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EMPIRICAL RESEARCH QUANTITATIVE

The paradoxical position of nurses regarding euthanasia and its legalisation: A descriptive quantitative study

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Abstract

Aims and Objectives: To learn about the attitudes of nurses working in the Andalusian Public Health System regarding euthanasia and its legalisation.

Background: Euthanasia often finds itself in the crosshairs of ethical and political debate on an international scale. Currently, the Spanish Organic Law 3/2021 of 24 March, 2021, recognises euthanasia as a fundamental right in Spain. It is of particular interest to know about the views, attitudes and stances that Andalusian nurses have of euthanasia as they are key players within the framework of euthanasia and administration of life-ending drugs. They play a central role in guiding patients through the euthanasia application process.

Design: Observational descriptive study.

Methods: A study of Andalusian Public Health System nurses was carried out using non-probability convenience sampling. 518 nurses with an average age of 44.75 years answered in a questionnaire that was distributed on an online platform. Sociodemographic and occupational variables were assessed, together with the Death Anxiety Scale and the Euthanasia Attitude Scale. A bivariate analysis and a multivariate linear regression model were performed. The STROBE checklist was used.

Results: The mean score obtained on the Euthanasia Attitude Scale was 75.95 (SD = 16.53). The mean score obtained on the Death Anxiety Scale was 7.56 (SD = 3.05). The variables age and work experience were negatively correlated with the total scores of the Euthanasia Attitude Scale and the categories 'Ethical considerations', 'Practical considerations' and 'Treasuring life'. On the other hand, there was a significant positive correlation between age and work experience and 'Spiritual beliefs' category.

Conclusions: The current situation shows a worrying paradox. There is a stark difference between positive professional attitudes towards euthanasia and the desire to participate in its application.

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Relevance to Clinical Practice: It is vital that educational and healthcare institutions make the necessary efforts to ensure that nurses develop sound moral judgement, displaying the moral conscience and ethical commitment required of this established profession.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
assisted suicide, death, ethics of care, euthanasia, nursing

1 | INTRODUCTION

In Spain, euthanasia has found itself in the crosshairs for several years as it not only causes social debate that affects healthcare professionals but also generates discussion within political, judicial and ethical spheres in Spain (De Lima et al., 2017; Radbruch et al., 2016). In Organic Law 3/2021, of 24 March, which regulates euthanasia (LORE), it is stated that 'there is broad agreement to limit the use of the term' euthanasia to that which is produced actively and directly so that actions by omission that were designated as passive euthanasia or those that could be considered as indirect active euthanasia have been excluded from the bioethical and legal-criminal concept of euthanasia. In addition, the definitions of euthanasia and medical aid for suicide can be compared: the first consisting of the intentional provocation of the death of a person suffering from an advanced or terminal illness, at the express request of the latter, and in a medical context, and the second, medical help to carry out a suicide, at the request of a sick person, providing them with the necessary drugs so that they can administer them themselves.

Currently, different countries in the European Union and the Americas have legalised euthanasia in their respective legislative systems (Emanuel et al., 2016). In the United States, euthanasia is illegal, but there are several states that have already regulated assisted suicide. The pioneer state in legislating euthanasia was Oregon in 1997, followed by Washington in 2008, Montana in 2009, Vermont in 2013, Colorado and Washington DC in 2016, California in 2016, Hawaii in 2018 and New Jersey and Maine in 2019. In addition, Canadá legaliza la "ayuda médica para morir" en 2016 Canada legalised "medical aid for dying" in 2016 (Velasco-Bernal & Trejo-Gabriel-Galan, 2022). In Latin America, Colombia is the only country that has legalised assisted dying. Although the Colombian Constitutional Court decriminalised "mercy killing" in 1997, it was not until 2015 that the Ministry of Health detailed and listed a protocol on how to proceed (Marcela-Torres, 2015).

The first country in the European Union to legalise euthanasia and assisted suicide was the Netherlands in 2001. Belgium also legalised euthanasia in 2002 and subsequently in 2014 legalised child euthanasia without an age limit provided that consent is obtained from both parents and an assessment is made of whether the child is aware of their decision (Abarshi et al., 2009; Roest et al., 2019; Smets et al., 2010). In Switzerland in November 2006, the Federal Court, through article 115 of its Penal Code, determined that assisted suicide would be allowed both for Swiss and non-Swiss individuals. Years later, Luxembourg was added to the list of countries in 2009 (Dierickx et al., 2020; Kelly, 2017).

Other authors have affirmed that the main differences of the LORE that regulates euthanasia in Spain, in comparison with other similar legislations, is that in Spain the rights of the conscientious objection of health professionals and their practical organisation are more greatly emphasised, and the fact that patients requesting euthanasia should receive prior comprehensive care is also stressed (Bellon et al., 2022; Velasco-Bernal & Trejo-Gabriel-Galan, 2022). Despite these guarantees, the LORE lacks certain details such as how to distinguish between euthanasia and physician-assisted suicide (Organic Law 3/2021). Neither does it

What is known about the subject?

The stance on euthanasia and assisted suicide among nurses dedicated to patient-centred care is largely more positive than those of other healthcare professionals. One of the most important influencing factors of stances on euthanasia is spirituality/religion.

What this paper adds to existing knowledge

The less work experience nurses have, the more positive their view of euthanasia. The new generations of nurses value the autonomy of their patients and accept the reduction or elimination of suffering in life. However, it must be noted that a substantial contradiction can be observed between theory and practice among professionals, between positive perceptions of euthanasia and the desire to partake in the process.

What are the implications for practice?

It is vital that educational and healthcare institutions make the necessary efforts to ensure that nurses develop sound moral judgement, displaying the moral conscience and ethical commitment required of this established profession.

This is the minimum requirement needed in this profession so that nurses can effectively tackle situations concerning patient requests for hastened death and further develop their roles as 'patient advocates'.

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specify the role of various other professionals involved in the process, and there is no role assigned to the healthcare team as a whole – a common factor with other current legislations (Velasco et al., 2021).

One of the pertinent questions regarding the LORE, which is mentioned in a large percentage of ethical debates on euthanasia, is that it focuses on the participation of the medical team. Rarely is attention focused on the involvement of nurses as active players, considering that nurses make up the central nucleus and/or heart of patient-centred care in terminal or end-of-life situations where requests for euthanasia are always a possibility (De Beer et al., 2004; Dierickx et al., 2020). In Spain and in other countries, nurses are in charge of administering drugs intravenously so they are strongly involved in the euthanasia act itself (Pesut et al., 2020). However, nursing functions are much broader as they are involved in caring for applicants and their families throughout the process (Bellon et al., 2022).

According to Polo-Moreno et al. (2021), nurses state that they experience significant emotional conflict regarding assisted dying, strongly suggesting that this is a difficult process for them. Moreover, some nurses need to find common ground between assisted dying and their own beliefs and moral values (Richardson, 2023). As seen both inside and outside Spain, there is a marked positive attitude towards the legalisation of euthanasia (Sandvik et al., 2022). In addition, the majority of working and student nurses at present report being in favour of the application of euthanasia in various clinical settings (Ortega-Galán et al., 2022; Velasco et al., 2021). Younger nurses have a general tendency to value euthanasia in a positive way (Green, 2021; Khatony et al., 2022).

It is of particular interest to know about the views, attitudes and stances that Andalusian nurses have regarding euthanasia as they are key players within the framework of euthanasia and administration of life-ending drugs. They play a central role in la información del derecho a su solicitud guiding patients through the euthanasia application process. The objective of this study is to learn the attitudes of the nurses working in the Andalusian Public Health System (APHS) regarding euthanasia and anxiety about death in relation to age and work experience.

Providing information on their rights to make a request for euthanasia and guide patients through the euthanasia application process. The aim of this study was, therefore, to learn about the attitudes of the nurses working in the Andalusian Public Health System (APHS) in terms of euthanasia and anxiety about death in relation to age and work experience.

2 | METHODS

2.1 | Study design

The authors carried out a descriptive, cross-sectional quantitative study. The STROBE checklist was followed to ensure the quality of the study (Cuschieri, 2019; see Appendix S1).

2.2 | Population and setting

Participants were recruited using an online questionnaire to which they responded while it was active. Professionals considered eligible for inclusion were those who were actively working in a clinical practice environment and/or in a healthcare setting and who had direct contact with patients. Exclusion criteria were professionals who were full-time union representatives, those who had a temporary disability or those who worked in healthcare administration and/or management. Several social media platforms, official professional associations, and various scientific societies were used as dissemination methods. Finally, a sample of 518 nursing professionals was obtained.

2.3 | Procedure and instruments

Data collection was conducted in the second term of 2021. A questionnaire was created using an online platform to facilitate the collection of data and dissemination of the study. The questionnaire was sent to participants digitally, and recruitment was carried out by the members of the board of directors as well as through several social networks. These questionnaires were self-reported, taking approximately 15 min per person to complete. Participation was voluntary and participants were asked to give informed consent.

Data collection included the following variables and instruments:

- Socio-demographic variables:
- Sex: dichotomous quantitative variable (male/female).
- Age: continuous quantitative variable (in years).
- Marital status: polychotomous quantitative variable (single, married or living with a partner, separated or divorced and widow/widower).
- Employment status: polychotomous quantitative variable (casual worker, temporary cover worker, worker on fixed-term contract, statutory employee and others).
- Workplace: polychotomous quantitative variable (inpatient unit, primary care, critical care unit, emergency department, medical/surgical unit, support services and others). Inpatient units refer to those units where the patient is admitted to a hospital room for prolonged periods of time. However, medical-surgical units refer to units where the patient undergoes a scheduled medical-surgical intervention and sometimes a hospital stay is not necessary (e.g. day hospital).
- Work experience: continuous quantitative variable (in years).
- Instruments:
- The Death Anxiety Scale (DAS) was developed by Templer in 1970 and later validated and translated into Spanish by Ramos in 1982. It is a 15-item dichotomous-response scale (true/false), which measures the degree of anxiety produced in the person by having to face death. The lowest score that can be obtained when completing the questionnaire is 0 points while the highest is 15 points, with higher scores indicating high levels of anxiety.

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- The Euthanasia Attitude Scale (EAS) was developed in the United States by Tordella and Neutens in 1979 and validated and translated into Spanish in 2019 by Onieva-Zafra. It is a 21-item scale divided into four sections: ethical considerations (11 items), practical considerations (4 items), treasuring life (4 items) and spiritual beliefs (2 items). The questions are answered using the 5-point Likert scale: 5 corresponds to 'strongly agree'; 4 to 'agree'; 3 to 'neither agree nor disagree'; 2 to 'disagree'; and 1 to 'strongly disagree'. The minimum and maximum scores are 21 and 105 points, respectively, with higher scores indicating more positive attitudes to euthanasia.

2.4 | Statistical analysis

The statistical analysis was carried out using the SPSS Statistics, version 27 software (IBM Corp). A descriptive analysis was performed in which the measures of central tendency were calculated alongside the measures of dispersion for quantitative variables. Percentages and frequencies were calculated for qualitative variables. The Kolmogorov–Smirnov test was used to test the normality of quantitative variables. 95% confidence intervals were obtained both for the means and proportions. Student's *t*-test was carried out to compare the mean between two independent groups (sex), and ANOVA was used for more than two groups (employment status). Pearson's correlation was also used to examine the correlations between quantitative variables. Finally, a multiple linear regression analysis was performed for the DAS and EAS total scores (dependent variables), considering as independent variables those that had significant correlations with these variables. To avoid collinearity, variables with a Variance Inflation Factor (VIF) greater than 10 were excluded from the model (Martínez-González et al., 2020). The statistical significance threshold was set at .05 for all results.

TABLE 1 Socio-demographic variables and the Death Anxiety Scale (DAS) and the Euthanasia Attitude Scale (EAS) ($n = 518$).

Variables	*N* (%)	Mean (SD)	Range	Median
Age (years)		44.75 (11.92)	22–69	47
Work experience (years)		21.09 (12.51)	0–48	22
Sex				
Female	397 (76.6)			
Male	121 (23.4)			
Marital status				
Single	112 (21.6)			
Married or living with a partner	362 (69.9)			
Separated or divorced	35 (6.8)			
Widow (er)	8 (1.5)			
Employment status				
Casual worker	141 (27.2)			
Temporary cover worker	29 (5.6)			
Worker on fixed-term contract	44 (8.5)			
Statutory employee	268 (51.7)			
Workplace				
sz	143 (27.6)			
Primary care	159 (30.7)			
Critical care unit	51 (9.8)			
Emergency department	34 (6.6)			
Medical/surgical unit	32 (6.2)			
Support services	19 (3.7)			
Other	65 (12.5)			
DAS (total score)		7.56 (3.05)	0–15	7.5
EAS (total score)		75.95 (16.53)	30–103	79.5
Ethical considerations		42.79 (10.5)	11–55	46
Practical considerations		2.37 (3.69)	4–20	13
Treasuring life		14.52 (3.56)	5–20	15
Spiritual beliefs		6.26 (1.59)	2–10	6

Abbreviations: DAS, Death Anxiety Scale; EAS, Euthanasia Attitude Scale; SD, Standard Deviation.

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2.5 | Ethical considerations

The study was presented to the Research Ethics Committee for the province of Huelva (ENF-EU-2021), obtaining a favourable report. Participants in the study gave their explicit consent before taking part. All participation was voluntary. Every person involved was properly informed about the study, their rights of participation and their right to withdraw at any time if deemed necessary without facing any form of retaliation, academic or otherwise. The following legislation applies to the execution of this study: Spanish Organic Law 3/2018 of 5 December, on Personal Data Protection and Guarantee of Digital Rights; Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 (GDPR) on the protection of natural persons with regard to the processing of personal data and on the free movement of such data; and the provisions laid out surrounding ethical principles in the Declaration of Helsinki. Finally, all data, results, discoveries and information gathered, obtained or developed during this study will not be used for any means other than their original intended use to meet the objectives laid out in this study.

3 | RESULTS

Of the total sample, 76.6% were women and 23.4% were men with the mean age of 44.75 (SD = 11.92) years old. A total of 30.7% of the sample worked in primary care, with 27.6% working in inpatient units. The remaining professionals worked in critical care units, emergency departments, medical/surgical units, mental health and outpatient consultations, among other services. The mean number of years of work experience was 21.09 (SD = 12.51) years. For the EAS scale, the mean score obtained was 75.95 (SD = 16.53), with the highest mean score being in the 'Ethical considerations' section of the questionnaire. Regarding the DAS, the mean score was 7.56 (SD = 3.05) (Table 1).

In the DAS scale, it was demonstrated that the total mean score of female participants ($M = 7.81$; SD = 2.98) was significantly higher than that of male participants ($M = 6.76$; SD = 3.13). This may be understood as women being more anxious and worried about death than men ($p = <0.001$) (Table 2).

With regards to the employment status of the survey group, there were substantial differences found within the EAS questionnaire – casual workers ($M = 80.87$; SD = 14.71) scored the highest in attitudes towards euthanasia ($p = <0.001$). Similarly, casual workers continued to present favourable attitudes in the 'Ethical considerations' ($p = 0.001$), 'Practical considerations' ($p = 0.004$) and 'Treasuring life' ($p = 0.001$) dimensions (Table 3).

There was also a significant negative correlation found between work experience and the DAS scale ($p = 0.003$; CI = −.04, −.21), as well as a very significant negative correlation between the EAS scale ($p = <0.001$: CI = −.10, −.27) and the 'Ethical considerations' ($p = <0.001$; CI = −.11, −.27), 'Practical considerations' ($p = 0.001$; CI = −.06, −.23) and 'Treasuring life' ($p = <0.001$; CI = −.08, −.25), categories – more years of work experience meant less anxiety about death, a less positive view of euthanasia, less concern with ethical considerations and less regard for treasuring life. Furthermore, there was also a significant negative correlation between age and

TABLE 2 Relationship between 'Sex' and the Death Anxiety Scale (DAS) and the Euthanasia Attitude Scale (EAS).

Variables	*N*	Mean (SD)	*t*	Sig. (two-tailed)*
DAS (total score)	518	7.56 (3.05)	3.34	<.001
Women	397	7.81 (2.98)		
Men	121	6.76 (3.13)		
EAS (total score)	516	75.95 (16.53)	−.095	.924
Women	395	75.91 (16.44)		
Men	121	76.08 (16.88)		
1. Ethical considerations	516	42.79 (10.50)	−.088	.930
Women	325	42.77 (10.52)		
Men	121	42.86 (10.45)		
2. Practical considerations	516	12.37 (3.69)	−.008	.994
Women	325	12.37 (3.62)		
Men	121	12.38 (3.94)		
3. Treasuring life	516	14.52 (3.56)	.680	.497
Women	325	14.58 (3.41)		
Men	121	14.33 (4.01)		
4. Spiritual beliefs	516	6.26 (1.59)	−1.920	.055
Women	325	6.18 (1.60)		
Men	121	6.50 (1.51)		

Abbreviations: DAS, Death Anxiety Scale; EAS, Euthanasia Attitude Scale; SD, Standard Deviation; Sig., Significant level; *t*, Student's *t*-test.

*$p < 0.05$.

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TABLE 3 Relationship between 'Employment Status' and the Death Anxiety Scale (DAS) and the Euthanasia Attitude Scale (EAS).

Variables	*N*	Mean (SD)	*F*	Sig. (two-tailed)*
DAS (total score)				
Casual worker	141	8.00 (2.85)	1.49	.188
Temporary cover worker	29	7.44 (2.94)		
Worker on fixed-term contract	44	7.36 (3.07)		
Statutory employee	268	7.41 (3.19)		
Other	35	7.20 (2.63)		
Total	518	7.56 (3.05)		
EAS (total score)				
Casual worker	141	80.87 (14.71)	4.18	<.001
Temporary cover worker	29	72.48 (17.12)		
Worker on fixed-term contract	44	75.59 (13.30)		
Statutory employee	266	74.04 (16.99)		
Other	35	73.34 (19.18)		
Total	516	75.95 (19.18)		
1. Ethical considerations				
Casual worker	141	45.92 (9.31)	4.04	.001
Temporary cover worker	29	41.44 (10.48)		
Worker on fixed-term contract	44	43.04 (8.06)		
Statutory employee	266	41.44 (10.96)		
Other	35	40.91 (11.76)		
Total	516	42.79 (10.50)		
2. Practical considerations				
Casual worker	141	13.26 (3.44)	3.54	.004
Temporary cover worker	29	11.27 (4.05)		
Worker on fixed-term contract	44	12.11 (3.22)		
Statutory employee	266	12.12 (3.67)		
Other	35	11.77 (4.38)		
Total	516	12.37 (3.69)		
3. Treasuring life				
Casual worker	141	15.56 (3.09)	4.04	.001
Temporary cover worker	29	13.69 (3.45)		
Worker on fixed-term contract	44	14.06 (3.71)		
Statutory employee	266	14.16 (3.70)		
Other	35	14.14 (3.37)		
Total	516	14.52 (3.56)		
4. Spiritual beliefs				
Casual worker	141	6.12 (1.58)	.538	.747
Temporary cover worker	29	6.06 (1.75)		
Worker on fixed-term contract	44	6.36 (1.73)		
Statutory employee	266	6.30 (1.56)		
Other	35	6.51 (1.59)		
Total	516	6.26 (1.59)		

Abbreviations: DAS, Death Anxiety Scale; EAS, Euthanasia Attitude Scale; *F*, ANOVA; SD, Standard Deviation; Sig., Significant level.
*$p < 0.05$.

the 'Practical considerations' category of the EAS scale ($p = 0.004$; CI = −.04, −.21), as well as substantial negative correlations between age and the EAS scale ($p = <0.001$; CI = −.09, −.26) and the 'Ethical considerations' ($p = <0.001$; CI = −.10, −.26) and 'Treasuring life' ($p = <0.001$; CI = −.08, −0.25) categories. Therefore, the older the age and lower the score in practical considerations regarding

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TABLE 4 Correlation between 'Work Experience' and 'Age' with regard to the Death Anxiety Scale (DAS) and the Euthanasia Attitude Scale (EAS).

Variables	*N*	Work experience	Age
DAS (total score)			
Pearson's correlation	518	−.129**	−.084
Sig. (two-tailed)		.003	.057
EAS (total score)			
Pearson's correlation	516	−.190**	−.177**
Sig. (two-tailed)		<.001	<.001
1. Ethical considerations			
Pearson's correlation	516	−.197**	−.185**
Sig. (two-tailed)		<.001	<.001
2. Practical considerations			
Pearson's correlation	516	−.150**	−.129**
Sig. (two-tailed)		<.001	.004
3. Treasuring life			
Pearson's correlation	516	−.170**	−.182**
Sig. (two-tailed)		<.001	<.001
4. Spiritual beliefs			
Pearson's correlation	516	.054	.089*
Sig. (two-tailed)		.222	.045

Abbreviations: DAS, Death Anxiety Scale; EAS, Euthanasia Attitude Scale; SD, Standard Deviation; Sig., significant level.

*Correlation is significant at the 0.05 level (two-tailed).; **Correlation is significant at the 0.001 level (two-tailed).

euthanasia, the lower the score for ethical considerations and treasuring life. Additionally, there was a significant positive correlation between age and the fourth category of the EAS scale: 'Spiritual beliefs' ($p = 0.045$; CI = .17, .002) (Table 4).

In the multiple regression model for DAS, age ($p = 0.015$), gender ($p = 0.001$) and work experience ($p = 0.001$), all have a significant influence on DAS. Of these three variables, work experience is that with the greatest weight (*Beta* = −0.40). This model explains 4% of the variance ($R^2 = 0.04$) (Table 5).

In contrast, in the multiple regression model for EAS none of the socio-demographic and occupational variables have a significant influence on the DAS dependent variable (Table 6).

4 | DISCUSSION

The main aim of this quantitative study has been to learn about the attitudes of nurses working in the Andalusian Public Health System in terms of euthanasia and the various aspects of the end-of-life process. The main results obtained in the study show that, among the attitudes towards euthanasia, those that concern practical considerations demonstrate that, with greater work experience and age, the positive vision of euthanasia and the intention to participate in the euthanasia context decrease. In terms of ethical considerations, it can be seen that younger staff with less work experience have more positive attitudes and perceptions of euthanasia, as well as a more utilitarian view of life. They, therefore, place more weight on how life is lived rather than the concept of being alive and also on the autonomy of their patients. This is the main objective of the profession in Western societies: to provide care within the framework of the patient's personal autonomy (García, 2020; Khatony et al., 2022; Rodríguez-Calvo et al., 2019).

In addition to respecting personal autonomy, other influencing factors towards a more positive view of euthanasia include experiencing uncontrollable pain, unbearable suffering and other unpleasant patient situations or circumstances (Cayetano-Penman et al., 2021). In other words, autonomy and freedom from pain and suffering are the most important values for younger nursing professionals. They are regarded as being more valuable than preserving life or even not causing death, which, in former times, was the core purpose of healthcare.

However, there is an interesting paradox in this respect, given the positive view of euthanasia among this collective, which is much higher than in doctors (Bužgova & Zapletalova, 2021; Martins et al., 2021). It could be a good strategy to give nursing staff a higher degree of responsibility and autonomy regarding how they approach hastened death requests from patients. But, this inevitably clashes with the idea of nurses having minimal involvement in the process, as suggested in the LORE (Organic Law 3/2021).

The real paradox, however, is that although there is a majority in favour of the legalisation of euthanasia, there are few professionals willing to work in contexts where euthanasia practices are carried out – perhaps it would give them much more responsibility than they are willing to take on (Bellens et al., 2020; Parozzi et al., 2021). Furthermore, it is clear that despite the positive opinions of euthanasia and a positive shift towards its legalisation, there are several misconceptions and a certain confusion about its definition among professionals (Bogado, 2020; García, 2020). Nurses also show a considerable lack of knowledge about euthanasia itself (Crusat-Abelló & Fernández-Ortega, 2021).

On the other hand, spirituality is identified as a primary factor in perceptions of euthanasia (Green, 2021; Saadeh et al., 2021). Some studies have found a direct link between views of euthanasia and spirituality, suggesting that regular religious practice is connected to negative perceptions of euthanasia (Badanta et al., 2022; Malliarou et al., 2022; Sabriseilabi & Williams, 2022). However, for younger professionals, religion and spirituality result in a better adaptive response to personal life events as they are understood as 'mediators' (Hardy et al., 2019; Schnitker et al., 2021).

Furthermore, it is claimed that younger professionals are capable of repurposing, redefining and/or reshaping aspects of great spiritual traditions to their own individual circumstances by taking ownership of the established norms but identifying less with them. A sense of belonging is no longer linked to religion and is beginning to manifest itself in areas relating to the meaning of life and spirituality (Silva-Dreyer et al., 2010). In this way, the evolution of religious and spiritual influence on professional nursing practice

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TABLE 5 Multiple linear regression for the Death Anxiety Scale (DAS).

	Non-standardised coefficients		Standardised coefficients			CI (95%)	
	B	Error *t*.	Beta	*t*	Sig.	Lower limit	Upper limit
Constant	7.47	.93		8.03	.000	5.64	9.29
Sex	−1.00	.31	−.14	−3.22	.001	−1.62	−.39
Age	.07	.03	.29	2.43	.015	.01	.13
Work experience	−.09	.03	−.40	−3.26	.001	−.15	−.03

Abbreviations: CI, confidence interval; Error *t*., Standard error; Sig., significant level; *t*, Student's *t*-test.

TABLE 6 Multiple linear regression for the Euthanasia Attitude Scale (EAS).

	Non-standardised coefficients		Standardised coefficients			CI (95%)	
	B	Error *t*.	Beta	*t*	Sig.	Lower limit	Upper limit
Constant	80.19	4.66		17.18	.000	71.02	89.36
Age	.02	.17	.01	.15	.878	−.31	.36
Work Experience	−.30	.16	−.23	−1.84	.066	−.62	.02
Employment status	.28	.58	.02	.48	.625	−.86	1.44

Abbreviations: CI, confidence interval; Error *t*., Standard error; Sig., significant level; *t*, Student's *t*-test.

could be a line of investigation for future study. Another line of research to be developed is an in-depth study of how experiences of contact with near-death influence the perception of euthanasia. Likewise, simulated clinical trials with training interventions in bioethics involving moral decisions could be used to verify their effect on professionals.

4.1 | Limitations

This study has a number of limitations. Firstly, this is a descriptive cross-sectional study without randomisation. As such, it does not determine the causality of the variables analysed, which would require a longitudinal study with more active observation over time. Despite this limitation, relationships or associations between the study variables have been identified. The online data collection can also be considered a weakness and implies a selection bias, so caution should be exercised when making generalisations. Finally, the professionals who participated in the study work in different health and social care settings. This may have influenced participants' responses. Nevertheless, the wide range of settings has provided an overview of health professionals' perceptions of euthanasia.

5 | CONCLUSIONS

We have been able to conclude from this study that nurses have positive views and attitudes of euthanasia practices. There is a stark difference between positive professional attitudes towards euthanasia (especially among young nurses) and the desire to participate in its application. Professionals show certain inconsistencies between values and practical orientation as on the one hand they express a positive assessment regarding the application of euthanasia, but they do not wish to participate in assisting such processes. As for spiritual aspects, it is important to highlight the influence of religious and/or spiritual belief on professional views of euthanasia and ethical conflicts. It is vital that beliefs and values are considered basic essential elements of professional development. It would be of interest to give more value in undergraduate and postgraduate training to knowledge about major ethical conflicts, the development of the capacity for moral discernment, and the moral conscience necessary for the ethical commitment typical of a developed profession.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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