

Nursing Ethics

OPINIONS OF NURSES REGARDING EUTHANASIA AND MEDICALLY ASSISTED SUICIDE.

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| Abstract: | <p>Background: Safeguarding the right to die according to the principles of autonomy and freedom of each person has become more important in the last decade, therefore increasing regulation of Euthanasia and Medically Assisted Suicide (MAS).</p> <p>Aims: To learn the opinions that the nurses of the Autonomous Region of Madrid have regarding Euthanasia and Medically Assisted Suicide.</p> <p>Research design: Cross-sectional descriptive study.</p> <p>Participants and research context: All registered nurses in Madrid. The study was done by means of a self-completed anonymous questionnaire. The variables studied were social-demographic, giving opinions about Euthanasia and MAS.</p> <p>Ethical considerations: Each participant was assured maximum confidentiality and anonymity, ensuring the ethical principles set out in the Declaration of Helsinki, as well as in the Organic Law 3/2018, on Personal Data Protection and guarantee of digital rights.</p> <p>Findings: A total of 489 nurses answered the questionnaire. In total, 75.7% of the nurses confirmed that Euthanasia should be regulated in Spain. 66.3% indicated that information on Euthanasia should be provided jointly by doctors and nurses, and 42.3% considered that it could be applied by both medical and nursing professionals. A total of 87.2% advocated the participation of nurses in health policies, influencing the drafting of the law. In the face of possible regulation, 35% would request Conscientious Objection, being closely related to their religious beliefs.</p> <p>Discussion: Different authors point out that nurses' perceptions and attitudes towards Euthanasia are conditioned by different factors, such as religion, gender, poor palliative care, legality and the patient's right to die.</p> <p>Conclusion: Nurses are positioned in favour of the regulation and practice of Euthanasia and MAS, depending on their age, years of experience, training, model of care and especially religious beliefs.</p> |

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TABLES

| COUNTRY | LEGISLATED/DECRIMINALISED PRACTICE |
|--------------------|---|
| USA (1998) | Medically Assisted Suicide |
| Netherlands (2002) | Euthanasia y Medically Assisted Suicide |
| Belgium (2002) | Euthanasia y Medically Assisted Suicide |
| Switzerland (2006) | Assisted Suicide (decriminalised) |
| Luxembourg (2008) | Euthanasia y Medically Assisted Suicide |
| Colombia (2014) | Euthanasia |
| Canada (2016) | Euthanasia y Medically Assisted Suicide |
| Australia (2019) | Euthanasia y Medically Assisted Suicide |
| Germany (2020) | Assisted Suicide (decriminalised) |
| New Zealand (2021) | Euthanasia y Medically Assisted Suicide |
| Spain (2021) | Euthanasia y Medically Assisted Suicide |

Table 1. Regulation of Euthanasia and Medically Assisted Suicide

| SITUATIONS RELATED TO EUTHANASIA/MAS | EXERCISE CONSCIENTIOUS OBJECTION | | | |
|--|----------------------------------|------------|-------------|--------------|
| | For sure, yes | I think so | I think not | For sure, no |
| Direct administration of the lethal drug | 31,9% | 12,3% | 18,2% | 35% |
| Drug preparation | 32,1% | 9,4% | 9,6% | 47% |
| Preparation and administration of the drug | 32,3% | 11,7% | 16,8% | 37% |
| Accompaniment during the euthanasia process | 32,1% | 7% | 7,2% | 52,1% |
| Providing the patient with all the necessary means to allow the patient to die by themself | 32,9% | 6,7% | 8,2% | 50,9% |
| Accompanying the patient during MAS | 32,5% | 6,7% | 8,2% | 50,9% |
| Participate in the process of dialogue and reflection with a patient who asks for assistance in dying. | 26,2% | 7,8% | 7,8% | 56,6% |
| Participate in the deliberative process with the patient and family about their diagnosis, therapeutic possibilities and expected outcomes, as well as about possible palliative care, making sure that they understand the information provided, including in writing | 25,2% | 9,4% | 4,7% | 58,9% |
| Advise and participate with the patient in the drafting of an advance directives document (DIP) reflecting the patient's wish for euthanasia in the event of incapacity. | 31,3% | 8,8% | 7,8% | 48,9% |
| Participate as the patient's witness to the written request for Euthanasia or MAS | 31,3% | 8,8% | 7,8% | 48,9% |
| Participate as a member of the advisory team to assess the appropriateness of requests for Euthanasia or MAS | 30,9% | 8,8% | 9% | 49,1% |
| Participate as a member of the Commission for the Evaluation and Monitoring of Euthanasia or MAS requests | 30,9% | 8,4% | 6,5% | 50,1% |
| Participate in a specific training programme on the provision of assistance in dying on request for Euthanasia or MAS. | 32,5% | 8,4% | 6,5% | 50,1% |

Table 2. Nurses' attitudes toward exercising Conscientious Objection to situations related to Euthanasia and Medically Assisted Suicide.

| | 21-30 years old | 31-40 years old | 41-50 years old | 51-60 years old | Value P |
|---------------------|------------------------|--------------------------|--------------------------|-------------------------|---------|
| Regulate Euthanasia | 66,7%(74) | 72,2%(91) | 55,8%(67) | 72,6%(53) | 0,08 |
| Regulate MAS | 59,5%(66) | 65,1%(82) | 47,5%(57) | 71,2%(52) | 0,05 |
| Joint Information | 77,5%(86) | 71,4%(90) | 61,7%(74) | 58,9%(43) | P<0,001 |
| Apply Euthanasia | 60,4%(67) | 69%(87) | 55%(66) | 69,9%(51) | 0,002 |
| Health policy | 81,1%(90) | 81,7%(103) | 75,85(91) | 89%(65) | 0,016 |
| Request CO | S23,4%(26) N45%(50) | S23,8%(30) N38,9%(49) | S41,7%(50) N32,5%(39) | S21,9%(16) 49,3%(36) | 0,009 |

Table 3. Correlation between nurses' attitudes and age.

| | PUBLIC | PRIVATE | Value P |
|---|----------------|-------------|---------|
| The right to decide about one's own life | 67,1%(280) YES | 46%(23) YES | 0,007 |
| Regulate Euthanasia by law | 69,5%(290) YES | 44%(22) YES | 0,001 |
| Regulate MAS | 62,4%(290) YES | 44%(22) YES | 0,001 |
| Apply Euthanasia by doctor/nurse | 66,9%(279) YES | 38%(19) YES | <0,001 |
| Participate in health policy | 81,5%(340) YES | 72%(36) YES | 0,046 |
| Right to exercise Conscientious Objection | 75,1%(313) YES | 92%(46) YES | 0,05 |
| Request Conscientious Objection regarding Euthanasia regulation | 44,1%(184) NO | 54%(27) YES | <0,001 |

Table 4. Correlation between nurses' attitudes and the health care model

| SITUATIONS | RELIGIOUS BELIEFS | EXERCISE CONSCIENTIOUS OBJECTION | | Value p |
|--|--------------------|----------------------------------|--------------|---------|
| | | For sure, yes | For sure, no | |
| Direct administration of the lethal drug | Religious believer | 48,1%(124) | 22,9%(59) | 0,001 |
| | Non believer | 13,9%(32) | 48,5%(112) | |
| Drug preparation | Religious believer | 46,1%(119) | 32,2%(83) | 0,001 |
| | Non believer | 16,4%(38) | 63,6%(147) | |
| Preparation and direct administration of the lethal drug | Religious believer | 48,1%(124) | 25,2%(65) | 0,001 |
| | Non believer | 14,7%(34) | 50,2%(116) | |
| Accompaniment during the Euthanasia process | Religious believer | 42,6%(110) | 39,1%(101) | 0,001 |
| | Non believer | 20,3%(47) | 66,7%(154) | |
| Providing the patient with the means for MAS | Religious believer | 47,3%(122) | 30,2%(78) | 0,001 |
| | Non believer | 16,9%(39) | 60,6%(140) | |
| Accompany the patient during MAS | Believer | 45%(116) | 36,8%(95) | 0,001 |
| | Non believer | 18,6%(43) | 66,7%(154) | |

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|--|--------------------|------------|------------|-------|
| Participate in the process of dialogue and reflection with a patient requesting assistance in dying | Religious believer | 32,6%(84) | 44,2%(114) | 0,001 |
| | Non believer | 19%(44) | 70,6%(163) | |
| Participate in the deliberative process with the patient and the family | Religious believer | 31,4%(81) | 47,7%(123) | 0,001 |
| | Non believer | 18,2%(42) | 71,4%(165) | |
| Advise and participate in the drafting of an Advance Directives document reflecting the will to Euthanasia | Religious believer | 43,4%(112) | 36%(93) | 0,001 |
| | Non believer | 17,7%(41) | 70,6%(163) | |
| Participate as a witness to the patient's written request for Euthanasia or MAS | Religious believer | 43,4%(112) | 32,9%(85) | 0,001 |
| | Non believer | 17,7%(41) | 66,7%(154) | |
| Participate as a member of the advisory team | Religious believer | 44,2%(114) | 35,3%(91) | 0,001 |
| | Non believer | 16%(37) | 64,5%(149) | |
| Participate as a member of the Assurance and Evaluation Commission | Religious believer | 43%(111) | 33,3%(86) | 0,001 |
| | Non believer | 17,3%(40) | 62,3%(144) | |
| Participate in a specific training programme | Religious believer | 46,9%(121) | 34,5%(89) | 0,001 |
| | Non believer | 16,5%(38) | 67,5%(156) | |

Table 5. Correlation between nurses' attitudes to Conscientious Objection (CO) and religious beliefs.

FIGURES

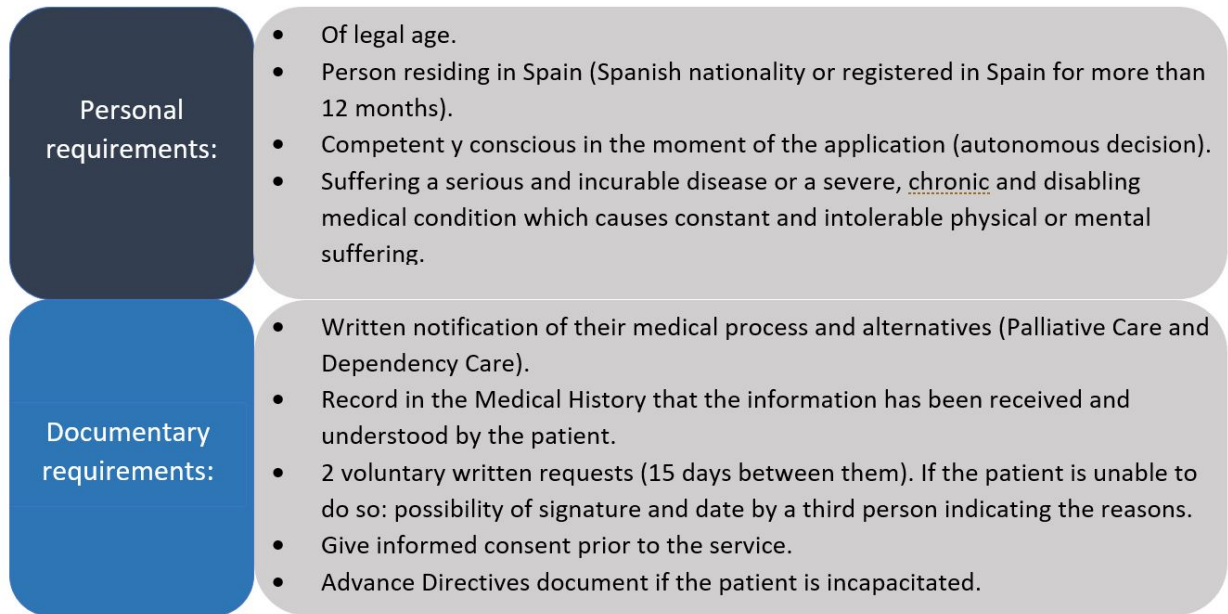


Figure 1. Requirements for the application of Euthanasia or MAS in Spain.

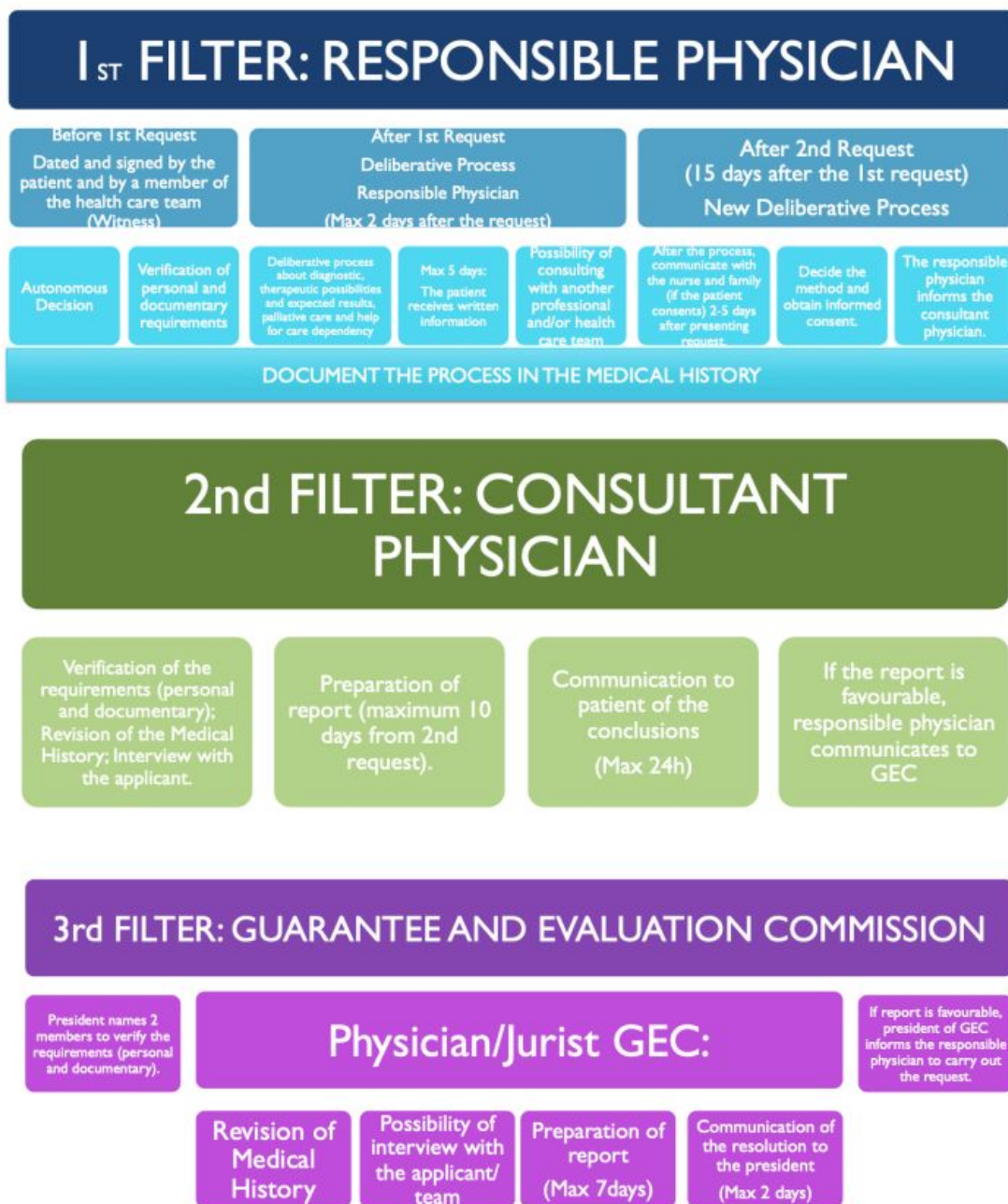


Figure 2. Procedure for the regulation of Euthanasia and MAS in Spain

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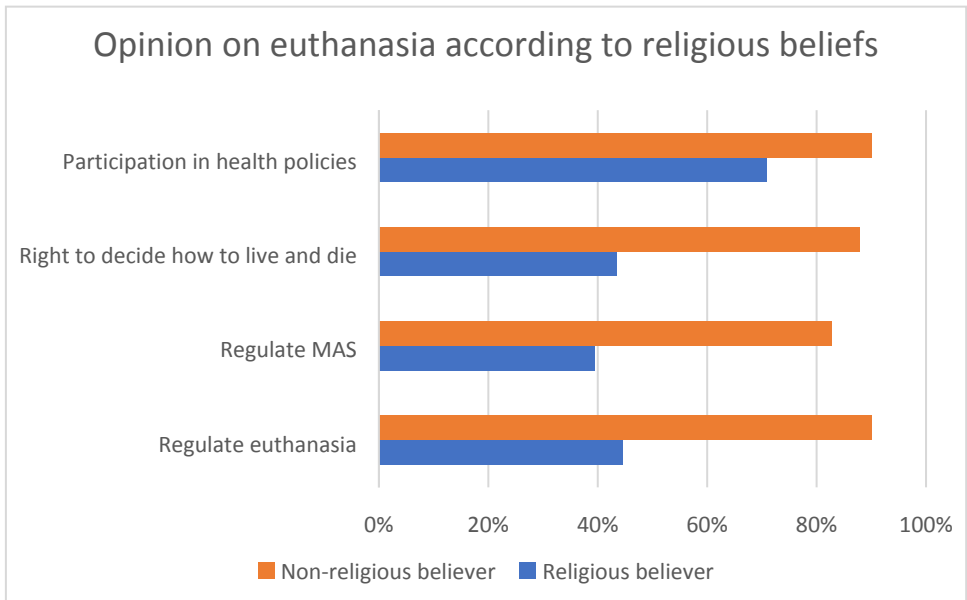


Figure 3. Opinion on euthanasia according to religious beliefs

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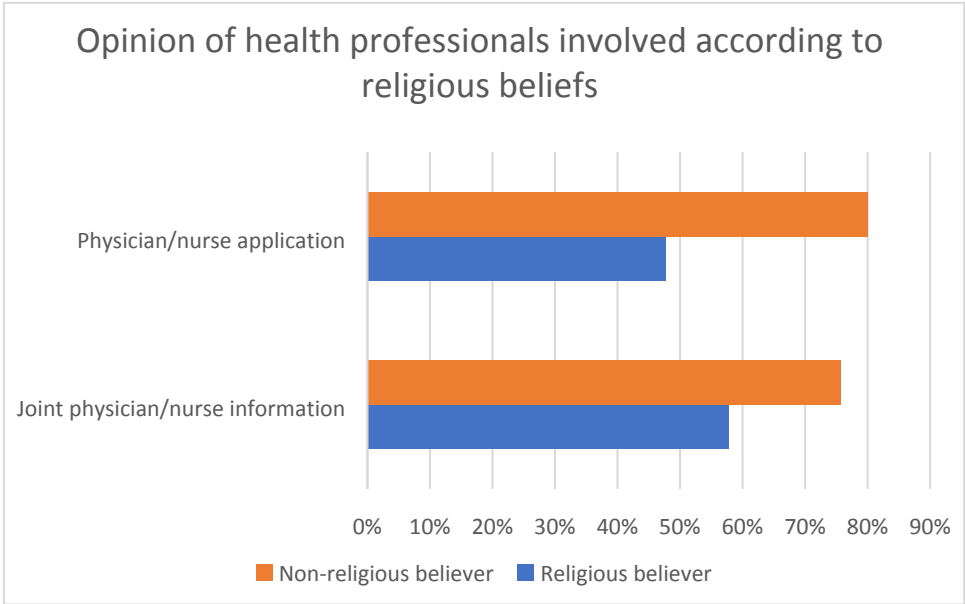


Figure 4. Opinion of health professionals involved according to religious beliefs.

OPINIONS OF NURSES REGARDING EUTHANASIA AND MEDICALLY ASSISTED SUICIDE

Background: Safeguarding the right to die according to the principles of autonomy and freedom of each person has become more important in the last decade, therefore increasing regulation of Euthanasia and Medically Assisted Suicide (MAS).

Aims: To learn the opinions that the nurses of the Autonomous Region of Madrid have regarding Euthanasia and Medically Assisted Suicide.

Research design: Cross-sectional descriptive study.

Participants and research context: All registered nurses in Madrid. The study was done by means of a self-completed anonymous questionnaire. The variables studied were social-demographic, giving opinions about Euthanasia and MAS.

Ethical considerations: Each participant was assured maximum confidentiality and anonymity, ensuring the ethical principles set out in the Declaration of Helsinki, as well as in the Organic Law 3/2018, on Personal Data Protection and guarantee of digital rights.

Findings: A total of 489 nurses answered the questionnaire. In total, 75.7% of the nurses confirmed that Euthanasia should be regulated in Spain. 66.3% indicated that information on Euthanasia should be provided jointly by doctors and nurses, and 42.3% considered that it could be applied by both medical and nursing professionals. A total of 87.2% advocated the participation of nurses in health policy, influencing the drafting of the law. In the face of possible regulation, 35% would request Conscientious Objection, being closely related to their religious beliefs.

Discussion: Different authors point out that nurses' perceptions and attitudes towards Euthanasia are conditioned by different factors, such as religion, gender, poor palliative care, legality and the patient's right to die.

Conclusion: Nurses are positioned in favour of the regulation and practice of Euthanasia and MAS, depending on their age, years of experience, training, model of care and especially religious beliefs.

Keywords: Euthanasia, Medically Assisted Suicide, nurses, attitudes, Bioethics, clinical ethics, Conscientious Objection.

Introduction

This document addresses nurses' attitudes towards Euthanasia and Medically Assisted Suicide (MAS) in relation to the regulatory text itself, a few months prior to the actual regulation of the Assistance in Dying Benefit in Spain. Special importance is given to possible cases of nurses showing conscientious objection and their participation in the process.

Background

The literature shows different studies^{1,2} related to nurses' attitudes towards euthanasia and its regulation. However, only few studies address the attitudes related to the nurses' own role during this process^{3,4}, including conscientious objection, which is one of the most important prerequisites for its legalisation, as has been pointed out by the International Association for Hospice and Palliative Care (IAHPC)⁵.

Despite the crucial role of nurses in the process of providing assistance in dying, they are in most cases not taken into account in such discussions³.

Spain has become the fourth European country to regulate Euthanasia and Medically Assisted Suicide⁶ (MAS), after the Netherlands, Belgium and Luxembourg. In the international context, 9 countries have regulated one or both practices and 2 have only decriminalised them⁷ (Table 1).

Death, beyond a biological event, encompasses a social, spiritual and anthropological fact that has been changing over time, influencing in an important manner the ways of acting, thinking and feeling of both patients and health care professionals.

Safeguarding the right to die according to the principles of autonomy and freedom of each person has become more important in the last decade. These arguments have created the greatest controversy in the ethical debate on Euthanasia and MAS⁸.

As the bioethicist Simón Lorda⁹ pointed out, there is a sufficient degree of ethical agreement with respect to the limitation of life-sustaining treatment, refusal of treatment and palliative sedation as acceptable actions, which are in turn included from the legal point of view. However, there is no such ethical agreement on Euthanasia or Medically Assisted Suicide, which is still classified as the criminal offence of homicide in many countries.

Nevertheless, within the ethical debate on the end-of-life process, it is worth considering whether there are differences between allowing death as a process of disease progression by limiting life-sustaining treatments, shortening life in the face of a refractory symptom in a terminal situation by means of palliative sedation, or causing death in a situation of total suffering expressed by a patient repeatedly by means of Euthanasia or MAS.

In recent years, in countries such as Spain¹⁰⁻¹⁵, these reflections have led to a growing social trend of support for the regulation of Euthanasia and MAS, both by citizens and health care professionals, reflected in several legislative proposals for their regulation.

In 2017, two legislative proposals were presented, one that sought the regulation¹⁶ of euthanasia and MAS, and another that proposed only the decriminalisation¹⁷ of both practices through the modification of the Spanish Penal Code¹⁸.

In 2018, another new attempt at regulation¹⁹ was presented, and finally, on 31st January 2020, the Chamber of Deputies approved the proposal for the Organic Law on the Regulation of Euthanasia²⁰, which, after several amendments by the Congress and the Senate, was approved on 24th March 2021¹, and came into force on 25th June 2021.

It establishes its purpose and scope of application, the requirements for people to be able to request the provision of aid in dying and the conditions for its exercise (Figure 1), using criteria

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3 very similar to previous international regulations, especially European ones; by highlighting the
4 need to be an autonomous, repeated decision, in a context of terminally ill or chronic,
5 advanced illness with unbearable suffering²¹.
6

7 The Spanish law sets out the procedure to be followed for the provision of aid in dying and the
8 guarantees to be observed, stipulating three mandatory prior verification filters: the
9 responsible doctor, the consultant doctor and the Guarantee and Evaluation Commission (GEC)
10 (Figure 2). It should be noted that this multidisciplinary commission is created at regional level
11 as a body with pre- and post-verification functions, which is one of the main differences with
12 the rest of the approved regulations of other countries, where the commissions only have
13 functions after the service has been provided, not before²¹.
14

15 The Spanish law guarantees equal access to the service for all citizens, including both public
16 and private centres.
17

18 It also regulates the right of the health professionals directly involved to exercise Conscientious
19 Objection (CO) by creating a specific register in each Community or Autonomous Region. In this
20 aspect, the main differences with European regulations are that the Netherlands and
21 Luxembourg only contemplate the possibility of CO for doctors, while Belgium includes, in
22 addition to doctors, that no professional will be obliged to provide assistance in a euthanasia
23 procedure, and nurses can be included in this sense²¹.
24

25 Organic Law 10/1995, of 23rd November 1995, of the Penal Code¹⁸ was amended with the aim
26 of decriminalising all Euthanasia related conducts to be carried out in the specific cases
27 established in the law, including all professionals involved, unlike in Holland, Belgium and
28 Luxembourg, where only the doctor is exempt from criminal liability²¹.
29

30 One of the main problems in the Spanish law is the lack of clarity regarding the role of health
31 care professionals in the provision of aid in dying, especially nurses, as is the case with most
32 regulations²¹. The word nurse only appears on two occasions in the entire law, the rest being
33 supposedly included under health professionals or health care team. The law only states that
34 the nurse will be informed of the outcome of the deliberation between the patient and the
35 assigned responsible doctor, without clearly defining her/his involvement or the functions
36 she/he will have during the process.
37

38 Studies²²⁻²⁷ on the role of the nurse in end-of-life care, including Euthanasia and MAS, point to
39 major shortcomings in both the establishment of the nurse's role and responsibilities.
40

41 In the Dutch law, for example, despite the efforts made during the legislative process by nursing
42 associations to include the nurse's functions throughout the process and also in the modification
43 of the criminal code, only the responsible doctor is referred to; without contemplating or
44 specifying the nurse's role, whose participation is penalised. However, different studies^{22,23}
45 show the importance of including the nurse in the regulatory text, as, since the Dutch regulation
46 of Euthanasia in 2002, the nurse has been involved before, during and after the provision of aid
47 in dying, with the legal consequences that may follow.
48

49 In the Belgian law, it at least stipulates that requests for Euthanasia must be discussed by the
50 nursing team that has regular contact with the patient. As such, the nurse is expected to play
51 a role during the deliberation stage, but with involvement during the administration of the drug
52 also being penalised. However, as in the Netherlands, there is great variability^{24,25} in both the
53 nurse's involvement in the deliberative process (100% nursing homes; 58.6% hospitals; 44.4%
54 homes) and in the process of direct administration of the lethal drug (0% nursing homes; 13.5%
55 hospital; 43% homes).
56

57 Therefore, whether the nurse's role is or is not recognised in the legal norm, the reality is that
58 it is part of the holistic care in the process of caring for people who request Euthanasia,
59 especially in the patient's need for accompaniment and support throughout the process of their
60 illness.

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3 At the end of a person's life, they experience a special fragility and care dependency, which,
4 without the recognition of their autonomy, can compromise their dignity. Therefore, when
5 faced with a request for assistance in dying, their care specifically implies establishing a
6 relational link with the patient that guarantees the creation of a context of well-being, that
7 allows the patient's values to be explored and their life experience to be addressed²⁶.
8

9 In this sense, there is much that nurses can contribute to the process of aid in dying, as reflected
10 in the Canadian context^{27,28} including participation in the assessment of the patient's
11 competence and capacity, providing information on aid in dying, coordinating the process,
12 preparing equipment and intravenous access, coordinating and informing health care personnel,
13 documenting, supporting patients and their loved ones, and providing after-care.
14

15 It will be essential for nurses to participate actively in the discussions and development of
16 policies involving care during the dying process, especially in the regulation of a practice that
17 has so many ethical, social, legal, deontological and clinical connotations such as Euthanasia
18 and MAS; including the defence of a comprehensive palliative approach and shared care
19 planning as the central axis of health care. The nurse, due to her/his privileged position of
20 continuous contact with the patient and the family, must ensure a correct process of reflection
21 and deliberation, acting as a guarantor of care, carrying out a holistic and comprehensive bio-
22 psycho-social and spiritual approach.
23

24 For all these reasons, nurses will play an important role in the process of providing assistance
25 in dying, and it is essential to know their opinion in order to be able to include it in the
26 regulatory text.
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29 **Objective**

30 To find out the opinion and attitudes of nurses in the Community of Madrid on the regulation
31 of Euthanasia and MAS in Spain.
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34 **Population and methods**

35 Design: an observational, descriptive, cross-sectional study was carried out from September to
36 November 2020.
37

38 Study population: all nurses registered in the Official College of Nurses of Madrid.
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40 Inclusion criteria: the nurses surveyed had to be members of the Official College of Nurses of
41 Madrid (*Colegio Oficial de Enfermería de Madrid*) and agree to participate in the study.
42

43 It should be noted that in Spain professional membership is compulsory in order to be able to
44 work as a nurse, so all nurses must be registered in their region's respective College of
45 Nurses.
46

47 Sampling: Non-probabilistic by convenience in order to facilitate the participation of all nurses
48 in the Community of Madrid, given that registration is compulsory, and thus ensure that they
49 could participate and express their opinion on a subject in which nursing is directly involved,
50 and to gather the different sensitivities and ideologies present in the group.
51

52 Sample size: The sample size was calculated based on the target population (53,000 registered
53 nurses), under the assumption of maximum uncertainty with an expected proportion of 50%,
54 which was estimated at 382 participants with a confidence level of 95% and a precision of 5%.
55 Taking into account a loss rate of at least 20%, 459 nurses would need to participate.
56

57 Measuring instrument: an *ad hoc*, structured, self-administered questionnaire was designed
58 through the *GoogleForms* platform, consisting of 34 questions with Likert-type, dichotomous
59 variables, based on studies²⁹ conducted by other professional associations to compare results,
60 and according to specific aspects included in the legislative proposal. Nine items related to
socio-demographic variables were included (sex, age, years of experience, speciality, model in

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3 which the main activity is practised, setting, beliefs, training in bioethics and palliative care);
4 and 25 items related to qualitative variables (opinion and attitudes towards Euthanasia and
5 MAS). To avoid bias caused by possible terminological confusion, the accepted definitions of
6 Euthanasia and MAS were included in the informed consent information sheet, on the basis of
7 which the rest of the questions were subsequently developed.
8

9 The following procedures were used to validate the questionnaire:

- 10
11 - Expert panel consisting of nurses with experience and training in clinical bioethics and
12 palliative care.
13
14 - Pilot study of a representative sample of the study population.

15 Data collection process: Through the database of the Official College of Nurses of Madrid, an
16 email was sent to all members informing them of the aim of the study and inviting them to
17 participate voluntarily, together with a link to access the online platform. The link to the survey
18 was kept open throughout the study period on the main CODEM (acronym in Spanish of the
19 Official College of Nurses of Madrid) web page.
20

21 Ethical considerations: Each participant was assured maximum confidentiality and anonymity,
22 ensuring the ethical principles set out in the Declaration of Helsinki. All information collected
23 was treated in accordance with Organic Law 3/2018, of December 5th, on Personal Data
24 Protection and guarantee of digital rights. The study was approved by the Ethics Committee.
25

26 Statistical analysis: Qualitative variables are described using absolute and relative frequency
27 percentages for each category, and associations were sought using the chi-square test or
28 Fisher's exact test. To calculate the estimated effect according to the Predominant Reasoning
29 (PR or exponent b) of the predictor variable "religious beliefs", the responses of the different
30 interventions in which nurses would declare themselves Conscientious Objectors were recoded,
31 dichotomising the categories for inclusion in a regression model. For the analysis variables, a
32 confidence interval for 5% alpha error was calculated using SPSS software ver. 22.0.
33

34 Results

35 Characteristics of the participants

36 A total of 489 surveys were obtained from the nurses in Madrid that participated in the study.
37 A total of 86.3% (422) were women aged between 31-40 years (202). A total of 25.8% (126) of
38 the respondents were professionals with more than 20 years of work experience. A total of
39 78.9% (386) worked in the public health system. Most of them, 68.3% (334) worked in hospital
40 care.
41
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43 With respect to training, 77.5% (379) did not have a recognised nursing speciality. A total of
44 60.7% (297) reported having received training in Bioethics during their degree and 48.3% (236)
45 had postgraduate training in palliative care.
46

47 Of the nurses surveyed, 52.8% (258) considered themselves to be religious believers, and 77.7%
48 (380) considered that religion influenced their attitude towards Euthanasia in a fairly or very
49 important way.
50

51 Participants' opinion on Euthanasia

52 75.7% (370) and 72.6% (355) of the nurses from Madrid who participated in the study said that
53 both Euthanasia and MAS respectively should be regulated by law in Spain, with 81% (396)
54 stating that each person has the right to decide how they want to live and choose how they
55 want to die.
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57 Likewise, 87.2% (426) said that nurses should participate in guiding and influencing the drafting
58 of the law through the Professional Colleges.
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3 As the main reason that leads a sick person to request to end his/her life, 59.5% (291) indicated
4 the loss of complete physical autonomy and freedom as a person, followed by unbearable
5 physical pain as the second cause in 30.7% (150).
6

7 The inferential analysis shows significant statistical relationships between age, years of work
8 experience as a nurse, training, model of care and especially religious beliefs.
9

10 Those over 51 years of age were more in favour of the regulation of both Euthanasia and MAS,
11 and of the involvement of nurses in health policy (Table 3).
12

13 With regard to work experience, respondents with more than 30 years' experience were more
14 in favour of the regulation of Euthanasia and MAS in Spain ($p=0,05$).
15

16 In relation to training, nurses from Madrid who participated in the study with postgraduate
17 training in both bioethics (100% PhD and 88.3% courses) and palliative care (83.9%) were more
18 in favour of the need for nurses' participation in health policy through Professional Colleges
19 ($p<0.001$).
20

21 Respondents working in public centres were more favourable than those working in private
22 centres to both the regulation of Euthanasia and MAS in Spain, and of the involvement of nurses
23 in health policy (Table 4).
24

25 The variable that showed the greatest differences in all categories was religious beliefs, where
26 religious believers were more opposed to the regulation of Euthanasia and MAS, to recognising
27 the right of a person to decide how they want to live and die, and to the need for nurses'
28 participation in health policy ($p<0.001$). Figure 3.
29

30 **Participants' opinion of the professionals involved in Euthanasia**

31
32 When faced with a patient's request for assistance in dying, 66.3% (324) of the nurses from
33 Madrid who participated in the study considered that the information on Euthanasia or MAS
34 should be provided jointly by the doctor and the nurse; as did 42.3% (207) of the nurses that
35 participated regarding the joint doctor/nurse application of Euthanasia.
36

37 The inferential analysis shows a significant statistical relationship between age, years of work
38 experience as a nurse, training, model of care and especially religious beliefs.
39

40 Respondents over 51 years of age were more in favour of the application of Euthanasia by both
41 nursing and medical professionals, while respondents between 21-30 years of age were more in
42 favour of providing joint information rather than applying the service jointly (Table 3).
43

44 In this sense, regarding work experience, respondents with 6-10 years of work experience
45 (83.1%) were the most in favour that when a patient requests assistance in dying, information
46 should be provided jointly. Meanwhile, with respect to the application, Madrid nurses who
47 participated in the study with less than 5 years of work experience (55.7%) were the least in
48 favour of it being carried out by both nursing and medical professionals ($p=0.001$).
49

50 With regard to training, nurses from Madrid who participated in the study with postgraduate
51 training in palliative care (80% Master's degree and 69.9% courses) were more in favour of the
52 need for joint information from the responsible doctor and responsible nurse for the request
53 for Euthanasia ($p=0,06$).
54

55 Respondents working in public centres were more in favour of the application of Euthanasia by
56 both nursing and medical professionals than those working in private centres (Table 4).
57

58 With regard to religious beliefs, non-believing respondents were more in favour of joint
59 information from the doctor and responsible nurse for a request for assistance in dying, as well
60 as of the application of Euthanasia by both nursing and medical professionals ($p<0,001$). Figure
4.

Opinion of the participants on the cases involving Euthanasia to which they would object

87.5% (428) believed that nurses should have the right to exercise conscientious objection to Euthanasia or MAS, with 35% (171) reflecting that they would request it in the face of possible regulation, compared to 61.9% (303) who would not.

The different scenarios in which the Madrid nurses who participated in the study would or would not exercise Conscientious Objection are shown in Table 2, with those that generate the highest degree of Conscientious Objection being the direct administration of the lethal drug, and the preparation and administration of the drug.

Factors influencing participants' opinions on Euthanasia.

Inferential analysis showed significant statistical relationships between age, years of work experience as a nurse, training, model of care and especially religious beliefs.

Those older than 51 years were less favourable to request Conscientious Objection (Table 3).

With regard to work experience, 45.8%(33) of respondents with 16-20 years of nursing experience would definitely apply for Conscientious Objection, compared to 48.1%(50) of those over 30 years of experience and 59.3% between 6-10 years of experience, who would not exercise Conscientious Objection ($p=0,002$).

Postgraduate training in bioethics (100% Master's degree, 83.9% master's degree and 71.9% courses) has a great influence on the knowledge of the right to exercise Conscientious Objection on the part of the nurses from Madrid who participated in the study (55.6% without training, $p=0,005$).

Respondents working in private centres were more favourable to declare Conscientious Objection to Euthanasia and MAS than those working in public centres (Table 4).

Finally, the greatest differences between variables were found with respect to religious beliefs.

The nurses from Madrid who participated in the study and reported being religious believers were more knowledgeable about the right to exercise CO to Euthanasia requests (85.7%) than non-believers (65.8%), $p<0,001$.

In this sense, the majority of religious believers (50.8%) would definitely declare CO to the regulation of Euthanasia and MAS, compared to non-believers (6.5%) ($p<0.001$), as shown in more detail in Table 5.

Discussion

Few studies²⁹⁻³⁵ have been carried out in Spain in relation to Euthanasia and MAS in health care professionals, possibly because it is a practice that until now has been illegal^{36,37}. However, like ours, most of them believed that the debate on Euthanasia and MAS was a social debate and not only a clinical or political one. They also agreed that the main reason for requesting Euthanasia was loss of complete physical autonomy and personal freedom. These results coincide with the reports published by the Canadian³⁸ and Belgian³⁹ GECs, which show that the main reason for requesting assistance in dying is loss of autonomy.

Our research shows that the nurses from Madrid who participated in the study coincide with the doctors and nurses of the country in a position in favour of regulating both Euthanasia and MAS, as well as the mainly positive attitude towards their regulation at an international level³⁶.

With regard to doctors, the first study carried out in Spain to specifically address this issue was conducted by the Bizkaya Medical Association²⁹ (Basque Country) in 2018, showing a majority position in favour of both Euthanasia (82.8%) and MAS (72.4%). This was followed in 2019 by four more Spanish Autonomous Regions with very similar results: Tarragona³⁰ (91% Euthanasia, 84% MAS), Las Palmas³¹ (81.9% Euthanasia, 68.5% MAS) and Madrid³² (86.49% Euthanasia).

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3 In nursing, a study carried out in 2012 by Tamayo³³ *et al.* in Andalusia showed that 70% of nurses
4 surveyed were in favour of regulating Euthanasia compared to 65% of regulating MAS. In 2014 a
5 study³⁴ of primary care nurses in Asturias showed that 87.75% were in favour of regulating
6 Euthanasia compared to 62.06% for MAS, finding that religious beliefs influenced all the
7 questions raised in their research, as in our study.
8

9 Finally, in 2019, the Official College of Nurses of La Rioja³⁵ showed that 83.3% of nurses
10 surveyed were in favour of the regulation of Euthanasia compared to 67.4% for MAS.

11 Regarding the application of Euthanasia, there are big differences between the opinion of
12 doctors and Spanish nurses.
13

14 Thus, 48.6% of doctors in Bizkaya²⁹, 45% in Tarragona³⁰, 57.5% in Las Palmas³¹ and 64.6% in
15 Madrid³², considered that Euthanasia should only be applied by a doctor, compared to 42.3% of
16 nurses in our study who said that it could be applied by any professional in the field of medicine
17 and nursing, as did the nurses in La Rioja³⁵.
18

19 The fact is, Spanish legislation⁶ does not specify the professional who will carry out the
20 practice; it only refers to it being carried out with the utmost care and professionalism on the
21 part of health care professionals, both being supposedly included; which is one of the aspects
22 that may generate the greatest controversy during its application. In this sense, defining the
23 role of the professionals throughout the process, especially nurses, will be essential to identify
24 when and how situations of Conscientious Objection may arise, the percentage of professionals
25 who would exercise it being initially low, both in doctors²⁹⁻³² (27-37%) and nurses³³⁻³⁵ (26-35%).
26

27 Moreover, this present study is the only one that analyses the different situations contemplated
28 by the Spanish law, and therefore the situations in which professionals would declare
29 Conscientious Objection. Knowledge of these situations is key to designing the necessary
30 procedures to safeguard both the right of professionals to exercise Conscientious Objection and
31 the right of patients to receive the requested aid in dying.
32

33 As for requests of aid in dying, a study³³ conducted in 2012 in Spain showed that 21.4% of the
34 Andalusian nurses surveyed had had Euthanasia requests, compared to 7.8% for MAS. Another
35 study⁴⁰ conducted in 2015 in Belgium also showed that more than half of the participating nurses
36 had been directly confronted with a request for Euthanasia, with more than 80% pointing out
37 the need to allow such requests to be analysed, not only by doctors, considering this way the
38 role of the nurse to be crucial in dealing with them. In this regard, 46% of the nurses who
39 participated in a 2016 study in the Netherlands⁴¹ indicated that the patient is more likely to
40 make a request for Euthanasia to a nurse than to a doctor, claiming this way the need for nurses
41 to be involved in dealing with such a requests and to participate in the decision-making process,
42 as this is not legally recognised for nurses in the Netherlands. Following these lines, in our
43 research most of the nurses surveyed in Madrid would also be willing to participate in the
44 process of reflection and deliberation with the patient when asked for help in dying.
45

46 In relation to direct involvement in the implementation of Euthanasia or MAS, there is a growing
47 trend of favourable positioning towards the practice of aid in dying both nationally and
48 internationally. A study carried out in Finland⁴² in 2017 showed that 74.7% of the nurses
49 surveyed had a positive attitude towards applying Euthanasia if it were regulated, as did the
50 study carried out in Canada⁴³ which also showed a favourable stance of 67.3%. In Spain, the
51 predisposition to participate in the application of Euthanasia and MAS in 2012³³ was 54% and
52 47.3% respectively, with results very similar to those found almost 10 years later in our
53 research. However, between both practices, the one that generates the highest percentage of
54 Conscientious Objection is the preparation and direct administration of the drug (Euthanasia)
55 as opposed to MAS. This coincides with the study by Zenz⁴⁴ *et al.*, which showed that
56 professionals were more willing to participate in MAS than in Euthanasia. On the other hand, it
57 should be noted that Spain is the first European regulation that allows direct administration of
58 the drug by the nurse, unlike Belgium, the Netherlands and Luxembourg, where only the
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3 responsible physician can legally do so; although in clinical practice there are situations in
4 which they do also participate in this process.

5
6 A systematic review³⁷ conducted in 2021 on nurses' perceptions and attitudes towards
7 euthanasia showed a number of factors associated with positioning for or against Euthanasia
8 practices. The factors determining the negative attitude and/or lack of support were religion
9 (like the results shown in our research to be one of the most conditioning factors),
10 moral/ethical dilemmas, the role of the health professional's gender and poor palliative care.
11 In contrast, factors associated with a positive and/or supportive attitude to such practices were
12 unbearable suffering or other distressing experiences of the patient, the legality of euthanasia
13 and the patient's right to die, as were the results found in our research.

14
15 Other studies⁴⁵⁻⁴⁶ show that education, age (especially young people) and gender (men) may
16 also influence favourable attitudes towards the provision of Euthanasia. However, in our study
17 statistically significant differences with respect to gender were not found, but there were
18 differences with respect to age. Our findings were, contrary to these publications, the older
19 the age and the longer the work experience as a nurse, the better the attitudes towards
20 Euthanasia; and also with training, with attitudes improving with postgraduate courses in
21 bioethics and palliative care. In this respect, another study⁴⁰ shows the need to include specific
22 training in the approach to requests for assistance in dying in order to provide a comprehensive
23 approach, highlighting its inclusion in undergraduate training.

24
25 The limitations of this research include the fact that the type of sampling used may make
26 extrapolation to other regions of Spain difficult, although studies have subsequently been
27 carried out in other regions such as Teruel or the Balearic Islands using the same instrument
28 that we developed, obtaining results very similar to those of our research.

29
30 Euthanasia and MAS pose a great challenge for nurses in their clinical practice^{47,48}. Nurses must
31 be informed of the existing legislation, as well as receive the necessary in-depth training to
32 enable them to adopt a position in accordance with their values and have professional
33 guidelines that facilitate the identification of their role. To this end, as our research has shown,
34 it will be key for nurses to participate in guiding and influencing the drafting of the law through
35 the Professional Colleges.

36
37 In this sense, with the aim of participating in health policy and exercising representation and
38 positioning in relation to an area in which the nursing profession is directly involved, based on
39 the results obtained in our research, on 14th December 2020 we published a report⁴⁹ in which
40 the different nurses' perspectives for the approval of Euthanasia and MAS were gathered, from
41 an ethical, social, deontological, legal and clinical approach. This report was sent to the
42 government, to all parliamentary groups, along with dissemination to other organisations, the
43 media and the public, with the aim of providing a series of recommendations; not only for
44 legislation, but also for its appropriate implementation in clinical practice. Particular emphasis
45 was placed on the inclusion of the participation of nurses throughout the dialogue process and
46 not merely as specific or instrumental acts, the modification of the Penal Code exempting both
47 doctors and nurses from liability (as initially it only included doctors) and the inclusion of nurses
48 as members of the Guarantee and Evaluation Commissions (as initially it only included doctors
49 and lawyers). It should be noted that some of the proposed recommendations were included in
50 the final regulatory text¹, such as the modification of the Penal Code and the inclusion of nurses
51 in the GECs.

52
53 Following the approval of the law on 24th March 2021, this research team published various
54 documents⁵⁰⁻⁵¹ on the nurse's role and CO, in order to bring the regulatory text closer to the
55 nurses' position in Madrid. An online information day was also held for both nurses and the
56 general public.

57
58 Finally, before its entry into force in May 2021, a new document⁵² was drafted, following a
59 proposal to do so by the body responsible for the Department of Health of the Community of
60 Madrid, to provide a series of recommendations for the correct application of the law. It

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3 emphasised the importance of defining the healthcare team involved in the process, in
4 particular clearly detailing the functions of the different professionals (including the role of
5 the nurse in charge), as well as the need to establish a series of profiles and requirements for
6 the composition of the GECs; and models for how to exercise Conscientious Objection. It should
7 also be noted that some of these recommendations have been included in the implementation
8 of the law in the autonomous region.
9

10 Since the law came into force in Spain, it has been possible to observe the great variability in
11 its application between the different autonomous regions, especially in the lack of clarity in
12 the roles of professionals. Also, further research is needed to explore the impact on the
13 emotional well-being of nurses, to identify their roles and to determine the support they need
14 when they participate in the provision of assistance in dying.
15

16 Conclusion

17 Based on the results obtained, the following conclusions can be drawn:
18

19 Firstly, the nurses in Madrid who participated in the study are mostly in favour of the regulation
20 of both Euthanasia and MAS, especially those over 50 years of age, with more than 30 years of
21 work experience, who work in the public sector and are not religious believers.
22

23 Secondly, attitudes towards the legislative aspects show a greater consensus on the
24 involvement of the deliberative process, joint information, and accompaniment during the
25 provision of aid in dying, than on the direct preparation and administration of the drug;
26 especially among professionals with postgraduate training in palliative care and bioethics, and
27 non-believers.
28

29 Thirdly, there is greater agreement on nurses' involvement in MAS than in Euthanasia, although
30 the nurses from Madrid who participated in the study consider that it can be applied by both a
31 doctor and a nurse.
32

33 Finally, there is a low percentage of Conscientious Objection, being related to age, years of
34 work experience, model of care and above all religious beliefs; the key being the protocolisation
35 of the procedure to safeguard both the ideological freedom of the professional, and the legally
36 established patient's right to this service.
37

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40

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44

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