Attitudes of Suicide Prevention Workers toward Euthanasia

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List of Abbreviations

ALS	Amyotrophic lateral sclerosis
CRD	Chronic respiratory disease
CVD	Cardiovascular diseases
df	Degrees of freedom
EUTH	Euthanasia
M	Median
MAiD	Medical Assistance in Dying
n	Sample size
p	*P*-Value
PAS	Physician-assisted suicide
SA	Suicide assisté
SPC	Suicide Prevention Centre
SCC	Supreme Court of Canada
SD	Standard deviation
SPWs	Suicide prevention workers
QASP	Quebec Association for Suicide Prevention
$\chi 2$	Chi^2-test

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Thesis Outline

This thesis is a "thesis by articles" and is composed of four chapters. Chapter one provides background information on medical assistance in dying (MAiD), specifically euthanasia and physician-assisted suicide. This chapter is comprised of six sections: introduction, terminology of euthanasia and physician-assisted suicide, legalization of both practices in different countries, legalization in Canada, support for euthanasia and physician-assisted suicide, mental health workers' attitudes toward euthanasia and physician-assisted suicide, and finally, euthanasia and suicide prevention.

Chapters two and three are comprised of two research articles. Chapter two presents findings from a literature review on the attitudes of mental health workers toward euthanasia and physician-assisted suicide. The objectives of the literature review were to: 1) give an overview of published literature on attitudes of mental health workers towards euthanasia and assisted suicide; and 2) examine the relationship between attitudes and the influence of sociodemographic factors as well as the influence of personal and professional experiences. Chapter 2 is written in French, has been formatted for submission to the journal *Criminologie* and conforms to the standards of that peer-reviewed journal. Chapter three presents findings from a cross-sectional study on the attitudes of suicide prevention workers (SPWs) toward euthanasia in Quebec. The objectives of the second study were to: 1) examine the attitudes of SPWs toward euthanasia for a non-descript person versus for a loved one; 2) verify the association amongst various factors (e.g. experiences and sociodemographics) and attitudes toward euthanasia; and 3) better understand personal experiences of SPWs in relation to grievous illness. This manuscript has been formatted

for submission to *OMEGA – Journal of Death and Dying* and conforms to the standards of that peer-reviewed journal.

Chapter four provides a general discussion of the results of the analysis with respect to the theoretical framework of the study. It also identifies areas for improvement based on findings from the literature review and from the cross-sectional study presented in chapters two and three, and draws conclusions based on these findings. Ways of applying the research as well as ideas for further studies are suggested.

CHAPTER ONE

Introduction

Advances in science and medical technology have played a key role in prolonging life and delaying death. In Canada, life expectancy at birth is 83.0 years and has been steadily increasing over the past ten years (Public Health Agency of Canada, 2016). As a consequence of increased longevity, quality of life may decrease among those who are suffering from a chronic illness. In fact, more than one in five Canadian adults are living with a chronic disease such as cardiovascular diseases (CVD), chronic respiratory disease (CRD), diabetes or cancer (Public Health Agency of Canada, 2016). Cancer has been diagnosed in around 800, 000 Canadians within the last ten years (Public Health Agency of Canada, 2016) and accounted for 75, 112 deaths in 2013 (Statistics Canada, 2013), making it the leading cause of death among Canadians (Public Health Agency of Canada, 2016; Statistics Canada, 2013). When suffering increases, such as is often the case in terminal cancer, patients may wish their lives to end and seek assistance in the termination of life. In fact, many studies have shown that euthanasia or physician-assisted suicide are usually chosen by patients affected with cancer (Chambaere, Vander Stichele, Mortier, Cohen & Deliens, 2015; Dierickx, Deliens, Cohen & Chambaere, 2015; Steck et al., 2013; Onwuteka-Philipsen et al., 2012; van der Heide et al., 2007) but is also the case with any life limiting illness (Hendry et al., 2012). For these reasons and others, including the rise in chronic illness, detailed discussions on medical aid in dying specifically on euthanasia and assisted suicide are of increasing importance in to Canadian society.

Terminology

Before we begin to discuss attitudes toward euthanasia and physician-assisted suicide, it is essential to fully understand the terms. Medical aid in dying, a term encompassing the concept of medical assistance in the termination of life, includes both the practice of euthanasia and physician-assisted suicide (Pappas, 1996). Etymologically, euthanasia has its roots in ancient Greece and is derived from *eu* (good) and *thanathos* (death), hence meaning "good death" (Marcoux, 2011). However, this term's meaning is complex and has changed several times throughout history and across jurisdictions (Griffiths, Weyers & Adams, 2008; Marcoux, 2011). As stated by Marcoux, Mishara and Durand (2007), a general consensus exists in research, legislation and in the medical field to take a definition similar to the one used in the Netherlands. Therefore, euthanasia will be defined as "the administration of drugs with the explicit intention of ending the patient's life, at the patient's explicit request" (van der Maas et al., 1996) throughout this thesis. In most industrialised countries, this is the "official" definition and it has served as a basis for regulating the practice in certain European countries (Marcoux, 2011). Physician-assisted suicide, on the other hand, will be defined as "the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life" (van der Maas et al., 1996).

The distinction between euthanasia and physician-assisted suicide lies in the person performing the act (Emanuel, 1994; Marcoux, 2011). In the case of euthanasia, a person other than the one who requested euthanasia performs the act by administering a fatal dose of medication for compassionate reasons. This is usually done by a physician or a nurse practitioner where law permits. Thus, the physician or the nurse is directly involved in the act. In the case of

physician-assisted suicide, the dying person carries out the act with the assistance of a physician or nurse practitioner who provides the means, such as lethal substances or information about how to kill oneself. Nevertheless, both euthanasia and physician-assisted suicide share the common effect of ending the life of a terminally ill person although practical and legal distinctions exist between these.

Euthanasia and physician-assisted suicide are often confused with other end-of-life practices such as withholding or withdrawing life-sustaining treatment (Gallagher, 2001; Marcoux, Mishara & Durand, 2007; Mishara & Wesstub, 2013). In withholding or withdrawal of life-sustaining treatment a natural death occurs without life being prolonged by artificial means (Mishara & Wesstub, 2013). Formerly, withholding life-sustaining treatment or life-sustaining treatment withdrawal were sometimes designated as "passive euthanasia" as some believed that the result of passive euthanasia (death) was the same as in the case of "active euthanasia" (inducing death with a lethal injection) (Marcoux, 2011). However, the term "passive euthanasia" is avoided since it is confusing and semantically meaningless (Marcoux, 2011).

The main difference between withholding or withdrawal of life-sustaining treatment and euthanasia and physician-assisted suicide rests in how death occurs. In the case of withholding or withdrawal of life-sustaining treatment, death occurs naturally which differentiates this practice from euthanasia or physician-assisted suicide in which death is induced by a lethal injection. As the name indicates, "Life-sustaining treatment" is when life is maintained by treatment. In other words, if the treatment is not given or removed, the patient will die "naturally" as death is an unavoidable outcome of the illness. Generally, withholding treatment or treatment withdrawal are medically accepted as good practices and are legal in most industrialized countries, including Canada, when performed in accordance with the patient's wishes (Marcoux, 2011). While

euthanasia and physician-assisted suicide remain illegal in most countries around the world and their ethical justifications continue to be highly debated.

Legal Perspectives

The increase in legalization of euthanasia and physician-assisted suicide globally makes it essential to grasp the legal status of these practices. Few countries around the world have laws legalizing euthanasia, physician-assisted suicide, or both. The following countries have legislation that legalizes these procedures under specific conditions.

Netherlands. The Netherlands was the first country, in Europe, to regulate euthanasia and physician-assisted suicide under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, in April 2002 (Griffiths, Wyers & Adams, 2008). Only physicians are permitted to carry out euthanasia and physician-assisted suicide in the Netherlands. In both cases, an adult patient must be suffering from an unbearable and untreatable physical or psychological illness. Although both of these practices were officially legalized only in 2002, they were already practiced by physicians under strict guidelines that had been established in the early 1990s (van der Heide et al., 2007). At that time, however, physicians could face prosecution under Dutch criminal law if they failed to adhere to certain rules (Gevers, 1996; van der Heide et al., 2003). In addition, under the new laws physicians are also allowed to perform euthanasia on competent minors aged 12 to 16 with parents' consent and on those aged 16 or 17 years if parents are notified (Vrakking et al., 2005). The minor must be in constant severe pain and not expected to live long (Verhagen & Sauer, 2005). Moreover, since 2007, physicians are

allowed to terminate the life of severely malformed newborns with presumably unbearable suffering and without prospect of improvement (Dutch Ministry of Security and Justice and the Dutch Ministry of Health, Welfare and Sport, 2007).

Belgium. Belgium was the second country in Europe to legalize euthanasia under The Belgian Act on Euthanasia which was sanctioned in September 2002 (Nys, 2003). The purpose of the act was to regulate euthanasia, however, the Federal Control and Evaluation Committee showed that physician-assisted suicide falls under the law as well (Schuklenk et al., 2011). Like the Netherlands, only a physician is allowed to perform euthanasia and physician-assisted suicide, and an adult patient can receive euthanasia as long as they have a terminal illness that causes unbearable suffering, including mental illness (Schuklenk et al., 2011; van Hoey, 2014). The Belgian government made it possible for critically ill minors aged 12 to 17 years to obtain euthanasia as long as the minor has the capacity to make sound decisions and is not suffering from a mental illness (Rietjens, Robijn & van der Heide, 2014; Siegel, Sisti & Caplan, 2014; van Hoey, 2014).

Luxembourg. In Luxembourg, both euthanasia and physician-assisted suicide were decriminalized in 2009 (Dyer, White & Garcia Rada, 2015). The law is somewhat similar to the ones in the Netherlands and Belgium. However, in Luxembourg only adult patients who are mentally competent and suffering from an incurable illness causing constant physical or psychological pain are eligible. The laws of the Netherlands, Belgium, and Luxembourg are known together as the Benelux Laws (Shariff, 2012).

Switzerland. Euthanasia is illegal in Switzerland but assisted suicide has not been prosecuted if performed for altruistic reasons since 1945 (Burkhardt & La Harpe, 2012; Hurst & Mauron, 2003). According to Article 115 of the Swiss Penal Code:

> Whoever, for selfish motives, incites another person to commit suicide or lends assistance with a view to suicide, if the suicide was carried out or attempted, shall be sentenced to a term of imprisonment of up to five years or a criminal fine. (Burkhardt & La Harpe, 2012).

Even though assisted suicide was never officially legalized in Switzerland, it still can be practiced; according to the definition above, assisted suicide is not considered a crime if the motive of doing so is non-egoistic. Unlike other countries, Switzerland allows someone other than a physician to perform assisted suicide, thus, a physician-patient relationship is not required. Physicians can carry out the act under strict directives issued by the Swiss Academy of Medical Sciences (SAMS) in 2004 (Burkhardt & La Harpe, 2012). Directives of SAMS state that assisted suicide may be considered by a physician when it is requested by a competent patient suffering from a terminal disease at the end-of-life. It should not however be seen as part of medical practice (Burkhardt & La Harpe, 2012). In summary, assisted suicide is not prosecuted in Switzerland only if it is done for unselfish reasons while euthanasia remains a punishable offense.

United States. In the United States, each state has the right to make decisions on physician-assisted suicide law (Lemmens & Dickens, 2001). By which, states can create different legislation surrounding the practice.

The state of Oregon was the first state to legalize physician-assisted suicide in 1997 with the *Oregon Death with Dignity Act* (Ganzini et al., 2000). Physicians are allowed to prescribe a dose of lethal medication to an adult patient for self-administration. Only adult residents of Oregon who have a prognosis of less than six months to live are eligible to request physician-assisted suicide. The patient must have a terminal disease that is irreversible. Two oral requests and one written request must be made by the patient over a period of 15 days (Goodwin, 1997). A second opinion must be sought by the consulting physician in order to assure that the patient meets the requirements of the state law. Finally, once the prescription is written, the physician has a duty to inform Oregon's Department of Human Services. Laws allowing physician-assisted suicide were also passed in Washington in 2008 (Washington State Legislature, 2009), Montana in 2009 (*Baxter v Montana*, 2009), Vermont in 2014 (Vermont State Legislature, 2013), California and New Mexico in 2015 (California State Legislature, 2015; Emanuel et al., 2016). Physician-assisted suicide remains illegal in all other US states, and euthanasia remains illegal in all US states.

Legalization in Canada

In recent years, assisted death has been widely discussed in Canada. The case that first prompted discussion on euthanasia and physician-assisted suicide was of Sue Rodriguez in the early 1990s (Cormack, 2000). Rodriguez, a terminally ill woman suffering from amyotrophic lateral sclerosis (ALS) also widely known as Lou Gehrig's disease, requested from the Supreme Court that she be allowed to end her life (Rodriguez v. British Columbia, 1993). She claimed that the Criminal Code (1985) violated her rights of freedom granted by the Charter of Rights and

Freedoms (1982) as it discriminates against individuals who suffer from degenerative diseases because they are not able to end their life without assistance. However, the application was dismissed by the British Columbia Supreme Court by a narrow margin (Rodriguez v. British Columbia, 1993). Another notable case is that of Robert Latimer. Latimer ended the life of his 12-year-old daughter who was suffering from cerebral palsy (R. v. Latimer, 1995). He was later found guilty of second-degree murder (R. v. Latimer, 1995) however the public raised concern that Latimer's act was a compassionate act rather than an act of murder (Lemmens & Dickens, 2001).

After many years of discussion, Quebec became the first province to authorize euthanasia in Canada. In 2009, a major discussion paper was published by the Quebec College of Physicians, in which it was advocated that euthanasia could be proposed as a final step in the continuum of appropriate end-of-life care in exceptional circumstances (Quebec College of Physicians, 2009). A few months later, the Quebec Assembly created a Select Committee on Dying with Dignity to address this question. After expert consultations, public hearings in numerous cities, debates, and delegations to the Netherlands and Belgium, the Select Committee on Dying with Dignity tabled a report called "Dying with Dignity", in March 2012, which recommended euthanasia in the form of "medical aid in dying" be legalized in the province of Quebec (Select Committee on Dying with Dignity, 2012). In the report, euthanasia was defined as "an act that involves deliberately causing the death of another person to put an end to that person's suffering" (Select Committee on Dying with Dignity, 2012, p.18). However, according to the Committee, the term euthanasia is "emotionally charged" and "not everyone agrees on its use" therefore the term was replaced by the expression "medical aid in dying" (Select Committee on Dying with Dignity, 2012, p.76). A year later, Bill 52, also known as an "Act respecting end-

of-life care" was presented in the National Assembly and passed the Quebec legislature in June 2015. The purpose of this Bill was to shed light on certain medical practices that are already allowed under Quebec law, for instance, palliative sedation, but also to approve a new practice: medical aid in dying. The law came into force in December 2015. As defined in the Act, medical aid in dying refers to "care consisting in the administration by a physician of medications or substances to an end-of life patient, at patient's request in order to relieve their suffering by hastening death" (National Assembly, 2014). Based on this definition, euthanasia is considered legal in Quebec. Only an adult patient suffering from a terminal illness and capable of giving consent can request euthanasia (National Assembly, 2014). Thereafter, the Supreme Court of Canada (SCC) legalized "medical assistance in dying" (MAiD) which refers to "the situation where a person seeks and obtains help to end their life" (Ministry of Justice, Government of Canada, June 2016). Amendments to the Criminal Code, which had previously criminalized suicide and equated euthanasia with murder, were completed. Individuals who are eligible for MAiD must be competent, consenting adults suffering from a grievous and irremediable medical condition which involves an illness, disease or disability that causes enduring suffering that is intolerable (Carter v Canada, 2015). MAiD can be obtained by two ways: 1) euthanasia defined as "where a physician or nurse practitioner directly administers a substance that causes the death of the person who has requested it"; or 2) physician-assisted suicide which is defined as "where a physician or nurse practitioner gives or prescribes to a person a substance that they can self-administer to cause their own death" (Ministry of Justice, Government of Canada, 2016). Under federal law, euthanasia or physician-assisted suicide are now legal in Canada in these circumstances. Only a physician or a nurse practitioner can directly administer a lethal medication or prescribe a medication that causes death to a patient for self-administration.

Support for Euthanasia and Physician-assisted Suicide

In the literature, attitudes toward euthanasia or physician-assisted suicide have been studied widely across different populations. Public opinion is particularly important since government legislation on the issue and how patients will be cared for in the future are partly based on public support for these practices (Moore, 2005). Support among the public for euthanasia and physician-assisted suicide has been steadily increasing in many countries around the world, for example, in the United States, support for euthanasia increased from 37% in 1947 to 53% in the early 1970s among the general population (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016). In Europe countries, from 1981 to 2008, the mean score of euthanasia acceptance has passed from 6.06 to 6.79 in Denmark, from 3.53 to 6.76 in Belgium, from 4.72 to 6.75 in France, from 3.11 to 6.08 in Spain and from 5.42 to 6.67 in the Netherlands (Cohen, van Landeghem, Carpentier & Deliens, 2013). Similarly, in Canada, support for euthanasia has increased since the 1950s (Anderson & Cardell, 1993). One survey conducted in 1992 among 365 residents in Edmonton demonstrated 65% were in support of euthanasia (Genius, Genius & Chang, 1994). This result is in line with another study in which 58% and 66% of Canadians across Canada approved assisted suicide and euthanasia respectively (Singer, Choudhry, Armstrong, Meslin & Lowy, 1995). Another study conducted in the Greater Vancouver Area found that 79% of residents supported physician-assisted suicide (Achille & Ogloff, 1997). Similarly, in a study conducted in Alberta, Wilson et al. (2013) concluded that the majority (76%) of Canadians supported assisted suicide. Hence a majority of the Canadian public has been in favor of both practices since the nineties. However, cautious interpretation of the results is required when comparing surveys such as those reported. Important methodological

differences exist in these studies and the lack of consistency in the definitions of euthanasia and physician-assisted suicide make interpretation of the results difficult across surveys. In addition, attitudes toward euthanasia and physician-assisted suicide are complex and affected by many factors. The differences in results may be attributed by these differences.

Mental Health Workers' Attitudes toward Euthanasia and Physician-assisted Suicide

Attitudes toward euthanasia and physician-assisted suicide are thoroughly studied from the perspectives of primary health professionals such as physicians and nurses (Emanuel Onwuteaka-Philipsen, Urwin & Cohen, 2016; Evans, 2015; Gielen, van Den Branden & Broeckaert, 2008; McCormack, Clifford & Conroy, 2011; Steck, Egger, Maessen, Reisch & Zwahlen, 2013; Verpoort, Gastmans & De Bal, 2004) and the general public (Cohen et al., 2006; Emanuel et al., 2016; Tomlinson & Stott, 2015). However, little is known about the attitudes of those who work specifically in the mental health field toward these two end-of-life practices. Due to the nature of their work, mental health workers such as psychologists, social workers and suicide prevention workers (SPWs) operate in a wide range of situations and are usually relied upon by individuals who are in need of perspective and support during delicate times. Although, SPWs are not involved in end-of life issues, it is possible that they may receive calls from individuals who are physically suffering and who wish to end their life. Studies focusing on this population have not been given the same attention. A better understanding of the factors that shapes their attitudes could clarify their thinking and their approval or disapproval of euthanasia and physician-assisted suicide, and help improve future interventions. To date, a review of the

literature specifically looking at the attitudes of mental health workers has not yet been undertaken.

Euthanasia and Suicide Prevention

Euthanasia and physician-assisted suicide are generally not perceived the same way as other suicides by the public. As highlighted by the Quebec Association for Suicide Prevention (QASP), in a brief submitted to the *Select Committee on Dying with Dignity* (2013), euthanasia and physician-assisted suicide are usually seen as end-of-life issues, while suicide is generally seen as an interruption to a life that is in progress. Furthermore, euthanasia and physician-assisted suicide are commonly associated with physical pain; suicide, on the other hand, is often associated with psychological suffering. However, although euthanasia and physician-assisted suicide are perceived as distinct from suicide by the general public, it may not be the case for an individual who is suffering. Suffering is a personal and subjective experience. Similar to a person who is aspiring to euthanasia or physician-assisted suicide, a suicidal individual may see their own suffering as intolerable, inevitable and endless. According to QASP, a suicidal person may not necessarily seek death; rather, he or she desires to stop their suffering, similar to the individual asking for euthanasia or physician-assisted suicide that is doing so to avoid the unbearable suffering that is associated with the terminal illness. Suicide prevention workers (SPWs) put in great efforts daily to prevent an individual from taking his or her own life by trying to relieve the suffering of a suicidal person. However, with the new law, SPWs may fear that suicide may now be normalized in the society and it may become more difficult for them to convey the message that suicide is not an option. The fundamental assumption of the QASP is

that the suicide rate of a society is influenced not only by the suffering experienced by the individuals of that society but also by the collective acceptance of suicide as a possible solution to this suffering. Therefore, it is important to assess the attitudes of SPWs toward euthanasia as death officially becomes an option under the new law, even if it is under strict conditions.

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CHAPTER TWO

ATTITUDES DES INTERVENANTS EN SANTÉ MENTALE ENVERS L'EUTHANASIE ET LE SUICIDE ASSISTÉ : UNE SYNTHÈSE DE LA LITTÉRATURE

The following chapter has been prepared as a manuscript that has been submitted to *Revue Criminologie*. This manuscript presents findings from a literature review conducted on the attitudes of mental health workers toward euthanasia and physician-assisted suicide. The objectives of the literature review were to:

1) provide an overview of the published scientific literature on the attitudes of mental health workers toward euthanasia and physician-assisted suicide;
2) highlight the relationship between attitudes and the influence of certain sociodemographic factors as well as personal and professional's experiences.

The MSc. Student is the first author of the current paper and was responsible for data collection, data analysis and dissemination via writing the manuscript. This paper was co-authored by Dr. Isabelle Marcoux who provided meaningful feedback on the development and revisions of the manuscript.

Attitudes des intervenants en santé mentale envers l'euthanasie et le suicide assisté : une synthèse de la littérature

Attitudes of mental health workers toward euthanasia and assisted suicide: a literature review

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L'objectif de cette synthèse de la littérature est de donner un aperçu des études scientifiques publiées sur les attitudes des intervenants en santé mentale vis-à-vis de l'euthanasie et du suicide assisté. Une recherche a été menée dans les bases de données Medline, PsycInfo et Embase; onze articles répondant aux critères d'inclusion ont été identifiés. Les résultats ont montré que les intervenants en santé mentale ont généralement des attitudes positives envers l'euthanasie et le suicide assisté, avec des attitudes un peu plus favorables envers ce dernier que pour l'euthanasie. Plusieurs études ont montré une corrélation négative entre l'importance de la religion et leurs attitudes, ainsi qu'avec les expériences professionnelles. Le lien entre les attitudes et d'autres caractéristiques personnelles (par ex. : le genre, l'âge, l'éducation) n'est toutefois pas constant d'une étude à l'autre. Des enjeux particuliers au plan de la méthodologie doivent être considérés dans l'interprétation des résultats, dont des différences dans les définitions et la terminologie utilisée, ainsi que dans la formulation des questions. Le lien entre les expériences personnelles et les attitudes envers l'euthanasie et / ou le suicide médicalement assisté devrait faire l'objet de recherches futures.

Mots-clés: Euthanasie, suicide assisté, intervenants en santé mentale, attitudes, aide médicale à mourir

Abstract:

The objective of this literature review is to provide an overview of published studies on the attitudes of mental health workers towards euthanasia and physician-assisted suicide. A search was carried out in the Medline, PsycInfo and Embase databases; eleven articles met the inclusion criteria and were included in this review. The results showed that mental health workers generally have positive attitudes towards euthanasia and assisted suicide, with more favorable attitudes toward physician-assisted suicide than to euthanasia. Several studies have shown a negative correlation between the importance of religion and the attitudes, as well as professional experiences. The relationship between attitudes and other personal characteristics (eg, gender, age, education) is not constant across studies. Specific methodological issues must be considered in interpreting the results, including differences in definitions and terminology used, as well as in the formulation of questions. The link between personal experiences and attitudes toward euthanasia and / or medically assisted suicide should be the subject of future research.

Keywords: Euthanasia, physician-assisted suicide, mental health workers, attitudes, medical assistance in dying

Introduction

Depuis les dernières décennies, on observe une augmentation de l'espérance de vie, grâce notamment aux progrès dans le domaine des technologies biomédicales. Les personnes malades ont maintenant accès à divers traitements médicaux encore plus efficaces qui leur permettent soit de guérir, soit de vivre plus longtemps. Or, malgré ces avancements positifs, des individus pourraient se sentir obligés d'accepter ces interventions, et l'acceptation de la mort pourrait de plus en plus être considérée comme un tabou social et moral (Evans, 2015). En contrepartie, une réappropriation du processus de mourir pourrait s'exprimer par la revendication d'un droit à l'euthanasie et au suicide assisté; des pratiques qui ont récemment obtenu une reconnaissance légale au Canada lorsque certaines conditions sont respectées.

L'euthanasie, définie comme étant « [l'administration de médicaments avec l'intention explicite de mettre fin à la vie du patient, à sa demande explicite] » (van der Maas et al., 1996, p.1700) et le suicide assisté, défini comme étant « [le fait de prescrire ou prodiguer des médicaments avec l'intention explicite de permettre au patient de mettre fin à sa propre vie] » (van der Maas et al., 1996, p.1700) sont des sujets sensibles et controversés. Après des années de discussions, le Québec a légalisé « l'aide médicale à mourir » en vertu de la *Loi sur les soins de fin de vie* qui est entrée en vigueur en décembre 2015 (Gouvernement du Québec, 2016). Tel que défini dans le projet de loi n ° 52, l'aide médicale à mourir réfère à « un soin consistant en l'administration de médicaments ou de substances par un médecin à une personne en fin de vie, à la demande de celle-ci, dans le but de soulager ses souffrances en entraînant son décès » (Assemblée nationale, 2014); définition qui concorde avec ce qui est considéré comme de l'euthanasie volontaire au plan de la littérature internationale. En juin 2016, la Cour suprême du Canada a également légalisé l'« aide médicale à mourir » qui peut-elle se décliner en deux

pratiques distinctes : (1) « l'administration directe, par un médecin ou un infirmier praticien, d'une substance provoquant la mort de la personne qui en a fait la demande » ou (2) « la remise ou la prescription, par un médecin ou un infirmier praticien, d'une substance que la personne peut s'administrer elle-même pour provoquer sa mort » (Ministère de la Justice, Gouvernement du Canada , 2016) qui réfèrent respectivement à l'euthanasie volontaire et au suicide médicalement assisté dans la littérature internationale.

Ces changements de loi imposent de nouvelles responsabilités aux professionnels de la santé, notamment les médecins et les infirmiers praticiens, dont l'évaluation et la prise en charge des personnes qui font une telle demande. Toutefois, ces lois n'ont pas seulement un impact sur ces professionnels de la santé. Elles risquent d'affecter également ceux qui travaillent au quotidien avec des personnes malades et/ou en fin de vie qui font face à toutes sortes de problèmes psychosociaux et qui désirent mourir prématurément. On peut penser à ceux et celles qui travaillent de près ou de loin en santé mentale, dont les psychologues, les travailleurs sociaux et les intervenants en prévention du suicide.

Jusqu'à ce jour, la majorité des études qui se sont intéressées aux attitudes envers l'euthanasie et/ou le suicide assisté parmi les groupes de professionnels ou d'intervenants ont été réalisées auprès de médecins et d'infirmières. Les résultats sont toutefois disparates avec un appui favorable qui varie entre 26% et 86% chez les médecins (Brits, Human, Pieterse, Sonnekus et Joubert, 2009; Broekman et Verlooy, 2013; Cohen, Fihn, Boyko, Jonsen et Wood, 1994; Craig et al., 2007; Emanuel, Fairclough, Daniels et Clarridge, 1996; Kouwenhoven, van Theil, Raijmakers, van der Heide et van Delden, 2014; Lee, Prince, Rayner et Hotopf, 2009; Smets et al., 2011), et entre 3,2% et 92% chez les infirmières (Asai, Ohnishi, Nagata, Tanita et Yamazaki,

2001; Kranidiotis, Ropa, Mprianas, Kyprianiou et Nanas, 2015; Inghelbrecht, Bilsen, Mortier et Deliens, 2009; Parpa et al., 2010; Tepehan, Özkara et Yavuz, 2009).

En général, l'appui envers ces pratiques semble être plus soutenu dans les pays où elles sont légales, notamment la Belgique (Miccinesi et al., 2005; Smets et al., 2011) et les Pays-Bas (Bolt, Snijdewind, Willem, van der Heide et Onwuteaka-Philipsen, 2015; Willems, Daniels, van der Wal, van der Maas et Emanuel, 2000). Par exemple, plus de 90% des infirmières en Belgique ont mentionné que l'euthanasie est acceptable pour un patient en phase terminale (Inghelbrecht et al., 2009), et plus de 80% des médecins de Belgique et des Pays-Bas ont indiqué qu'ils pourraient effectuer eux-mêmes une euthanasie ou un suicide assisté dans certaines situations (Bolt et al., 2015; Smets et al., 2011). Par contre, dans les pays où l'euthanasie ou le suicide assisté ne sont pas autorisés, plus de 60% des médecins ne seraient pas disposés à effectuer une euthanasie ou un suicide assisté, et la majorité se disaient contre la légalisation de ces actes (Kranidiotis et al., 2015; Löfmark et al., 2008; McCormack, Clifford et Conroy, 2011; Müller-busch, Oduncu, Woskanjan et Klaschik, 2005; Subba et al., 2016; Zenz, Tryba et Zenz, 2015). Des constatations semblables ont été rapportées chez les infirmières où plus de la moitié des infirmières n'étaient pas favorables à l'euthanasie ou au suicide assisté et ne seraient pas disposées à effectuer l'un des deux actes (Asai et al., 2001; Bendiane et al., 2009; Kranidiotis et al. , 2015; Naseh, Raflei et Heidari, 2015; Poreddi, Nagarajaiah, Kondouru et Math, 2013; Zenz et al., 2015), et moins de 15% soutenaient la légalisation de l'euthanasie (Asai et al., 2001; Tanida et al., 2002). Bien que les attitudes de la population en générale soient systématiquement plus favorables à l'euthanasie et au suicide assisté que les médecins et les infirmières, on observe également cette différence de soutien dans les pays où ces pratiques sont légalisées (Emanuel, Onwuteaka-Philipsen, Urwin et Cohen, 2016; Rae, Johnson et Malpas, 2015; Tomlinson et Stott, 2015).

Les attitudes à l'égard de l'euthanasie et du suicide assisté varieraient également selon certaines caractéristiques des individus sondés. Tout d'abord, les professionnels de la santé qui s'identifient à une religion ou qui pratiquent une religion sont moins favorables à l'euthanasie et au suicide assisté (Bülow et al., 2012; Inghelbrecht et al., 2009; McCormack et al., 2011; Tepehan et al., 2009; Tomlinson et Stott, 2015) et moins susceptibles d'effectuer ces actes (Bachman et al., 1996; Naseh et al., 2015). Concernant l'âge, de nombreuses études ont démontré que les jeunes professionnels de la santé ont tendance à avoir des opinions plus permissives envers l'euthanasie que les professionnels plus âgés (Miccinesi et al., 2005; Ryynänen, Myllykangas, Viren et Heiro, 2002; Verpoort, Gastmans et Dierckx de Casterlé, 2004). En ce qui a trait au genre, quelques études ont démontré que les femmes auraient des opinions plus conservatrices concernant l'euthanasie (Di Mola et al., 1996; Levy, Azar, Huberfeld, Siegel et Strous, 2013), bien que le lien entre les attitudes à l'égard de l'euthanasie et/ou du suicide assisté et le genre ne soit pas toujours constant (Gielen, Van Den Branden et Broeckaert, 2008).

En plus des caractéristiques personnelles des professionnels de la santé ainsi que du statut légal de l'euthanasie et/ou du suicide assisté du pays dans lequel ils résident, des expériences professionnelles ou personnelles pourraient également influencer les attitudes envers ces actes. Les médecins qui sont généralement confrontés à des patients en phase terminale, tels que ceux qui travaillent dans le domaine de l'oncologie, de la gériatrie et des soins palliatifs, auraient des attitudes plus négatives à l'égard de l'euthanasie et du suicide assisté (Gielen, Van Den Branden et Broeckaert, 2008). De même, les infirmières qui travaillent en soins palliatifs auraient tendance à avoir des attitudes moins favorables à l'euthanasie (Farsides, 1998; Kitchener, 1998).

Il se peut que les infirmières soient plus attirées par le travail dans une organisation dont la vision personnelle correspond à la leur (Verpoort et al., 2004) puisque l'euthanasie va à l'encontre de la mission des soins palliatifs qui ne visent ni à retarder la mort, ni à la devancer. D'un autre côté, les personnes qui travaillent fréquemment avec des personnes en fin de vie pourraient avoir une vision plus mitigée de l'euthanasie comme solution pour mettre fin à la souffrance d'une personne. En ce qui concerne les expériences personnelles, une seule étude s'est intéressée au lien entre les expériences des professionnels de la santé avec un membre de la famille en phase terminale et leurs attitudes envers l'euthanasie et le suicide assisté, et les résultats ne semblent pas concluants (Grassi, Magnani et Ercolani, 1999). Toutefois, une revue systématique d'études réalisées auprès de patients, soignants et de la population générale a révélé une corrélation positive entre les expériences avec un membre de la famille mourant et les attitudes envers l'euthanasie et le suicide assisté (Hendry et al., 2013). Bref, les études portant sur les expériences personnelles des professionnels de la santé et les attitudes demeurent limitées.

Bien qu'il existe des recensions exhaustives de la littérature sur les attitudes des médecins et des infirmières vis-à-vis l'euthanasie et du suicide assisté, des recensions portant spécifiquement sur les intervenants en santé mentale n'ont pas encore été menées. En raison de la nature de leur travail, ces intervenants risquent d'être interpelés par des personnes qui vivent des moments difficiles et qui ont besoin de soutien ou d'aide, dont des personnes qui pensent à mourir par euthanasie et suicide assisté. Une meilleure connaissance de leurs attitudes ainsi qu'une meilleure compréhension des facteurs qui influencent ces attitudes pourrait nous aider à clarifier leur réflexion sur le sujet.

Objectif

L'objectif général de cette recension de la littérature est de donner un aperçu des études scientifiques publiées sur les attitudes des intervenants en santé mentale vis-à-vis de l'euthanasie et du suicide assisté. L'objectif est de mettre en lumière la relation entre les attitudes et l'influence de certaines caractéristiques sociodémographiques ainsi que de leurs expériences personnelles et professionnelles. Nous tenterons donc de répondre aux deux questions de recherche suivantes : (1) Quelles sont les attitudes envers l'euthanasie et / ou le suicide assisté des intervenants en santé mentale? (2) Les caractéristiques sociodémographiques, les expériences personnelles et / ou professionnelles jouent-elles un rôle dans la teneur des attitudes des intervenants en santé mentale vis-à-vis l'euthanasie et/ou le suicide assisté ?

Méthode

Selon la nomenclature proposée par Grant et Booth (2009), nous présentons dans cet article une synthèse de la littérature présentée sous forme narrative ; celle-ci portant sur les attitudes des intervenants en santé mentale envers l'euthanasie et le suicide assisté. Une recherche de la littérature a été menée en octobre 2016 dans les bases de données Medline, PsycInfo et Embase; la stratégie de recherche exacte par base de données peut être obtenue sur demande à l'auteure principale. Les références des articles sélectionnés ont également été examinées pour identifier des articles supplémentaires pertinents. Les critères d'inclusion des articles sont : (1) source primaire d'études quantitatives, qualitatives ou de méthodes mixtes; (2) étude sur les attitudes des intervenants en santé mentale envers l'euthanasie et / ou le suicide

assisté, y compris les psychologues, les travailleurs sociaux, les intervenants en prévention du suicide; (3) publication en anglais ou en français (4) article évalué par les pairs. Aucune exclusion n'a été appliquée quant au lieu de l'étude et la date de publication.

Résultats

La recherche a permis de repérer onze articles pertinents. Les caractéristiques de l'étude et la méthodologie utilisée sont résumées dans le tableau 1. Huit études ont été réalisées auprès de travailleurs sociaux, deux auprès de psychologues et une auprès d'étudiants en counselling. Nous n'avons trouvé aucune étude menée auprès d'intervenants en prévention du suicide. La majorité des études ont été effectuées aux États-Unis (n = 10) et une seule au Canada. La taille de l'échantillon variait entre 66 à 862 et les taux de réponse entre 36,7 et 78%. La plupart des études ont été menées à la fin des années 90 et au début des années 2000. L'objectif principal de toutes les études incluses était d'examiner les points de vue ou les attitudes des intervenants en santé mentale sur l'euthanasie ou le suicide assisté. Toutes les études utilisaient un devis transversal et la méthode de collecte de données était principalement réalisée par la poste (n = 9), tandis que deux études ont administré le questionnaire en face à face.

TABLEAU 1

Caractéristiques et méthodes des études

	Auteurs	Pays	Objectifs	Population d'intérêt	*N* (taux de réponse	Collecte de données
1	Bevacqua et Kurpius (2013)	Texas, États-Unis	Examiner le lien entre l'autonomie du client en situation d'euthanasie avec l'expérience clinique, les valeurs religieuses et les attitudes à l'égard de l'euthanasie.	Étudiants en counseling en santé mentale	83 (NM)	Questionnaire administré en personne
2	Csikai (1999a) Csikai (1999b)	Texas, États-Unis	(a) Explorer les attitudes sur des enjeux liés à la fin de vie, en particulier l'euthanasie et le suicide assisté. (b) Examiner l'impact des valeurs personnelles et professionnelles sur les attitudes envers l'euthanasie et le suicide assisté.	Travailleurs sociaux œuvrant en milieu hospitalier	129 (42 %) 122*	Enquête par la poste
4	DiPasquale et Gluck (2001)	Nouveau-Mexique, États-Unis	Identifier les attitudes à l'égard de la légalisation et de la participation au suicide assisté. Mieux comprendre l'interaction entre les croyances philosophiques, les valeurs personnelles et la volonté de participer aux situations complexes de fin de vie.	Psychologues et psychiatres agréés	Total : 269 (44 %) Psychologues : 202 (43 %) Psychiatres : 59 (42 %)	Enquête par la poste
5	Erlbaum-Zur (2005)	New York, États-Unis	Examiner les attitudes envers le suicide assisté et les facteurs qui influencent leurs attitudes.	Travailleurs sociaux œuvrant en milieu de soins de longue durée	312 (36, 7%)	Enquête par la poste
6	Fenn et Ganzini (1999)	Oregon, États-Unis	Obtenir les opinions sur le suicide assisté et sur le processus d'évaluation des patients qui demandent une telle assistance.	Psychologues agréés	461 (74 %) 423*	Enquête par la poste
7	Manetta et Wells (2001)	Caroline du Sud, États-Unis	Examiner les opinions sur le suicide assisté et déterminer si le fait d'avoir	Travailleurs sociaux assistant à un atelier	66 (NM)	Questionnaire administré en

			suivi un cours universitaire ou une formation concernant le suicide, les problèmes de santé mentale et l'éthique a pu influencer leur opinion.	sur le suicide		personne
8	Miller *et al.* (2004)	Oregon, États-Unis	Non mentionné	Infirmiers et les travailleurs sociaux œuvrant en milieu de soins palliatifs	Total : 397 (NS) Infirmiers : 306 (71 %) Travailleurs sociaux : 116 (78 %) 110*	Enquête par la poste
9	Ogden et Young (1998)	Colombie-Britannique, Canada	Explorer les attitudes et expériences concernant l'euthanasie volontaire et le suicide assisté.	Travailleurs sociaux membres de l'Association des travailleurs sociaux de la Colombie-Britannique	527 (41,3 %) 516*	Enquête par la poste
10	Ogden et Young (2003)	Washington, États-Unis	Examiner les attitudes et les expériences concernant l'euthanasie et le suicide assisté.	Travailleurs sociaux	862 (34,5 %)	Enquête par la poste
11	Portenoy *et al*. (1997)	New York, États-Unis	Explorer l'influence de caractéristiques personnelles et professionnelles sur leur volonté d'appuyer le suicide assisté.	Médecins, infirmiers et travailleurs sociaux œuvrant dans différents types d'hôpitaux	Total : 547 (48 %) Médecins : 200 (33 %) Infirmiers : 276 (64 %) Travailleurs sociaux : 71 (72 %)	Enquête par la poste

NM : Non mentionné; * Échantillon final retenu.

Six études portaient exclusivement sur les attitudes envers le suicide médicalement assisté, une étude sur l'euthanasie, alors que les quatre autres études portaient sur l'euthanasie et le suicide assisté. Parmi les études incluses, sept ont également touché les aspects de légalisation. La plupart des études se sont abstenu d'utiliser le terme « euthanasie » ou « suicide assisté » et les définitions ou une brève description de l'acte ont été fournies dans leurs questionnaires. Les sujets couverts et la définition des termes utilisés dans chaque étude sont présentés dans le tableau 2.

Les principaux résultats des études sont résumés dans le tableau 3. Des thèmes communs ont émergé des études et ont été classés en sept catégories : les attitudes envers l'euthanasie, les attitudes envers le suicide médicalement assisté, les attitudes envers la légalisation, les différences d'attitude envers l'euthanasie et le suicide assisté, les caractéristiques socio-démographiques, les expériences professionnelles et les expériences personnelles.

TABLEAU 2

Sujets étudiés et définition(s)

Auteurs		Sujets			Définitions[2]	
		Euthanasie (EUTH)	Suicide assisté (SA)	Légalisation	Dans le questionnaire	Dans l'article
1	Bevacqua et Kurpius (2013)	✓	X	X	NM	SA : « Cessation intentionnelle de la vie par un autre à la demande explicite de la personne qui souhaite mourir "et" causer le décès d'une personne par une action directe en réponse à une demande de cette personne. »
2	Csikai (1999a, b)	✓	✓	✓	EUTH : « Le fait d'administrer de façon délibérée une surdose de médicament à un patient gravement malade, à sa demande, avec l'intention première de mettre fin à sa vie. » SA : « Le fait de prescrire des médicaments et de conseiller un patient malade afin qu'il puisse utiliser une surdose pour mettre fin à sa vie. »	NM
4	DiPasquale et Gluck (2001)	X	✓	✓	SA : « Lorsqu'un médecin fournit de l'information à un patient ou lui prescrit un médicament ou tout autre moyen pour lui permettre de s'enlever la vie. »	NM
5	Erlbaum-Zur (2005)	X	✓	✓	NM	SA : « L'acte prodiguer les moyens de se suicider à un patient qui ne serait pas capable physiquement de le faire lui-même. »
6	Fenn et Ganzini	X	✓	✓	SA : « Écrire une prescription de	SA: « Un médecin peut prescrire des médicaments

[2] Traduction libre des auteures.

	(1999)				médicaments dans le but de permettre au patient de mettre fin à sa vie. »	létaux visant à provoquer la mort aux personnes en phase terminale compétentes qui le demandent volontairement. »
7	Manetta et Wells (2001)	X	✓	X	NM	SA : « Survient lorsqu'un médecin fournit les moyens pour mettre fin à la vie d'un patient et que ce dernier pose le geste lui-même. »
8	Miller *et al.* (2004)	X	✓	X	NM	NM
9	Ogden et Young (1998)	✓	✓	✓	EUTH : « L'administration d'un traitement ou un acte qui provoque la mort à la demande du patient (par exemple, une injection létale). » SA : « Lorsque le patient a reçu les moyens (par exemple, un surdosage de médicament) spécifiquement pour le suicide. En général, le patient est celui qui pose le geste qui cause la mort (par exemple, qui avale les médicaments létaux). »	NM
10	Ogden et Young (2003)	✓	✓	✓	EUTH : « L'administration d'un traitement ou un acte qui provoque la mort à la demande du patient (par exemple, une injection létale). » SA : « Lorsque le patient a reçu les moyens (par exemple, un surdosage de médicament) spécifiquement pour le suicide. En général, le patient est celui qui pose le geste qui cause la mort (par exemple, qui avale les médicaments létaux). »	EUTH : « Implique un acte, comme une injection létale, pour mettre fin à la vie de patient qui le demande. » SA: « Implique de l'aide, comme la prescription d'une dose létale de médicaments, afin qu'un patient puisse se suicider. »
11	Portenoy *et al.* (1997)	✓	✓	X	Vignettes utilisées : EUTH : Tuer par balle un ami qui est un camarade d'armes qui se fait capturé par l'ennemi et qui demande l'euthanasie.	NM

					SA : Être disposé à écrire une ordonnance d'une grande quantité de barbiturique à une patiente qui vient de recevoir un diagnostic de cancer du sein potentiellement curable et qui demande le suicide assisté.	

TABLEAU 3

Résultats principaux et facteurs d'influence

	Auteurs	Résultats principaux	Facteurs d'influence
1	Bevacqua et Kurpius (2013)	NM	- Religiosité : • Une forte religiosité est liée à des attitudes plus négatives à l'égard de l'euthanasie
2	Csikai (1999a; b)	- 55 % étaient en désaccord ou fortement en désaccord avec l'énoncé « l'euthanasie n'est jamais éthique » - 50 % étaient en désaccord ou fortement en désaccord avec l'énoncé « le suicide assisté n'est jamais éthique » - 57 % étaient en accord ou fortement en accord avec l'énoncé « l'euthanasie devrait être légale dans certaines circonstances » - 47 % étaient en accord ou fortement en accord avec l'énoncé « le suicide assisté devrait être légal dans certaines circonstances »	- Expérience professionnelle : • Plus les travailleurs sociaux sont expérimentés, plus ils ont tendance à participer à l'euthanasie et au suicide assisté - Expérience personnelle : • Aucune association - Éducation : • Les répondants avec une maîtrise étaient plus d'accord avec les énoncés que l'euthanasie et le suicide assisté devraient être légaux que ceux qui ont un baccalauréat
4	DiPasquale et Gluck (2001)	- 75 %[3] ont répondu que le suicide assisté devrait être légalisé dans certaines conditions	- Religiosité : • Un niveau plus bas de conviction religieuse et moins grande importance de la religion dans la vie des répondants sont positivement associés à la volonté d'aider si le suicide assisté était légal
5	Erlbaum-Zur (2005)	- 71,5 % sont en désaccord avec l'énoncé « le suicide assisté n'est jamais éthique » - 46,8 % sont d'accord avec l'énoncé « le suicide assisté devrait être légalisé »	- Expérience professionnelle : • La durée de travail dans un établissement de soins de longue durée est négativement corrélée à l'attitude envers le suicide assisté • Le fait de travailler sur les problèmes de fin de vie est négativement corrélé à l'attitude envers le suicide assisté. Les connaissances sur la gestion de la douleur sont négativement corrélées à l'attitude envers le suicide assisté - Identification à une religion[4] :

[3] Ce résultat inclut les psychiatres.
[4] Lorsque le niveau de religiosité est contrôlé, une religion particulière n'était pas significative.

			• Les répondants qui ne s'identifiaient à aucune religion étaient plus favorables au suicide assisté que ceux qui s'identifiaient à une religion • Les répondants catholiques étaient les moins favorables au suicide assisté • Les répondants juifs étaient plus favorables au suicide assisté que les catholiques - Religiosité : • Plus le niveau de religiosité est élevé, moins les attitudes sont favorables au suicide assisté
6	Fenn et Ganzini (1999)	- 85 % ont déclaré que le suicide assisté pouvait être moralement acceptable dans certaines circonstances - 56 % et 29 % ont répondu « dans certaines circonstances » et « toujours » respectivement à l'énoncé : « Si un patient compétent en phase terminale le demande, pensez-vous qu'un médecin devrait être autorisé à faire ce qui suit : rédiger une ordonnance de médicaments dont le seul but serait de permettre au patient de mettre fin à sa vie »	- Expérience personnelle : • Aucune association n'a été décelée mais ils sont plus disposés à effectuer une telle évaluation - Âge : • Le fait d'être plus jeune est considéré comme un prédicteur d'opposition au suicide assisté - Genre : • Aucune association
7	Manetta et Wells (2001)	- 50 % sont favorables au suicide assisté	- Formation : • Un peu plus de personnes favorables au suicide assisté avaient suivi une formation en éthique, mais le résultat n'est pas statistiquement significatif
8	Miller *et al.* (2004)	- 46 % sont favorables au suicide assisté - 72 % appuient la Loi sur la mort avec dignité de l'Oregon	- Identification à une religion : • Les répondants qui ne s'identifiaient pas à une religion étaient plus en faveur du suicide assisté que ceux qui s'identifiaient à une religion - Religiosité : • Corrélation négative
9	Ogden et Young (1998)	- 71,5 % ont répondu « non » à l'énoncé « l'euthanasie volontaire est immoral». - 74,2 % ont répondu « non » à l'énoncé « le suicide assisté est immoral». - 75,9 % ont répondu « oui » à l'énoncé « l'euthanasie volontaire devrait être légalisée dans certaines circonstances » - 78,2 % ont répondu « oui » à l'énoncé « le suicide assisté devrait être légalisé dans certaines circonstances »	Aucune mesurée
10	Ogden et Young	- 67,7 % ont répondu « non » à l'énoncé « l'euthanasie volontaire est	- Identification à une religion :

	(2003)	immoral». - 73,3 % ont répondu « non » à l'énoncé « le suicide assisté est immoral » - 67,2 % ont répondu « oui » à l'énoncé « l'euthanasie volontaire devrait être légalisée dans certaines circonstances » - 77,6 % ont répondu « oui » à l'énoncé « le suicide assisté devrait être légalisé dans certaines circonstances »	• Les catholiques et les protestants[5] sont plus susceptibles de voir à la fois l'euthanasie volontaire / suicide assisté comme étant immoral - Religiosité : • Corrélation négative
11	Portenoy *et al.* (1997)	- 70,1 %[6] ont répondu qu'il était « moral et juste » de tirer sur le soldat mourant - 97,4 %[7] refuseraient d'assister le suicide d'un patient potentiellement curable	- Expérience professionnelle : • Corrélation négative avec le temps passé à gérer la douleur ou tout autre symptôme des patients atteints de cancer • Les répondants à l'hôpital consacrés à la prise en charge des malades en phase terminale étaient beaucoup moins enclins à être favorables au suicide assisté que ceux qui n'avaient pas cette même expérience • Corrélation négative avec les connaissances de la gestion des symptômes - Identification à une religion : • Les répondants catholiques étaient les moins favorables • Les répondants juifs étaient plus favorables que les catholiques - Religiosité : • Corrélation négative - Âge : • Aucune association - Genre : • Aucune association

[5] Les attitudes des protestants concernant le suicide assisté n'étaient pas statistiquement significatives.
[6] Ce résultat inclut les médecins, les infirmiers et les travailleurs sociaux.
[7] Idem.

Attitudes générales

Attitudes envers l'euthanasie. Plusieurs études ont montré que les intervenants en santé mentale ont généralement des attitudes positives à l'égard de l'euthanasie. Par exemple, Csikai (1999a) a constaté que l'euthanasie était considérée éthique par 55% des travailleurs sociaux. Bien que l'euthanasie ait reçu un appui majoritaire, ces derniers n'étaient pas nécessairement disposés à participer à l'acte, avec seulement 28% d'entre eux disposés à le faire. En Colombie-Britannique, l'euthanasie n'était pas considérée moralement répréhensible pour 72% des travailleurs sociaux (Ogden et Young, 1998). Des résultats similaires ont été observés dans une autre étude par ces mêmes auteurs où 68% des travailleurs sociaux ont déclaré que l'euthanasie n'était pas considérée immorale (Ogden et Young, 2003). Portenoy et al. (1997) ont quant à eux mené une étude auprès de différentes populations, dont les travailleurs sociaux, et 70% des répondants ont indiqué qu'il était moralement acceptable et juste de commettre l'euthanasie. Toutefois, il faut mentionner ici que la question posée faisait référence à un contexte bien particulier qui ne correspond pas celui d'intérêt pour cette recension puisqu'il s'agissait d'un soldat qui fait une demande d'euthanasie (définie par l'acte de mettre fin à sa vie par balle) pour lui éviter d'être pris par l'ennemi.

Attitudes envers le suicide assisté. Dans plusieurs études, les intervenants en santé mentale ont une opinion favorable envers le suicide assisté. Fenn et Ganzini (1999) ont constaté que, dans certaines situations, le suicide assisté était jugé acceptable par la majorité (85%) des psychologues. Par ailleurs, le suicide assisté n'a pas été considéré comme moralement inacceptable par plus de 70% des travailleurs sociaux au Canada (Ogden and Young, 1998) et

aux États-Unis (Ogden and Young, 2003). De même, 71% des travailleurs sociaux oeuvrant en soins de longue durée étaient en désaccord avec l'affirmation selon laquelle le suicide médicalement assisté n'est jamais éthique (Erlbraum-Zur, 2005). D'autre part, Manetta et Wells (2001) ont observé qu'autant de travailleurs sociaux ont des attitudes favorables que défvorables envers le suicide assisté.

Attitudes envers la légalisation

Sept études ont examiné les attitudes à l'égard de la légalisation de l'euthanasie ou du suicide assisté (tableau 2). Le pourcentage des intervenants en santé mentale qui étaient en faveur de la légalisation de ces pratiques varie de 47% (Csikai, 1999a) à 78% (Ogden & Young, 2003). En ce qui concerne la légalisation de l'euthanasie, les études ont montré que les intervenants en santé mentale qui soutenaient l'euthanasie étaient également plus favorables à la légalisation de cette pratique (Csikai, 1999a; Ogden et Young, 1998; Ogden et Young, 2003). À l'instar de l'euthanasie, les opinions sur la légalisation du suicide assisté étaient associées à une vision positive de l'acte en général (Csikai, 1999a, Fenn et Ganzini, 1999, Ogden et Young, 1998, 2003). Ainsi, la majorité des intervenants en santé mentale étaient en général favorables à la légalisation de ces actes.

Différences dans les attitudes envers l'euthanasie et le suicide médicalement assisté.

Dans les études qui mesuraient les attitudes à l'égard de l'euthanasie et du suicide assisté, aucune différence significative n'a été observée concernant l'acceptation générale du suicide assisté et de l'euthanasie. Cependant, dans la majorité des études, les intervenants en santé mentale étaient légèrement plus favorables au suicide assisté (DiPasquale et Gluck, 2001; Fenn et Ganzini, 1999; Ogden et Young, 1998; Ogden et Young, 2003) et également plus favorables à la légalisation du suicide assisté que de l'euthanasie (DiPasquale et Gluck, 2001, Fenn et Ganzini, 1999, Ogden et Young, 1998, 2003). Une seule étude de Csikai (1999a) a révélé le contraire, dans lequel les travailleurs sociaux étaient plus susceptibles de favoriser la légalisation de l'euthanasie (57%) que le suicide médicalement assisté (47%). Enfin, les différences d'attitudes ne semblaient pas varier entre les types d'intervenants en santé mentale.

Facteurs liés à l'individu

Caractéristiques socio-démographiques. Peu de caractéristiques socio-démographiques sont liées aux attitudes des intervenants en santé mentale. Tout d'abord, de nombreuses études ont souligné que la caractéristique la plus influente liée aux attitudes des intervenants en santé mentale est la religion. La religion a été mesurée de plusieurs façons et peut être classée selon deux groupes à savoir l'appartenance religieuse et l'importance de la religion dans la vie.

Quelques études ont mesuré l'appartenance à la religion en demandant aux répondants à quelle religion ils s'identifient. Les travailleurs sociaux qui n'ont déclaré aucune religion avaient des attitudes plus positives à l'égard du suicide assisté comparé à ceux qui s'identifient à une

religion (Miller et al., 2004). Les participants catholiques étaient moins disposés à endosser à la fois l'euthanasie et le suicide assisté (Erlbaum-Zur, 2005; Ogden et Young, 2003; Portenoy et al., 1997) alors que l'attitude des répondants juifs envers les deux pratiques de fin de vie était plus indulgente (Erlbaum-Zur, 2005; Portenoy et al., 1997).

Au-delà de l'appartenance religieuse, de nombreuses études ont également souligné que l'importance de la religion est une variable déterminante pour l'étude des attitudes envers l'euthanasie et/ou le suicide assisté ; on observe systématiquement une corrélation négative entre les deux (Bevacqua et Kurpius, 2013; Csikai, 1999b; Dipasquale et Gluck, 2001; Erlbaum-Zur, 2005; Miller et al., 2004; Ogden et Young, 2003; Portenoy et al., 1997). Erlbaum-Zur (2005) a notamment constaté que lorsque le lien entre les attitudes et les facteurs sociodémographiques était contrôlé par le niveau de religiosité, l'appartenance religieuse n'était plus significative, démontrant par le fait même la supériorité de cet indicateur lors de la mesure de la religion comme facteur d'influence. Il est toutefois important de tenir compte de la façon dont les indicateurs sont mesurés dans l'interprétation des résultats.

Une seule étude a évalué la relation entre le niveau d'éducation et les attitudes à l'égard de l'euthanasie et/ou du suicide assisté et une relation significative a été démontrée entre les deux. Selon Csikai (1999b), les travailleurs sociaux ayant une éducation supérieure, par exemple ceux qui ont une maîtrise, étaient plus susceptibles d'être favorables à la légalisation de l'euthanasie et du suicide assisté. La comparaison n'a toutefois été faite qu'entre ceux qui détenaient un baccalauréat en service social et ceux qui avaient obtenu leur maîtrise, car seulement 1% des répondants détenaient un doctorat. Par conséquent, la comparaison n'a pas été faite entre ce groupe.

Seules deux études sur les 11 retenues ont mesuré le lien entre l'âge et le sexe (Fenn et Ganzini, 1999; Portenoy et al., 1997) avec les attitudes envers l'euthanasie et/ou le suicide assisté. Seule celle de Fenn et Ganzini (1999) a révélé une corrélation négative entre l'âge et les attitudes envers le suicide médicalement assisté, bien qu'aucune différence entre le genre et les attitudes n'ait été décelée.

Expériences professionnelles. Peu d'études ont examiné l'association des expériences professionnelles et des attitudes envers l'euthanasie et/ou le suicide assisté (n = 3), mais elles ont toutes montré que celles-ci avaient une influence sur les attitudes des intervenants en santé mentale. Dans l'étude de Portenoy et al. (1997), une différence significative a été constatée entre les répondants qui ont passé la plupart de leur temps avec des patients en phase terminale et des répondants d'un hôpital général ou d'un centre de lutte contre le cancer. De fait, les travailleurs sociaux qui œuvraient auprès de patients en phase terminale étaient moins favorables au suicide assisté que ceux qui avaient été moins exposé à ce type de patients. En outre, le temps passé à gérer la douleur et d'autres symptômes de patients atteints de cancer était négativement corrélé avec l'acceptabilité du suicide assisté. Une autre étude réalisée par Erlbaum-Zur (2005) a révélé que le troisième prédicteur le plus important des attitudes envers le suicide assisté était la durée d'emploi : les travailleurs sociaux qui avaient plus longtemps travaillé en soins de longue durée ou auprès de patients en fin de vie étaient moins susceptibles d'avoir des attitudes positives envers le suicide assisté. Enfin, ceux qui connaissaient mieux la gestion de la douleur se disaient moins favorables au suicide médicalement assisté que ceux qui avaient moins de connaissances dans ce domaine. D'autre part, Csikai (1999b) a observé des travailleurs sociaux qui avaient plus d'expériences dans le milieu médical étaient plus disposés à participer à l'euthanasie et au suicide

assisté. Par conséquent, le fait d'avoir plus d'expérience avec des patients en phase terminale semble négativement associé aux attitudes envers l'euthanasie ou le suicide assisté, tandis que le fait d'avoir de l'expérience dans le domaine de la santé semble, en revanche, associé positivement à la volonté de participer dans ces actes.

Expériences personnelles. Quelques études se sont intéressées aux expériences personnelles des intervenants en santé mentale avec un membre de la famille en phase terminale. Dans l'étude de Csikai (1999b), 64% des travailleurs sociaux ont eu une telle expérience et 5% d'entre eux ont indiqué que l'euthanasie ou le suicide assisté a été utilisé. Ils ont toutefois observé que les expériences personnelles n'auraient pas eu plus d'impact sur les attitudes envers l'euthanasie ou le suicide assisté. Selon l'étude de Fenn et Ganzini (1999), les expériences personnelles des psychologues avec un membre de la famille en phase terminale ne semblent pas non plus influencer leurs opinions sur le suicide assisté. Cependant, les psychologues qui avaient des expériences personnelles avec un membre de la famille ou un ami en phase terminale étaient plus susceptibles de refuser d'effectuer une évaluation telle que déterminée en vertu de la Loi sur la mort avec dignité de l'Oregon qui concerne le suicide assisté que ceux qui n'avaient pas de telles expériences (Fenn et Ganzini, 1999). D'autre part, environ 18% et 13% des travailleurs sociaux des études d'Ogden et Young (1998, 2003) respectivement ont déclaré avoir eu des expériences avec l'euthanasie et le suicide assisté dans leur vie personnelle, et plus de la moitié des travailleurs sociaux ont déclaré qu'ils envisageraient l'euthanasie ou le suicide assisté comme option pour eux-mêmes ou pour un membre de la famille en cas de maladie terminale. De la même façon, Erlbaum-Zur (2005) a constaté que 60% des travailleurs sociaux souhaitaient avoir

la possibilité de recourir au suicide assisté pour eux-mêmes ou un membre de leur famille en cas de maladie incurable.

Discussion

L'objectif de cette synthèse de la littérature était de faire état des résultats d'études sur les attitudes des intervenants en santé mentale envers l'euthanasie et le suicide assisté et des facteurs qui influencent ces attitudes. L'ensemble de la littérature sur les attitudes des intervenants en santé mentale envers ces deux pratiques est à ce jour limitée ; seuls 11 articles ont été inclus dans cette synthèse et ils datent de la fin des années 90 pour la majorité.

Les résultats ont montré que les intervenants en santé mentale ont généralement des attitudes positives envers l'euthanasie et le suicide assisté. Cependant, une différence d'attitudes semble montrer un appui légèrement supérieur pour le suicide assisté que pour l'euthanasie. Une interprétation possible est que, dans le cas d'un suicide assisté, le patient prend sa propre vie à l'aide d'un médicament létal prescrit par un médecin alors que dans le cas de l'euthanasie, le médecin injecte lui-même la substance mortelle et est donc directement responsable de l'acte qui cause la mort. Par conséquent, il serait logique que les intervenants en santé mentale soient plus favorables à la légalisation du suicide assisté parce que l'autodétermination des patients est en quelque sorte mieux protégée. Cette hypothèse a été proposée par plusieurs études (DiPasquale et Gluck, 2001; Fenn et Ganzini, 1999; Miller et al., 2004; Ogden et Young, 1998; 2003). De tels résultats sont comparables à des recensions de littérature sur les attitudes des médecins (Emanuel et al., 2016, Tomlinson et Stott, 2015) où on observe que les médecins sont plus favorables au suicide assisté qu'à l'euthanasie. Dans ce cas-ci, l'interprétation possible de ces résultats est que

les médecins, qui sont habituellement ceux qui accompliront l'acte d'euthanasie et qui seront donc directement responsables de la mort du patient, préfèreraient avoir un rôle plus passif comme dans le cas du suicide assisté.

À l'instar des médecins et des infirmières, de nombreuses études ont montré que la religion est le facteur le plus important associé aux attitudes des intervenants en santé mentale envers l'euthanasie et le suicide médicalement assisté. La plupart des religions partagent une croyance commune selon laquelle seul Dieu ou le Divin Créateur peut interférer avec la vie et la mort des individus, ce qui explique pourquoi elles interdisent généralement la pratique de l'euthanasie ou du suicide assisté. La religion est toutefois une variable complexe qui peut être mesurée de différentes façons à travers les études. Certains auteurs ont évalué la relation entre la religion et les attitudes envers l'euthanasie et / ou le suicide médicalement assisté à partir de l'affiliation religieuse (i.e. catholiques, protestants, juifs, etc.). Dans cette recension, nous avons constaté que les catholiques étaient moins favorables à l'euthanasie et à l'aide au suicide que les répondants juifs (Erlbaum-Zur, 2005; Portenoy et al, 1997) et pourrait peut-être s'expliquer par le fait que la dignité humaine serait considérée comme sacrosainte dans certaines formes de judaïsme (Evans, 2015).

D'autres études se sont intéressées à l'importance de la religion qui a elle été mesurée par le biais de plusieurs questions telles que la pratique actuelle, la pratique pendant l'enfance, le degré d'engagement religieux, la participation à l'église et/ou l'importance de la religion dans sa vie. Il a été démontré que les personnes qui considéraient leur religion importante étaient moins favorables à l'euthanasie et au suicide assisté par rapport à ceux qui considéraient la religion moins importante, et qu'il existait une corrélation négative entre les deux (Bevacqua et Kurpius, 2013; Csikai, 1999; Dipasquale et Gluck, 2001; Erlbaum- Zur, 2005; Miller et al., 2004; Ogden

et Young, 2003; Portenoy et al., 1997). Une étude a utilisé les deux variables et a conclu que l'importance de la religion serait un meilleur prédicteur que l'affiliation à la religion puisque celle-ci n'est plus significative lorsque l'on contrôle pour le niveau de religiosité (Erlbaum-Zur, 2005). D'autres études devraient toutefois être menées pour corroborer ce résultat. Bref, la religion est considérée comme un facteur d'influence important des attitudes des intervenants en santé mentale, mais la comparaison des résultats d'études est difficile en raison de diverses manières dont cette variable est mesurée, entraînant peut-être une surestimation ou sous-estimation de l'influence de la religion.

Dans cette synthèse de la littérature, une seule étude (Csikai, 1999b) a montré que les travailleurs sociaux ayant un niveau de scolarité plus élevé étaient plus favorables à l'euthanasie et au suicide médicalement assisté que ceux qui avaient un niveau d'éducation inférieur. Cette constatation va dans le sens d'une recension de la littérature d'études effectuées auprès d'infirmières (Evans, 2015), et d'une enquête européenne auprès de la population générale ont également (Cohen et al., 2006). Cependant, une revue systématique de Tomlinson et Stott (2015) a révélé des résultats contradictoires entre le niveau d'éducation et les attitudes de différentes populations d'intérêt. D'autres recherches supplémentaires sont nécessaires pour confirmer ou infirmer cette association chez les intervenants en santé mentale.

Les études incluent dans cette synthèse ont révélé un lien ténu entre le genre ou l'âge avec les attitudes envers l'euthanasie et/ou le suicide assisté. Seuls Fenn et Ganzini (1999) ont observé que les femmes étaient moins disposées à effectuer une évaluation telle que déterminée en vertu de la Loi sur la mort avec dignité de l'Oregon (suicide assisté). Cette constatation irait donc dans le même sens que les résultats d'autres enquêtes réalisées auprès de médecins ou d'infirmières (Di Mola et al., 1996; Levy et al., 2013; Miccinesi et al., 2005; Ryynanen et al., 2002) qui ont

démontré que les femmes seraient moins susceptibles d'accepter l'euthanasie ou le suicide assisté. D'autres études seraient donc nécessaires pour mieux cerner le lien entre le genre et les attitudes des intervenants en santé mentale. En ce qui concerne l'âge, Fenn et Ganzini (1999) ont observé que les plus jeunes psychologues étaient moins favorables au suicide assisté. L'âge étant habituellement associé aux années d'expériences, les intervenants en santé mentale expérimentés pourraient donc avoir été exposés à plus de patients en phase terminale que les plus jeunes, ce qui pourrait jouer sur leurs attitudes comme l'ont démontré certaines études. De plus, cette constatation est à l'inverse des résultats d'autres recherches (Kitchener, 1998; Miccinesi et al., 2005; Ryynänen et al., 2002; Verpoort et al., 2004), où les médecins et les infirmières plus jeunes semblaient avoir une opinion plus favorable envers l'euthanasie et le suicide assisté. Ces résultats contradictoires mériteraient une attention plus poussée et une attention particulière devrait être portée à la façon dont cette variable est mesurée, à savoir selon des catégories prédéterminées ou comme variable continue.

Cette synthèse a également permis d'observer que les expériences professionnelles seraient associées aux attitudes des intervenants en santé mentale. Un contact régulier avec des patients atteints d'une maladie terminale serait lié à des attitudes moins favorables envers l'euthanasie ou le suicide assisté (Erlbaum-Zur, 2005; Portenoy et al., 1997). Ce constat est comparable à celui de Cohen et al. (1994) où les médecins qui avaient été exposés plus régulièrement à des patients en phase terminale étaient moins favorables au suicide assisté. D'autres études menées auprès de médecins (Craig et al., 2007) et d'infirmières (Verpoort et al., 2004) ont montré des résultats similaires. Ces résultats pourraient s'expliquer par le fait que ceux qui ont plus d'expériences en fin de vie ont plus de connaissances des enjeux associés à la fin de vie et des diverses options qui s'offrent aux patients. D'un autre côté, dans l'étude de Csikai

(1999b), les travailleurs sociaux qui étaient plus expérimentés étaient plus disposés à participer à l'euthanasie ou au suicide assisté. D'autres études seraient nécessaires pour mieux comprendre le lien entre les expériences professionnelles et les attitudes envers l'euthanasie et le suicide assisté auprès des intervenants en santé mentale.

Enfin, deux études se sont intéressées au lien entre les expériences personnelles et les attitudes envers le suicide assisté et elle n'a décelé aucune relation entre les deux (Csikai,1999b; Fenn et Ganzini, 1999). Trois autres études inclues dans cette synthèse ont soulevé la question de l'expérience personnelle, mais n'ont pas mesurées le lien entre cette dernière et les attitudes entre l'euthanasie ou le suicide médicalement assisté. Pourtant, les études portant sur les patients, les soignants et la population générale ont conclu que les individus qui avaient vécu la mort d'un proche en souffrance à la fin de sa vie étaient plutôt favorables au suicide assisté (Hendry et al., 2013). Bref, cette relation n'a pas été observée dans la présente synthèse et des études supplémentaires seraient nécessaires pour mieux statuer sur un lien entre les expériences personnelles des intervenants en santé mentale et leurs attitudes à l'égard de l'euthanasie et du suicide assisté.

La comparaison des résultats de cette synthèse de la littérature devrait se faire avec prudence. Les études ont été menées dans deux pays différents, les États-Unis et le Canada, et publiées sur une période allant de 1997 à 2013 où les débats publics sur ces questions n'ont pas nécessairement suivi les mêmes trajectoires. L'interprétation des résultats de différents pays est une tâche difficile en raison des différences culturelles, mais aussi du statut juridique de l'euthanasie et du suicide assisté (notamment dans différents États américains). L'euthanasie et / ou le suicide assisté étaient illégaux au moment où ces études ont été menées à l'exception d'une

qui a été menée en Oregon (Miller et al., 2004). Ces différences pourraient jouer un rôle important dans la comparaison des attitudes des intervenants en santé mentale de l'époque. Bien que les études aient utilisées des méthodes de collecte de données similaires (e.g. enquête par la poste ou questionnaire administré en personne), les différences d'attitudes peuvent également s'expliquer par des différences méthodologiques, dont la terminologie utilisée et la façon dont les questions sont posées (Hagelin, Nilstun, Hau et Carlsson, 2004; Ho, 1998; Marcoux, Mishara et Durand, 2007; Magelssen et al., 2016; Nilstun, Melltorp et Hermerean, 2000; Snelling, 2004). De fait, certaines études n'ont pas mentionné comment l'euthanasie ou le suicide assisté ont été définis dans leurs enquêtes et ont simplement utilisé le terme tel quel dans leur question. Toutefois, une description de l'action devrait être fournie au lieu d'utiliser le terme « euthanasie » afin d'éviter toute confusion puisque celui-ci peut être interprété différemment par les répondants (Marcoux, 2011; Marcoux et al., 2007). Cette confusion a un impact sur la façon de répondre aux questions d'attitudes sur l'euthanasie. De fait, dans l'étude de Marcoux et al. (2007), il a été démontré que ceux qui ne pouvaient pas identifier la description spécifique de l'euthanasie étaient plus susceptibles de considérer l'euthanasie comme inacceptable et que ceux qui ont confondu l'euthanasie avec d'autres pratiques de fin de vie ont trouvé l'euthanasie plus acceptable. De plus, tel que démontré au tableau 2, il n'y avait pas vraiment de définitions communes de l'euthanasie et du suicide assisté parmi les études qui ont fournis une telle définition. La non utilisation d'une terminologie commune entraîne non seulement une confusion et affecte les attitudes, mais rend également la comparaison très difficile entre les études (Nilstun et al., 2000). Enfin, en raison de la nature délicate du sujet, les résultats des études incluses peuvent avoir fait l'objet d'un biais de non réponse ou d'un biais de désirabilité sociale où, les

répondants ont pu prodigué des réponses qui sont socialement jugées plus acceptables ou plus conformes aux valeurs véhiculées dans leur milieu de travail.

Conclusion

À notre connaissance, il s'agit de la première synthèse critique portant sur les attitudes des intervenants en santé mentale vis-à-vis de l'euthanasie et du suicide assisté. Les intervenants en santé mentale démontrent généralement des attitudes positives à l'égard de ces deux pratiques, mais ils seraient un peu plus favorables au suicide médicalement assisté qu'à l'euthanasie. Des facteurs tels que la religion et les expériences professionnelles semblent influencer les attitudes des intervenants de la santé mentale. Compte tenu des résultats inconstants sur l'influence de facteurs tels que l'âge, le genre et l'éducation, des recherches futures quant à leur influence sur les attitudes des intervenants en santé mentale sont nécessaires. Des enjeux particuliers au plan de la méthodologie doivent être considérés dans l'interprétation des résultats, surtout pour l'euthanasie, dont les différences dans les définitions, la terminologie utilisée et la formulation des questions. Puisque l'euthanasie et l'aide médicalement assisté sont de plus en plus débattus dans le monde entier et légalisés en certains endroits dont le Canada, les attitudes des intervenants en santé mentale nécessitent une attention plus accrue car cette population n'a pas été assez étudiée dans la littérature. Il est notamment important pour ces intervenants de comprendre leurs positions concernant ces questions puisqu'ils pourraient être amenés à apporter du soutien à ceux qui auront besoin de leur aide pendant leurs moments difficiles. De plus, une meilleure connaissance et compréhension de leurs attitudes pourrait aider à améliorer les interventions futures et à mieux informer les pratiques et les politiques. La compréhension de la

relation entre l'expérience personnelle et les attitudes envers l'euthanasie et / ou le suicide assisté par un médecin peut être une direction importante pour les recherches futures.

Déclaration de Conflit d'intérêts

Les auteurs n'ont déclaré aucun conflit d'intérêts.

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CHAPTER THREE

SUICIDE PREVENTION WORKERS' ATTITUDES TOWARD EUTHANASIA: DO IDENTITY OF THE PATIENT, EXPERIENCES AND SOCIODEMOGRAPHIC FACTORS HAVE AN INFLUENCE?

The following chapter has been prepared as a manuscript for submission to the Journal *OMEGA – Journal of Death and Dying*. This manuscript builds on the literature review conducted in Chapter Two. The chapter presents the attitudes of SPWs toward euthanasia. The objectives of the study were to:

1) examine the attitudes of SPWs toward euthanasia for a non-descript person versus for a loved one;
2) to verify the association between factors (experiences, sociodemographics) and attitudes toward euthanasia;
3) to explore personal experiences of SPWs in relation to grievous illness.

The MSc. Student is the first author of the paper, participated in data collection, and was responsible for data analysis and dissemination via writing the manuscript. This paper was co-authored by Dr. Isabelle Marcoux and Brittany Irvine. Dr. Marcoux came up with the conception of the project and provided meaningful feedback, guidance on statistical analyses, interpretation of data and revisions of this manuscript. Brittany Irvine helped with qualitative analysis and provided meaningful feedback on the development and revisions of this manuscript.

Suicide Prevention Workers' Attitudes toward Euthanasia: Do Identity of the Patient, Experiences and Sociodemographic Factors Have an Influence?

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Keywords: suicide prevention workers, attitudes, euthanasia, personal experience, Quebec

Abstract

Extensive research has been conducted on the attitudes of physicians and nurses toward euthanasia. However, little is known on the attitudes of suicide prevention workers (SPWs). The objectives of this study were to: (1) examine the attitudes of SPWs toward euthanasia for a non-descript person versus for a loved one; (2) verify the association between personal factors (experiences, sociodemographics) and attitudes, and (3) explore personal experiences of SPWs in relation to grievous illness. A survey was sent out to all suicide prevention centres across Quebec (n=32). A majority of SPWs (55.7%) held positive attitudes toward euthanasia for a non-descript person and for a loved one (49.5%). Statistically significant differences were found in attitudes among SPWs who had personal and professional experiences. There were no other statistically significant differences in the attitudes of SPWs toward euthanasia for a non-descript person or for a loved one, and any of the sociodemographic factors. Three themes emerged from the qualitative analysis of open-ended question on personal experiences of SPWs: respect of choice, suffering/low quality of life and palliative care. While some findings may be concluded from this study, it is essential that this topic be explored further as research on SPWs' attitudes on euthanasia is limited. Research outcomes of this study can have important short-term and long-term implications on suicide prevention and training of SPWs to improve services offered to clients.

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Introduction

Advances in the fields of medical science and technology have increased longevity necessitating more attention on end-of-life practices. Apart from the development of practices devoted to management of pain and symptoms for the dying, and particularly palliative care, discussions increasingly concern whether a terminally ill person has the legal right to die by euthanasia. Euthanasia, defined as "the administration of drugs with the explicit intention of ending the patient's life, at the patient's explicit request" (van der Maas et al., 1996) may be among the most passionately debated topics in the field of medical ethics (Sher, 2012). Debates around the world have led to countries reconsidering the legal status of the practice. As of 2017, euthanasia has been legalized in three European countries, namely, the Netherlands (Griffiths, Wyers & Adams, 2008), Belgium (Nys, 2003) and Luxembourg (Dyer, White & Garcia Rada, 2015).

After years of discussions, in December 2015, the province of Quebec (Canada) also enacted the Act Respecting End-Of-Life Care that legalized "medical aid in dying" (Government of Québec, 2016). The purpose of the Act was to shed light on certain end-of-life practices that are already in place in Quebec such as palliative sedation and withdrawing life-sustaining treatments, but also to allow incurably ill adult patients who are continuously suffering to obtain medical aid in dying. In the Act, "medical aid in dying" is defined as "care consisting in the administration by a physician of medications or substances to an end-of life patient, at patient's request in order to relieve their suffering by hastening death" (The National Assembly of Québec, 2014). The term "medical aid in dying" is synonymous to what has been defined as euthanasia in the scientific literature (Marcoux, 2011; van der Maas et al., 1996). Quebec

becomes, therefore, the first province in Canada as well as in North America, to allow physicians under strict conditions, to administer lethal drugs on the voluntary request of a terminally ill patient.

As a result of this now legal practice, suicide prevention workers (SPWs) are faced with a dilemma concerning messaging around suicide prevention efforts in Quebec. Suicide and medical aid in dying are two distinct situations, particularly because a suicidal person does not necessarily meet the criteria stipulated by the medical aid in dying law. However, as mentioned by the Quebec Association for Suicide Prevention (QASP) (2013) in a brief submitted to the *Select Committee on Dying with Dignity*, these two realities have a commonality: in both situations, individuals wish to end their life in order to alleviate their "unbearable" suffering. SPWs are focussed on trying to prevent death by suicide, as a means to relieve the suffering experienced by certain individuals. However, according to the QASP (2013), it may become more difficult for SPWs to convey the message that suicide is not an option under the new law as death officially became an option even if it's under strict conditions. It is therefore essential that SPWs' attitudes be understood with respect to situations in which individuals seek medical help to end their lives.

Research on health professionals' attitudes toward euthanasia has been mostly restricted to physicians and nurses since they are the designated professionals to enact the process. A number of surveys on health care providers' attitudes toward euthanasia have found variation in results according to the legal status of euthanasia. For instance, support for euthanasia is often lower in countries where the practice is illegal (Asai, Ohnishi, Nagata, Tanida & Yamazaki, 2001; Brits, Human, Peitserse, Sonnekus & Joubert, 2009; Dany et al., 2015; Leppert, Majkowicz & Forycka, 2013; McGlade, Slaney, Bunting & Gallagher, 2000; Miccinesi et al., 2005; Singh, Gupta, Singh

& Madaan, 2016). While, in the few countries where euthanasia is legalized, studies have found remarkably consistent results, with 77-85% of physicians accepting euthanasia (Bolt, Snijdewind, Willem, van der Heide & Onwuteaka-Philipsen, 2015; Miccinesi et al., 2005; Smets et al., 2011). Similar findings have been observed from surveys on nurses in which 84-92% of nurses hold positive attitudes toward euthanasia (De Hert et al., 2015; Inghelbrecht, Bilsen, Mortier & Deliens, 2009).

Studies on mental care providers such as psychologists and social workers' attitudes toward euthanasia have shown that euthanasia acceptance ranges between 55-72% (Csikai, 1999a; Ogden & Young., 1998; 2003; Portenoy et al., 1997). Very limited research compares these types of results to the data on attitudes of physicians and nurses.

The existing evidence suggests that attitudes are often the result of many factors that exert influence on an individual's opinion. Attitudes toward euthanasia are not as simple as giving an opinion in favour or against it. Factors such as the person for whom euthanasia is being considered, sociodemographic factors (e.g., age, gender, education, religious identity, the degree to which religion is actively practiced), professional and personal experiences with grievous conditions have been considered to play a role in shaping attitudes toward euthanasia (Chong & Fok, 2005; Gielen, van Den Branden & Broeckart, 2008; McCormack, Clifford & Conroy, 2011).

Attitudes have been shown to vary depending on whether the person for whom euthanasia is being considered is, for example, a non-descript patient, a loved one or oneself. Notably, studies found that physicians were less supportive of euthanasia for a patient or a loved one than for themselves (Brits et al., 2009; Rathor et al., 2014). However, contrasting results have also been reported, in which physicians were more in agreement when euthanasia was considered for their

loved one or themselves, as opposed to a non-descript patient (Chong & Fok, 2005). Another study by Kinsella & Verhoef (1993) showed that the proportions of physicians who would consider euthanasia for themselves (49%) were similar to the proportions of physicians who would consider the practice for a close relative (45%) or their patients (44%). However, physicians were more uncertain about considering euthanasia for a close relative (21%) than for themselves (16%) or their patients (10%). Relationship is also a factor that influences the general public where euthanasia was more supported for a non-descript person than for a loved one (Ho, 1998; Ho & Chantagul, 2015). A study by Chog and Fok published in 2005, found that the level of support for euthanasia was the weakest among the general public when it was considered for a loved one and strongest for themselves and for a non-descript patient. Attitudes toward euthanasia, therefore, seem to vary as a function of the relationship with the person being considered for the act.

Among sociodemographic factors, religion has been shown to be one of the most influencing factors. For instance, health professionals who identify themselves as Catholic or Protestant usually have more conservative attitudes toward euthanasia (Berghs, de Casterlé & Gastmans, 2005; Grassi, Magnani & Ercolani, 1999; Ogden & Young, 2003; Portenoy et al., 1997). Further, those who attribute more importance to religion were less likely to accept euthanasia (Bevacqua & Kurpius, 2013; Bülow et al., 2012; Csikai, 1999b; Ogden & Young, 2003; McCormmack, Clifford & Conroy, 2011; Portenoy et al., 1997; Rathor et al., 2014; Tomlinson & Stott, 2015). However, religion is a complex variable and can be measured through several ways.

In addition to religion, many studies have found that age is an influencing factor, with younger health professionals being more accepting toward euthanasia than their older

counterparts (Berghs et al., 2005; Kitchener, 1998; Miccinesi et al., 2005; Ryynänen, Myllykangas, Viren & Heiro, 2002; Verpoort, Gastmans, De Bal & Dierckx de Casterlé, 2004). Regarding gender, females seem to be less favourable of the act (Di Mola et al., 1996; Levy, Azar, Huberfeld, Siegel & Strous, 2013; Vézina-Im, Lavoie, Krol, Olivier-D'Avignon, 2014), but the relationship between gender and attitudes is not always clear (Gielen, Van Den Branden & Broeckaert, 2008; Kitchener, 1998). Finally, health professionals who have a higher education level are more likely to support euthanasia (Csikai, 1999b; Vézina-Im et al., 2014). According to some authors (Bobo & Licari, 1985; Caddell & Newton, 1996; Weakliem, 2002), such a result is expected because personal freedom, individualism and autonomy are often more valued by individuals with higher levels of education than those who have lower levels of education.

Many studies have also highlighted the influence of professional experiences on attitudes toward euthanasia. Acceptance of euthanasia was inversely associated to experience with terminally ill patients and with years in the profession (Asai et al., 2001; Berghs et al., 2005; Gielen et al., 2008; Holt, 2008; Portenoy et al., 1997; Tanida et al., 2002; Verpoort et al., 2004).

Regarding personal experiences, two studies on physicians (Grassi et al., 1999; Silvoniemi, Vasankari, Vahlberg, Clemens & Salminen, 2010) and one on mental health workers (Ciskai, 1999b) assessed the relationship between attitudes toward euthanasia and personal experiences with a terminally ill family member or end-of-life care of relatives. The results were inconclusive. By contrast, studies conducted with the general population seem to indicate that personal experiences with a dying loved one can affect attitudes. For example, a systematic review by Hendry and colleagues (2013) found that participants who witnessed suffering or the death of a loved one at the end-of-life were more strongly in favour of euthanasia or assisted

dying. More research is needed to more fully understand how these experiences influence attitudes of health care professionals toward euthanasia.

Even though SPWs are expected to intervene on a day-to-day basis with individuals who want to end their life, limited research has been conducted on the opinions of SPWs surrounding euthanasia. To our knowledge only one study (MacDonald, 2005) has been undertaken to specifically look at the attitudes of suicide prevention trainees toward euthanasia. The results of that study showed that the majority of trainees (60%) agreed that people suffering from an incurable illness should be allowed to die by suicide in a dignified manner and 51% were in agreement that suicide is an acceptable means to end an incurable disease. However, in the questions, the word suicide was used, and the term euthanasia was not explicitly mentioned nor was an explanation of the term given. It is particularly important in studies on this topic to use a descriptive formulation of the term euthanasia because participants may not fully understand its meaning (Marcoux, Mishara & Durand, 2007) and acceptability may vary according to the understanding of the term (Hagelin, Nilstun, Hau et Carlsson, 2004; Magelssen, Supphellen, Nostvedt & Matersvedt, 2016). Furthermore, the study did not assess other factors (e.g., personal experiences and participant characteristics) that may have played a role in determining these attitudes.

Awareness of SPWs' attitudes is important since an individual in crisis may call to seek support and guidance. Besides awareness of their attitudes toward euthanasia, it is also important to better understand how acceptance of euthanasia might be influenced by other factors such as who is to receive euthanasia, the SPW's professional and personal experiences, and certain sociodemographic factors as this might help in explaining different views. The current study attempts to address this gap in the literature. To the best of our knowledge, no previous research

has been done on this matter. Only the attitudes toward euthanasia were assessed in this study as only euthanasia (labelled as medical assistance in dying) is permitted in the province of Quebec.

Objectives

The objectives of this study are threefold: (1) to examine the attitudes of SPWs toward euthanasia for a non-descript person or for a loved one; (2) to verify the association amongst various personal factors (experiences, sociodemographics) and attitudes toward euthanasia; (3) to explore personal experiences of SPWs in relation to grievous illness.

Methods

Participants

SPWs working in one of the 32 suicide prevention centers (SPC) across Quebec were invited to participate in the study. In order to be eligible, participants had to (1) be an employee or volunteer in a SPC in Quebec; (2) be working or volunteering part-time or full-time; (3) be involved in intervention by telephone or other methods with suicidal persons, their relatives or individuals bereaved by suicide; (4) be able to read and understand French. A list of emails of current SPWs was provided by the QASP (n=400). Every individual on the list was directly approached by email with a request to participate in the study by the researchers. In the email, participants were directed by URL to a confidential survey hosted by LimeSurvey. In order to reach SPWs who were not on the email list, posters containing information on the study and the URL to the confidential survey were also distributed to every SPC with prior permission of the

directors of each center. According to the directors' estimations, the population of SPWs across the province was approximately 557 at the time of the study.

Questionnaire Development

The questionnaire was prepared in French. To ensure content reliability and validity, the questionnaire was pre-tested twice with two groups of ten individuals (n=20). These individuals had similar characteristics and experiences to potential participants but were not working in a SPC. The questionnaire was adjusted and finalized based on their comments and suggestions.

Measures

Attitudes. Attitudes were explored by asking respondents about their acceptance levels on a 4-type Likert response scale (from 1= totally acceptable to 4= totally unacceptable), using two statements adapted from Marcoux et al. (2007), the first one dealing with euthanasia for a non-descript person and the second one for a loved one: (1) *A person suffering from serious and incurable disease asks his doctor to end his suffering and cause his death by giving him a lethal injection of drugs. The doctor accepts and causes the death of the person. According to me, this situation is…; (2) One of your loved ones suffers from a serious and incurable illness and asks his doctor to end his suffering and cause his death by giving him a lethal injection of drugs. The doctor accepts and causes his death. According to me, this situation is…* Participants also had the options to answer "I don't know" or "Refuse to answer". To avoid possible confusion around terminology and answers given (Hagelin et al., 2004; Magelssen et al., 2016) and also to ensure

participants understood the questions in the same way (Marcoux, 2011; Marcoux et al., 2007), the word "euthanasia" was purposefully not used, but indicated by the "act of giving a lethal injection of drugs".

Personal and professional experiences. Professional experience was measured by asking respondents if they had ever been faced with a situation in which an adult with a grievous and incurable illness wanted to die. The options provided were "yes" and "no". Personal experience questions were dichotomous and were assessed by two questions: (1) *Have you ever suffered from a serious illness?* and (2) *Has one of your loved ones ever suffered from a serious and incurable disease*? Respondents had the options "yes", "no" and "refuse to answer" to these questions. If respondents said "yes" to either of these two questions, they were also asked to specify the type of disease in question. Finally, an open-ended question was also asked to obtain more insights on SPWs' personal experiences related to the subject of the study: *Do you have any personal experiences on the subject of this study you would like to share*.

Socio-demographic factors. Respondents were also requested to provide socio-demographic information on their gender, age, religion and education level. Respondents had to enter their age, while the level of education was measured as the number of years of education completed. The response categories were "7 years or less (primary)", "8 to 12 years (secondary)", "13 to 15 years (college/technical school)", "16 years or more (university)".

With regard to religion, two variables were used: religious identification and self-rated religiosity. For religious identification respondents could choose from a list of affiliations, namely, Catholic, Protestant, Jewish, Muslim, Greek Orthodox, Buddhist and other, with a no religion/atheists/agnostic option. Self-rated religiosity concerns frequency of religious service attendance. For participants who indicated affiliation to a religion, self-rated religiosity was

assessed by the following statement: “In the past 12 months, how often have you gone to a place of worship (church, mosque, temple, other sacred or ritual place)?” The response categories were “Once a week or more”, “About once a month”, “A few times a year”, and “Once a year/Never”.

Data Collection

Data were collected between September and December 2016 through an online self-administered questionnaire on a secured platform (LimeSurvey). In order to improve response rates, researchers sent out two reminder emails, in October and November, to participants on the list provided by QASP.

Ethical Consideration

Prior to data collection, ethics approval for the project was obtained from the Research Ethics Board of the University of Ottawa.

Data Analysis

All analyses were carried out using Statistical Package for the Social Sciences (SPSS), version 24 for Windows. Descriptive statistics were used to describe the study sample and to examine attitudes toward euthanasia. The “totally acceptable” and “rather acceptable” responses were combined, as were the responses “totally unacceptable” and “rather unacceptable”. This allowed for an overall understanding of the binary distribution of the responses. Chi-square (x^2)

tests were used to explore the relationship (for categorical variables) and t-test (for continuous variables i.e. age) were performed to explore relationships between attitudes, respondent characteristics and personal and professional experiences. A p-value of 0.05 or less was considered statistically significant.

The open-ended question was analysed using the thematic analysis method based on the guidelines outlined by Braun and Clark (2006). The first step consisted of reading and re-reading the responses. Then, categories were generated from the data and sorted into potential themes. Themes were then reviewed and refined by other authors (BI and IM). Finally, each theme were named by the researchers.

Results

Characteristics of Respondents

A total of 100 questionnaires were returned, with 3 refusals to consent. The final sample consisted of 97 participants. The sociodemographic characteristics of the respondents are shown in Table 1. The mean age of respondents was 35.0 years (M= 32.0; SD=11.2, range 21 - 66). Most respondents were female 79.3% (n=73) and 20.7% (n=19) were male. For education, 27.2% (n =25) had 13 to 15 years of education (college/technical school) and 72.8% (n=67) had 16 years or more of education (University). With regard to religious identification, 55.4% (n=51) self-identified as atheist/or having no religion and 44.6% (n=41) as Catholic. A minority (2.2%) said they attended a place of worship once or more per week, another 3.3% said about once a month, 13.0% said a few times a year while the majority (81.5%) said once a year or never. A

majority (76.3%) of SPWs stated they have been confronted in their career with a situation in which an adult with a grievous and incurable disease wanted to die. With respect to personal experiences with grievous illness, 12.4% (n=11) of SPWs reported they suffered from a serious disease, (the most reported disease was cancer (n = 5), and 77.85% (n=70) reported one of their loved ones had suffered from a grievous and incurable disease. Once again, the most prevalent disease was cancer (n = 45) followed by Alzheimer's disease (n=11) and multiple sclerosis (n=4).

TABLE 1. Demographic Characteristics and Experiences of Respondents

Variable	M	SD
Age	35.0	11.2
	N[1]	**%**
Gender		
Male	19	20.7
Female	73	79.3
Education		
13-15 years (college/technical school)	25	27.2
16+ years (university)	67	72.8
Religious identification		
Atheist	51	55.4
Catholic	41	44.6
Self-rated religiosity		
Once or more than once a week	2	2.2
About once a month	3	3.3
Few times a year	12	13.0
Less than once/never or once a year	30	81.5
Personal experiences		
Ever suffered from a grievous illness		
Yes	11	12.4
No	78	87.6
One of loved ones ever suffered from a grievous and incurable illness		
Yes	70	77.8
No	20	22.2
Professional experiences		
Yes	74	76.3
No	23	23.7

[1] Total may differ due to missing data

Attitudes toward Euthanasia for a Non-descript Person and for a Loved One

Attitudes on euthanasia for different situations are summarized in table 2. The majority of SPWs (n=54) held positive attitudes toward euthanasia for a non-descript person of which 18 and 36 of SPWs respectively said it was totally or rather acceptable. On the other hand, when asked about their attitudes toward euthanasia for a loved one, 14 respondents said it was totally acceptable while 34 said it was rather acceptable. Participants were slightly more accepting (i.e. found the act totally or rather acceptable) when euthanasia was being considered for a non-descript person than for a loved one (55.7% vs 49.5%). Of those who found euthanasia acceptable for a non-descript patient, 93.6% also found euthanasia acceptable for a loved one, ($X^2 = 51.7$; df = 1; $p<0.001$).

TABLE 2. Suicide Prevention Workers' Attitudes Toward Euthanasia in Different Scenarios

In relation to the following statements, indicate your level of acceptability:	**Totally acceptable**	**Rather acceptable**	**Rather unacceptable**	**Totally unacceptable**	**Don't know**	**Refuse to answer**
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A person suffering from a serious and incurable disease asks his doctor to end his suffering and cause his death by giving him a lethal injection. The doctor accepts and causes the death of the person. According to me, this situation is:	18 (18.6)	36 (37.1)	24 (24.7)	14 (14.4)	3 (3.1)	2 (2.1)
One of your loved ones suffers from a serious and incurable illness and asks his doctor to end his suffering and cause his death by giving him a lethal injection of drugs. The doctor accepts and causes the death of the person. According to me, this situation is:	14 (14.4)	34 (35.1)	30 (30.9)	13 (13.4)	5 (5.2)	1 (1.0)

Factors Impacting Attitudes toward Euthanasia

Experiences (personal and professional) related to grievous disease and attitudes toward euthanasia. Analysis could not be performed for respondents who have suffered from a serious disease since 20% of the cells expected frequencies were less than five. Among respondents who had experienced a loved one suffering from a serious and incurable disease, 52.9% said that euthanasia was acceptable for a non-descript person ($X^2 = 3.60$; df = 1; $p \leq 0.05$). When asked if euthanasia was acceptable for a loved one, 51.5% said it was acceptable, however the result was not statistically significant.

As for professional experiences, SPWs who had been confronted in the last 12 months with a situation in which an adult with a grievous disease wanted to die were less likely to accept euthanasia for a non-descript person compared to those who have never been confronted to such situation ($X^2 = 4.78$; df = 1; $p \leq 0.03$). Similarly, those who had more professional experiences were also less likely to accept euthanasia for a loved one but the results were not statistically significant (see Table 3 and 4).

Sociodemographic Factors. As shown in Table 3 and 4, there were no statistically significant ($p > 0.05$) differences in the attitudes of SPWs toward euthanasia for a non-descript person or for a loved one, and any of the sociodemographic factors (gender, age, education, religion identification and self-rated religiosity).

Table 3. Factors Associated with Suicide Prevention Workers' Attitudes toward Euthanasia for a Non-descript Patient

Attitudes toward euthanasia for a non-descript person			
Sociodemographic factors	***Acceptable***	***Inacceptable***	***T- test p-value***
	M (SD)	M (SD)	
Age	35.0 (12.19)	34.7	0.2
	N (%)	***N (%)***	***χ^2 p-value***
Gender			
Male	13 (68.4)	6 (31.6)	0.30
Female	38 (55.1)	31 (44.9)	
Education level			
13-15 years (college/technical school)	16 (64.0)	9 (36.0)	0.47
16+ years (university)	45 (55.6)	28 (44.4)	
Religious identification			
Atheist	29 (61.7)	18 (38.3)	0.45
Catholic	22 (53.7)	19 (46.3)	
Self-rated religiosity			
Few times a year, about once a month, once or more than once a week	7 (43.8)	9 (56.3)	0.24
Less than once/never or once a year	16 (53.3)	14 (46.7)	
Never/no religion	28 (66.7)	14 (33.3)	
Personal experiences			
Have suffered from a grievous disease			
Yes	-	-	-
No	-	-	
Loved one suffered from a grievous and incurable disease			
Yes	36 (52.9)	32 (47.1)	0.05*
No	14 (77.8)	4 (22.2)	
Professional experiences			
Yes	38 (52.8)	34 (47.2)	0.03*
No	16 (80.0)	4 (20.0)	

*$p \leq 0.05$

Table 4. Factors Associated with Suicide Prevention Workers' Attitudes toward Euthanasia for a Loved One

Attitudes toward euthanasia for a non-descript person			
Sociodemographic factors	***Acceptable***	***Inacceptable***	***T-test p-value***
	M (SD)	M (SD)	
Age	35.4 (12.0)	34.7 (12.0)	0.2
	N (%)	*N (%)*	***χ^2 p-value***
Gender			
Male	10 (52.6)	9 (47.4)	0.98
Female	36 (52.9)	32 (47.1)	
Education level			
13-15 years (college/technical school)	14 (58.3)	10 (41.7)	0.53
16+ years (university)	32 (50.8)	31 (49.2)	
Religious identification			
Atheist	25 (53.2)	22 (46.8)	0.95
Catholic	21 (52.5)	19 (47.5)	
Self-rated religiosity			
Few times a year, about once a month, once or more than once a week	7(43.8)	9 (56.3)	0.65
Less than once/never or once a year	15 (51.7)	14 (48.3)	
Never/no religion	24 (57.1)	18 (42.9)	
Personal experiences			
Have suffered from a grievous disease			
Yes	-	-	-
No	-	-	
Loved one suffered from a grievous and incurable disease			
Yes	34 (51.5)	32 (48.5)	0.37*
No	12 (63.2)	7 (36.8)	
Professional experiences			
Yes	35 (49.3)	36 (50.7)	0.21*
No	13 (65.0)	7 (35.0)	

*$p \leq 0.05$

Response to the Open-ended Questions

To the open-ended question "*Do you have any personal experiences on the subject of this study you would like to share*", 51 respondents (55%) left comments. Of these, 14 comments were specifically on personal experiences. The remaining comments were on professional experiences and respondents' opinions, and were therefore not considered in the current study. Three themes emerged from SPWs answers on personal experiences: respect of choice (n=5), suffering/low quality of life (n=6) and palliative care (n=3). Although several comments touched on two or even on all of the themes, the comments were classified based on which one of themes was predominately expressed in the comment.

Respect of choice. Five respondents gave comments that were categorized as being about respect for choice. The comments displayed how respondents wanted to be respectful of their loved ones' choices regarding use of medical assistance in dying and hence how they would find it acceptable. For example, one SPW wrote[8]:

> As a suicide prevention worker, I fundamentally believe that suicide is not an option and that it is a permanent solution to a temporary problem. Although an illness may be an ongoing problem, the associated suffering causing the person to want to kill himself is not permanent. However, in my family I have been confronted with diseases that inevitably lead to death in a short time and also causing great suffering. Although my family members wanted to fight till the end and did not want to end their lives, I respect the choice of people who would like to die faster. I would have understood if my family members made that choice and I would have accepted it.

[8] Comments were originally in French. Some terms were changed in order to protect participants' privacy.

Two other respondents commented:

> I had [a family member] who suffered 15 years of her life. In the end she could not get up, walk, eat, so much her bones crumbled despite treatments. We all felt her suffering. No one should have to suffer that way. If a medical aid in dying had existed at that time and she would have made that choice, I would have understood her decision.
>
> [A family member], who had cancer and died, did not have adequate palliative care and he suffered a lot. If she had asked for medical help in dying, I think I would have found it acceptable.

Suffering/quality of life. Six comments described the poor quality of life or the suffering of a loved one at the end of life. Three SPWs reported the following:

> [A family member] died of a blazing cancer, she suffered a lot.
>
> A lot of suffering the medication allowed him to live longer but unconscious.
>
> [A family member] is the person whose symptoms I described in the last question. One person in the family did everything to keep her alive, called for resuscitation after a cardiac arrest several years after stroke and paralysis. We always wondered about her quality of life since [the family member] had already mentioned to us that in no case she would want to live paralyzed and non-autonomous.

Palliative care. Finally, three comments were predominately on the theme of palliative care. All three respondents discussed experiencing excellent palliative care received by family and the value of palliative care in facilitating the dying process. For instance, one respondent described the following:

> A loved one suffering from lung cancer received excellent palliative care, surrounded by family. We made sure he had no physical pain and we accompanied him [till] last breath. He never mentioned during the illness that he wanted assistance to die, and yet all his life (before illness) he was the first to name that he would commit suicide before going to this stage.

Another respondent discussed two situations comparing two family members' final days:

> [A family member] took 3 years to die of brain cancer in 1983. The impact on my family has been extremely difficult and we are still paying the price of this disease. [Another family member], in 2000, died of the same cancer, in 6 months, accompanied by palliative care. For her, as for us, I believe that this death was much more peaceful and left much less traumatic traces. I know that palliative care and assisted dying are not the same thing. At the same time, we now know that in palliative care, comfort care is given […] which did not exist at the time of my [family member].

Discussion

To the best of our knowledge, this is the first study to assess the attitudes of SPWs toward euthanasia and the factors that influence these attitudes. The first aim of this study was to examine the attitudes of SPWs toward euthanasia for a non-descript person and for a loved one. Overall, a little more than half of SPWs felt that euthanasia was acceptable for a non-descript patient suffering from a serious and grievous disease, and a little less than half of SPWs considered euthanasia acceptable for a loved one. This is consistent with other studies on mental health workers in which a majority were in favour of euthanasia (Csikai, 1999a; Ogden & Young, 1998;2003). The finding that SPWs were slightly less in favour of euthanasia for a loved one suffering from a grievous and incurable disease than for a non-descript patient corroborates findings of other surveys on health professionals (Brits et al., 2009; Rathor et al., 2014) in which euthanasia was less supported when the patient was a loved one, probably because SPWs were more practical or sensitive in their attitudes when a loved one was considered for euthanasia. According to a study by Wade and Anglin (1987), respondents employed different criteria in

their decision-making based whether the subject was a loved one or themselves. For instance, when the decision of euthanasia was related to a loved one, participants were unsure of the conditions under which it would be appropriate to terminate life, however, they were more certain when the decision was for oneself (Wade & Anglin, 1987). It is therefore possible that SPWs were more prudent in their decision when a loved one was considered for euthanasia than for a non-descript patient, which resulted in lower support for euthanasia when the former was considered.

The second aim of this study was to verify the association between factors (sociodemographics and experiences) and attitudes toward euthanasia. In the present study, neither gender nor age had significant associations with attitudes toward euthanasia. This observation corroborates previous studies where gender (Gielen et al., 2008; Kinsella & Verhoef, 1993; McCormack et al., 2011; Portenoy et al., 1997) and age (Kinsella & Verhoef, 1993; Maitra, Harfst, Bjerre, Kochen & Becker, 2005; McCormack et al., 2011; Portenoy et al., 1997; Silvoniemi et al., 2010) were not found to be influential factors. Though, evidence on age is mixed with few studies concluding that younger health professionals have more positive attitudes toward euthanasia compared to their older counterparts (Kitchener, 1998; Miccinesi et al., 2005; Ryynänen et al., 2002; Verpoort et al., 2004). It is important to keep in mind that results may be affected by various ways in which the age variable is measured across surveys (e.g. predetermined categories or continuous variable), therefore affecting the significance of the result.

Furthermore, we were not able to find a statistically significant association between attitudes toward euthanasia and other sociodemographic factors such as gender, education, religious-affiliation and self-rated religiosity in this study. This is surprising since in other

surveys, attitudes toward acceptance of euthanasia were found to be associated with these factors. Studies have shown that highly educated individuals are less likely to oppose euthanasia than individuals with lower education levels (Csikai, 1999b; Evans, 2015). However, in our study, no such significant difference was noted in terms of education of respondents. Our result might be explained by the fact that there is not enough variation between education categories as the participants seemed to be quite similar on the specific variable. Regarding religion, even though atheist participants found euthanasia more acceptable than their Catholic counterparts, there was no significant relationship found between participants who identified as religious and those who did not. In regard to previous research, religious-identification and self-rated religiosity have repeatedly been found to be the most influencing factors (McCormack et al., 2011). However, this relationship could not be established among SPWs in Quebec. It has been seen that the correlation between religious affiliation and attitudes toward euthanasia may be mediated by self-rated religiosity (Brudette, Hill & Moulton, 2005; Bülow et al., 2012). As it can be seen from Table 1, 49% of respondents reported being Catholic, however only five individuals reported going to a place of worship at least once or few times a week or once a month while the majority stated going to a place of worship few times a year or never. This suggests that SPWs who identified themselves as Catholics, were mostly non-practicing. As a consequence, they were presumably not actively religious. This lack of religious practice amongst the Catholic respondents may in part explain why we did not find significant results regarding religious-identification and self-rated religiosity as Catholics respondents may have attitudes closer to atheist due to the low self-rated religiosity.

A small minority of SPWs in this study suffered from a grievous disease themselves and a majority had a loved one suffering from an incurable and grievous disease. Experience with a

loved one suffering from a grievous and incurable disease was found to be marginally related to positive attitudes toward euthanasia for a non-descript patient. This result corresponds to other studies (Hendry et al., 2013; Malpas, Wilson, Rae & Johnson, 2014) where personal experiences with a sick or dying loved one contributed to a higher rejection of euthanasia, and in contrast with studies on health professionals which concluded that personal experience is not related to attitudes toward euthanasia (Csikai, 1999b; Grassi et al., 1999; Silvoniemi et al., 2010). However, no statistically significant difference was found when euthanasia was considered for a loved one. We have not come across other studies that investigate the difference between attitudes when euthanasia is considered for a non-descript patient and a loved one among those who have personal experience with a terminally ill family member. Hence, we cannot compare the result obtained to other surveys. It is possible that respondents in our study were neutral in attitudes toward euthanasia when it was considered for a loved than a non-descript person due to uncertainty under which conditions it would be appropriate to terminate the loved one's life and the kind of experiences they had. However, these conclusions are worthy of further investigations.

With regards to professional experiences, those who were never confronted to a situation in which an adult suffering from a grievous and incurable disease wanted to die were more likely to accept euthanasia for a non-descript person than those who were never confronted with such situation. This finding supports previous research in which more professional experience with the terminally ill led to negative attitudes toward euthanasia (Berghs et al., 2005; Holt, 2008; Portenoy et al., 1997; Verpoort et al., 2004). It is possible that those who are often confronted to work situations, in which an adult suffering from a grievous and incurable disease wanted to die

have more knowledge of end-of-life issues and options available to patients (e.g., palliative care), and therefore may have a less positive attitude.

The third aim of our study was to explore personal experiences of SPW in relation to grievous illness. Themes that emerged from the qualitative analysis were respect of choice, suffering/low quality of life and palliative care. Many participants raised concerns about the right to choose after witnessing the suffering at the end of loved ones' lives and understood a request of euthanasia as a way to alleviate the suffering of the terminally ill. In sum, participants expressed that euthanasia would contribute to a better quality of death by shortening suffering and allowing for maintenance of dignity. They also emphasized that they found euthanasia acceptable and understood when a loved one wanted to make that choice. Other studies have found similar results (Georges et al., 2007; Hendry et al., 2012; Tomlinson, Spector, Nurock & Stott, 2015). It may be concluded that participants who left a comment of this sort were likely to accept euthanasia as they think that the choice for euthanasia of the suffering patient should be respected or understood.

A few SPWs also mentioned that they witnessed their loved ones suffering at the end of their lives. Acceptance of euthanasia is often seen to increase in situations where the patient is in pain and suffering (Kouwenhoven et al., 2012; Radulovic & Mojsilovic, 1998; Roelands et al., 2014) as suffering usually affects the end-of-life experience for patients and caregivers (Abrahm, 2001). A systematic review on the views of patients, carers and the public showed that the views of respondents on euthanasia was influenced by experiencing suffering at the end of their loved ones' lives. Participants in these studies gave particularly powerful descriptions of how this had motivated them to be strongly in favour of assisted dying (Hendry et al., 2013). The most common argument in support of euthanasia is that the act may be the only way to relieve

unbearable suffering (Ho & Chantagul, 2015). When treatment and medication stop working and the suffering becomes unbearable, as mentioned by a participant in our study, family members may accept euthanasia as a beneficent option (Abrahm, 2001; Brody, 1992; Pitorak, 2003). Therefore, we can suppose that, for participants who left a comment to the open-ended questions, having an experience of a loved one suffering at the end of their life may increase acceptance of euthanasia.

Few SPWs also noted that good palliative care was helpful during the last days of their loved ones' lives. According to a systematic review by McCormack and colleagues (2011), the provision of palliative care was a major theme in studies and was often presented as an alternative of euthanasia. One of the most important arguments for rejecting euthanasia is believing in the palliative care services which control symptoms and that patients may change their minds when their symptoms are properly controlled (Chapple, Ziebland, McPherson & Herxheimer, 2006; Verpoort et al., 2004). For example, a few studies have found that patients had wished to die eventually changed their mind when their pain was controlled (Eliott & Olver, 2008; Johansen et al., 2005). A qualitative study by Young & Ogden (2000) showed that many nurses believed that palliative care can make patients' last day bearable. Patients wishing to die usually want to escape from pain and suffering but not necessarily from life, and when pain and suffering are controlled, their wish to die may disappear (Young & Ogden, 2000). Thus, it is possible that euthanasia is less accepted among SPWs who mentioned that a palliative care service was received during their loved ones' last days. In the face of the new legislation in Quebec that legalizes euthanasia and more uptake of the practice over time, additional research that seeks to more fully understand the reasons behind SPWs attitudes and the attitudes of other health professionals toward euthanasia is warranted.

Finally, all comments that were categorized in the respect of choice and suffering/low quality of life themes pertained to negative experiences related to the suffering of their loved ones (n=11). The three comments that were categorized in the palliative care theme were all about positive experiences about the use of palliative services. A potential explanation for the considerable number of negative responses to the open-ended question could be the negativity bias (Dasborough, 2006; Garcia, Evans & Reshaw, 2004; Poncheri, Reanna, Lindberg, Thompson & Surface, 2008). Usually, negative events can have a higher impact than positive events (Lewicka, Czapinski, Peeters &1992). Therefore, it is possible that results found in this study supported the phenomenon of negativity bias. In other words, SPWs who did not leave a comment in the open-ended question may have had positive or neutral experiences, while those who had negative experiences were more likely to share their personal experiences. In addition, it can be presumed from the comments that those who had negative experiences were more likely to hold positive attitudes toward euthanasia while those who had positive experiences were more likely to reject euthanasia. A little less than half of SPWs accepted euthanasia for a loved one in our study, therefore, it can be supposed that those who left a comment are not representative of the population surveyed due to the negativity bias.

Limitations and Strengths

The results of the present study need to be interpreted in light of the study limitations. A list with all SPWs in Quebec could not be obtained due to ethical reasons. Hence, the precise response rate could not be calculated. Moreover, two non-random selection and recruitment

strategies were used, therefore, the findings may not be representative of the SPWs in Quebec, and could not be generalized to SPWs from Canada or internationally. The majority of our participants were females and had a university degree. Larger and randomly selected samples are needed to make more inferences about attitudes of SPWs toward euthanasia and to enhance the generalizability of the findings. In addition, attitudes are complex and not easily measured in surveys (Blackhall et al., 1999). It is hard to gain a thorough understanding of SPWs' attitudes from just two questions. Finally, due to the sensitive nature of the subject, the results of this study may have been subject to a non-response bias or a social desirability bias. Participants may seek to give acceptable answers that are socially considered correct or consistent with the values that correspond to their workplace.

Despite limitations, there are also several noteworthy strengths of this study. First of all, this is the first study to elicit the attitudes of SPWs toward euthanasia. In addition, the terminology used to describe euthanasia in the questionnaire was unlikely to be confusing which increased the study validity. Finally, the open-ended question gave participants the possibility to provide more insight on their personal experiences related to the topic of this study. Having a quantitative and qualitative component made for a robust survey and allowed for deeper exploration into the topic at hand.

Conclusion

It is apparent that research on SPWs' attitudes on euthanasia is limited. While some findings may be concluded from this study, it is essential that this topic be explored further. More studies on this population should be conducted in order to validate the results of the current

paper and examine further areas that were not conclusive or explored in this study. Future research should examine the attitudes of a larger sample of SPWs throughout Canada. Multiple-item measures should be used in studies that assess both SPWs' attitudes and actual behaviour during interventions for clients suffering from a grievous illness. Crisis intervention training programs should stress knowledge about dealing with this specific issue. It is important for SPWs to have the training needed and to be comfortable assisting individuals to deal with these difficult issues. Research outcomes of this study can have important short-term and long-term implications on suicide prevention and training of SPWs to improve services offered to this type of clients.

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Conflict of interest

The authors declare no conflict of interest.

Author contributions

IM was responsible for the study conception and design. JK was responsible for the drafting of the manuscript. JK performed the data collection in collaboration with IM. JK performed quantitative data analysis, JK and BI performed the qualitative data analysis. JK, BI

and IM made critical revisions to the paper. IM supervised the study, revised the manuscript and approved the final version. All authors read and approved the final manuscript.

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CHAPTER FOUR

General Discussion

Hastening the death of a patient through euthanasia or physician-assisted suicide has been the subject of intense debate nationally and internationally. Recent changes in the law to allow euthanasia and/or physician-assisted suicide have been adopted and implemented in Quebec and in the rest of Canada. The overarching goals of the current thesis were to review the literature on mental health workers' attitudes to euthanasia and physician-assisted suicide, and to investigate the attitudes of SPWs toward euthanasia and to explore the relationship of these attitudes to personal factors such as sociodemographic characteristics and experiences that may be associated with these attitudes. This topic is both relevant and timely.

Firstly, a literature review was performed to build an understanding of the attitudes of mental health workers toward euthanasia and physician-assisted suicide, and factors impacting these attitudes. Articles that responded to the selection criteria concerned the attitudes toward euthanasia and/or physician-assisted suicide of any of the following mental health workers: psychologists, social workers and mental health counsellors. On the basis of the inclusion criteria, eleven relevant articles were deemed eligible to be included in the review. This literature review was the first to collect and summarize articles on the attitudes of mental health workers toward euthanasia and physician-assisted suicide. Overall, mental health workers held positive attitudes toward euthanasia and physician-assisted suicide. However, existing research indicated that personal characteristics and experiences of mental health workers may influence their attitudes toward euthanasia and physician-assisted suicide. Precisely, this review indicated that

mental health workers' religious-identification and self-rated religiosity as well as professional experiences are associated with their attitudes towards euthanasia and/or physician-assisted suicide. The relationship between attitudes and other sociodemographic factors such as age, gender and education were inconsistent amongst surveys. We have also attempted to provide explanations in the review, for the inconsistencies found between certain variables and attitudes toward euthanasia among mental health workers.

However, the comparison of the results from the literature was difficult due to methodological limitations. Different questionnaires were used in the studies and there was a lack of consistency amogst definitions and measurement tools. Results of surveys may have been impacted by the way in which the questions on euthanasia and potential answers were phrased (Hagelin, Nilstun, Hau & Carlsson, 2004; Marcoux, Mishara & Durand, 2007). For instance, in a Canadian study by Marcoux et al. (2007), 72% of respondent identified physician-assisted suicide as euthanasia, and 66% confused treatment withdrawal with euthanasia, while 38% identified withholding treatment as euthanasia. Two main findings surfaced from the study. First, respondents who could not identify the specific description of euthanasia as euthanasia were more likely to find euthanasia unacceptable. Second, euthanasia was more acceptable among people who confused euthanasia with other end-of-life decisions. It is important to be aware of such difficulties with terminology before interpreting survey results. For future studies, it is recommended to avoid using the word "euthanasia" but to use a description of the action instead (Marcoux et al., 2007; Quill, Meier, Block & Bilings, 1998; van der Maas et al., 1996). It would also be beneficial to avoid including tendentious terms, and keep the question short and right to the point. In addition, it is suggested to use a four-point scale in order to allow the respondent more flexibility (Marcoux et al., 2007). Finally, the need for consistent definitions of euthanasia

and physician-assisted suicide is not only important to make sure study participants understand the questions in the same manner but also to be able to compare future research studies.

The review of the literature has conferred greater understanding of the extent to which euthanasia and physician-assisted suicide are accepted among mental health workers and different factors that may have played a role in determining these attitudes. It may be valuable for mental health workers to examine their attitudes toward euthanasia and physician-assisted suicide, with special consideration as to how these factors may shape their attitudes. While it is rare that SPWs are confronted to situations in which a client is seeking euthanasia calls their centre, however, SPWs should be careful not to impose their values onto clients as it is still possible that those who are uncertain about their desire to die will use their services. As stated by Werth (1999), the role of the mental health workers is to help clients through their life-and-death decisions by making sure that procedures used to deal with the situation align with clients' values, and not their own.

There is extensive research on the attitudes of health professionals toward euthanasia and physician-assisted suicide though the body of work is mostly focused on the attitudes of nurses and physicians. No empirical data exists regarding the attitudes of SPWs toward euthanasia despite the fact they come in daily contact with people wishing to die but not necessarily seeking euthanasia. Although, one study has been conducted on the attitudes of suicide prevention trainees (Macdonald, 2006), this study had methodological limitations. The aim of the study was to examine the attitudes of trainees in suicide prevention toward euthanasia and suicide in people who are not terminally ill. However, the questions that were used in the survey to assess the attitudes were "People with incurable disease should be allowed to commit suicide in a dignified manner", and "Suicide is an acceptable means to end an incurable disease". We could say that

this study examined the attitudes of trainees toward suicide rather than euthanasia as no description of the process of euthanasia was included in the question. Furthermore, the study by Macdonald (2006) did not investigate potentially influential variables such as sociodemographic factors, professional and personal experiences. As a consequence, data on the determinants of SPWs' attitudes toward euthanasia are not yet available. Finally, this Canadian study was conducted more than ten years ago when the euthanasia and physician-assisted suicide law was not yet enacted in Canada. Based on the outlined gaps in the existing literature, the second part of this thesis, a cross-sectional survey of SPWs attitudes towards euthanasia, was designed to address some of these issues. It is important to explore the attitudes of SPWs since they are daily in contact with individuals wishing to die.

In our study, a majority of SPWs had positive attitudes toward euthanasia for a non-descript patient. This result is comparable to other findings on mental health workers, in which the majority of mental health workers found euthanasia acceptable (Csikai, 1999a; Ogden & Young, 1998;2003; Portenoy et al., 1997). Less SPWs found euthanasia acceptable when it was considered for a loved one. To our knowledge, there exist no studies on mental health workers which compared attitudes when euthanasia is considered of a non-descript patient and for a loved one. However, studies on health professionals observed that acceptance usually decreases when euthanasia is considered for a loved one compared to a non-descript patient or oneself (Brits, Human, Pieterse, Sonnekus & Joubert, 2009; Rathor et al., 2014). Studies on the general population have shown similar results (Ho, 1998; Ho & Chantagul, 2015). It is possible that SPWs applied different decisional criteria when euthanasia was considered for a loved one than for a non-descript patient, therefore were less likely to accept euthanasia for a loved one.

With regards to sociodemographic factors, we did not find any significant associations between attitudes toward euthanasia and gender or age for both a non-descript patient and a loved one. This result is congruent with previous findings in which gender (Gielen, Van den Branden & Broeckaert, 2008; Kinsella & Verhoef, 1993; McCormack, Clifford & Conroy, 2011; Portenoy et al., 1997) and age (Kinsella & Verhoef, 1993; Maitra, Harfst, Bjerre, Kochen & Becker, 2005; McCormack et al., 2011; Portenoy et al., 1997; Rathor et al., 2014; Silvoniemi, Vasankari, Vahlberg, Clemens & Salminen, 2010) were not influencing factors. However, few studies have found that older health professionals are usually less in favor of euthanasia compared to younger health professionals (Kitchener, 1998; Miccinesi et al., 2005; Ryynänen et al., 2002; Verpoort et al., 2004). It is possible that older health professionals are more religious than their younger counterparts, therefore, holding less positive attitudes toward euthanasia (Gielen et al., 2008). In other words, association between age and attitudes toward euthanasia may be mediated by religion. Thus, this relationship could not be established in our study, due to the limited number of participants who considered themselves religious in our study. In addition, inconsistencies in results could be explained by different ways in which the age variable is measured across surveys.

Furthermore, we were unable to establish a significant association between SPWs' attitudes toward euthanasia and education of respondents. This was surprising since previous literature has identified a number of robust correlations with regard to those who have higher education and positive attitudes toward euthanasia (Csikai, 1999b; Evans, 2015; Rietjens, van der Heide, Onwuteaka-Philipsen, van der Maas & van der Wal, 2005; Rurup, Onwuteaka-Philipsen, van der Wal, van der Heide & van der Maas, 2005; Vézina-Im et al., 2014). Potentially our education categories were not granular enough to detect a statistically significant

association. More granular categories, for instance to detect differences between having undergraduate or graduate studies, or categories based on field of study may be necessary in future research since participants were quite similar on this particular factor in our study.

Finally, no statistical significant results were found when religious affiliation and self-rated religiosity with attitudes toward euthanasia were examined. However, euthanasia is rejected by most religious authorities (Vatican, 1980). The pattern of support for attitudes toward euthanasia and religious affiliation has been observed in several studies in which Catholic religion and high self-rated religiosity is associated with negative attitudes toward euthanasia (Berghs, de Casterlé & Gastmans, 2005; Grassi, Magnani & Ercolani, 1999; Ogden & Young, 2003; Portenoy et al., 1997). The homogenous nature of our study sample may be a potential explanation of why we were unable to find a statistically significant association between the two variables and attitudes toward euthanasia. In our study, there were not enough variations between categories, in particular, religious affiliation variable was dichotomised, and participants mentioned being either Catholic or atheist. Moreoever, according to the scientific literature, religious affiliation and attitudes toward euthanasia may be influenced by self-rated religiosity (Bulow et al., 2012; Erlbaum-Zur, 2005). For the study purposes, we used attendance to a place of worship such as church or temple, in the past 12 months, to measure self-rated religiosity. It is important to note that 45% of SPWs stated being Catholic, however, only 3% stated they have attended a place of worship once or more than once a week, while 82% stated they have never attended a place of worship or attended once a year. This suggests that SPWs in Quebec who considered themselves as Catholic do not practice the religion, therefore their attitudes may resemble of those who are atheists.

Regarding professional experience, having experience with a situation in which an adult with a grievous and incurable disease wanted to die was significantly associated with attitudes toward euthanasia. Those who had such experience were more likely to oppose euthanasia. This phenomenon is in line with previous research in which health professionals were less likely to accept euthanasia when they had professional experiences with terminally ill patients (Berghs, de Casterlé & Gastmans, 2005; Holt, 2008; Kitchener, 1998; Verpoort et al., 2004). This was also concluded from our literature review on the attitudes of mental health workers. It is possible that SPWs who were confronted to situations in which an adult with grievous and incurable disease wanted to die were more knowledgeable about end-of-life management and options available to such patients (e.g., palliative care), and therefore hold negative attitudes toward euthanasia.

With respect to personal experience, having experience with a loved one suffering from a grievous and incurable disease seemed to influence the attitudes to euthanasia of SPWs. Those who had such experiences were less likely to accept euthanasia for a non-descript patient ($p<0.05$). This result is in agreement with studies on the general population, in which personal experience was associated with positive attitudes toward euthanasia (Hendry et al., 2013; Malpas, Wilson, Rae, & Johnson, 2014). Somewhat surprisingly, we found no relationship between attitudes and personal experiences when euthanasia was considered for a loved one. This is in line with studies, among primary care physicians and social workers that have found no association between attitudes toward euthanasia and personal experiences with terminally ill family members (Csikai, 1999b; Grassi et al., 1999; Silvoniemi et al., 2010). However, it is worthy to note that the attitudes mentioned in the studies above were assessed in regards to euthanasia in general. In other words, authors did not compare attitudes when euthanasia is considered for non-descript patients or loved ones. It would be interesting to see in future

research how having a personal experience with a terminally ill family member affect attitudes toward euthanasia.

Three main themes emerged from the analysis of qualitative data, notably, respect of choice, suffering/low quality of life and palliative care. Some participants emphasized that if their suffering family member had made a request for euthanasia at the end of their life, they would have understood it. Few explicitly voiced their opinions in support of euthanasia. Similar themes emerged from a qualitative study on the views of dementia carers on euthanasia and physician-assisted suicide. In the review, participants said they would understand if a person with dementia asked for assisted death (Tomlinson, Spector, Nurock & Stott, 2015). Many participants had witnessed the suffering of their loved one at the end of their life. In previous qualitative studies, it was concluded that witnessing suffering at the end of loved ones' life influences participants to hold positive attitudes toward euthanasia and physician-assisted suicide (Chapple, Ziebland, McPherson & Herxheimer, 2006; Hendry et al., 2013; Malpas et al., 2014). Therefore, it is possible that SPWs who have witnessed a loved one suffering at the end of their life be more in favour of euthanasia.

In our study, palliative care was mentioned a few times in comments. Respondents mentioned that their loved one received good palliative care at the end of their life, and none of the dying family member had made a request for euthanasia. In connection with this, health professionals are of the opinion of that pain control and good palliative care may eliminate the request of euthanasia. For instance, studies show the majority of nurses thought that patients who received high-quality palliative care do not request help to die (Tamayo-Velázquez, Simon-Lorda & Cruz-Piqueras, 2012). Similarly in another study, a majority of physicians believed that more attention to quality of life concerns and pain control may eliminate the need for euthanasia

(Grassi et al., 1999). Palliative care may address the issue as a whole by tackling biopsychosocial and spiritual factors at the end of life. However, it is argued that it is not always possible to relieve all suffering at the end of life and palliative care may not necessarily provide a permanent solution. There needs to be more dialogues for euthanasia and physician-assisted suicide (Dees, Vernooji-Dassen, Dekkers & van Weel, 2010; Harris, Richard & Khanna, 2006). Dependency, burden on family or loss of self are usually the reasons why patients desire euthanasia or physician-assisted suicide rather than pain itself (Lavery, Boyle, Dickens, Maclean & Singer, 2001; Seale & Addington, 1995). Hence, as suggested by Ogden (1994), palliative care and assisted death may not be conceptualized as dichotomies, but instead exist as a continuum of health care alternatives.

Finally, personal experiences with illness in the family may have an influence on the attitudes of SPWs. For example, SPWs who have utilized palliative service when caring for a loved one suffering from a terminal disease in the past may recommend the use of such services. On the other hand, those who have experienced a loved one suffering at the end of their life may be more susceptible to accept euthanasia in order to avoid the unnecessary suffering at the end-of-life.

In the present study, SPWs were not asked to give their opinions toward euthanasia in relation to personal experiences but were merely asked to share their experience related to the topic of the study. Through this qualitative approach, SPWs were able to provide detailed recounts of their personal experiences of loved one suffering from a grievous illness. It would be interesting to see in future research further exploration into the relationship between attitudes toward euthanasia and personal experiences. SPWs also made comments relating to their professional experiences or opinions. Those comments were not analyzed in our study as it was

out of the scope of the current thesis. However it is hoped that these comments will be used in a future stand-alone qualitative paper.

Need for further study

Further high-quality research into attitudes on euthanasia and physician-assisted suicide and the factors associated with these attitudes is required. Results from these kinds of studies would lead to a better understanding of the attitudes of SPWs toward euthanasia and physician-assisted suicide. One of the first things that may be evident from our review of the literature is the relatively small body of literature exploring the attitudes of mental health workers toward euthanasia and/or physician-assisted suicide. As highlighted in our review, the attitudes of mental health workers and SPWs are then underrepresented in comparison with attitudes of healthcare professionals and should be explored further. In order to precisely measure attitudes, consistent definitions of euthanasia and physician-assisted suicide are essential. In regards to further research, it is apparent that research on SPWs and euthanasia or physician-assisted suicide attitudes is extremely limited. While some conclusions can be drawn from this study, it is imperative that this topic be explored further, both with the hopes of validating the results presented here, and examining areas that were either inconclusive or unexplored in this work. Because this study was carried out at the time where the law permitting euthanasia was just enacted in Quebec, further research is recommended on the attitudes of SPWs toward euthanasia or physician-assisted suicide, as well as their experiences (personal and professional), in the context of current legalization. The present study provides a baseline for future studies aimed at examining the changes over time of SPWs attitudes toward euthanasia and/or physician-assisted

suicide. It will be interesting to see if viewpoints change over the years as medical assistance in dying (euthanasia and physician-assisted suicide) become more commonly used in Canada. Such information will contribute to the advancement of knowledge and inform current discussions, with a view to improve suicide prevention interventions for people with serious and incurable illnesses.

A number of differences exist between the Quebec (Government of Quebec, 2016) and the federal law (Ministry of Justice, Government of Canada, 2016) that are worth mentioning, in order to understand the context of results obtained in the present thesis. Quebec legislation allows only euthanasia while the amendments to the criminal code at the federal level were made to permit both euthanasia and physician-assisted suicide. According to the federal law, in order to be eligible for MAiD, intolerable suffering must be caused by a medical condition, while this is not a strict requirement under the Quebec law. However, the Quebec law requires the patient to be at the end of life while the Canadian law stipulates that natural death must be reasonable foreseeable. Lastly, in Quebec only a physician is allowed to perform euthanasia, while the federal law permits both physicians and nurse practitioners to perform euthanasia or physician-assisted suicide in other jurisdictions. Hence, the reason why we performed our study only on the subject of euthanasia, and we did not measure attitudes on physician-assisted suicide. Research in other provinces of Canada would add to the results of the present study, which was restricted to SPWs in the province of Quebec, Canada.

Additional qualitative work on this topic would be useful, as qualitative research allows for a better understanding of the contours of experiences which shape personal attitudes towards these contested but legal practices. Information obtained from qualitative work may be different from what has been obtained from quantitative work, this argument stems from that qualitative

data question can provide alternative or additional information to the quantitative data (Mossholder, Settoon, Harris & Armenakis, 1995). Furthermore, qualitative information may be used to supplement what has already been obtained from closed questions (Jackson & Trochim, 2002). It would be interesting to see if the personal experiences provided by asking a more specific question could enhance the understanding of the attitudes of SPWs on euthanasia.

Conclusion

To summarize, this work provided information on the attitudes of SPWs in Quebec, Canada. This project was the first to highlight the attitudes of SPWs toward euthanasia in Quebec. Results from this work have shed light on the complexity of attitudes to euthanasia and physician-assisted suicide. It is hoped that this study will give rise to further research exploring the attitudes of SPWs toward euthanasia/physician-assisted suicide. There are a number of implications from this research that pertain to practice, policy, and further research. It is apparent that this research could be of use in SPWs training, specifically in improving, the services offered to patients who are suffering. Baseline information on this subject may be useful for future research aimed at improving end-of-life care or identifying areas of practice that can be improved.

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APPENDICES

Appendix A : Questionnaire

Merci d'avoir accepté de participer à cette étude qui s'intéresse à votre opinion et à vos expériences en lien avec un désir de mort chez des personnes atteintes d'une maladie grave et incurable. Il n'y a pas de bonnes ni de mauvaises réponses, veuillez choisir l'énoncé qui correspond le mieux à ce que vous pensez ou à ce que vous avez vécu.

1re section : votre opinion

3a. En lien avec l'affirmation qui suit, indiquez votre niveau d'acceptabilité :
*Une personne **atteinte d'une maladie grave et incurable** demande à son médecin de mettre fin à ses souffrances et de causer sa mort en lui donnant une injection létale de médicaments. Le médecin accepte et cause la mort de la personne.*
Selon moi, une telle situation est:

a) Tout à fait acceptable
b) Plutôt acceptable
c) Plutôt inacceptable ☐ passez à la question 4
d) Tout à fait inacceptable ☐ passez à la question 4
e) Ne sais pas
f) Refus de répondre

3f. En lien avec l'affirmation qui suit, indiquez votre niveau d'acceptabilité :
*Un de vos proches est atteint **d'une maladie grave et incurable et** demande à son médecin de mettre fin à ses souffrances et de causer sa mort en lui donnant une injection létale de médicaments. Le médecin accepte et cause sa mort.*
Selon moi, une telle situation est :

a) Tout à fait acceptable
b) Plutôt acceptable
c) Plutôt inacceptable
d) Tout à fait inacceptable
e) Ne sais pas
f) Refus de répondre

2e section : vos expériences professionnelles

8a. Avez-vous déjà été confronté(e) à une situation où une personne adulte voulait mourir **et** disait être atteinte d'une maladie grave et incurable ?

a) Oui
b) Non ☐ passez à la question 9

3e section : vos expériences personnelles

14a. Avez-vous déjà souffert d'une maladie grave ?

a) Oui. Spécifiez _____
b) Non
c) Refus

14b. Est-ce qu'un de vos proches a déjà souffert d'une maladie grave et incurable ?

a) Oui. Spécifiez _____
b) Non
c) Refus

15. Vous avez des expériences personnelles que vous aimeriez partager en lien avec le sujet de cette étude ? Merci de le faire dans l'espace qui suit.

4e section : données sociodémographiques

Les renseignements que vous nous fournissez ici serviront à décrire l'échantillon et à pouvoir comparer les réponses au questionnaire selon les données sociodémographiques. Il n'y aura aucune évaluation individuelle de vos résultats.

16. À quel genre vous identifiez-vous?

a) Féminin
b) Masculin
c) Autre(s)

17. Votre âge :

(OUVERT)

19. Combien d'années d'études avez-vous complétées ?

a) 7 années ou moins (primaire)
b) 8 à 12 années (secondaire)
c) 13 à 15 années (cégep / collège, école technique)
d) 16 années ou plus (université)

20. À quelle communauté religieuse, spirituelle ou philosophique vous identifiez-vous ?

a) Catholique
b) Prostestant(e)
c) Juif(ve)
d) Musulman(e)
e) Grec Orthodoxe
f) Bouddhiste
g) Autre. Précisez _____
h) Aucune religion/Athée/Agnostique ☐ passez à la question 22
i) Ne sais pas

j) Refus de répondre ☐ passez à la question 22

21. Au cours des 12 derniers mois, à quelle fréquence êtes-vous allé(e) dans un lieu de culte (église, mosquée, temple, autre lieu sacré ou de rituel) ?

a) Une fois par semaine ou plus
b) Environ une fois par mois
c) Quelques fois par année
d) Une fois par année ou moins/Jamais

Appendix B: Ethics Certificate from the University of Ottawa Ethics Board

Numéro de dossier: H09-14-08 **Date (mm/jj/aaaa):** 03/17/2015

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Certificat d'approbation déontologique

CÉR Sciences et science de la santé

Chercheur principal / Superviseur / Co-chercheur(s) / Étudiant(s)

Prénom	Nom de famille	Affiliation	Rôle
Isabelle	Marcoux	Sciences de la santé / Autres	Chercheur principal

Numéro du dossier: H09-14-08

Type du projet: Professeur

Titre: Quand une personne atteinte d'une maladie grave et incurable veut mourir: attitudes et expériences des intervenants en prévention du suicide.

Date d'approbation (mm/jj/aaaa)	Date d'expiration (mm/jj/aaaa)	Approbation
03/17/2015	03/16/2016	Ia

(Ia: Approbation complète, Ib: Autorisation préliminaire de libération de fonds de recherche)

Conditions Spéciales / Commentaires:
N/A

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, room 154 Ottawa, Ontario K1N 6N5 Canada
(613) 562-5387 • Téléc./Fax (613) 562-5338
www.recherche.uottawa.ca/deontologie/ www.research.uottawa.ca/ethics/

Appendix C: Email to Director General of SPC

Titre du courriel : *Étude sur les attitudes et expériences des intervenants en prévention du suicide dans le contexte d'une maladie grave et incurable*

Madame/Monsieur [NOM], directeur(trice) général(e) du CPS [NOM]

L'an dernier, nous vous avions fait parvenir un courriel concernant la tenue prochaine d'une telle étude. Celle-ci a toutefois dû être retardée, mais nous sommes enfin prêts à la mener à bien!

La Loi concernant les soins de fin de vie (loi 2) est entrée en vigueur en décembre 2015 au Québec. En février 2015, la Cour suprême du Canada a voté en faveur de l'euthanasie et de l'aide au suicide dans le cas d'une personne malade dont les souffrances ne peuvent être apaisées. Ces lois permettent à une personne souffrante en fin de vie d'obtenir l'aide d'un médecin pour mettre fin à ses jours. Elles affirment donc que, selon certaines conditions, il peut être acceptable d'aider une personne qui le demande à devancer l'heure de sa mort. Un tel changement social pourrait avoir des répercussions sur la prévention du suicide de manière générale, mais aussi sur ceux et celles qui œuvrent dans ce domaine.

Jusqu'à ce jour, il n'existe aucune donnée (provinciale, nationale et même internationale) sur ce sujet. En collaboration avec l'AQPS, nous souhaitons mener une étude qui s'intitule : *Quand une personne atteinte d'une maladie grave et incurable veut mourir : attitudes et expériences des intervenants en prévention du suicide*. Cette étude vise à sonder l'opinion des intervenants dans le contexte particulier d'un désir de mourir chez les personnes atteintes d'une maladie grave et incurable et à connaitre leurs expériences (ou non) d'intervention auprès de cette clientèle particulière. De telles informations pourraient contribuer à une meilleure connaissance de la situation actuelle dans une perspective d'enrichissement de la formation des intervenants en prévention du suicide auprès de cette clientèle. Un suivi de l'évolution dans le temps de ces attitudes et expériences permettrait également une meilleure compréhension de l'impact de ces changements de lois sur la prévention du suicide.

Les intervenants qui ont reçu la formation *Intervenir auprès de la personne suicidaire à l'aide de bonnes pratiques* seront invités à participer à cette étude par courriel, dont la liste nous a été fournie par l'AQPS. Puisque cette liste ne contient pas tous les noms des intervenants qui travaillent dans les CPS au Québec, nous souhaitons également les informer de l'étude et solliciter leur participation par le biais d'une affiche (voir document attaché). À cet effet, nous sollicitons votre collaboration pour que cette affiche soit exposée dans votre centre. Si vous avez des questions à propos de l'étude, n'hésitez pas à contacter la chercheure principale, Isabelle Marcoux, aux coordonnées indiquées ici-bas. Si vous avez des objections à l'exposition de l'affiche dans votre centre, veuillez nous le signifier par courriel d'ici le (JOUR/MOIS/ANNÉE). Si nous n'avons aucune nouvelle de votre part, nous enverrons une version imprimée de l'affiche à votre centre le (JOUR/MOIS/ANNÉE).

Nous vous remercions de votre collaboration.

Appendix D: Email to Suicide Prevention Centers

Titre du courriel : *Étude sur les attitudes et expériences des intervenants en prévention du suicide dans le contexte d'une maladie grave et incurable*

Madame/Monsieur,

En juin 2014, le Québec a adopté *La Loi concernant les soins de fin de vie* (loi 2) qui est entrée en vigueur en décembre 2015 et, en février 2015, la Cour suprême du Canada a voté en faveur de l'euthanasie et de l'aide au suicide dans le cas d'une personne malade dont les souffrances ne peuvent être apaisées. Ces lois permettent à une personne souffrante en fin de vie d'obtenir l'aide d'un médecin pour mettre fin à ses jours. Elles affirment donc que, selon certaines conditions, il peut être acceptable d'aider une personne qui le demande à devancer l'heure de sa mort. Un tel changement social pourrait avoir des répercussions sur la prévention du suicide de manière générale, mais aussi sur ceux et celles qui œuvrent dans ce domaine.

Jusqu'à ce jour, il n'existe aucune donnée (provinciale, nationale et même internationale) sur ce sujet. En collaboration avec l'AQPS, nous souhaitons mener une étude qui s'intitule : *Quand une personne atteinte d'une maladie grave et incurable veut mourir : attitudes et expériences des intervenants en prévention du suicide*. Cette étude vise à sonder l'opinion des intervenants dans le contexte particulier d'un désir de mourir chez les personnes atteintes d'une maladie grave et incurable et à connaitre leurs expériences (ou non) d'intervention auprès de cette clientèle particulière. De telles informations pourraient contribuer à une meilleure connaissance de la situation actuelle dans une perspective d'enrichissement de la formation des intervenants en prévention du suicide auprès de cette clientèle particulière. Un suivi de l'évolution dans le temps de ces attitudes et expériences permettrait également une meilleure compréhension de l'impact de ces changements de lois sur la prévention du suicide.

Il y a deux semaines, nous avons fait parvenir un courriel à cet effet au directeur/directrice général(e) de votre centre pour qu'une affiche informative sur l'étude puisse être exposée dans votre CPS. Vous la recevrez par la poste dans les prochains jours. Nous vous serions reconnaissant de l'afficher dès réception dans un endroit où elle sera visible par la majorité des intervenants de votre centre. Pour toute question, n'hésitez pas à communiquer avec la chercheure principale de l'étude, Isabelle Marcoux, ou avec Jaskiran Kaur, étudiante à la maitrise, aux coordonnées indiquées ici-bas.

Merci de votre collaboration.

Appendix E: Participants Recruitment Email

Titre du courriel : *Étude sur les attitudes et expériences des intervenants en prévention du suicide dans le contexte d'une maladie grave et incurable*

Bonjour,

Vous recevez ce courriel parce que vous avez reçu la formation *Intervenir auprès de la personne suicidaire à l'aide de bonnes pratiques* de l'Association québécoise en prévention du suicide (AQPS).

Nous vous invitons à participer à une étude réalisée avec la collaboration de l'AQPS. Cette étude vise à connaitre votre opinion dans le contexte particulier d'un désir de mourir chez les personnes atteintes d'une maladie grave et incurable ainsi que vos expériences (ou non) d'intervention auprès de cette clientèle particulière. De telles informations pourraient contribuer à une meilleure connaissance de la situation actuelle dans une perspective d'enrichissement de la formation des intervenants en prévention du suicide auprès de cette clientèle particulière. Un suivi de l'évolution dans le temps de ces attitudes et expériences permettrait également une meilleure compréhension de l'impact, en prévention du suicide, des changements de lois récents, à savoir la *Loi concernant les soins de fin de vie* (Loi 2) au Québec qui est entrée en vigueur en décembre 2015, et la décision récente de la Cour Suprême de permettre l'euthanasie et l'aide au suicide dans le cas d'une personne malade, dont les souffrances ne peuvent être apaisées.

Nous avons obtenu votre courriel par le biais de l'AQPS parce que vous avez suivi cette formation en intervention auprès des personnes suicidaires. Le questionnaire est destiné aux intervenants en prévention du suicide qui sont âgés de 18 ans ou plus et qui œuvrent à titre de salariés ou de bénévoles pour un CPS au Québec. Le questionnaire doit être rempli en ligne et est programmé sur LimeSurvey. Ce système ne permet ni au gestionnaire de la base de données ni à la chercheure d'établir un lien entre vos réponses et votre identité. Toutes les mesures sont mises en place pour assurer votre anonymat ainsi que la confidentialité des réponses au questionnaire. Afin d'assurer votre anonymat, nous ne pouvons vous demander de signer un formulaire de consentement. Conséquemment, le fait de répondre au questionnaire et de le soumettre constitue en soi un consentement de votre part à participer à l'étude.

La complétion du questionnaire devrait vous prendre entre 5 et 15 minutes. Pour ce faire, rendez-vous en ligne au https://opinionsante.uottawa.ca/preventionsuicide
Nous vous invitons à le remplir d'un lieu et à un moment où vous ne risquez pas d'être interrompu(e). Pour assurer la confidentialité de vos réponses et votre anonymat, assurez-vous que personne ne puisse avoir accès à vos réponses pendant que vous complétez le questionnaire.

L'étude a été approuvée par le Bureau de la recherche et de l'intégrité de l'Université d'Ottawa (numéro de réf : #H09-14-08).

Pour toute question, veuillez communiquer avec la chercheure principale :

Annexe F: Information to Consent for Study Participants

Information pour consentement

Invitation à participer: Je suis invité(e) à participer à l'étude : *Quand une personne atteinte d'une maladie grave et incurable veut mourir : attitudes et expériences des intervenants en prévention du suicide*. Cette étude est menée par Isabelle Marcoux et a reçu un financement de la Faculté des sciences de la santé de l'Université d'Ottawa.

But de l'étude: Cette étude vise à sonder mon opinion dans le contexte particulier d'un désir de mourir chez des personnes atteintes d'une maladie grave et incurable et à connaitre mes expériences (ou non) d'intervention auprès de cette clientèle particulière.

Participation: Si j'accepte de participer à ce projet, je n'ai qu'à remplir le questionnaire en ligne. Ceci devrait me prendre entre 5 et 15 minutes.

Nous aimerions que vous complétiez le questionnaire avant le [DATE]. Puisque l'ensemble du processus est anonyme, nous ne pourrons savoir si vous l'avez complété ou non. Tous les participants recevront des rappels. Si vous avez déjà rempli le questionnaire, nous vous remercions et vous invitons à ignorer tous les rappels qui suivront.

Bénéfices: Ma participation à cette étude peut alimenter ma réflexion quant à mon rôle d'intervenant(e) en prévention du suicide et aux particularités de mon travail lorsque confronté(e) à des personnes atteintes de maladie grave et incurable qui désirent mourir. Mes réponses au questionnaire pourraient servir à identifier des besoins spécifiques au plan de la formation des intervenants et éventuellement améliorer les services offerts aux personnes malades en situation de souffrance qui font appel à nos services. Aussi, une telle étude m'informerait moi, les autres intervenants, la population et les législateurs sur les impacts potentiels des changements récents de loi *(Loi 2 concernant les soins de fin de vie* au Québec, modification du Code criminel pour permettre l'aide au suicide dans le cas d'une personne malade dont les souffrances ne peuvent être apaisées) sur la prévention du suicide en général et sur les intervenants en prévention du suicide. De telles informations contribueront à l'avancement des connaissances et alimenteront les discussions actuelles, et ce, dans une perspective d'amélioration des interventions en prévention du suicide auprès des personnes atteintes de maladie grave et incurable.

Risques: Certaines questions reliées aux attitudes et aux expériences pourraient être susceptibles de marginaliser le participant dans son milieu de travail. Une partie de ce projet sera utilisée par une étudiante à l'Université d'Ottawa pour les fins de sa thèse de maîtrise en sciences interdisciplinaires de la santé. Afin de contrer les risques associés à l'identification des personnes qui répondent au questionnaire, plusieurs mesures ont été adoptées afin de garantir **l'anonymat complet et irréversible** (voir la section confidentialité et anonymat ci-dessous). De cette façon, il est impossible de lier une réponse spécifique à une personne en particulier. De plus, nous vous

invitons à répondre au questionnaire d'un lieu et à un moment où vous avez le moins de risques d'être interrompu(e) pour éviter qu'une autre personne puisse voir vos réponses. Enfin, si jamais le fait de répondre au questionnaire provoque chez vous un certain malaise au plan psychologique ou émotionnel, nous vous invitons à contacter une ressource d'aide de votre région. Si vous le désirez, vous pouvez contacter la chercheure principale de l'étude aux coordonnées mentionnées ici-bas pour obtenir la liste des ressources disponibles par région.

Confidentialité et anonymat: L'information que je partagerai demeurera strictement confidentielle. Le contenu ne sera utilisé qu'aux fins de cette étude et seules la chercheure principale et l'agent(e) de recherche y auront accès. Aussi, plusieurs mesures ont été mises en place pour assurer **l'anonymat complet et irréversible** des participants à l'étude :

- Un nombre limité de données sociodémographiques est demandé pour éviter l'identification indirecte par couplage de réponses;
- Le questionnaire en ligne ne comporte aucune marque d'identification qui pourrait permettre d'identifier les répondants. Cette mesure implique que des rappels seront envoyés à tous les participants puisqu'il sera impossible de savoir qui a déjà répondu ou non au questionnaire;
- Les listes contenant les noms et adresses des intervenants en prévention du suicide seront conservées dans un endroit sécurisé et détruites par la chercheure principale lorsque la collecte des données sera terminée. Ainsi les intervenants qui ont été invités à répondre au questionnaire ne pourront être identifiés;
- Les informations recueillies sur un serveur sécurisé de la Faculté des sciences de la santé par le biais de LimeSurvey seront détruites dès que les données auront été transférées à la chercheure principale.

En ne possédant AUCUNE information permettant d'identifier une personne en particulier, la chercheure principale et son équipe ne peuvent ainsi fournir de telles informations dans le cas d'une intervention d'un tiers.

Conservation des données : Les données électroniques seront transférées dans un logiciel de gestion de base de données (SPSS) et seront transférées du serveur de la Faculté des sciences de la santé à la chercheure principale. À la fin de la collecte de données, la base de données contenant les réponses aux questionnaires en ligne sera cryptée et conservée sur une clé de mémoire USB, dans un classeur verrouillé, dans le bureau de la chercheure principale à l'Université d'Ottawa pour une période de cinq ans. Après cette période, la clé sera détruite. Toutes les informations contenues dans les ordinateurs seront correctement effacées.

Participation volontaire : Je n'ai aucune obligation à participer et, si je choisis de le faire, je peux refuser de répondre aux questions auxquelles je ne veux pas répondre. Le fait de remplir et soumettre le questionnaire en ligne indique mon acceptation à participer à ce projet. Étant donné le caractère anonyme du questionnaire, je comprends que je ne pourrai me retirer de l'étude une fois que celui-ci sera soumis.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec la chercheure principale, aux coordonnées ci-haut mentionnées ou avec étudiante à la maitrise aux coordonnées suivantes:

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au responsable de l'éthique en recherche à l'Université d'Ottawa.

Nous vous remercions pour votre temps et votre intérêt. Vous pouvez conserver ce formulaire dans vos dossiers.

Cordialement,