you thought or said?
2. When you think about euthanasia, what behaviors do you associate with it?

3. Thinking about those behaviors that you have just mentioned, what advantages do you associate with them? (Interviewer to use notes to assist participant to recall behaviors that they [and other participants] have identified).
4. Still thinking about those behaviors, what disadvantages do you associate with them? (Interviewer to use notes to assist participant to recall behaviors that they [and other participants] have identified).

REFERENCES

- Achille, M. A., & Ogloff, J. R. (1997). When is a request for assisted suicide legitimate? Factors influencing public attitudes toward euthanasia. *Canadian Journal of Behavioural Science, 29*, 19-27.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational and Human Decision Processes, 50*, 179-211.
- Ajzen, I. (2006). *TPB model*. Retrieved 28 March 2007 from <http://www-unix.oit.umass.edu/~ajzen/att.html>
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. New Jersey: Prentice Hall.
- Asch, D. A., Shea, J. A., Jedrzejewski, M. K., & Bosk, C. L. (1997). The limits of suffering: Critical care nurses' views of hospital care at the end of life. *Social Science Medicine, 45*, 1661-1668.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.
- Dickinson, G. E., Clark, D., Winslow, M., & Marples, R. (2005). US physicians' attitudes concerning euthanasia and physician-assisted death: A systematic literature review. *Mortality, 10*(1), 43-52.
- Dickinson, G. E., Lancaster, C. J., Clark, D., Ahmedzai, S. H., & Noble, W. (2002). U.K. physicians' attitudes toward voluntary active euthanasia and physician-assisted suicide. *Death Studies, 26*, 479-490.
- Douglas, C. D., Kerridge, I. H., Rainbird, K. J., McPhee, J. R., Hancock, L., & Spigelman, A. D. (2001). The intention to hasten death: A survey of attitudes and practices of surgeons in Australia. *Medical Journal of Australia, 175*, 511-515.
- Emanuel, E. J., Fairclough, D. L., Daniels, E. R., & Clarridge, B. R. (1996). Euthanasia and physician-assisted suicide: Attitudes and experiences of oncology patients, oncologists, and the public. *Lancet, 347*, 1805-1811.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley.
- Hassan, R. (1996). Euthanasia and the medical profession: An Australian study. *Australian Journal of Social Issues, 31*, 239-252.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277-1288.
- Joffe, H., & Yardley, L. (2004). Content and thematic analysis. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical health psychology* (pp. 56-68). London: Sage.
- Kelly, B., Burnett, P., Badgers, S., Pelusi, D., Varghese, F. T., & Robertson, M. (2003). Doctors and their patients: A context for understanding the wish to hasten death. *Psycho-oncology, 12*, 375-384.

- Kitchener, B. (1998). Nurse characteristics and attitudes to active voluntary euthanasia: A survey in the Australian Capital Territory. *Journal of Advanced Nursing*, 28, 70-76.
- Kitchener, B., & Jorm, A. F. (1999). Conditions required for a law on active voluntary euthanasia: A survey of nurses' opinions in the Australian Capital Territory. *Journal of Medical Ethics*, 25(1), 25-30.
- Kuhse, H., & Singer, P. (1988). Doctors' practices and attitudes regarding voluntary euthanasia. *The Medical Journal of Australia*, 148, 623-627.
- Kuhse, H., Singer, P., Baume, P., Clark, M., & Rickard, M. (1997). End-of-life decisions in Australian medical practice. *Medical Journal of Australia*, 166, 191-196.
- Kuuppelomäki, M. (2000). Attitudes of cancer patients, their family members and health professionals toward active euthanasia. *European Journal of Cancer Care*, 9, 16-21.
- Martin, E. A. (2003). *Concise medical dictionary*. Oxford: Oxford University Press.
- Mason, J. (1996). *Qualitative researching*. London: Sage.
- Matzo, M., & Schwarz, J. (2001). In their own words: Oncology nurses respond to patient requests for assisted suicide and euthanasia. *Applied Nursing Research*, 14(2), 64-71.
- McInerney, F., & Siebold, C. (1995). Nurses' definitions of and attitudes towards euthanasia. *Journal of Advanced Nursing*, 22, 171-182.
- Miccinesi, G., Fischer, S., Paci, E., Onwuteaka-Philipsen, B. D., Cartwright, C., van der Heide, A., et al. (2005). Physicians' attitudes towards end-of-life decisions: A comparison between seven countries. *Social Science and Medicine*, 60, 1961-1974.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. London: Sage.
- Mitchell, K., & Owens, R. G. (2004). Judgments of laypersons and general practitioners on justifiability and legality of providing assistance to die in a terminally ill patient: A view from New Zealand. *Patient Education and Counseling*, 54, 15-20.
- Northern Territory of Australia Rights of the Terminally Ill Act. (1995).
- Oberle, K., & Hughes, D. (2001). Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *Journal of Advanced Nursing*, 33(6), 707-715.
- Onwuteaka-Philipsen, B. D., Fisher, S., Cartwright, C., Deliëns, L., Miccinesi, G., Norup, M., et al. (2006). End-of-life decision making in Europe and Australia: A physician survey. *Archives of Internal Medicine*, 166, 921-929.
- Richardson, D. S. (1994). Oncology nurses' attitudes toward the legalization of voluntary active euthanasia. *Cancer-Nursing*, 17, 348-354.
- Ryynänen, O., Myllykangas, M., Viren, M., & Heino, H. (2002). Attitudes towards euthanasia among physicians, nurses and the general public in Finland. *Public Health*, 116, 322-331.
- Sanson, A., Dickens, E., Melita, B., Nixon, M., Rowe, J., Tudor, A., & Tyrrell, M. (1998). Psychological perspectives on euthanasia and the terminally ill: An Australian Psychological Society discussion paper. *Australian Psychologist*, 33(1), 1-11.
- Shuman, C. R., Fournet, G. P., Zelhart, P. F., & Roland, B. C. (1992). Attitudes of registered nurses toward euthanasia. *Death Studies*, 16, 1-15.
- Sikora, J., & Lewins, F. (2007). Attitudes concerning euthanasia: Australia at the turn of the 21st century. *Health Sociology Review*, 16, 68-78.
- Sprung, C. L., Carmel, S., Sjøkvist, P., Baras, M., Cohen, S. L., Maia, P., et al. (2007). Attitudes of European physicians, nurses, patients, and families regarding end-of-life decisions: The ETHICATT study. *Intensive Care Medicine*, 33, 104-110.

- Stevens, C. A., & Hassan, R. (1994). Management of death, dying and euthanasia: Attitudes and practices of medical practitioners in South Australia. *Journal of Medical Ethics, 20*, 41-46.
- Teisseyre, N., Mullet, E., & Sorum, P. C. (2005). Under what conditions is euthanasia acceptable to lay people and health professionals? *Social Science and Medicine, 60*, 357-368.
- Verpoort, C., Gastmans, C., De Bal, N., & Dierckx de Casterlé, B. (2004). Nurses' attitudes to euthanasia: A review of the literature. *Nursing Ethics, 11*, 349-365.
- Verpoort, C., Gastmans, C., & Dierckx de Casterlé, B. (2004). Palliative care nurses' views on euthanasia. *Journal of Advanced Nursing, 47*(6), 592-600.

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