Understanding Australian Nurses' Intentions To Respond To Requests For Legal Assisted Dying

Submitted by

Michael Richard Wilson

Adelaide Nursing School

Adelaide Medical and Health Sciences

University of Adelaide

11 October 2021

Abstract

Background. As assisted dying becomes a legal end-of-life choice in Australia, nurses will frequently encounter requests about or for that option. It is well established in nursing research that nurses can experience ambivalence in responding to these questions, regardless of individual attitudes toward assisted dying. The theory of planned behaviour guided this research to explore and explain how nurses in Australia intend to respond and how psychosocial influences shape those responses. Specifically, this research examines how attitudes, subjective norms, perceived control, and ethical beliefs inform response intentions.

Method. To assess the impacts of those variables, this study had three objectives: 1) identify the range of possible responses; 2) assess the impact of the psychosocial variables on those intentions using data from an online survey distributed to members of professional nursing bodies; 3) identify patterns of intentions to form profiles of nursing cohorts, and examine the psychosocial variables that distinguish these profiles. A mixed-method approach was employed for these objectives. First, the range of intended responses was identified using Q-methodology that classified the subjective views of 45 nurses who work in typical end-of-life settings. Second, using survey data from 377 nurse respondents, the likelihood of an intended response was calculated as an interaction (or main effect) of attitude and the other variables of normative, control and ethical beliefs, using generalised linear modelling processes. Third, using k-means cluster analysis, five profiles were identified of nurses who shared similar patterns of intentions, and multinomial logistic regression calculated the likelihood of a psychosocial variable predicting a nurse's membership in a profile.

Results. Most nurses would intend to explore the meaning of the request and assess the requestor's needs, and a large proportion of nurses would deflect the request to consider palliative alternatives based on some objection to the request. All nurses intended to refer the request to the responsible doctor regardless of their attitude toward assisted dying. The strength of each of those intentions, measured by the mean score of each intention, formed five different patterns of intentions that constituted profiles of Facilitators, Expediters, Compliers, Objectors, and Detached. The strength of respondents' belief in beneficence predicted membership in most profiles, but only the Expediter profile reflected a balance of beneficence and respect for autonomy. The expectations of significant others to assist with a request predicted membership in all profiles except for Objectors and Detached.

Conclusion. The results demonstrate the multiplicity of a nurse's intentions in responding to requests for assisted dying and the beliefs that shape those intentions. Examining this issue with mixed-method design using regression models extends the knowledge base in a useful way for a profession adjusting to a legally novel and ethically contentious medical choice. These results have implications for organisational policy and professional development. Nurses can be supported for these encounters by knowing the law relevant to their role, understanding professional guidelines, and cognitively rehearsing their response to mitigate ambivalence in responding to requests while respecting patient autonomy.

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and, where applicable, any partner institution responsible for the joint award of this degree. The author acknowledges that copyright of published works contained within this thesis resides with the copyright holder(s) of those works.

I give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Signed: Dated: 1 Oct 2021

Acknowledgements

More of a dedication than an acknowledgement, I want to remember my sister, Hannah Allen, who encouraged my decision to pursue this research throughout the last months of her illness. Her good cheer for this research shone through her suffering and solidified my commitment to this project.

This thesis is the product of years of discussion with colleagues in New Zealand, Dr Pam Oliver and Associate Professor Phillipa Malpas of the University of Auckland. However, the focus and theoretical framework became clear after months of discussions with my wife, Professor Marie Wilson. Marie convinced me that there was material in this question that would make for an interesting, useful PhD study. So, thanks, Marie, for mentoring me into and throughout this situation (no, seriously, I mean it).

I am grateful to my supervisors, Dr Rick Wiechula and Associate Professor Lynette Cusack of the Adelaide Nursing School, University of Adelaide. They took a chance to support a non-traditional doctoral student with a hot-button research question, and they worked to keep me focussed and in line with University expectations. Thank you both. Furthermore, thanks for invaluable assistance from Dr Tim Schultz, now of Flinders University, for getting me oriented and keeping me to time, and to Dr Kate Cameron and Dr Michael Proeve for their assistance in evaluating my candidature.

I also had the advantage of significant mentoring, encouragement and support from Professor Cheri Ostroff of the University of South Australia, who showed me how to remain true to the data, almost de-fluff my writing, and get my head around multinomial regression and logit models. Suzanne Edwards of the Adelaide Health Technology Assessment Centre in the Faculty of Medical and Health Sciences was a key influence on developing my understanding of data structures and confidence in data interrogation.

I also wish to acknowledge the assistance of the Adelaide Graduate Centre staff who made this journey far less mysterious than it might have been and who provided so many opportunities for valuable research training. Thanks to the Laura Bassi Scholarship (Editing Press, Oxford) for their copy editing support, and later to Pam Oliver for relentless proofreading.

Table of Contents

This thesis contains the following manuscripts:

Wilson, M., Wiechula, R., Cusack, L., & Wilson, M. (2020a). Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study. *Journal of Advanced Nursing*, *76*, 642–653. https://doi.org/10.1111/jan.14257

Wilson, M., Wilson, M., Edwards, S., Cusack, L., & Wiechula, R. (2020b). The role of attitude in nurses' intentions to respond to requests for legal assisted dying. *Nursing Ethics*, *28*(5), 670–686. https://doi.org/10.1177/0969733020966777

Wilson, M., Ostroff, C., Wilson, M. E., Wiechula, R., & Cusack, L. (2021). Profiles of intended responses to requests for assisted dying: A cross-sectional study. *International Journal of Nursing Studies*, *124*, 104069. https://doi.org/10.1016/j.ijnurstu.2021.104069

Chapter One: Introduction

The topic of legal assisted dying usually brings to mind the notion of a polarised controversy. This polarisation is often couched as the tension between public demand for right to an assisted death (Hendry et al., 2012) , and medical resistance to being tasked with providing that assistance (Lee et al., 2009); or the ethical tension between respect for a person's autonomous choice and the beneficence in the duty of care (Quaghebeur et al., 2009). An examination of nursing literature in this area shows that such a characterisation can be superficial. The space between those poles of 'for' and 'against' is frequently occupied by nurses who demonstrate support for legal assisted dying (Kitchener, 1998; Kuhse & Singer, 1993) while harbouring complex reactions, including ambivalence, to hearing requests for this end-of-life option (Beuthin et al., 2018; Elmore et al., 2016).

The rapid emergence of assisted dying as an end-of-life care option in Western democracies has arrived with the pressures of advanced medical technology to prolong life, a demographic wave of an aging population, and the secularisation of society that prioritises personal choice over compliance with the teachings of religious institutions. These forces have required ongoing professional examination among nurses, and the need to understand how nurses might adjust to the likelihood of legalised assisted dying. Any examination of the nurse's role in this end-of-life option must take into account the legal requirements for eligibility, constraints on the responses nurses can have while remaining legally safe, in addition to the relationship the nurse has with the requestor. Complicating this already-complex challenge is the changing nature of the above considerations. For example, in Canada, a :reasonably foreseeable" death was initially a requirement under the law governing medical assistance in dying (Bill C-14). However, within two years that requirement was removed under the subsequent amendment of Bill C-7. This change caused a re-calibration of nurses' dialogic relationship with requestors, their own internal attitudes toward AD, and the need to develop sophisticated communication skills in this regard (Pesut et al., 2021).

This research project was designed to explore influences on nurses' intentions to respond to requests about or for assisted dying in advance of its legal implementation in Australia. The assumption behind this question was that matching nurses' intentions with emerging legislative frameworks could highlight specific needs for workforce development and support in this new practice environment.

1.0. The Research Question

This thesis will address the question: How do Australian nurses intend to respond to informal requests for legal assisted dying, and what underlying influences shape those intended responses?

This chapter provides the context and background for this research project, the research question, and the activities undertaken to address it.

1.1. Context of this research

This research project is conducted in the context of expanding the legalisation of voluntary assisted dying in Australia. The term 'assisted dying' is generally accepted as the broader term that can include legislation that specifies euthanasia (e.g., Belgium, Quebec), a term that usually refers to the administration of a substance to cause death, or physician-assisted suicide (e.g., state laws in the United States), a term that refers to self-administration of a prescribed drug, or a hybrid (e.g., federal Canada) (Holt, 2019). Assisted dying (hereafter, "AD") will be used in this thesis to refer to any of these practices, except when using other terms specific to legislation or in the text of a referenced author.

Data for this project were collected as the first State law legalising voluntary assisted dying was passed (but a year before it was implemented). Historically, the Northern Territory of Australia was the first jurisdiction, in 1994, to pass any law that permitted active euthanasia. Even though that law was repealed by the federal parliament in 1996, the idea that an Australian citizen could choose the time and manner of his/her own death raised national awareness of this possibility. Although only four people availed themselves of legal assisted dying in the one full year that euthanasia was legal (1995), one estimate identified that 1.8% of Australia's non-sudden deaths occurred through administering drugs to cause death (Deliens et al., 2000). Since the repeal of the Northern Territory's legislation, assisted dying has been proposed and debated in parliaments across Australia sixty-six times. None of those efforts was successful until 2017, when Victoria passed the Voluntary Assisted Dying Act. That legislation was soon followed by Western Australia's adoption of similar legislation in 2019 and Tasmania and South Australia in 2021. However, only Victoria and

Western Australia had implemented those Acts when submitting this thesis, but data were collected before any implementation in either State.

The earliest research into nurses' involvement with forms of AD also emerged in Australia, with surveys of attitudes toward legal euthanasia in Victoria (Kuhse & Singer, 1993) and South Australia (Stevens & Hassan, 1994). Those surveys found strong support by nurses for legalised euthanasia, 78% and 68% respectively. Kuhse and Singer also found complicit behaviour in completing tasks delegated by doctors to implement it, despite euthanasia not being legal. Kitchener's 1998 survey of nurses' attitudes toward assisted dying took a more finely-grained view of various subgroups of nurses based on religion, clinical setting and exposure to terminally ill patients, but with an overall finding that 69% of those surveyed supported legal reform (Kitchener, 1998). In 2016, as the Victorian bill was being prepared for the debate, the Australian Nursing and Midwifery Federation issued its position statement affirming respect for a terminally ill person's right to self-determination, compassionate engagement, and its support for legislative reform to permit AD.

1.2. Background

This section presents an overview of the nurse's AD-related roles in this research project, specifically the dialogue involved in hearing a request for AD from a patient and responding to it.

Where it is legal, the process that can lead to a person receiving medical assistance to die begins with their formal request for it. However, before the formal request, the person seeking assistance in dying often begins to make informal, exploratory enquiries (Oliver, 2016). Due to their unique role as information brokers in end-of-life care, nurses are often the professionals to hear and respond to these exploratory requests (Fujioka et al., 2018; Wright et al., 2017). Since not all formal requests are approved or completed, the act of responding to these tentative enquiries might be the most frequently occurring involvement of nurses in legal assisted dying processes. Understanding the dynamics and intentions in these private, sometimes fleeting discussions (De Bal et al., 2008) is important because the nurses' response can influence the requestor's subsequent choices and decisions. There are several ways that a response can influence a patient's decision. For example, the order in which options are presented or presenting an overload of information (Johnson et al., 2012) can direct attention to the nurse's preferred choice for the patient. This possibility has its own significance in the Australian context. The laws passed in Australian states require a system of prospective approval at each stage of the process, creating a time barrier, of up to 9 days, in what is often an urgent situation (White et al., 2021). The bureaucratic delays in getting a request approved or denied suggest that implicit biases in response to the request could amplify this barrier, for example, a request delivered to a nurse who objects to referring it to a colleague or a doctor.

Early research into nurses' participation in assisted dying assumed that nurses' would be engaged in advanced clinical procedures and serve as family liaison. The 2004 literature review by De Beer et al. (2004) identified "listening to and interpreting the patient's request, reporting and explaining the request to other nurses and physicians" as central to nursing participation (De Beer et al., 2004, p. 494). This early description of a nurse's response was only that the nurse would "register" the request with colleagues but did not focus on the nurse's response to the requestor. However, as the pace of legalisation of assisted dying has accelerated internationally, attention has returned to this interaction, as evidenced by the proliferation of nursing bodies' position statements that offer high-level guidance for managing requests for assisted dying. An example of this guidance, taken from the position statement on assisted dying from the Australian College of Nursing, reads: “Nurses may be asked about Voluntary Assisted Dying, thus it is essential for each nurse to be familiar with relevant legislative frameworks, as well as being skilled in having sensitive conversations about end-of-life concerns, including a person’s choices and preferences.” (Australian College of Nursing, 2018, n.p.).

Recent research has explored what nurses have recalled of prior requests and their responses to them. For example, Canadian research has examined nurses' moral experiences (Elmore et al., 2016) and the complexity in encountering requests (Pesut, 2019; Wright et al., 2017). Beuthin, et al. categorised nurses' participation as either supporting the requestor, objecting to the participation, and – for most nurses – 'something in-between', outlining a broader set of options for nurse-requestor interaction (Beuthin et al., 2018). That research has provided important insights into the range of nurses' responses, where assisted dying had already been legalised. However, to understand nurses' responses in jurisdictions where it was not yet legal and implemented, it is necessary to understand how nurses intend to respond to these requests (Wright et al., 2017).

The details of Australian laws vary by State, but the critical feature of these laws is the certification that the request is voluntary. That voluntary request is codified in these laws as the first "formal" request to a qualified medical practitioner. From that point, a protocol of prospectively approved decision-making and procedures is set in motion, including an assessment of the requestor's decision-making competency and a second opinion by a specialist doctor. However, the antecedents to the formal request (i.e., tentative, exploratory enquiries) are not subject to regulation. How the nurse responds to an informal exploratory request can be critical to the requestor's wellbeing and available choices (Oliver, 2016).

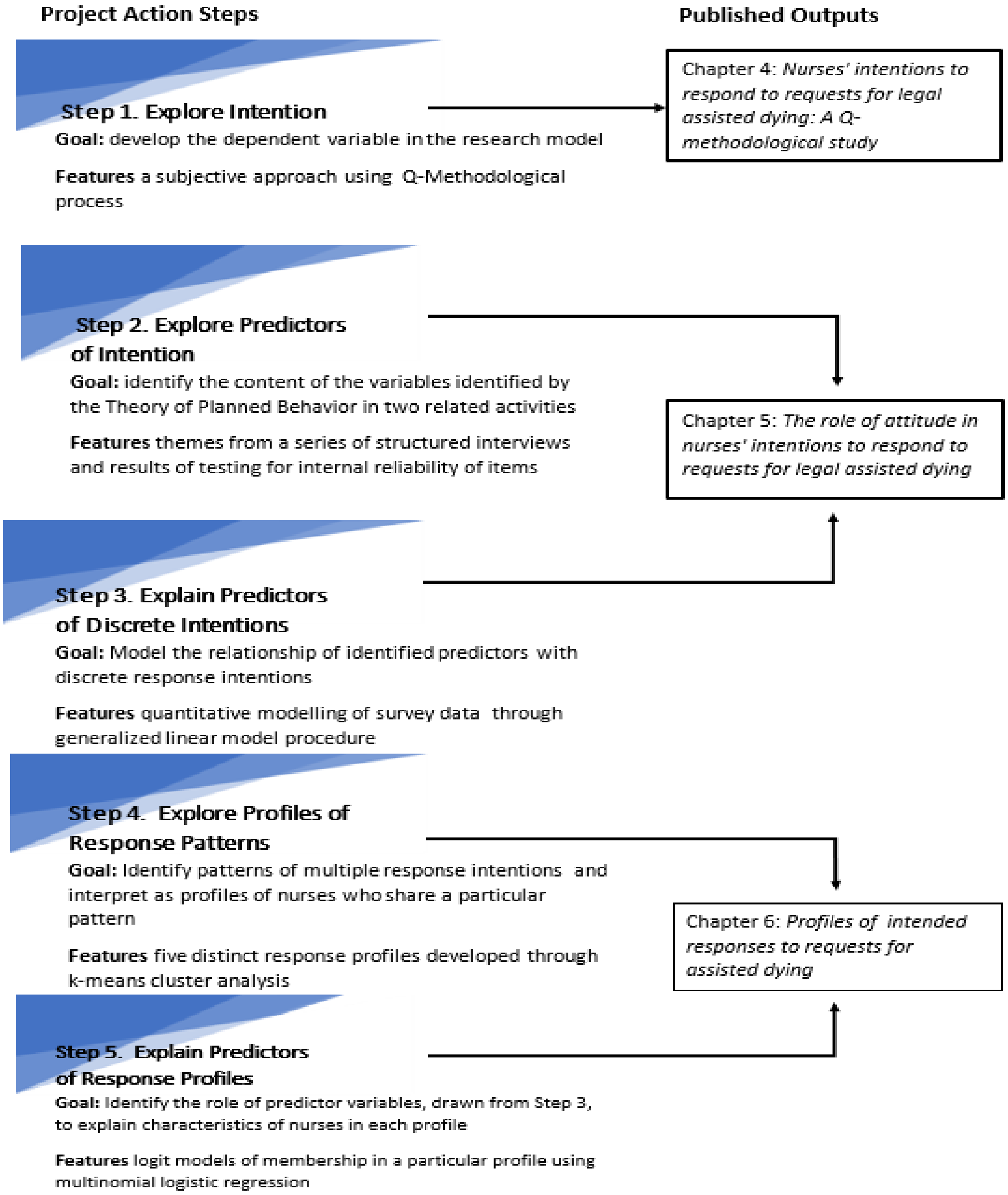
The exploratory request and the nurse's response distinguish the aim of this thesis in the larger body of research into nursing participation in forms of AD. As we have seen, research assumes that participation in AD involves activities in advanced stages of the process once the formal request is made: liaison with family, advanced care planning, cannulation or administration, witnessing and attending the death, and bereavement support. This research focuses on the beginning of those processes where a patient voluntarily presents a question about ending their life and how the nurse responds.

The bulk of recent research on nurses' responses to requests for AD has come from Canada since the legalisation of MAiD. The Canadian Supreme Court’s 2015 ruling in Carter v Canada (AG) (Criminal Code of Canada, 2016) was notable for two reasons: 1) it directed federal law that determined medical and nursing practice in this matter across disparate provinces; and 2) it identified specific authorities for nurses in the processes of assessing, prescribing and administering in AD cases. Canadian nurses have produced a record of qualitative research in this area that has revealed the beginnings of a typology of responses to being involved with MAiD (Beuthin et al., 2018) and a complex of conflicting ethical and professional obligations for nursing in this new legal environment (Elmore et al., 2016; Wright et al., 2017). That body of research showed that various nurses' responses are influenced by psychological dynamics, such as attitudes and ethical beliefs, and contextual constraints, such as expectations of significant others (Lavoie et al., 2016). That blend of influences can drive responses that are different but not exclusive. Some nurses will actively assist a person to access MAiD, a few will object, but most harbour a degree of uncertainty that requires a sensemaking activity to integrate AD with nursing practice (Beuthin et al., 2018). This research aims to build on those qualitative findings and develop quantitative models that explain the variety of responses Australian nurses might have and what factors influence those responses.

1.3. Objectives of this research

This thesis will address the question: How do Australian nurses intend to respond to exploratory requests for legal AD, and what underlying influences shape those intended responses? The research project to meet that goal has three objectives: 1) to develop a typology of intended responses by Australian nurses; 2) to test how psychosocial variables explain why individual nurses hold discrete response intentions; 3) to investigate how nurses might hold multiple intentions to respond, and how those intentions form profiles of responses, and what characteristics of the nurses distinguish one profile from another. These objectives are addressed through a mixed-method sequential research design with five key activities or steps described in Chapter 3, “Methods”. Figure 1.1 below offers a high-level summary of those action steps and the published research outputs.

Figure 1.1 Research project action steps



The production of three manuscripts marks the output of the action steps of the project. Those manuscripts form Chapters 4, 5 and 6 of this thesis and form the core of the results of this mixed-method exploration. The following section presents the theoretical and analytical framework.

1.4. Theory of Planned Behaviour

In the mid-late 20th century, there was a tendency to attribute differences among participants in social science surveys and field studies to sociodemographic factors, such as race, religion, or gender (Blaxter, 1990). The association of sociodemographic factors with nurses' views about AD has been a key feature of nursing research in this field. However, many sociodemographic factors are not amenable to change even though nurses' views on AD are far from uniform. For instance, nurses might support legalisation, but they might not want to participate in it, or if they decide to participate, they are more likely to prefer information brokerage activities than advanced clinical procedures such as cannulation or infusion (Wilson et al., 2019). This research drew on a more dynamic model to understand the phenomenon at hand to find a closer correspondence between independent influences and resulting behaviours. The Social Ecology model has demonstrated the range of interactions between individual and group decisions and behaviours and the constraints that those interactions impose on the individual (Kilanowski, 2017). For example, we can examine some nurses' reluctance to participate in AD as a dynamic rooted in high-level cultural norms, such as bioethical principles, that can then be interpreted through policy positions of professional nursing bodies or, more locally, by employers. Individual nurses' actions, decisions, attitudes, and beliefs are nested in this hierarchy of influences, but the unit of analysis in this study is the individual nurse’s intentions to act.

The optimal theoretical framework will acknowledge social, institutional and possibly cultural levels of influence that interact to shape an individual's intention. That theory must support a model to explain how individual psychosocial variables such as attitude and beliefs can be understood to mediate and moderate intentions to respond to AD requests. The Theory of Planned Behaviour has been found to provide an effective guide to study individuals’ intentions and behaviours (Armitage & Conner, 2001) and healthcare-related behaviours specifically (Godin & Kok, 1996). This theory helps to integrate the literature and inform the specific method of the research.

A systematic review of studies of how clinicians decided to discuss end-of-life planning, including AD, identified the Theory of Planned Behaviour as a framework used to understand intentions to initiate such discussions with patients (Scherrens et al., 2018). The Theory of Planned Behaviour (hereafter, "TPB") has shown large effect sizes in predicting intention across various healthcare behaviours (Godin & Kok, 1996). TPB explains the variance in intentions, and often in subsequent behaviours, through the influence of three specific cognitions: attitude toward the object of inquiry, perceived expectations of significant others (subjective norms), and self-efficacy (perceived behavioural control) (Ajzen, 1991).

An extended version of the TPB model has been adopted for this research, including cultural-level ethical norms for healthcare (Beauchamp & Childress, 2001). The TPB framework operationalises these ethical norms as internalised beliefs (Manstead, 2000), which apply to AD. Research from Québec that used TPB to study nurses' intentions toward participation in AD includes "moral norms" as a predictor of intentions to participate in 'an act of euthanasia' (Lavoie et al., 2016). Extending the theoretical framework by including moral norms relevant to the question has substantially enhanced the model's performance (Manstead, 2000). The relationship of the Social Ecology model and the Theory of Planned Behaviour as the guiding framework for this research is explored in Chapter 2, “Review of the Literature”.

1.5. Significance of this study

This research advances our knowledge in at least two important ways. First, by using a mixed-methods approach to examining nurses’ intentions to respond to AD requests, we see that intentions vary in strength, that they form patterns that can be described as profiles of nurses who share those intentions, and that psychosocial variables distinguish those profiles. Second, this research is advances opportunities for or the professional development of nurses, those in undergraduate preparation and those already in the workforce, to help shape their responses in light of legal and policy constraints while optimising patient outcomes. Understanding how nurses respond enables nursing educators and mentors to help nurses form their intentions to minimise their own moral burden and assist requestors in overcoming systemic barriers to access that are unique to the Australian model for approving voluntary assisted dying.

1.6. Positionality Statement

It is a tenet of post-positivist social science research that researchers are embedded in their questions and the answers they uncover. For the purpose of transparency I must state that I am not not an advocate for legal assisted dying, nor do I oppose it. My advocacy in this research if for nurses’ understanding of what patients need when they make requests for or about assisted dying.   My undergraduate preparation in philosophy and ethics, my work in mental health nursing, and my concern about the balance between minimised coercion in mental health settings versus the risk of suicide brings a unique curiosity to the study of assisted dying. However, when I first came to this issue – particularly as it pertained to a nurse’s role – I was struck by the superficiality of the pro/con debate at the core of this apparently controversial topic. As I immersed myself in the literature around this issue, and the contentious concept of ‘rational suicide’, I looked for the indicators of what Pesut (2019) called “shades of grey” in nurses’ responses to assisted dying becoming part of their practice. The sense that there was far more to this debate than polarised stances informed my approach to a method that deliberately sought to identify what other stances were held among Australian nurses as we faced imminent legalisation of assisted dying across Australian States. My openness to whatever results emerged supported my selection of a methods, variables, and models that are somewhat more inclusive than most research I have encountered in my reading. This openness led to me seeking to better understand the intentions and attitudes of Australian nurses who must now integrate legal assisted dying into their practice.

1.7. Outline of the Thesis

Chapter One introduces the context of the issue under consideration, the research question, related motivations for asking this question, the theoretical framework supporting the approach to addressing the question, the significance of the study, and the outline of this thesis.

Chapter Two presents a review of the nursing research literature on participation in AD, the specific act of hearing and responding to AD requests. This review is contextualised in the social ecology framework and leads to a review of the elements of the theory that will guide the analysis presented in Chapter Three.

Chapter Three describes the methods used to approach the research question. The chapter begins with an elaboration of mixed-method approaches that inform the research project's sequential structure, the theoretical models that justify this approach, and a wider description of method for each action step of the project that is not found in the Methods sections of the three published manuscripts due to word limit constraints.

Chapters Four, Five and Six are the published manuscripts that report on the action steps, as diagrammed in Figure 1.1.

Chapter Seven presents a discussion of the findings taken as a whole, the limitations of this research and suggestions for future research, and implications for practice.

1.8. Summary

This chapter has provided an overview of the problem the research project addresses and introduces the analysis frameworks and the discrete action steps that address elements of the project. The next chapter will explore the literature of nurses' involvement with AD and the development of the constructs identified that can explain a specific level of involvement: intentions to respond to requests for AD.

Chapter Two: Literature review

2.1. Introduction

As Chapter One established, AD is an intrinsically complex healthcare option because of its evolution across the cultural contexts in various jurisdictions where it has been legalised. It is also a healthcare option that is becoming increasingly common in Australia, and through shifting the legal and regulatory framework of end-of-life, care AD can present unique nursing practice challenges.

This chapter reviews empirical research on nurses' participation in and responses to the requirements of legal AD, and what nursing participation might mean in the Australian context, as well as the theoretical frameworks used to frame the research question.

A social ecology model guides this literature review's scope, an approach that introduced systems theory into an understanding of individual behaviour, highlighting the influence one part of a system has on the functioning of the whole (Bronfenbrenner, 1989). The social ecology model opens a way for structured multilevel research into nurses’ participation in AD. As mentioned in Chapter One, the field of nursing research in AD issues has dealt with individual components of participation in AD (e.g., attitudes, demographics, religion, culture). The social ecology approach provides a multilevel framework that can account for individual attitudes and beliefs, along with situational or larger organisational or institutional contexts, and cultural meaning, in an integrated framework (McLaren & Hawe, 2005).

The social ecology framework proposed an interacting complex of social systems nested in a hierarchy. The hierarchy grew from a system of immediate individual factors (micro-system) to close personal relationships (meso-system), then to the system of social structures that do not contain the individual but indirectly affect their attitudes and beliefs (exo-system), and to the prevailing cultural systems of laws and values that guide the exo-system’s structures (macro-system). The ultimate field in which these systems are embedded is the field of historical changes over the individual's lifetime (chrono-system). Urie Bronfenbrenner (1979) developed the social ecology model to provide a naturalistic setting for the study of child development and proposed that, since the individual child was the focus of analysis, then the micro-system was the most influential level in the model (Onwuegbuzie et al., 2013).

Approaching the individual nurse's micro-system as the unit of analysis, it becomes apparent how the social ecology approach allows for a multilevel integration of influences on attitudes and beliefs. That model is depicted in Figure 2.1.

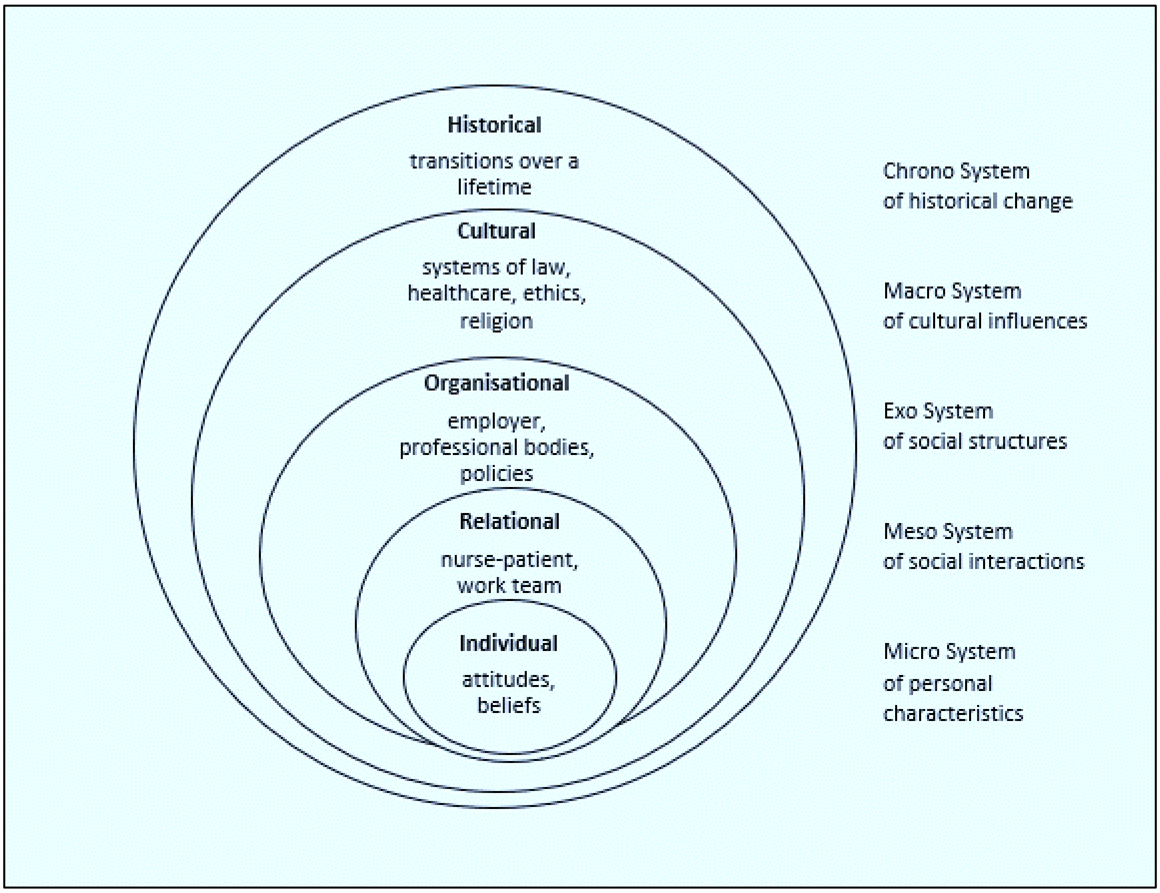


Figure 2.1. Social ecology model for nursing participation in AD*

*Adapted from P Oliver, 2016

The social ecology model's relevance to nurses' participation in AD is in many ways analogous to nurses' participation in abortion services for women. Nurses' involvement in abortion provision came about through the historical transition caused by women's demand for greater autonomy in Western democracies. Emblematic of this historical-level transition is an example from the United States. The passage of the Equal Rights Amendment to the United States (US) constitution by the US Senate in 1972, ensuring that women had control over their reproduction, among other freedoms. While the Equal Rights Amendment languishes 50 years on for lack of ratification by a majority of US states, it did provide the background for the macro-system of cultural change in 1973 with the US Supreme Court decision, *Roe v. Wade,* which struck down a Texas law banning abortion.

The legalisation of abortion required changes in the workplace and policies related to care for women pre- and post-termination (e.g., the clinical setting for service provision, pain management, ongoing contraception). It also required the development of standards for training and competency assessment of nurses involved in delivering abortion services. The sensitive nature of abortion weighed heavily on women seeking the service and the nurses who assisted in providing it; that moral burden positioned clinic teams as sometimes the only source of social support for nurses and the women they served (McLemore & Levi, 2011). Individual religious beliefs fueled the controversial nature of abortion provision. While religious norms exist at the macro level of culture, nurses also hold these beliefs at the micro-level of the individual, and such cultural beliefs have been attributed as the source of negative attitudes toward abortion. These individually held beliefs then opened up specific changes in the macro system's cultural landscape and carved out specific protections in law for conscientious objection (Magelssen et al., 2019).

2.2. Social ecology of AD

Medical advances that have led to the possibility of interventions in almost every stage of life have constituted a hallmark of historical change from the mid-20th century. The implications of techniques related to genome editing in human reproduction, through to life extension or accelerating death, have come to the fore of bioethical analysis and regulation (Nuffield Council on Bioethics, 2021). The rise of legal euthanasia practices and AD has also marked a historical transition, at the chrono-level, in end-of-life care that has impacted systems of law and healthcare, along with social norms and ethics.

The first nation to regulate AD was Switzerland, in 1936, where a person who had no potential for gain through another's suicide was permitted to assist with that person's suicide[1]. However, in the Benelux countries, with distinctly different cultural practices related to end-of-life, doctors came to be permitted to administer a drug to cause the person's death at their request (or to prescribe a drug self-administration). The

---

[1] Legal theorists have argued that the Swiss Penal Code did not 'legalise' AD, but rather provided an exemption from criminal liability for doctors who adhered to amended criminal codes (see Glenys Williams, 2007).

Benelux countries' nursing milieu provided most of the early research into nursing participation in these events. Most of that research reported nurses' views toward the practice and the influences on those views (Verpoort et al., 2004). One of the primary determinants of nurses’ attitudes toward and willingness to participate in AD was religion, which often provided a basis for ethical objection or reluctance.

2.2.a. Macro-System: Culture and religion

The role of religion as a belief system that contributes to attitudes toward AD seems to be confused and confusing, both in practice and measurement. Given the opposition to AD from all major councils of the world's religions and sub-denominations (Pew Research Center, 2013), the Uniting Church being an exception, it is not surprising to find that religious beliefs and practices influence nurses' attitudes (Gielen et al., 2009). However, what exactly is the influence of religion? The most recent review of the influence of religion on nurses' attitudes toward AD examined 31 relevant articles and found a lack of comparability among the studies and an unevenness in the way 'religion' was operationalised in the studies, which "negatively influenced the usefulness of the results" (Gielen et al., 2009).

Evans' review of nurses’ attitudes toward assisted suicide found that religion explained 24% of the variance in attitudes, and those nurses who attached less importance to religion were more supportive of legalised AD (Evans, 2015). An exception to that relationship between religion and reluctance to participate in AD was found in the study of Japanese nurses' attitudes (Tanida et al., 2002), where the low rate of support for AD (23%) was found to be related not to religion but secular ethics specific to Japanese culture involving respect for parents. A study of Belgian nurses in Flanders found that even though 92% of nurses accepted euthanasia for terminally ill people with intractable pain, ‘religious’ nurses – particularly Catholics – often supported palliation as an alternative to AD (Inghelbrecht et al., 2009). A separate study found that 42% of nurses who opposed AD claimed religious beliefs as the primary basis of their opposition (Gielen et al., 2009). Evans' finding of the significance of religion highlights an important finding outlined by Berghs et al. that the role of religion was dynamic, that is, nurses were able to set aside their own religious convictions for the patient's interest (Berghs et al., 2005), a point Evans concedes but without elaboration. Vezina-Im et al. found that religion was a stronger influence on physicians' attitudes than nurses' and that among all health professionals, religion was negatively correlated with motivation to practice euthanasia only in locations where AD was not legal; where it was legal, the influence of religion did not appear (Vézina-Im et al., 2014).

Even though religion's operationalisation and measurement are conflicted, religion remains an important variable because religion can encode cultural norms that guide ethical behaviour. Ethical principles related to the AD controversy linked religious doctrines with bioethical principles, highlighting the role of beliefs, whether religious or secular, in shaping attitudes toward AD (Gorsuch, 2006).

Early representations of nurses' willingness to be involved in AD were those of an act centred on beneficent compassion for terminal suffering. The ethics of beneficence, working for the person's best interests (Savulescu, 2015), is a cornerstone of nursing ethics (Kennedy, 2017), but the nurse's religious beliefs can shape its effects. Nurses affiliated with a religion or who attributed personal importance to religion believed that a hastened death was less in the person's interest than more effective palliative care. In contrast, nurses who were not religious or less religious would assist a person's death, as the end of futile suffering was believed to be in the patient's best interest (Gielen et al., 2009). Beneficence, like religion, has a complex relationship with AD; some nurses have been shown to intend to participate in AD, even where a patient's wishes were not known to the nurse, but because the nurse believed it was in that person's best interest (Lavoie et al., 2014).

2.2.b. Macro-System: Culture and law

Key factors have been identified in the literature that have propelled AD into moral consciousness in the late 20th Century. Chief among those factors might be advancement of human rights as an international commitment after the second world war. That commitment, in the form of the Universal Declaration of Human Rights (United Nations, 1948) came at the same time that Western democracies were loosening the power of religious institutions so that secular values flourished. In medical ethics we can see this as the shift away from paternalism to shared decision-making, and from beneficence to respect for autonomy (World Medical Association, 2017). Concurrently with that shift in medical practice we have seen a rise in the priority of consumer rights that privilege the end user, sometimes, over medical expertise. An example of this shift is the right to refuse medical treatments, a right confirmed both in legislation (e.g., Consent to Medical Treatment and Palliative Care

Act 1995 (South Australia)) and common law (e.g., Australian Charter of Health Care Rights) (Legal Services Commision of South Australia, 2021).

Law and regulation are the most salient aspects of AD. Even though AD had long been permitted in Switzerland, it was never constituted as a separate piece of legislation enabling the practice of assisting someone to hasten death, but rather as an amendment to the Penal Code. That amendment rescinded the legal sanction for a person assisting suicide. The Northern Territory of Australia was the first jurisdiction to legalise euthanasia in 1995. The law was enacted in 1996 and remained valid for nine months until the Australian Federal Parliament overturned it. Since then, over 60 relevant Bills have been introduced into Australian state parliaments for debate, but all had failed to progress into law until 2017. Despite enduring popular support for AD across Australia (Hanrahan, 2019), the opposition of religious bodies and the Australian Medical Association had been instrumental in blocking legalisation attempts.

It was not until 2017 that any of these attempts succeeded when the Voluntary Assisted Dying Act 2017 (Victoria) was legislated (White & Willmott, 2018). A hallmark of the Victorian law was its restrictiveness, with 68 safeguards in place, ostensibly to protect vulnerable individuals but just as likely as a mechanism to "navigate the politics of controversial legislation" (Onwuteaka-Philipsen et al., 2019).

Some subsequent Australian VAD laws (Western Australia and Tasmania) adopt frameworks similar to those of federal Canada and the US State of Hawai'i) that allow qualified advanced practise nurses to participate directly in recording formal requests and undertaking some clinical procedures related to AD. The Victorian law is silent about nurses' role, except to prohibit the initiation of a discussion about AD. In contrast, the Western Australian Voluntary Assisted Dying Act 2019 allows qualified nurse practitioners to initiate a discussion of AD with someone in their care and undertake the role of medication administration at death (but not other roles that are reserved for doctors, such as competency assessment and specialist opinion) (Western Australia Health Department, 2020). The Tasmanian law allows for a specifically qualified registered nurse to act in the role of ‘administering health professional’ (End Of Life Choices [Voluntary Assisted Dying] Bill, 2020).

2.3. Exo-system: Organisational

From a time when suicide was regarded as both a crime and a sin to when physician-assisted suicide has become legalised, the historical transition has directly influenced organisational practices. Professional and industrial nursing bodies have generally moved from a position of studied neutrality about AD (Johnstone, 2012) to positions of clear endorsement of the law change and a qualified person's right to AD. Since those shifts in position guidance, documents have emerged that provide high-level advice for jurisdictions where AD is not yet legal (e.g., Royal College of Nursing, 2016), where it is legal in some federal sub-jurisdictions but not others (e.g., American Nurses Association, 2019), and where it is legal at a federal level (e.g., Canadian Nurses Association, 2017).

2.3.a Organisational: practice setting

The findings from the reviews of studies on the impact of the practice setting on the expression of attitude are mixed. Even though attitudes might differ by the patient's situation, the Dutch and Belgian nurses with the most exposure to patients at the end-of-life (e.g., oncology and palliative nurses) were the least positive toward AD (Berghs et al., 2005; Verpoort et al., 2004). Subsequent research by Berheim et al. (2008; 2017) highlighted the fact that in Belgium the movements to develop palliative care and to legalise euthanasia emerged concurrently in the 1980s.   By 2002 the Belgian Parliament passed Bills on expanding palliative care (The Belgian Act on Palliative Care) and legalising euthanasia (the Belgian Act on Euthanasia) with language that promoted an the complementarity of both services. The following year, the Flemish Palliative Care Association endorsed the integration of both end-of-life services. Bernheim’s 2008 research found that Catholic palliative care workers accepted that regulation of euthanasia was at least preferable to secretive practices to end life or the continuation of futile palliative practices. Even in this narrow jurisdiction of Belgium we can see that the interaction of religion and organisational practice setting produces a conflicted picture of support.

In contrast to the Belgian context, Australian palliative care workers are consistently the least supportive of legalised AD among health care specialties. Sheahan’s 2015 survey found a clear majority of palliative care physicians (75% - 85%) were opposed to the prospect of legalised AD (Sheahan, 2016). A multi-site survey of Victorian hospital based clinicians, conducted after Victoria had implemented its Voluntary Assisted Dying Act found that only 27% of palliative or geriatric care professionals supported the Act (Sellars et al., 2021). At the current stage of the evolution of these two EOL choices, there is little support for the integration of palliative care and voluntary assisted dying. The contrast between the Belgian and Australian data suggests that the influence of practice settings on attitudes toward AD has a meaningful dependence on national culture.

On the other hand, another review found that intensive care nurses were more supportive of AD than other nurses, citing more frequent exposure to requests for hastened deaths and discontinuation of life-saving interventions (Vézina-Im et al., 2014). That suggestion that nurses with the greatest exposure to suffering were more likely to support access to AD echoed the earliest survey of US intensive care nurses that found 19% of nurses in that survey had engaged in (illegal) acts of euthanasia and that 70% of had a favourable view of euthanasia. Again that high percentage of support among these nurses was attributed to a “critical nurses may have a special understanding of the needs of critically ill patients” (Asch, 1996, p. 890).

It is debatable whether intensive care nurses have a greater exposure to suffering than palliative care nurses, and these varying and sometimes contradicting accounts make it difficult to draw useful conclusions beyond asserting the relative importance of practice context in attitude expression.

2.3.b. Organisational: professional guidance

Professional nursing associations provide guidance around managing AD requests, which varies by the legality of AD in the relevant jurisdiction. In the United Kingdom (UK), the Royal College of Nursing is explicit in its guidance that nurses cannot do or say anything that would offer advice about accessing an assisted death, as it is not legal in the UK (Royal College of Nursing, 2016). That guidance encourages the nurse to be direct but compassionate in explaining the limits of their ability to respond while encouraging the nurse to explore the patient's motivations and needs to the extent that they feel capable of doing so.

The tone of the UK Royal College of Nursing’s guidance contrasts with the revised American Nurses Association position statement that balances advice for a nation where assisted suicide is legal in 20% of its states. US national nursing guidance has a decidedly cautious tone. The 2019 document (American Nurses Association, 2019) revised the previous position statement of 2013 that stated that nurse participation in AD would be an ethical breach that could have professional consequences. That earlier position statement placed nurses who worked in jurisdictions where AD was legal in the situation where helping a patient to access a legal entitlement could risk nursing licensure (Vogelstein, 2017). The revised 2019 position statement recognises a plurality of views but presses the point (three times in two pages) that nurses have a right to object for reasons of conscience.

While the American Nursing Association guidance has no specific recommendations for responding to a request, nurses are advised to be familiar with the law of the state they practise in, to protect the confidentiality of the patient and other health professionals involved in the decision, to pledge non-abandonment, and to be aware of their right to object to any participation. The list of recommendations in that document ends with "[f]urthermore, research is needed to understand better the phenomenon [of responding to a request]." (American Nurses Association, 2019, p. 2).

2.4. Meso-system: Relational context of nurses' participation

In contrast to the notion that clinical decisions result from a studied reflection on an ideal path of action, decisions made in time-limited, pressured, or high-stakes situations more often draw upon a complexity of factors that are grasped intuitively, such that decisions are made almost automatically (Nibbelink & Brewer, 2018). A factor shaping these 'automatic' decisions is experience, meaning the degree to which one decision by an individual matches patterns of previous decisions. However, the intuitive grasp of previous patterns of behaviours or decisions might not lead to an optimal outcome in a high-stakes situation.

Rycroft-Malone et al. (2009) found that nurses' clinical decision-making is largely a social activity based on collegial relationships, and Cappelleti et al. (2014) identified collegial consultation as one of the more important ways nurses refine their decisions. In acute care nursing situations, nurses often rely on the support and advice of colleagues to confirm or enhance their own decisions, preferring a highly-regarded opinion over protocol or evidence (Nibbelink & Brewer, 2018).

In end-of-life care settings, other relationships can also influence decision-making. In the context of patient-centred care, shared decision-making between nurses and patients has become an established framework for optimising patient outcomes. Interventions to promote shared decision-making often highlight the interpersonal nature of that process (Thompson-Leduc et al., 2015). Apart from making peer and professional expectations more salient to clinicians to promote shared decision-making, a key determinant in shaping the outcome focuses on the patient's expectations. In their review of the nurse's roles in end-of-life care decisions, Adams et al.(2011) characterised the nurse as enacting strategies to advocate for the patient’s requirements. Advocacy usually involved brokering information between other influential stakeholders in decisions, namely, the family and the medical team. Empirical evidence of the effectiveness of shared decision-making is mixed (Clark et al., 2009), but establishing that treatment approach in contemporary nursing care identifies the patient as a key referent for decision-making, particularly at the end of life.

2.5. Micro-system: The individual nurse

The social ecology model is centred on the individual and their attitudes, perceptions and beliefs. Nurses bring their attitudes and beliefs, built within the institutional and cultural context of their professional and personal experiences, to the development of AD services in their workplace. The initiation of nursing activity concerning AD is in responding to a patient’s request. The present research examines those responses at the level of the individual nurse who operates in the complex cultural, institutional and organisational context that has influenced the nurse’s attitudes and beliefs.

This thesis takes a narrow and specific view of nurses' participation in AD compared to most nursing research focused on attending to permitted clinical tasks. This more narrow, specific view focuses on what David Wright of the University of Ottawa School of Nursing calls the 'dialogic care process', which encompasses far more complexity than is described in most nursing literature in AD as 'participation' (Wright et al., 2017). The complexity begins when the patient first articulates an interest in or a request for access to an assisted death, which often initiates a back-and-forth information brokerage between the patient, family and healthcare provider and may continue until the patient makes a formal request or decides against it (Wright et al., 2017). Involvement in further aspects of AD (e.g., assessing the patient's decisional competency, witnessing, assistance at the death) becomes a secondary concern, not only because these actions are usually limited to medical practitioners or delegated by them, but also because they miss the point that nurses' meaningful participation in an encounter with a request for AD is in the dialogue of care (Wright et al., 2017).

The ’dialog of care’ is core to the relationship the nurse has with the requesting patient. This relationship has been characterised in nursing literature as one where the nurses assumes a serious responsibility for the ongoing wellbeing of a person who requests that their life be ended. This responsibility has been shown to include requirements of ensuring optimal optimal care, sometimes with the aim of helping the patient to reach a point where they no longer wish to die. The relationship also has been represented as closeness with the patient in responding to a request, such that nurses feel the need to verify the authenticity of the request and to explore alternatives to AD. The seriousness of this encounter often engenders a sense of advocacy in the nurse to ensure that the patient’s request is referred, and heard, by other team members (Elmore et al., 2016).

Empirical examinations of the communication with patients who request AD is relatively recent (Muskin, 1998). The 2004 literature review by De Beer et al. identified four distinct phases of nursing involvement in AD – 'observing' the request, assisting with decision-making, administration at the time of death, and aftercare (De Beer et al., 2004). That review identified that the act of "listening to and interpreting the patient's request, reporting and explaining the request to other nurses and physicians" was central to nursing participation (p498). This present research focuses on the dialogue of care by examining the listening, interpreting, responding, and reporting the request to the requesting patient's doctor.

The process leading to a medically assisted death begins with a formal request presented to a qualified health practitioner. However, before the request is formalised, there is often a period of informal tentative, exploratory requests about AD (Oliver, 2016). While it might seem like a superficial level of involvement, compared to shared decision-making with the treating doctor or participating in advanced clinical procedures, responding to a request has powerful implications for the patient’s outcomes. The implications for the requestor stem from the nurse’s own bias for or against one treatment over another that can translate as an influence to direct the requestor’s attention to preferred alternatives. The difference in perceptions between health professionals and patients about the meaning of ‘hastening death’ has been depicted as an ‘epistemic contest’ of authority and ethics (Young et al., 2021). The epistemic contest that can be inherent in these discussions can sometimes manifest a ‘choice architecture’ in the nurse’s response

The nurse's response can be a choice-altering intervention based on many factors that can influence the response favouring one outcome over the other. How the nurse responds can restrict the patient's choices, expand them, or nudge them toward an outcome that the nurse perceives to be in the patient's best interests. Cohen (2019) describes this influence as the paternalism built into the ’general welfarist’ understanding of beneficence. In this case, where beneficence and autonomy are discrete values and where one value operates to the exclusion of the other, the nurse’s task is to rank order alternatives – a ranking often done intuitively on a case-by-case basis (Cohen, 2019). Here, the nurse’s views on the requestor’s best interests can trump respect for the requestor’s autonomy and assumptions can be made about what the person is requesting in a way that guides – possibly coercively – the requestor’s choices.

This research project builds on a recently developed but expanding literature on nurses' moral experiences responding to requests (Beuthin et al., 2018; Elmore et al., 2016; Pesut, 2019). That literature is distinctive for two reasons: it is retrospective, having emerged after AD had been legalised in the relevant jurisdictions where it was produced, and it consists of qualitative studies or reviews of qualitative studies. Those distinctions point to the importance of that research to make sense of a change to nursing practice that resulted from a larger social change.

On the other hand, Lavoie et al. (2016) sought to examine prospectively, in advance of legalisation, whether or not nurses intended to participate in 'an act of euthanasia in the province of Québec just before the legalisation of medically assisted death in that province. While they did not specify what 'the act of euthanasia' meant in practice, their research suggested some clinical involvement *after* the formal request had been assessed. This current research project looks only at that period *before* a patient submits the formal request. However, it is similar in its prospective orientation by examining the crucial determinant of participation – the intention to respond.

2.6. The individual nurse as the level of analysis

The remainder of this literature review explores the meaning of ‘intention’ and ‘response’. Following that review, attention is turned to the meaning and usefulness of influences that have demonstrated an ability to explain and predict intention. Research on TPB (Ajzen, 1991) has shown that attitude, subjective norms and perceived behavioural control are reliable predictors of intention. Further research has shown that ethical beliefs, or moral norms, are also significant predictors of intention where the intention has a meaningful ethical component (e.g., Rivis et al., 2009). The following sections discuss the literature relevant to each theory element – intention, attitude, subjective norms, perceived control, and an additional variable of ethical beliefs. Implications of the relationship between social ecology and TPB as a framework guiding the execution of this project are presented in Chapter Three, Methodology and research design.

2.7. Response Intentions

As the mediator in the attitude-behaviour relationship, intention has been described as the effort required to perform a behaviour or a willingness to act (Fishbein & Ajzen, 1975) or as "instructions people give themselves to behave in certain ways" (Triandis, 1980, p.203). In this research, formulating an intention will be compared to a cognitive rehearsal or the development of an internal script that can be used to preserve safety in communication (Griffin & Clark, 2014).

The degree of intention formation has been shown to impact the attitude-intention relationship that makes the intention a better predictor of behaviour. Intention formation refers to how an intention is developed and held. Experimental research has found that when intentions are well-formed, they more frequently lead to the intended behaviour, and when they are not well-formed, attitude has a more direct influence on behaviour (Bagozzi & Yi, 1989). The difference between stronger and weaker intention formation is an important consideration for understanding intention as a type of 'cognitive rehearsal' for an event that can minimise affective bias in responding to a request and optimise a more thoughtful engagement (Griffin & Clark, 2014).

Conceptualising intention in the context of nurses' participation in AD goes beyond intending to participate in the procedural steps required to complete a legally assisted death (e.g., attendance, equipment setup). To the extent that a nurse participates in AD, these clinical procedures are often delegated to the nurse and do not describe the experience of simply deciding how to respond to the informal request. The most relevant research into nurses' response intentions has come from qualitative studies among Canadian nurses. A study among oncology nurses found that maintaining a therapeutic presence in the face of hearing a request "might mean assessing underlying meanings behind the request, searching for palliative solutions, or advocating on behalf of the patient to have [the] request taken seriously by the physician" (Wright et al., 2017). Beuthin et al. found that Canadian nurses made sense of their participation by 'taking a stand' to oppose or support the request or ‘something in between’ (Beuthin et al., 2018).

Expert opinion (e.g., Lo, 2018; e.g., Quill et al., 2016), case studies (e.g., Lehto et al., 2016; Ohnsorge et al., 2012), and research findings (e.g., Gamondi et al., 2019; Emanuel, 2005) from the United States and Europe have also developed approaches to responding to legal AD requests. Much of that advice is directed toward medical professionals, consistent with the predominance of research into physicians’ views over nurses’ (Terkamo-Moisio et al., 2017). Research findings and case studies uncover what nurses recall of their experiences or what they may have said in encounters with requesting patients. Expert opinion is a source for single recommendations as well as interdisciplinary guidelines. Taken as a whole, they provide a rich resource of likely responses to a request for a hastened death.

Each of these sources presents a unique response or an array of different responses which have been thematised as an intended response type. The themes themselves present various intentions, from affirming the patient’s request to objecting to the request. Apart from those two intended types of responses, most of the suggestions look to 1) explore the meaning of the request, as if to be sure the request is understood accurately; 2) assess the mental state of the patient, or information and other needs; 3) check whether responses seek to dissuade the patient from that path, usually by promoting consideration of palliative alternatives; 4) avoid the question by not answering or by asking the person to talk with someone else about it.

Appendix 2.1 represents thematised findings from relevant literature with responses that health professionals might present to requesting patients.

2.8. Attitude

This section discusses attitude as a research construct and its relationship to the research question. The authors of the TPB identified attitude as a belief about a behaviour. Reflecting their cognitive psychology discipline, they operationalised attitude in line with expectancy-value theory as a cognitive process of evaluating an object (e.g., a person, issue, idea) in light of expected consequences or outcomes. Expectancy-value models of attitude have become a cognitive paradigm in TPB-type studies, despite important problems in its scaling measurement (Bagozzi, 1984).

This research project does not use the expectancy-value approach to the measurement of attitude for two reasons. First, AD is self-evidently not analogous to either a consumer product purchase (the most frequent application of expectancy theory) or routine clinical practices such as handwashing or documentation. Managing a patient's request for AD is not a purely cognitive enterprise but an immediately relational one (Wright et al., 2017). Second, attitude formation is closely linked with personal values, sometimes articulated as ethical principles, distinct from calculating the expected benefits of action (Sheppard et al., 1988).

Attitude is generally operationalised in the relevant nursing research on AD as either a global evaluation of its acceptability or willingness to participate in its delivery. Braverman, writing about nurses' views of AD, assumes attitude to be "favorability of justifications for or against… legalisation" (Braverman et al., 2017, p.4). Inghelbrect et al., in various articles about attitudes toward AD, provide no working definition of what is meant by attitude but represent attitude as an opinion or view on the subject (Inghelbrecht et al., 2008, 2009).

Understanding the role of attitude in this context, as shaped by moral intuition, varies from the utilitarian model of attitude assumed in most studies of clinical behaviour guided by the TPB. Many TPB-based studies of clinicians' behaviours are suited to an expectancy-value construction of attitude because they deal with important but routine nursing tasks such as compliance with guidelines (Nelson et al., 2014). These types of behaviours do not often require an evaluation of moral or ethical acceptability but only an evaluation of the outcome of the behaviour.

Deviating from the standard measurement of attitude as an arithmetically derived product of expectancy-*x*-value (Francis et al., 2004) may have the effect of altering its role as a predictor of intention. The present study operationalises attitude as an *explanation*, not a *prediction*, of multiple intentions.

2.9. Subjective norms

This section describes the construct of subjective norms, their limits and interactions. In this research, subjective norms represent the operationalisation of the meso-system of relational influences on the individual, per Figure 2.4. Subjective norms are constructs distinct from moral norms, being an interpretation of social pressure rather than an ethical requirement to perform an act or not. Subjective norms are posited to be perceived expectations of significant others as a source of pressure to act (Fishbein & Ajzen, 1975).

Research has found that intentions based on subjective norms are weaker predictors of behaviour than intentions based on attitude (Sheeran et al., 1999). The authors of the TPB posited that the relative strengths attributed to attitude and subjective norms would vary for different types of behavioural intentions (Ajzen & Fishbein, 2000). It is likely that participation in AD – even at the basic level of responding to the patient's request for it – presents a unique challenge for nursing, such that where attitude is not strong, the expectations of significant others to perform in a certain way will carry additional weight. The study by Lavoie et al. (2016) used multi-item measures of subjective norms and found that the strength of expectations of significant others was a significant determinant (along with moral norms) to predict an intention to practice euthanasia in palliative care (Lavoie et al., 2016).

2.10. Perceived behavioural control

This section describes the construct of perceived behavioural control (PBC) as a representation of the exo-system of organisational context in the individual nurse. PBC reflects beliefs an actor has about control in a given situation. Unlike attitude, as an expression of beliefs about behaviour, or subjective norms expressing beliefs about social expectations, PBC has been a more controversial component of the TPB framework.

The initial definition of PBC was ambiguous and attracted critique and subsequent refinement. The representations of the construct of PBC evolved from an externally-oriented "degree of control over the performance of the behaviour itself" (Ajzen, 2006, p.668) into an assessment of the ease or difficulty of performing the behaviour (Ajzen & Madden, 1986), and into a measure of self-efficacy ("I can do this if I want to") (Ajzen, 1991, p.184). The TPB authors asserted that self-efficacy and controllability could reflect internal or external control factors. In other words, "They are different aspects of the same overarching question that people ask when considering performing a particular behaviour: Can I carry out the behaviour?" (Yzer, 2012, p.115). The different aspects of the construct suggest two distinct measurement items reflecting volitional self-efficacy and capacity.

The inclusion of the construct of perceived behavioural control by Ajzen and Madden improved the model's predictive ability when behaviour was under incomplete or imperfect control of the actor (Ajzen & Madden, 1986). Subsequent meta-analytic reviews of TPB-based studies validated the inclusion of PBC into the model, accounting for 14% additional variance after controlling for the effects of attitude and subjective norms (Godin & Kok, 1996).

2.11. Ethical beliefs and norms

This section describes the construct of ethical beliefs derived from the cultural norms described in the macro-system of the social ecology framework. Ethical norms have been described as a perceived obligation to act (Rivis et al., 2009) and represent "personal feelings of . . . responsibility to perform, or refusal to perform, a certain behaviour" (Ajzen, 1991, p.199). Drawing on the review by Verpoort et al.(2004) and other studies, Berghs et al.(2005) implicitly linked attitudes toward legalising or participating in AD with bioethical principles. While that early review described a set of ethical positions to justify either side of the polarised debate on the issue, it also highlighted that nurses commonly make ethical decisions in practice at an intuitive level rather than reasoning from abstract principles (Snelling, 2004). Subsequent reviews of nursing research revealed how ethical principles operate parallel with attitudes for or against AD, but they also reveal that nurses' experiences with AD have a moral dimension. The 'moral work' of a nurse in the context of participating in AD processes "involves a complex navigation in-between multiple and sometimes competing moral agents" (Elmore et al., 2016, p.958). The complexity of decision-making in a morally conflicted and time-pressured clinical situation further suggests that nurses do not resort to philosophical theorising as a guide to action in the first instance. Haidt described arriving at a moral judgement in ambiguous situations, such as encountering a request for AD, as a perception rather than deliberative reasoning (Haidt, 2001).

The two principles of respect for personal autonomy and the commitment to non-maleficence provide ethical descriptions of the polarities in the current debate about AD (Gorsuch, 2006), but for many nurses, "the decision may be more nuanced, contextual, and, indeed, gray" (Pesut, 2019, n.p.). The present research incorporates bioethical principles as measures of polarity in this controversial topic and the nuanced territory in the middle represented by beneficence and justice.

Non-maleficence has been described as a defining ethical argument for the sanctity or inviolability of human life (Quaghebeur et al., 2009). Non-maleficence is often derived from the deontological (duty-based) principle that human life is inviolable. This ethical principle is often the basis of nurses' objections to AD when the nurse's religion is an important consideration (Berghs et al., 2005). In debates conducted both in the media and in parliaments, ‘sanctity of life’ has appealed to faith-based communities to resist the legalisation of AD (Hendry et al., 2012). Attempts to disentangle 'sanctity of life' from religious language and secularise the term have been associated with Kant's categorical imperative (Nilstun et al., 2016), and with Kant's virtue ethics emphasising moral self-improvement, a feature of one's efforts rather than a divine gift (Baranzke, 2012). These more recent attempts to secularise the term also rob it of its emotive power in a polarised debate; thus, the religious dimension of the term tends to dominate the current debate, almost as a ‘culture wars slogan’ (Gushee, 2006).

Personal autonomy is the principle implicit in the critique of the sanctity argument offered by Kuhse and Singer. They proposed a quality-of-life argument as one relevant to nurses, asserting the primacy of the quality of one's life over its duration (Kuhse & Singer, 1989). Respect for personal autonomy refers to the competent person being the best judge of what is good or bad for them, in the words of John Stuart Mill, "in so far as these concern the interests of no person but himself" (Mill, 1900, p.167).

By implication, the autonomy principle requires that the patient's treatment choices be respected even if medical or nursing judgment does not agree that choice would serve the patient's well-being. Respect for patient autonomy is a key aspect of shared decision-making in contemporary health services and advanced end-of-life care directives. Bullock argues that the concept of personal autonomy does not have an intrinsic value, but is merely a utilitarian device that constrains a clinician's action from obstructing AD or promoting it out of compassion, "not because the autonomous patient views her suffering to be unbearable, but because it is in her objective best interests [to end it] and she permitted it via her consent" (Bullock, 2015, p.11).

Beneficence, defined as working for the other's best interest (Savulescu, 2015), is a principle that is ambiguous in the debate around AD. The review of ethical arguments related to AD by Quaghebeur et al. reveals an 'indistinctness' about beneficence that frequently links it with non-maleficence and the principle of respect for autonomy (Quaghebeur et al., 2009).

The fluidity of beneficence risks the conflation of respecting a person's autonomy as *de facto* working for their best interests, for example, supporting a person's request for AD simply because they believe it is in their best interests. From the perspective of 'do no harm', a patient's interests are never served by causing death since death robs the person of autonomy (Varelius, 2006). McCabe (2007) has argued that the nurse who abandons a patient to their own choices regarding AD fails as a professional. Progressing a request for AD just because it is the requestor's free choice neglects the nurses' moral agency in this encounter, reducing their role to that of a service provider (Pesut, 2019). Simultaneously, though, determining what is in another's best interest is paternalistic if it overrides another's preferences, even for beneficent reasons (Beauchamp, 2019).

On the other hand, the paternalism inherent in judging what is in another's interest can be blunted when an action taken to support those interests is based on, or at least accommodates, respect for their autonomous choice (Cohen, 2019). The ambiguities represented in the principle of beneficence suggest challenges for operationalising beneficence as a variable. These challenges are explored further in Chapter Three (Methods).

Justice is a principle in nursing often used to discuss equity or fairness in the process of deliberation (Beauchamp & Childress, 2001). Justice has at least two different meanings depending on the context of care. Distributive justice is concerned with equal access to limited resources, regardless of one's situation. According to Savalescu, distributive justice would deny treatment to those with incurable life-limiting defects and thus is a warrant for an AD intervention (Savulescu, 2015). In the context of AD, distributive justice seems to be invalid on its face since AD cannot be performed for the benefit of a third party.

The meaning of justice operationalised in this research is consistent with nursing literature on social justice, which is concerned with equity, not equality or merit. Social justice posits that certain rights exist in a social relationship and combines a focus on accepting both the benefits and burdens in society (Boutain, 2005). The rights-based approach of social justice is the format for operationalising justice to assess this ethical principle's role in forming intentions toward AD.

2.12. Conclusion

This chapter has reviewed the literature relating to nurses’ participation in AD, specifically the act of responding to a request for access to that option where it is legal, in light of a global framework of social ecology and TPB. The following chapter will explain how those frameworks informed the methodology for this research project.

Chapter Three: Methodology and study design

3.1. Introduction

This chapter provides an overview of and justification for the mixed-methods approach and the sequential design used for this research project. The chapter starts with a justification of the design by comparing research models and theoretical frameworks in relation to the research question. The activities of each step (Step) are outlined in connection with the published manuscript that was the output of those activities. These Steps iterate from exploratory activities to explanatory ones.

Although reporting results in a methods chapter is unconventional, this project's sequential design requires some brief discussion of early results to background the findings presented in the published manuscripts. To minimise repetition of material presented in the published manuscripts, reference will be made to relevant thesis chapters and page numbers.

A brief review of the most relevant findings from the first exploratory Step of this research (developing the dependent variable) should help the reader understand the project's subsequent Steps. Attention is also placed on the results of two inter-related activities that developed the independent variables, namely a series of interviews to develop survey questions (elicitation activity) and assessing the internal reliability (Cronbach's alpha) of the scales formed by those question items. Explanation of those activities and their results are presented here to background the results presented in the related manuscripts, which have a restricted presentation of those activities. Full results of each Step are reported in the next three chapters containing the portfolio of published manuscripts.

3.2. Sequential mixed-model project design

Mixed-model designs. The distinction between qualitative and quantitative research in social and behavioural sciences had produced rigid distinctions between adherents of either approach. These two 'camps' of methodologies reflected a uniquely 20th-century tension between two epistemological traditions – the 'objective' post-positivist and the 'subjective' constructivist.

Post-positivism emerged in the late 1940s as a counter to the tradition of rational positivism that had its genesis in Cartesian dualism. A central tenet of positivism was that there was only one reality and that it could only be known through a value-free scientific inquiry to verify its existence (Mertens, 2005). Post-positivism turned the criterion of verification on its head, asserting the usefulness of falsification or the quantitative testing of a null hypothesis (Ramlo & Newman, 2011). The rejection of the purely positivist approach led to new research designs and the explication of different research validity types (e.g., construct or predictive validity). Those new research designs, often referred to as quasi-experimental, "allow[s] multiple empirical probes of the causal hypothesis under scrutiny *on the assumption that this usually rules out more threats to internal validity*" (Cook et al., 1990, p. 491, emphasis added). These new designs' core concerns were to minimise researcher bias. The focus on enhancing validity by limiting bias is a tacit acknowledgement that the researcher and the research object are entwined and that at least parts of reality are constructed and not merely discovered (Ramlo & Newman, 2011).

The assertion that at least parts of reality are constructed by the researcher's interaction with the object of study is central to post-positivism's dialectical partner, constructivism. Constructivism is a general term that refers to various research concepts but suggests "that people do not passively see things as they are in any sort of unproblematic fashion, but are instead continually and actively selective in their attention" (Watts & Stenner, 2012, p. 51). Being 'selective in their attention' denotes humans' psychological focus in sense-making of their social or physical world. The constructivist method of studying sense-making activity has roots in the social sciences and is associated with qualitative research methods, just as post-positivism is associated with quantitative methods.

By the late 1980s, the distinction between quantitative and qualitative methods had relaxed, creating the space for the emergence of what Creswell (2010) called a mixed-methods approach. The truce in the so-called paradigm wars gave rise to a "methodological eclecticism [that] stems from a rejection of the *incompatibility of methods thesis* which stated that it was inappropriate to mix qualitative and quantitative methods" (Teddlie & Tashakkori, 2003, p. 8). Methodological eclecticism signalled freedom to construct the quality of research design using the most suitable available methods. Deploying that research freedom is a hallmark of mixed-methods research (hereafter, MMR) in which researchers work within the "pragmatist paradigm…interested in both numeric and narrative data and their analyses" (Teddlie & Tashakkori, 2009, p. 4).

The rise of MMR has generated various design types to identify how to engage quantitative and qualitative methods in a cyclical approach. Theorists have developed classifications of approaches that have common elements, contributing to a larger model. Table 3.1 presents three classification systems of MMR designs to illustrate differences and commonalities. Caracelli and Greene (1997) introduced three component-based design models (in addition to four integrated design structures not listed here). These three components of triangulation, complementarity and expansion are echoed in the typology developed by Creswell and Plano Clark (Creswell & Plano Clark, 2007).

A third typology, developed by Teddlie and Tashakkori (2003), which the authors called 'families' of design models, is a multi-strand classification system. These designs are characterised by three dimensions, where three data sources can subdivide each 'family'. These dimensions are: 1) the use of two methods to answer either exploratory or confirmatory research questions; 2) the various steps where quantitative and qualitative data are integrated; and 3) the timing for the integration – either sequential or concurrent. Just as Creswell and Plano Clark's typology resembles in some ways Caracelli and Greene's typology, Teddlie and Tashakkori (2003, p. 688) acknowledge the similarity of their model with Creswell's exploratory/explanatory model.

Theorist	Design Model	Design Components	Mix	Timing
Caracelli & Greene (1997 : 23)	Triangulation	Different methods associated with different paradigms	Different methods examine the object to enhance validity through convergent results	Concurrent or Iterative
	Complementary	One type of data is a basis for another type	One method enhances the results of another method	Sequenced or Nested
	Expansion	Different inquiry paradigms for various aspects of the question	Results are presented side-by-side	Concurrent or Sequenced
Creswell & Plano Clark (2007: 85)	Triangulation	QUAN-QUAL	Merge at analysis	Concurrent
	Embedded or Nested	QUAL (quan) OR QUAN (qual)	Larger design incorporates the other method as an adjunct	Concurrent or Sequential
	Exploratory or Explanatory	QUAN – qual or QUAL - quan	Data are related across stages of research	Sequential
Teddlie & Tashakkori (2003: 24)	Concurrent	Each subdivided by data source: • Multiple samples • Same/subsample • Multi-level samples	<u>Multiple samples</u>: QUAL + QUAN collected side-by-side but not linked. Timing varies by purpose	
	Sequential		<u>Same/subsample</u>: QUAL + QUAN available from various members and 'linked at some point' in analysis	
	Conversion		<u>Multi-level</u>: QUAL collected at one level (e.g., parents) QUAN at another level (children). Linked at analysis/inference	

Table 3.1. Comparative Mixed-Method Research Models

<u>Sequential project design</u>. In line with Teddlie and Tashakkori's typology (2003), the sequential model links exploratory research activities with explanatory inferences derived from the previous exploratory phase. Iteratively, the explanatory inferences of those activities then open the research question to further exploration for future hypothesis development. The sequenced activities in this project are described as ‘Steps’ toward explaining nurses' intentions to respond, based on the iterations of exploratory and explanatory activities. However, before these Steps are defined and the research methods are described, the entire research project must be placed in

the context of the theoretical frameworks that guide these Steps – social ecology, and the TPB.

3.3. Theoretical frameworks of the research design

The social ecology model is premised on a reality where individual cognitions and actions are embedded in a hierarchy of contexts or fields of influence. This research project seeks to link that model with the individual at the level of analysis by using the predictive theory of intention and behaviour, the TPB as formulated by Fishbein and Ajzen (1975). As discussed in Chapter Two, the TPB models the relationship among attitudes, subjective norms and perceived behavioural control with intention. For theoretical reasons, that model has been expanded for this research to include ethical beliefs. Figure 3.1 shows the points of connection of the social ecology framework with TPB, which guides the present research design and methods at the individual level of analysis.

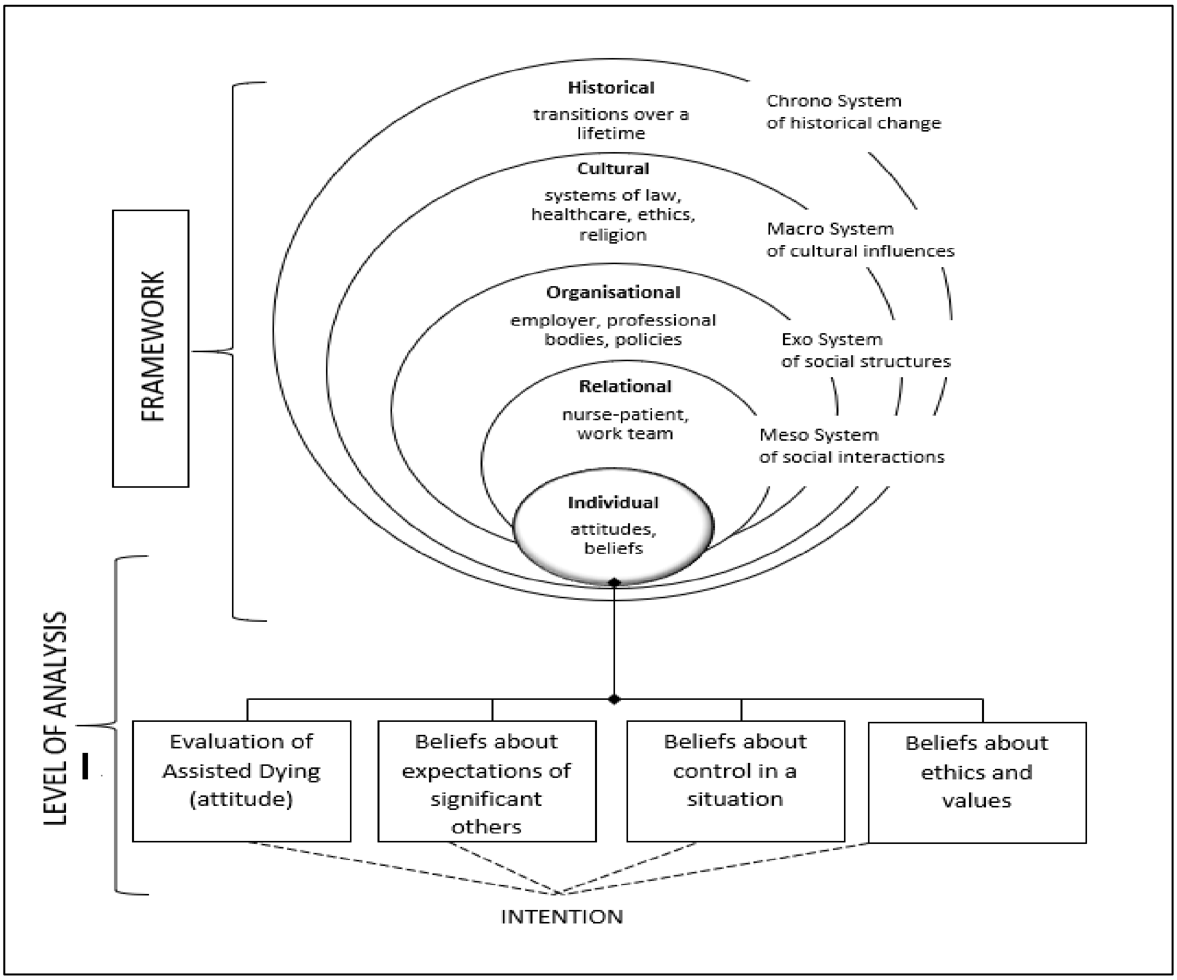


Figure 3.1 Relationship of social ecology and TPB frameworks

3.4. The theory of planned behaviour

Intention has been described as the effort required to perform a behaviour, or a willingness to act, or as "instructions people give themselves to behave in certain ways" (Triandis, 1980, p. 203). The construct of intention rose to prominence shortly after the apparent collapse the power of attitude alone to explain behavioural choices. Since the 1930s, attitude was thought by cognitive psychologists to be the primary driver of behaviours, but the review of studies of the relationship of attitude and behaviour by Wicker in 1969 challenged that assumption (Wicker, 1969). His evidence showed that attitudes were unrelated or only weakly related to observable behaviours. His findings sparked new research to strengthen the role of attitude, and the dominant approach that emerged posited intention as the key determinant of behaviour and attitude as an influence shaping intention (Olson & Zanna, 1993). The most widely used formulation of that dominant approach was the Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975). The TRA posited that intention was the cognition linking individual attitudes with wider social norms to form an intention to act directly. The theory was subsequently expanded to include a measure of facilitators and barriers, 'perceived behavioural control', and the theory became better known as the theory of planned behaviour (TPB) (Ajzen, 1991). The 2008 systematic review by Godin et al.(2008) of studies of the intention-behaviour connection among healthcare professionals found that attitude and social norms predicted intention better for nurses than for doctors or other health professionals. The approach of TPB researchers that used intention to predict as yet unrealised behaviours eventually found its way into nursing research into AD. The work by Lavoie et al. integrated that approach to assessing the likelihood that a nurse would or would not participate in an 'act of euthanasia' in advance of its legalisation (Lavoie et al., 2016).

The TPB is a framework for assessing the factors that shape an intention to adopt a particular behaviour. Three factors contribute to forming an intention to act – attitude, subjective norms, and perceived behavioural control. As the TPB emerged from the TRA, attitude was constructed as a subjective evaluation of an action's acceptability (to the actor) based on beliefs about the value to the actor of the action's outcomes.

Subjective norms, arising from normative beliefs in the TRA, are beliefs about expected social pressures to act. The third influence on intention, perceived behavioural control, is the degree of control the person believes they have over the target behaviour or self-efficacy. Figure 3.2 below diagrams the development of the TPB.

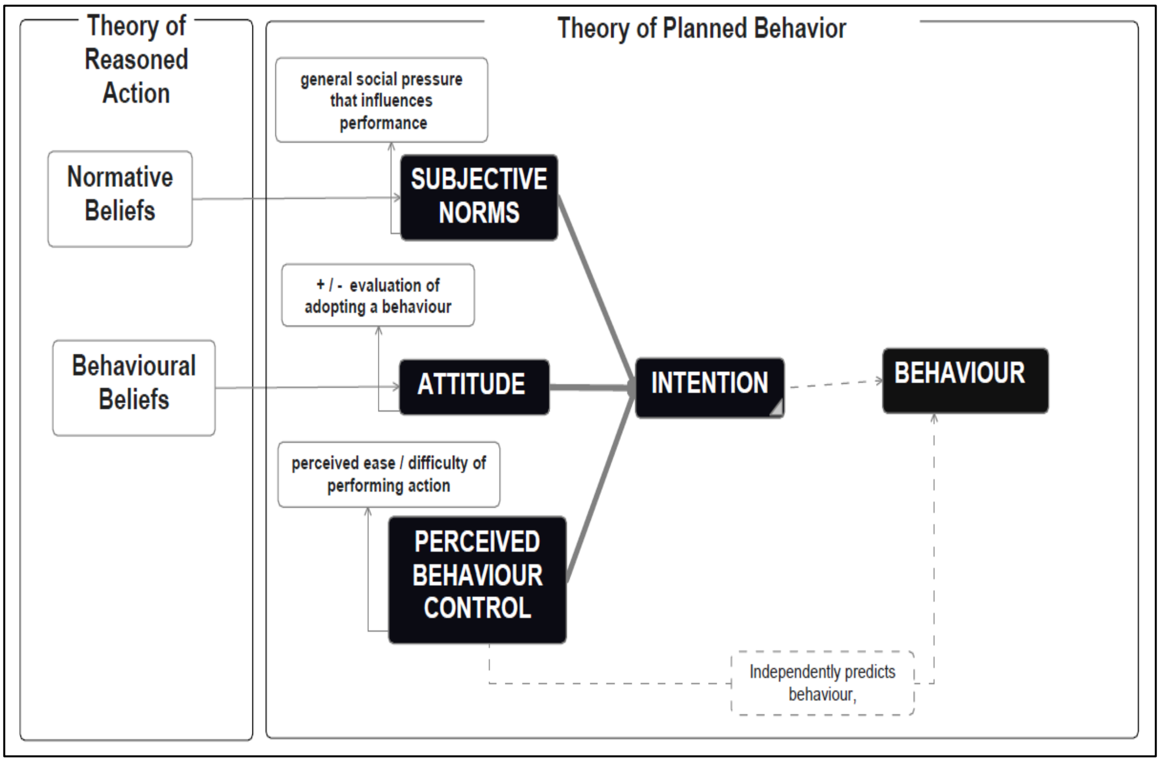


Figure 3.2. Development of TPB

Implicit in the TPB model, as diagrammed in Figure 3.2, is the possibility that the relations between variables could change, depending on the value of competing variables. For instance, an intention can change when a positive attitude interacts with a negative social context that discourages the intended behaviour or when the ability to act is so weak that neither a positive attitude nor social encouragement can change the intention. Interactions among variables specify boundary conditions that "may reflect the operation of different social processes which better explain the relationship between variables in…the TPB" (Conner & McMillan, 1999, p. 201). The interacting dynamic among the TPB variables resembles the interacting fields of the social ecology model but is viewed from the individual's perspective.

The relationship between the models that framed this research is illustrated in Figure 3.3, which captures the range of variables in the expanded TPB model that guides this research.

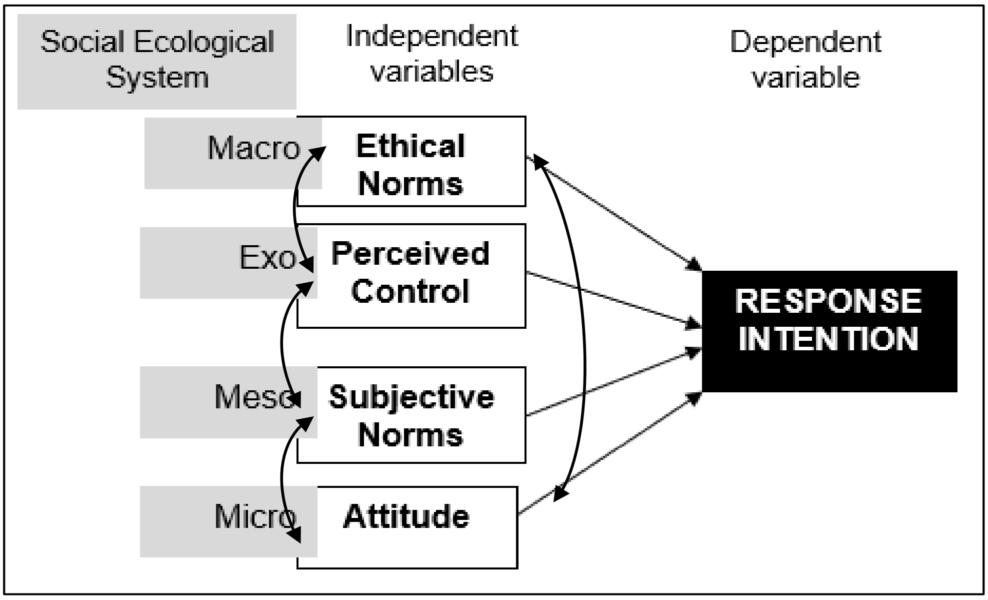
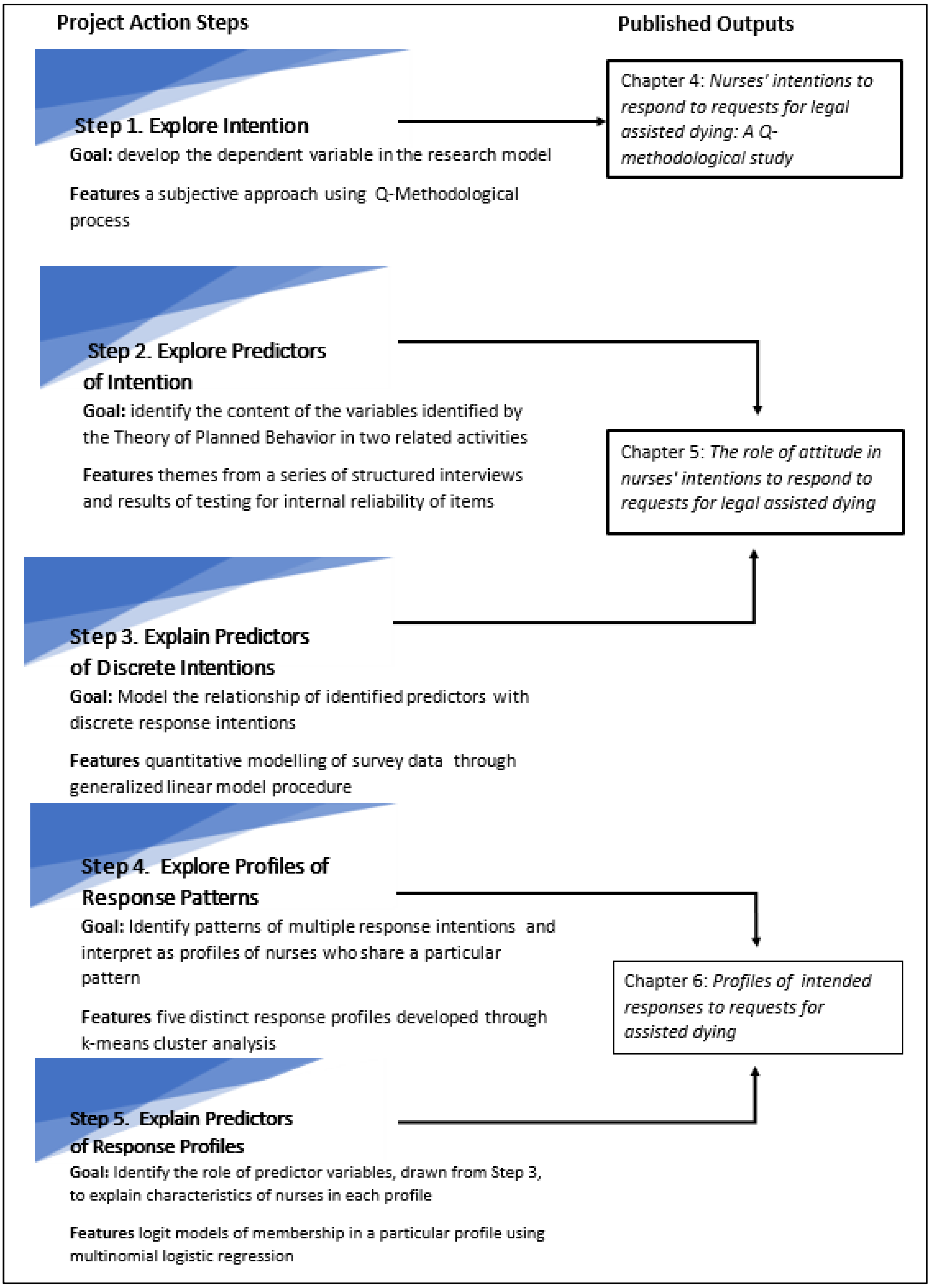


Figure 3.3. Expanded TPB model of this research in relation to social ecology model

The interacting dynamic of the independent, explanatory variables suggests an iterative process of understanding their influences on the dependent variable of intentions to respond to requests for AD. That iterative process informs the sequential design of this project. This project's design is a series of Steps, beginning with exploring the meaning of 'response intention', then moving through a series of activities to see how the independent variables influence the selection of responses. That sequence of activities opens up the possibility for further exploration of patterns of responses that nurses might hold – explored as profiles of nurses' intentions – and how the independent variables differentially explain those profiles. Those action Steps that constitute the sequential design of this research project are diagrammed in Figure 3.4 below.



Goal: develop the dependent variable in the research model

Features a subjective approach using Q-Methodological process

Chapter 4: *Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study*

Goal: identify the content of the variables identified by the Theory of Planned Behavior in two related activities

Features themes from a series of structured interviews and results of testing for internal reliability of items

Chapter 5: *The role of attitude in nurses' intentions to respond to requests for legal assisted dying*

Goal: Model the relationship of identified predictors with discrete response intentions

Features quantitative modelling of survey data through generalized linear model procedure

Goal: Identify patterns of multiple response intentions and interpret as profiles of nurses who share a particular pattern

Features five distinct response profiles developed through k-means cluster analysis

Chapter 6: *Profiles of intended responses to requests for assisted dying*

Goal: Identify the role of predictor variables, drawn from Step 3, to explain characteristics of nurses in each profile

Features logit models of membership in a particular profile using multinomial logistic regression

Figure 3.4. Project Steps in the sequential mixed-model design

3.5. Ethics statement

This research project was approved by the University of Adelaide Human Research Ethics Committee reference: HREC 2018-234. Evidence of approval is in Appendix 3.1.

3.6. Developing dependent variables

This section deals with the initial Step of the research design: developing the dependent variable of intention. This Step constituted a separate study leading to a published output (presented in Chapter Four). A discussion of the processes of this Step, and some of its results, is presented to background the manuscript presented in Chapter Four.

This Step comprised a study of the subjective evaluation of possible responses to requests for AD that were compiled from a review of published literature on the topic. Q-methodology was selected as the process for this study's construction and analysis because that method had a unique focus on the participants' subjectivity who helped develop the response typology.

Q-methodology was first articulated in the early 20th century by William Stephenson (Stephenson, 1935), a British physicist-turned-psychologist. Stephenson's goal in developing the method was to make the subjectivity of a person's preferences scientifically observable through the statistical process of factor analysis. Stephenson described this approach's potential in his 1935 letter to *Nature* by distinguishing it from the factor analysis developed by his doctoral supervisor, Charles Spearman, as an inversion of Spearman’s method (Bartholomew, 1995).

The innovation achieved by Stephenson's inversion of the Spearman method of factor analysis, or correlations derived by Pearson's *r* (‘R’ method) arose by diverting from the tradition in psychology of measuring individual differences. R method studies measure the variance or covariance among variables mapped to a population but does not and "cannot facilitate a thorough comparison of their individual differences…Q-method factor analysis innovation draws data from "a population of *n* different tests (or essays, pictures, traits or other measurable material), each of which is measured or scaled by *m* individuals" (Watts & Stenner, 2012, p. 32).. Stephenson proposed that the inversion of a correlation matrix would have "interesting applications. It brings the factor technique from group and fieldwork into the laboratory, and reaches into spheres of work hitherto untouched or not amenable to factorisation" (Stephenson, 1935, p. 297).

In his letter to *Nature*, the principal 'sphere of work' that Stephenson was alluding to was 'subjectivity'. By subjectivity, he was not referring to an introspective state but asserted that subjective experience was a purposeful behaviour and was as quantifiable as physical behaviours (S. R. Brown, 1993). Quantifying subjectivity required the inversion of *by-item* factor analysis to a *by-person* factor analysis to identify correlation strength with others with similar views. The description of *by-person* factor analysis "requires a new form of data, which is derived when a sample or population of items are measured or scaled relatively by a collection of individuals" (Watts & Stenner, 2012, p. 32).

3.6.a. Q-method activities

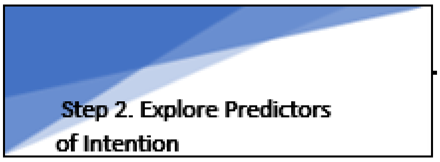
This new type of data sample was called a *Q-set*. In this study, the Q-set was derived from a review of documents relating to clinicians' responses to requests for an assisted or hastened death. The process of reviewing those documents is outlined in Chapter Four (p 61).

The review of guidance documents findings distilled a Q-set of 49 representative statements in consultation with an international reference group of nursing or medical ethics researchers in this area and clinical educators (identified in the manuscript's acknowledgements in Chapter Four). This Q-set of statements, with referenced source documents, is attached as Appendix 3.2.

The Q-set was loaded into a template to prepare an online Q-sort survey, using Q-Assessor software (Epimetrics, LLC, Portland, Oregon), an automated platform that manages the life-cycle of operations related to Q-methodology surveys. Survey respondents sorted these statements into categories along a 5-point scale anchored as 1= ‘I WOULD say this’, to 5= ‘I WOULD NOT say this’. This process is known in the literature as a Q-sort and produces a dataset of responses that could be processed through factor analysis to identify latent, underlying structures in the dataset that remain true to individual responses.

An overview of the Q-method study results is presented below to help the reader understand the rationale for instrumentation decisions in the study's subsequent Steps. The factor analysis of the Q-sort dataset identified four factors, or response types, that nurses might use in responding to a patient's request for medical assistance in dying. These factors were identified from the correlation of Q-set items. Each of these response types, labelled ‘Refer & Support’, ‘Explore & Engage’, ‘Assess and Inform’, and ‘Deflect or Object’, is made interpretable by the statements that distinguish each factor uniquely. The distinguishing statement selection was guided by rules outlined in the Methods section of the manuscript in Chapter Four, (pages 63-65). The distinguishing statements for each factor are also detailed in Chapter Four (page 65).

3.7. Developing independent variables



The purpose of the second exploratory activity of the project was to identify and develop scales to measure the independent variables related to attitude, subjective norms and perceived behavioural control. Additional scales were developed to measure ethical beliefs.

This Step involved 1) collecting qualitative data to elicit the meanings implicit in the independent variables, 2) developing scales from those items, and 3) testing the reliability of those scales.

<u>Elicit meanings implicit in the independent variables</u>. The authors of the TPB were clear that variables in the model should be grounded in local understandings of the meaning of those constructs (attitude, norms, intentions). Understanding the meaning of constructs of ‘attitude’ and the other independent variables required qualitative data collection. That activity is a procedure recommended for TPB studies called an ‘elicitation’ activity (Francis et al., 2004). The TPB authors recommended that before any of the independent variables in the model were measured, the researcher "should first conduct an elicitation study to identify the salient modal beliefs in the target population" (Sutton et al., 2003, p. 234). ‘Modal salient beliefs’ are those that are readily accessible in memory and are thought to automatically activate

expectancies about an object or action (Ajzen, 2001). A salient belief could be identified through an unrehearsed response to a question.

An elicitation exercise was conducted to identify:

1) behavioural beliefs, using questions to probe the advantages and disadvantages of responding to a patient's request for or about AD;

2) normative beliefs, using questions to probe which individuals or groups would approve and disapprove of responding to a patient's request for or about AD;

3) control beliefs, using questions to probe what factors would enable or deter responding to a patient's request for or about AD.

3.7.a. Elicitation procedure

The elicitation activity is mentioned in passing in the manuscript in Chapter Five, so a full explanation is provided here. As the purpose of the elicitation activity was to ground the meaning of variables or constructs in the real-world context of Australian nurses, the study was conducted through semi-structured interviews with nurses who worked in practice settings where end-of-life care was common (e.g., oncology, ICU, aged care, palliative care). Twelve interview questions included three screening questions to ensure that participants met inclusion criteria (agreement to record the interview, current nursing registration, practice setting). The stems of the remaining nine questions were drawn from a manual for health service researchers, "Constructing questionnaires based on the theory of planned behaviour" (Francis et al., 2004). These questions are listed in Appendix 3.3: Interview Questions and were presented to advanced practice nurses who volunteered to be interviewed. The recruitment process through which this subsample of nurses volunteered is explained below.

Interview Sample: A convenience sample for the elicitation sub-study was identified from a question in the Q-methodology survey (Step 1) that invited respondents to contact the researcher if they wanted to participate in an interview about their beliefs about legal AD. Seven advanced practice nurses contacted the researcher by email to express interest. On receipt of their expression of interest, the researcher sent an information sheet about the purpose of the interviews (but not the questions) and a consent form. The participants then nominated the date and time for the interview. The interviews were conducted between14 December 2018 and 17

January 2019. The sample consisted of three palliative care nurses (one nurse manager, two nurse practitioners), three intensive care nurses (each with at least ten years of ICU experience), and one nurse who was the organ donation coordinator of an urban medical centre.

Data collection and processing*:* Audio recordings of the interviews were transcribed by Outscribe, a transcription service in Adelaide, South Australia, then formatted for analysis in NVivo Version 12 software. NVivo was formatted with *a priori* nodes of: 1) Attitude 1.a: advantages, 1.b: disadvantages; 2) Subjective Norms 2.a: approves, 2.b: disapproves; and 3) PBC 3.a: facilitators and 3.b: barriers. The researcher reviewed each transcript, categorised excerpted text to the respective node, and then grouped them by themes. An independent assessor, a co-author of the manuscript that constitutes Chapter Five, reviewed the themes, and minor adjustments to coding were made.

Classification of responses into themes: Table 3.3 summarises the classification structure and themes that developed the survey items measuring independent variables. Table 3.3 also includes representative statements from the texts, the numbers of similar statements, and a summary description of items reclassified to other variables. That information is presented to provide background to the development of survey items and resulting scales that measured independent variables, discussed in the section describing survey construction (below, at 3.7.b).

Variable	Theme	Sample Content	No. items	%
Attitude	**Caution**	"My personal values might influence my professional practice in this situation"; "This is an opportunity to explain benefits of other options"	10	40%
	Beneficence	"There is a risk I can misinterpret"; "I must be attuned to the narrative that will emerge to ensure they get the care they need"	8	32%
	Patient rights	"If this were a legal option for that patient, I would be truthful about it"; "The patient has a right to seek this"	5	20%
	Non-maleficence	"Having this discussion makes the person think that assisted dying is the best or only option"; "I can't let the patient feel safe to explore a harmful option"	2	8%
		Total items	25	100
Subjective Norms	**Team**	"A lot of my colleagues do not support this"; "Most people I work with are open to this"; "Doctors do not think it is nurses role to discuss this"	10	38%
	Employer	"Policies that allow for that conversation"; “What if the employer is uncertain? What if they prohibit legal access?”	7	27%
	Associations	"Professional associations", "Union", "Political parties"	6	23%
	Own family	"Some conservative family members would not like this"	3	12%
		Total items	26	
Summary:	29 Coded Responses 1 theme of 3 items (Self-Efficacy) was classified to Perceived Behavioural Control. Final set of 4 themes, 26 items			
Perceived Behavioural Control	**Timing**	"Having the time in a busy clinical workload"; "Deferring the conversation to a better time"; "Timing and context must be right"	8	
	Training	"Practice with simulations, critical feedback"; "Being trained, feeling confident"; "Feeling safe in admitting to a patient that I don't have the skills to answer that"; "If I am not prepared, this can emotionally harm the person"	5	
	Ease - Difficulty	"My own religious belief makes that difficult"; "These discussions take a toll on your own well-being"; "I don't seek approval for work that I do"	5	
		Total items	18	
Summary:	31 coded items: 1 theme deleted after expert review (Patient's family - 6 items); 1 theme (Organisation / Policy) of 7 items reclassified to Subjective Norms. Final set of 3 themes of 18 items			

Table 3.2: Themes of responses in elicitation sub-study

3.7.b. Scale development

Scales were constructed to assess attitude, subjective norms, PBC, and ethical beliefs. Guidance for developing question stems came from the manual for constructing questionnaires for TPB-based studies (Francis et al., 2004), and the content of question items was drawn from the coded responses from the elicitation activity described above.

Attitude scale: During the coding process of feedback from elicitation study interviews, it became clear that an alternative approach to defining this project's attitude construct would be necessary. Respondents deflected questions about advantages or disadvantages in responding to a request for AD to discuss other beliefs, as seen from the resulting themes. As one respondent said, "*It's not a question of an advantage. Advantage for who? This is not a case where there are advantages*."

Adopting an alternate approach to eliciting attitude statements to allow a free flow of the discussion from the interviewees required two adjustments to coding the response text: 1) the responses to attitude questions that related to non-attitudinal issues, such as workplace constraints or team expectations, were re-coded to the nodes for 'perceived behavioural control' or subjective norms; and 2) the statements about attitude toward responding to these requests that reflected ethical beliefs (Patient rights and Non-maleficence) were thematised separately and grouped as 'ethical beliefs', using the classification set out by Beauchamps and Childress (Beauchamp & Childress, 2001). These coding solutions retained the text of responses but conflated attitude to a set of ethical beliefs or beliefs about good nursing practice in responding to a request.

The conflation of ethical beliefs and attitude was an unexpected development in the elicitation activity. It required a return to the literature to identify elements of attitude that could be abstracted as measures of a basic psychological tendency of a judgement of approval or disapproval (Eagly & Chaiken, 1993, p. 1). Three items assessing attitude were drawn from the literature about an evaluation of the acceptability or rightness of legalising AD Acceptability was assessed through the level of agreement or disagreement from three perspectives:

1. acceptability of legalisation (Lavoie et al., 2016) ("*Assisted dying should be legal where I practice nursing*")
2. acceptability of AD for 'this patient' (Berghs et al., 2005; Dierckx de Casterlé et al., 2006) ("*This patient should have access to legal A*D,")
3. degree of the personal value of AD (Oliver, 2016) ("*I would choose assisted dying for myself if that were an end-of-life option*").

Subjective norms scale. Four items assessed the expectations of significant others (injunctive norms), and four items assessed the importance of those expectations to the respondent (compliance norms). The 'significant others' were identified in the elicitation activity as 1) colleagues, 2) the respondent's own family, 3) the employer, and 4) relevant professional association. Each item was measured on a five-point Likert type scale where 1= ‘strongly agree or very important’. The question stems for injunctive norms were phrased, "My [significant other] would expect me to help this patient to access legal assisted dying", and the stem for the compliance norms was phrased, "How important to you is your [significant other's] position about assisted dying?"

The score for each set of norms was determined as the sum of the four items, with the composite subjective norms score determined by adding the summed score from each norm.

Perceived behavioural control scale. Six items were scaled for perceived control variable under two groupings – self-efficacy, and barriers (Sheeran et al., 2009). The four self-efficacy questions were answered on a five-point Likert-type scale related to the ease/difficulty of responding and the degree to which the respondent felt the situation was under his/her control. The initial Cronbach's alpha for this scale was an unsatisfactory .38, but the recommended deletion of two self-efficacy items (PBC_SE2 and PBC_SE4(r)) improved internal consistency to a marginally acceptable alpha of .61. The two items assessing barriers were questions about the ability to respond adequately "even if I had not been specifically trained to handle this situation" and "even if I did not feel like I had the time to handle this situation".

The PBC score was derived by summing the sums of each of the two scales.

Ethical beliefs scales. As an additional variable to the TPB model, emergent ethical beliefs were drawn from responses to the elicitation activity and thematised in summary as patient rights, non-maleficence, and duty of care (beneficence and caution). These themes were mapped to an existing scale (for social justice) and the bioethical principles developed by Beauchamps & Childress (2001) to strengthen psychometric properties. The social justice item was drawn from the Social Justice Scale (Torres-Harding et al., 2012), while belief statements related to the rights of the patient and beneficence were drawn from reviews of literature related to the ethics of AD (Gorsuch, 2006; Quaghebeur et al., 2009). These scales were developed by summing the three items for autonomy, one item for social justice, and two items for beneficence and non-maleficence. These items were scaled from 1=’strongly agree’ to 5=’strongly disagree’.

Initial review of the items revealed poor internal consistency within each norm, prompting an exploratory factor analysis using principal axis factoring, revealing two underlying factors for the eight items.

Factors with eigenvalue >1 were retained. Items were retained where they presented with loadings of >5 in one factor and where the item did not load at >4 in the other factor. Table 3.5 presents the rotated factor matrix. Boldfaced scores indicate the item selected to construct the relevant scale. The text for the selected items indicates the meaning of those items.

	Factor 1	Factor 2	Item text
Autonomy_1	.304	-.068	
Autonomy_2	**.776**	-.222	"This person should have input into own decisions about assisted dying"
Beneficence_1	.269	-.036	
Beneficence_2	-.094	**.570**	"I would help this patient to find ways to live as well as possible instead of seeking assisted dying"
Non-maleficence_1	-.224	**.684**	"Human life should never be violated, regardless of the person's situation"
Non_maleficence_2	-.348	.196	
Autonomy_3	**.671**	.237	"This person has the right to make decisions in their own best interest"
Justice_1	**.770**	.152	"This person has the right to speak and be heard about their decisions for an assisted death"

Table 3.*3* Rotated factor matrix of ethical belief items

The three items in factor 1 were retained as a new ethical belief variable, labelled ‘Autonomy’. The two items in factor 2 were retained as a new variable, ‘Beneficence’. The revised ethical variables were scaled as the mean of the sum of each set of items.

Demographic data: Background and contextual information about the respondents were assessed through seven questions about current practice setting, gender, years of experience as a nurse, geography (urban, regional, remote), state location in Australia, prior experience with receiving AD requests, and claimed religious affiliation (yes/no).

One demographic item was transformed into four categorical variables. The question that asked respondents to identify their usual practice setting had 12 response options plus one ‘Other’ option. Those responses were recategorised into four categories: 1) settings where end-of-life care is more common than other care settings (ICU, oncology, palliative, and aged care settings); 2) settings in other tertiary care areas (emergency, inpatient mental health, general medical/surgical areas that included midwifery and speciality day-surgery operations); 3) community settings (family/community practice); and 4) other (management, teaching or research).

3.7.c. Reliability test of independent variables scales

The final activity of Step 2 assessed the internal consistency of the scales developed from the elicitation activity. The sample of respondents to the 23-item questionnaire was identified through the 'human intelligence task' workforce of Amazon's Mechanical Turk (MTurk) service, where respondents were restricted to those who held a US baccalaureate degree and were employed in the healthcare industry (Buchheit et al., 2018).

The procedures for assessing the scales' internal reliability and the results (expressed as Cronbach alphas) are presented in the Methods section (Instrumentation subsection) of the published manuscript in Chapter Five (p 77).

3.8. Survey methods

Step 3. Explain Predictors of Discrete Intentions

This section discusses the processes related to the instrumentation of the survey used to collect data for Steps 3, 4 and 5, the sampling procedures, and the order of analyses related to Step 3.

3.8.a. Survey construction

The survey instrument comprised 53 questions in an anonymous online survey hosted by Qualtrics© (2020) (see Appendix 3.4 for the survey items). The survey items were presented in three conceptually related sections: demographics and practice characteristics, behavioural intentions, and independent variables. Details of instrumentation are presented in the manuscript in Chapter Five (p 77). Appendix 3.5 presents the contents of each scale, the transformation of the items comprising the scale, and the reliability coefficients of each scale.

3.8.b. Dependent variable items transformation

As described in Step 1, the dependent variable of the intended response produced a four-fold typology of responses – Refer/Support, Explore/Engage, Assess/Information, and Deflect/Object. Qualitative research with Canadian nurses has identified three basic positions nurses take toward encountering these requests – support actively, or object, and/or an activity of sense-making (Beuthin et al., 2018; Pesut, 2019). To assess the usefulness of the findings from Canadian research to guide the development of the dependent variable in Step 1, an exploratory principal components factor analysis (EFA) was conducted to produce a three-factor response typology. The resulting three factors, outlined in Table 1 (Instrumentation) in Chapter Five, were labelled ‘Refer’, ‘Discuss’, and ‘Deflect’.

The procedure for the EFA and the results of the subsequent confirmatory factor analysis follow.

EFA was performed on the 16 behavioural intention variables, requesting three factors. The three factors had Eigenvalues (i.e., variance explained) of 4.8 (Factor 1). 2.0 (Factor 2) and 1.4 (Factor 3) with a cumulative proportion variance explained of 0.51.

Using EFA (based on the Rotated Factor Pattern), the three factors were assigned the following variable names where ‘BI’ means ‘behavioural intention’:

- 'Refer' group includes questions BI_R_S1, BI_R_S2, and BI_R_S3;
- 'Explore' group includes questions BI_A_I1, BI_R_S4, BI_A_I2, BI_E_E3, BI_A_13, BI_E_E1, BI_E_E2, and BI_A_14;
- 'Deflect' group includes questions BI_O_D3, BI_O_D1, BI_O_D2, BI_E_E4, and BI_O_D4.

Two main decision rules were used for factor extraction: first, variables should yield an eigenvalue greater than 1.00, indicating that a factor explained more variance than a single item; second, using the Rotated Factor Pattern results, items loading at >0.50 on one factor and <0.40 on all others were considered for inclusion (Newman & Ramlo, 2010).

Confirmatory factor analysis (CFA) was used to test whether the data fitted a hypothesized measurement model based on EFA. Model fit measures were obtained to assess how well the proposed model captured the model's covariance across all the items or measures. If the constraints the researcher has imposed on the model are inconsistent with the sample data, then the results of statistical tests of model fit will indicate a poor fit, and the model will be rejected. If the fit is poor, it may be due to some items measuring multiple factors. It might also be that some items within a factor are more related to each other than others.

Tests of goodness of fit used in the CFA are as follows:

(i) Akaike Information Criterion (AIC): a lower value indicates a lower quality of a statistical model.

(ii) Root mean square error of approximation (RMSEA): greater than 0.1 indicates a poor fit.

(iii) Standardised root mean square residual (SRMR): <=0.08 indicates an acceptable model fit.

(iv) Goodness of fit index (GFI): >=0.90 indicates an acceptable model fit.

(v) Comparative fit index (CFI):>=0.90 indicates an acceptable model fit.

(vi) Correlations between factors: a weak-moderate correlation (r<0.70) indicate that the factors are generally independent.

The Akaike Information Criteria (AIC) is 434 relative to other models in terms of goodness of fit. The RMSEA=0.087 (indicating good fit), the SRMR=0.087 (close to good fit), the GFI=0.84 (not quite good fit) and the CFI=0.73 (indicating a less than acceptable fit). The weak to moderate correlation coefficients (r=0.40, 0.23 and 0.64) show that the factors are generally independent. Overall, the CFA model appears to be a good fit for the data, and the CFA groupings are fairly consistent with the intended three main groups – refer, explore and deflect (evident in the titles of the variables). The statistical software used was SAS 9.4 (SAS Institute Inc., Cary, NC, USA). Validation of these items is presented in Chapter Five.

3.8.c. Sample

The sample discussed here is different from the sample discussed in Step 1, 45 participants for the Q-methodological survey. Details of the recruitment, number and characteristics of participants, and power calculations are presented in Chapter Five (p 62).

Sample size. Based on a total population of 286,000 registered nurses in Australia (Australian Government Department of Health, 2018), the ideal sample size would be 384, using a 95% confidence interval and allowing for a 5% margin of error. The survey attracted 470 respondents, which, after exclusions, left a sample of 377 nurses (Qualtrics, 2020).

3.8.d. Analysis plan

Explaining the effects of the independent predictor variables on the three discrete response intentions identified in Step 2 depends on how the analysis is conducted. Studies based on the TPB usually assume an intention to act (or not) which is treated as a single dichotomous variable (e.g., to participate or not) against which the independent variables are regressed. Relevant examples of nursing studies that follow that practice include research into intentions to integrate research findings into practice (Côte et al., 2012), to use a peripherally inserted central catheter (Bertani et al., 2016), to practise hand hygiene (White et al., 2015), and to participate in an act of euthanasia (sic) (Lavoie et al., 2016).

A typical approach to analysing TPB studies uses hierarchical or stepwise regressions to estimate the additional variance explained by adding variables to the model indicated by adjusted r^2 values (e.g., Asare, 2015). That analytic approach is especially relevant to a predictive study, as it optimises model fit, but it comes at the expense of understanding the roles of individual variables (Sainani, 2014). Further, hierarchical regression assumes a single dependent variable, which is not the case in the present research project. This research has identified multiple dependent variables, constructed as scales (continuous data), impacted by several independent variables of either categorical or continuous data.

Since the variables in this research comprised different data types, a different approach to analysis was required that could accommodate multiple dependent variables and tolerate non-normal (skewed) distributions and a mix of data types, which simple linear regression does not allow. Generalised linear modelling (GLM) extends linear regression to allow each outcome of the dependent variable to come from non-normal distributions (IBM Knowledge Center, 2014).

3.9. Exploring response profiles

Step 4. Explore Profiles of Response Patterns

Step 4 is the third exploratory activity of the research project. This Step aimed to identify how the patterns of response intentions form profiles of nurses who share similar patterns of intentions.

Methods that identify not-yet-discovered groups within a data set are described as classification procedures or cluster analyses (Beckstead, 2002). Cluster analysis separates observations into classes that share common characteristics. Clustering aims to ensure both homogeneity of within-group observations and their heterogeneity from other groups. Clustering contrasts with the generalised linear modelling described in the previous Step, which aimed to make inferences about this sample's population parameters. The aim here was to group nurses with similar response intentions different from other groups to form the basis for future hypothesis generation. Hence, cluster analysis is an exploratory method (Landau & Ster, 2010) that can generate typologies and hypotheses (Beckstead, 2002).

3.9.a. Cluster analysis procedures

The following discussion elaborates the clustering method beyond what is found in Chapter Six. Beckstead (2002) describes the following three steps used here to conduct this cluster analysis: 1) define the set of entities and their features; 2) calculate the proximity measures (distance coefficients) among those entities; 3) visualise the resulting profiles of those entities.

1) Define the set of entities and their features. The entities selected to measure this sample are the response intention variables. The sample that provided the data in these variables is slightly smaller than the sample from the activities of Steps 2 and 3. In this Step 4, eight cases were excluded that had missing data on the response intention scales, taking the sample from n = 377 to n = 369.

Step 3 (see section 3.7) identified three response intentions through a principal components analysis. By way of reminder, that factor analysis was constrained to three factors that came to be labelled ‘Refer’, ‘Discuss’, and ‘Deflect’. However, for the cluster analysis in Step 4, a separate principal component factor analysis was conducted on data for response intentions, but this analysis had no *a priori* theoretical constraints on the number of factors. All behavioural intention items were compiled into a rotated component matrix, outlined in the published manuscript in Chapter Six (p 95).

The optimal number of factors had to be calculated because there was no a priori determination of the number of factors. That calculation required plotting the eigenvalues of all of the identified factors into a scree plot (Kaufman & Rouseeuw, 2008), displayed in Figure 3.5 below. That plot identified an optimum set of five response factors, using the elbow of the line to mark the number of factors. Those factors were labelled according to the themes of the distinguishing statements associated with each factor. The five response intentions were labelled ‘Refer’, ‘Explore’, ‘Assess’, ‘Deflect’, and ‘Object’.

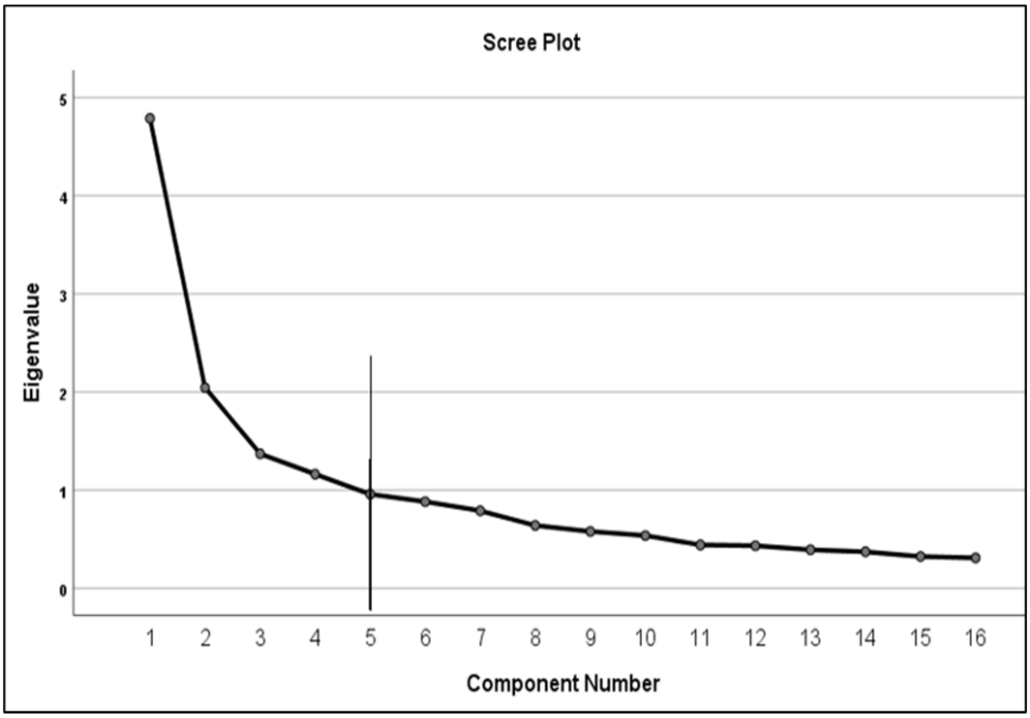


Figure 3.5 Scree plot of eigenvalues of factors

<u>2) Calculate proximity measures among all the entities</u>: Discovering the number of entities (i.e., intended responses) that constitute the dependent variables for the cluster analysis contrasts with the next step in the procedure. The next step, calculating proximity measures among those entities, requires the *a priori* determination of the number of clusters. That step generally requires choosing between hierarchical clustering and *k*-means clustering approaches. Hierarchical clustering uses agglomerative partitioning; k-means clustering uses an optimised iterative partitioning of the data. Agglomerative partitioning groups the sample into nested arrangements such that higher-order clusters are formed from lower-order ones and displayed as dendrograms or nests of hierarchies. Hierarchical clustering does not require an a priori identification of optimal clusters because “there are situations in which clusters have subclasses within them, which in turn have subclasses of their own” identified in the process of clustering (Beckstead, 2002, p308). (An example of hierarchical clustering is biological taxonomy from genus through to kingdom that contains several subclasses within each clustered group.)

K-means clustering does not force a nested structure but rather partitions all of the data in one step to find all clusters simultaneously. A unique requirement for the *k*-means analysis is the need for the *a priori* determination of a fixed number (*k*) of clusters, compared to hierarchical clustering, which does not have that requirement

(Dunn et al., 2018). The *k*-means clustering algorithm identifies clusters that minimise the distance between individual data points by calculating a point representing a random mean of all data for a given cluster (centroid). Cluster analysis is described as an 'unsupervised' algorithm that draws inferences from the data without regard to the classification outcome. That approach does not readily find the optimal outcome; rather, the algorithm iteratively calculates the distances of each data point from a randomly-placed centroid until all distances are minimised, and centroids remain stable in their relationship to all data points. The procedure for determining the number of clusters is presented below.

<u>Procedures for determining the number of clusters</u>. This analysis, following the procedure outlined in Kaufman and Rouseeuw (2008), identified five clusters. The procedure consisted of the following three steps:
1) To determine the optimal number of clusters for the *k*-means analysis, enter the response intention scores into the algorithm (from the factors identified in Chapter Four). The response scores were the variables that the *k*-means algorithms used for the iterations that calculated the distance coefficients that indicate homogeneity within clusters (the proximity scores).
2) Assess the numerical summary of the cluster solution based on within-cluster-sum-of squares (WCSS). The optimal cluster solution occurs in a sudden 'gap' where the space between the distance coefficients jumps to an extended distance between the ratios.
3) The final step in determining the number of clusters is diagrammed by the scree plot of the distance coefficients against the number of cases in the sample (Figure 3.6). The scree plot identifies visually where the 'gap' occurs in the distribution of distance coefficients. The gap location is calculated by identifying the case number just before the beginning of the 'elbow' – the point where the map line began its steep upward climb. Then that case number is subtracted from the number of total cases in the sample, and the difference is the optimal number of clusters. In this case, the elbow began at case 363, so the gap began at case 362. Thus, the calculation was 367 minus 362, arriving at the number five as the optimum number of clusters (Kaufman & Rouseeuw, 2008).

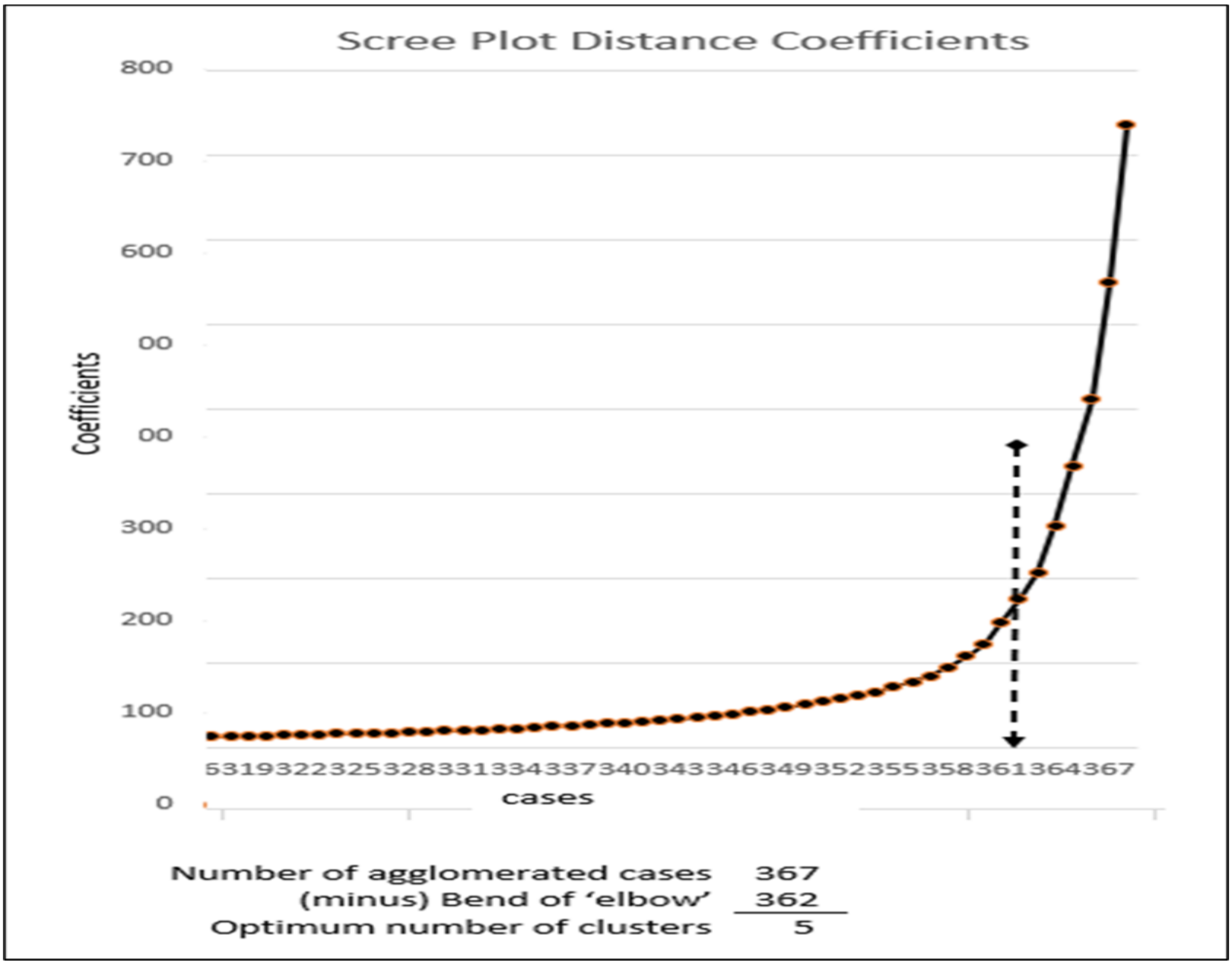


Figure 3.6. Scree plot indicating the optimal number of clusters

Using the *k*-means clustering algorithm, a stable set of clusters was identified in nine iterations of calculations of proximity scores. That number of iterations falls below the SPSS default number of 10 iterations and suggests a relatively stable solution (IBM Docs, 2021). The groupings that emerged were patterns comprised of dips and elevations of the response intentions' standardised mean scores (Beckstead, 2002). Those patterns of groups of nurses with similar response intentions were profiled with the labels ‘Assessor’, ‘Uncertain’, ‘Deflector’, ‘Engager’, and ‘Objector’. The content and meaning of the resulting profiles are discussed in Chapter Six (p 96).

3. Visualise profiles of the response patterns. An obstacle to visualising these clusters is the overall variability of data, which for most of the response intentions is highly skewed (for example, the intended response, ‘Refer’, has a mean of 4.69 out of 5, with an SD of 0.56). Standardising the mean scores for each response intention facilitated the interpretation of results by highlighting variance among the scores. The

graphic output of the profiles' relationship is presented and discussed in Chapter Six (p 96).

3.10. Step 5: Predicting membership of response profiles

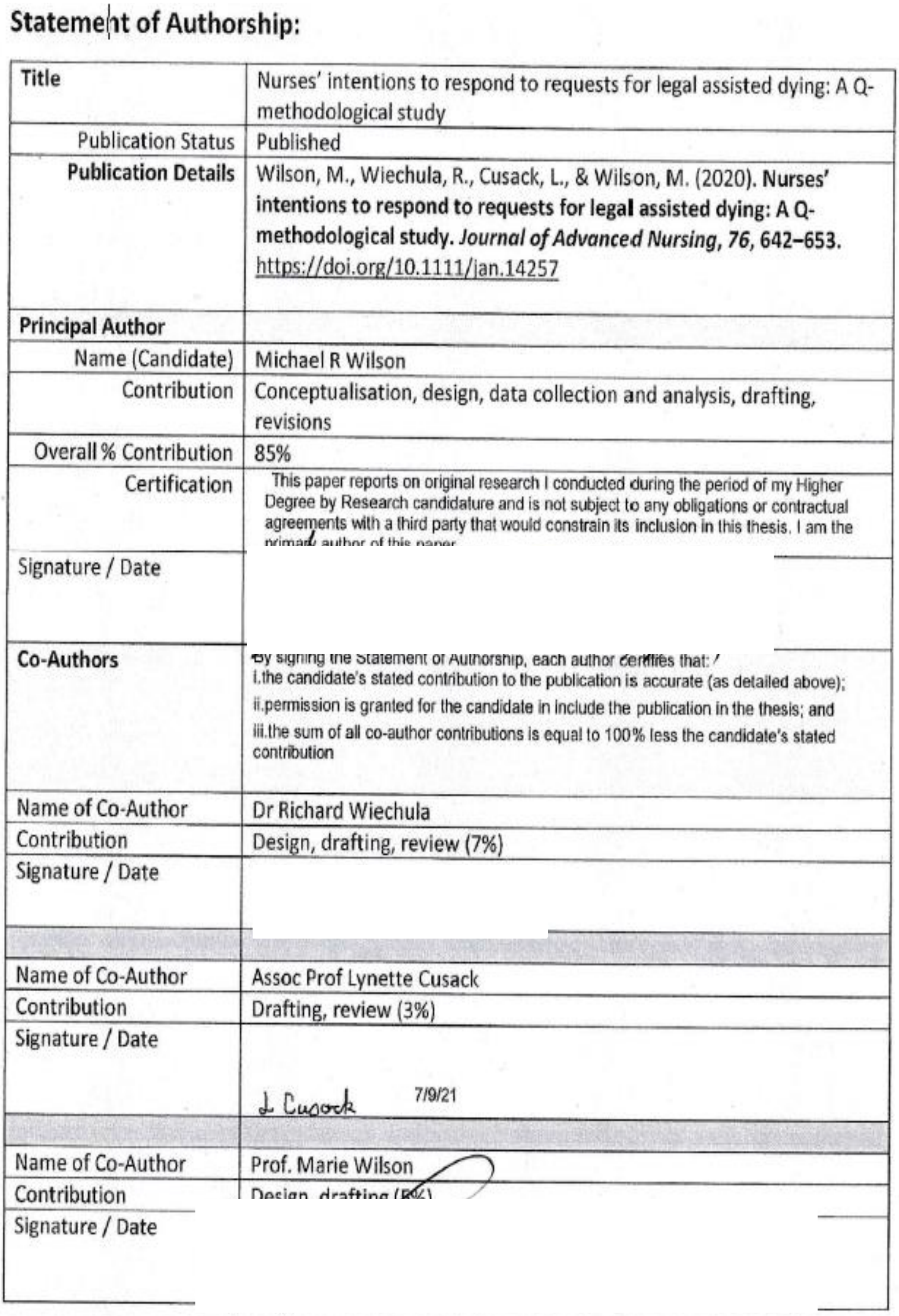
Step 5. Explain Predictors of Response Profiles

The task of identifying the factors that might predict the likelihood of a nurse's membership in a response profile is addressed through multinomial logistic regression (hereafter, 'logit'). Logit regression carries three assumptions: 1) the dependent variable (a profile or cluster) is categorical and not ordered in any meaningful way; 2) there are multiple categories; 3) the independent variable that predicts the profile is specific to the individual case where each predictor has a single value (scores for attitude, subjective norms, ethical beliefs, perceived behavioural control). Ensuring that the logit model identifies a case's probabilities of membership in one profile only, membership must be tested against alternative profiles where one profile is held constant (the reference profile) and alternatives are compared against it sequentially (Everitt & Skrondal, 2010). The details of the calculation of odds ratios for each predictor variable for each category are fully described in Chapter Six. The summary of each logit model is available as a supplementary table (online only) for the manuscript in Chapter Six but is available in this document as Appendix 6.1.

Chapter Four: Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study

This chapter consists of the following manuscript:

Wilson, M., Wiechula, R., Cusack, L., & Wilson, M. (2020a). Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study. *Journal of Advanced Nursing*, *76*, 642–653. https://doi.org/10.1111/jan.14257



Statement of Authorship:

Title	Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study
Publication Status	Published
Publication Details	Wilson, M., Wiechula, R., Cusack, L., & Wilson, M. (2020). **Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study.** ***Journal of Advanced Nursing*, *76*, 642–653.** https://doi.org/10.1111/jan.14257
Principal Author	
Name (Candidate)	Michael R Wilson
Contribution	Conceptualisation, design, data collection and analysis, drafting, revisions
Overall % Contribution	85%
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the [redacted]
Signature / Date	[redacted]
Co-Authors	By signing the Statement of Authorship, each author certifies that: i.the candidate's stated contribution to the publication is accurate (as detailed above); ii.permission is granted for the candidate in include the publication in the thesis; and iii.the sum of all co-author contributions is equal to 100% less the candidate's stated contribution
Name of Co-Author	Dr Richard Wiechula
Contribution	Design, drafting, review (7%)
Signature / Date	[redacted]
Name of Co-Author	Assoc Prof Lynette Cusack
Contribution	Drafting, review (3%)
Signature / Date	L Cusack 7/9/21
Name of Co-Author	Prof. Marie Wilson
Contribution	Design, drafting [redacted]
Signature / Date	[redacted]

Received: 26 March 2019 | Revised: 31 August 2019 | Accepted: 22 October 2019
DOI: 10.1111/jan.14257

JAN Leading Global Nursing Research
WILEY

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH – MIXED METHODS

Nurses' intentions to respond to requests for legal assisted-dying: A Q-methodological study

Michael R. Wilson M Ed, RN, PhD Candidate[1] | Rick Wiechula BA, DNurs, RN, Senior Lecturer[1] | Lynette Cusack MHA, PhD, RN, Associate Professor[1] | Marie Wilson MS, JD, PhD, Professor[2]

[1]Adelaide Nursing School, University of Adelaide, Adelaide, South Australia, Australia

[2]Division of Business and Law, University of South Australia, Adelaide, South Australia, Australia

Correspondence
Michael R. Wilson, Adelaide Nursing School, University of Adelaide, Adelaide, SA, Australia.
Email: michael.r.wilson@adelaide.edu.au

Funding information
Australian Government Research Training Program

Abstract

Aims: To explore the intentions of nurses to respond to requests for legal assisted-dying.

Background: As more Western nations legalize assisted-dying, requests for access will increase across clinical domains. Understanding the intentions of nurses to respond to such requests is important for the construction of relevant policy and practice guidelines.

Design: Mixed-methods.

Data Sources: A total of 45 Australian nurses from aged, palliative, intensive, or cancer care settings surveyed in November 2018.

Method: Q-methodology studying nurses' evaluations of 49 possible responses to a request for a hastened death. Data consisted of rank-ordered statements analysed by factor analysis with varimax rotation.

Findings: Four distinct types of intentions to respond to requests for assisted-dying: a) refer and support; b) object to or deflect the request; c) engage and explore the request; or d) assess needs and provide information.

Conclusion: The findings underscore the complexity of intentionality in assisted-dying nursing practice and differences from other forms of end-of-life care, particularly regarding patient advocacy and conscientious objection. This study enables further research to explore determinants of these intentions. It can also assist the development of professional guidance by linking policy and clinical intentions.

Impact: Identified a basic range of nurses' intentions to respond to requests for assisted-dying, as there was no evidence at present. Developed a fourfold typology of intentions to respond with most nurses intending to engage in practices that support the requestor and sometimes the request itself. A minority would object to discussing the request. The relatively low level of advocacy within the intended responses selected also is distinctly different from other end-of-life care research findings. This research could assist nursing associations in jurisdictions transitioning to legal assisted-dying to develop guidance ways nurses can frame their responses to requests.

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.14257

KEYWORDS

assisted-dying, Australia, factor analysis, intention, nursing, Q-methodology, Theory of Planned Behaviour

1 | INTRODUCTION

In developed economies significant public policy debates are emerging regarding end-of-life care, questioning advanced medical interventions versus palliation and more recently, increases in legalized pathways to assisted-dying (Sheridan, 2017). Despite the jurisdictional and cultural variations in legalized assisted-dying, nurses retain unique roles in facilitating end-of-life decision-making with patients and their families since they are the health professional who often has the closest relationship with them (Bloomer, Lee, & O'Connor, 2011; Lehto, Olsen, & Chan, 2016). Adams, Bailey, Anderson, and Docherty (2011) identified three typical roles nurses assume in end-of-life situations in acute care settings: (a) Support, an activity directed to building trusting relationships with family to help them manage the impact of interventions and cope with ultimate outcomes; (b) Information broker, to gather relevant information about status and prognosis to formulate a 'big picture' to support the family; and (c) advocating for decision-making with the medical team on behalf of patients and family, or with family on behalf of patients. This advocacy often pivots planning from a focus on curative interventions to palliative strategies.

Enacting usual end-of-life care roles becomes particularly complicated with the uneven uptake of regulated access to assisted-dying across jurisdictions, particularly when those laws are inconsistent across federated states (e.g., the US & Australia). Intentions to respond are influenced by the presence or absence of legislation (Lavoie et al., 2014). Further complexity arises when patients can choose the time and manner of death, when an assisted death becomes a commodity and is open to negotiation (Monteverde, 2017). In contrast to most nursing roles in end-of-life care, negotiating assisted-dying is uniquely constrained. For example, in most jurisdictions where assisted-dying is legal clinicians must not initiate a discussion about it (federal Canada being an exception). This proscription and protections for conscientious objection, have arisen in a context of professional bodies adopting a 'premeditated practice of being neutral in the dispute about euthanasia' (Johnstone, 2012, p. 898). This challenge to usual nursing roles in these circumstances will become more important as increasing legalization leads to more frequent requests.

1.1 | Background

Legislation in most jurisdictions is silent on nurses' participation in assisted-dying, but the research is not. Much of the nursing research on assisted-dying before 2014 focused on attitudes towards legalization and participation in the practice. A pattern of attitudes emerged that correlated strongly with religion, years of practice, and clinical specialty. This pattern suggested that nurses with weaker religious affiliations and those who practiced in emergency and intensive care had the more positive attitudes towards assisted-dying. Early evidence of nurse participation in euthanasia was in the Benelux countries where retrospective review of records (Lavoie et al., 2014) and surveys (van Bruchem-van de Scheur, van der Arend, van Wijmen, Abu-Saad, & ter Meulen, 2008) showed that nurses were often involved in euthanasia practices. It was not until 2014 and 2016 when research appeared that began to explore nurses' attitudes and practices towards euthanasia from a theoretical framework (Lavoie et al., 2016; Vézina-Im, Lavoie, Krol, & Olivier-D'Avignon, 2014). That framework sought to identify motivation and intention to participate. This was an important development as intentions, rather than attitudes, are generally understood to be how people cognitively rehearse future actions or plans for behaviour (Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008).

There are several theories that help to understand intention-formation related to the end-of-life, but behavioural theories have demonstrated usefulness both as an explanatory and predictive approach. The Theory of Planned Behaviour (TPB) has been the most widely used framework to study clinicians' initiation of discussions about end-of-life care planning (Scherrens et al., 2018). The TPB links personal and contextual predictors to behaviour through a person's intention to act (Ajzen & Fishbein, 2000). Intention is described as the likelihood of performing an action, based on a decision about how much effort to put into that action (Ajzen, 1985). Intention is subjective and can vary widely across situations and even within individuals (Bagozzi & Yi, 1989).

The review of clinical decision-making by Scherrens et al. (2018) found that most TPB-based studies failed to examine intention, a key determinant for behaviour. Only four of the nine reviewed studies examined the role or status of intention. Three of those four TPB studies emerged from a research group at Laval Université in Quebec, as the Province was in transition to legalizing euthanasia and examined physicians' and nurses' intentions to participate in procedures related to euthanasia (Lavoie et al., 2014, 2015, 2016). These studies represent the first applications of a theoretical framework to explain nursing intentions in this field, but they studied a very rare event: willingness to participate in an act of euthanasia. While this knowledge is important to understand how nurses intend to act in these conditions, these studies operationalized intention as a binary variable, as a high/low or positive/negative intention to participate in processes related to euthanasia. Studying intention as a binary choice is probably appropriate when considering a discrete action (e.g., participation in a process such as cannulation, equipment setup).

Intentions-to-respond to requests about assisted-dying are unlikely to be binary. The complexity that gives rise to the request for assisted-dying suggests that underlying motivations for responding might be equally complex. How the nurse engages with a patient in this encounter may be shaped by workplace factors, personal salient beliefs, skills and/or confidence (Elmore, Wright, & Paradis, 2016; Wright et al., 2017). This suggests that the typology of role enactment in end-of-life care decision-making, described above by Adams et al. (2011), might not capture the complexity of intentions when access to legal assisted-dying is possible.

2 | THE STUDY

2.1 | Aims

The aim of this study was to develop a grounded understanding of the types of intentions that nurses who practice in end-of-life settings have towards responding to a request for assisted-dying. Understanding these intentions-to-respond can support evidence-based guidance, policy, and interventions.

2.2 | Design

The study of intention requires a method that can explain subjective views. Subjectivity is the central construct of Q methodology and is defined as: 'the sum of behavioural activity that constitutes a person's current viewpoint' (Watts & Stenner, 2012, p. 54). The focus of Q method is to capture subjectivity as it expresses itself through an action.

Q methodology has been described as a systematic approach that blends qualitative data – the communicated views on a topic – with the statistical processes of factor analysis that reveal the latent structure of those views (Akhtar-Danesh, Baumann, & Cordingley, 2008). Q methodology has demonstrated adequacy for identifying latent frames of reference and is appropriate to understanding nurses' views of a wide range of clinical and training issues (Thompson & Baker, 2008).

This method is a five-step process: 1) constructing a sample of statements (the Q-set) that is representative of a larger concourse of statements of responses to requests for a hastened death; 2) recruiting participants to sort by rank-order the Q-set of statements to produce a Q-sort: 3) production of the Q-sort by the participants; 4) factor analysis of the Q sorts; and 5) factor interpretation.

Establishing the Q-set required a sampling process that inductively selected the items from a search of the Scopus database, for articles from 2000 to 2017, using keywords 'nurse OR doctor OR physician' AND 'response OR reaction' AND 'euthanasia OR assisted-dying OR physician-assisted suicide OR hastened death" AND 'patient requests'. Figure 1 diagrams the search process that identified the initial concourse of 92 response statements that were relevant to this clinical encounter at the end of life. The challenge to reduce this large set in a way that achieved a representative set of statements balanced with the complexity of the decision-processes and the time-burden on the participant, was resolved in an initial set of 58 statements. The principles that guided the selection or rejection of any of the 92 response statements included: whether the response was discipline-specific (e.g., medical specialist); assessing whether the response blocked or promoted patient disclosure; or whether the response was to a frankly suicidal statement.

That literature comprised clinical guidelines (Baile et al., 2000; Hudson et al., 2006; Turner et al., 2005), case study/expert opinion (Bascom & Tolle, 2002; Emanuel, 2005; Lehto et al., 2016) and research studies from nursing, medicine, and law (Elmore et al., 2016; Gamondi, Borasio, Oliver, Preston, & Payne, 2017; Lo, 2018; Ohnsorge, Keller, Widdershoven, & Rehmann-Sutter, 2012; Oliver, 2016; Quill, Back, & Block, 2016).

The initial concourse of 58 statements was then reviewed by an international group of six expert advisors familiar with end-of-life care and assisted-dying. Reviewers evaluated each statement for readability and uniqueness, proposed new statements drawn from their own experience and edited some statements to improve clarity of meaning or grammar. When most reviewers [3 or more] recommended that a statement be deleted due to similarity with another statement, it was removed from the set and the preferred statement was retained. Their expert review resulted in 11 statements being eliminated, 19 statements edited for clarity and two statements added. The resulting set of 49 statements formed the Q-set, the instrument that provided the basis for the sorting exercise performed by the study participants.

2.3 | Sample and setting

Q method looks for correlations among people's views across a sample of variables (the Q-set) and is distinguished from R-method studies that would seek to identify generalizable correlations of a few variables across a large sample of people. Thus, a large sample size is not required for Q studies and a sample size of fewer participants than statements in the Q-set is advised (Watts & Stenner, 2012). A non-probability purposive sample of registered nurses was recruited through professional nursing associations in Australia whose members were likely to work in end-of-life care areas. Forty-five nurses completed the survey. These nurses were at least one year past their initial registration as a nurse and had a primary clinical practice in oncology (*N* = 14, 31%), critical or intensive care (*N* = 13, 29%), palliative care (*N* = 15, 33%) and other domains where end-of-life care was a feature of practice (*N* = 3, 6%)

2.4 | Data collection

Data were collected over two weeks from 15 to 30 November 2018 using a live web-based application designed specifically to manage individual rank-ordering of Q-sets (Q-Assessor®, Epimetrics Group, LLC, USA). To minimize the potential for socially desirable response bias inherent in an ethically sensitive survey, data were collected anonymously (Joinson, 1999). Participants were asked to read each response statement in the Q-set while considering the following

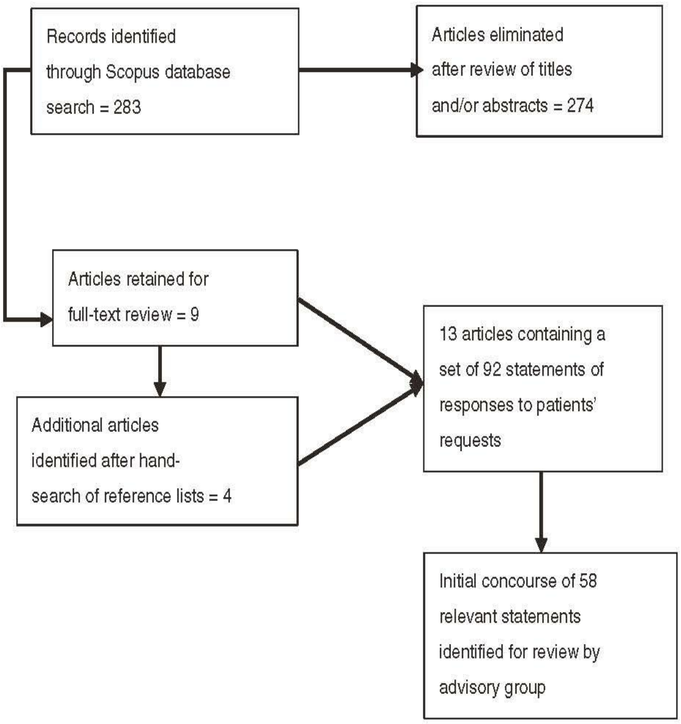


FIGURE 1 Process of concourse statement selection

scenario: *Assisted-dying is legal where you practice nursing. A patient with a terminal illness whose death is reasonably foreseeable (in the patient's view) asks you for assistance to access assisted-dying.*

The product of the data collection is the Q-sort. Using a drag-and-drop interface each participant reviewed each statement during a two-tier sorting process. The first sort categorized each statement into one of three values: 'would say this', 'would not say this' and 'not sure'. The second sort elaborated that previous sort along a 7-point scale with 'would' and 'would not' at either pole, with decreasing levels of certainty about remaining statements toward a 'not sure' midpoint. The resulting sort is usually imaged as a grid with a normal distribution of statements, with the fewest statements at each pole of the scale and most of the statements clustering in a forced choice distribution toward the more neutral centre, illustrated in Figure 1.

After the second sorting exercise the participants were asked to discuss their motivations for choosing the statements that they ordered at each of the extreme ends, or poles, of the scale. These qualitative data were linked back to the relevant Q-sorts to assist in the interpretation of the identified underlying factors.

2.5 | Ethical considerations

This research was approved by the research ethics committee of the university where the research was conducted and the research conforms to the standards of the Helsinki Declaration. The protocol included guidance for participants who might find themselves distressed as a result of their participation The authors were not contacted by a participant for assistance with this.

2.6 | Data analysis

Factor analysis is the primary statistical approach to analysing Q data, designed to transform a large set of variables into smaller sets to reveal patterns of association among them (Bannigan & Watson, 2009). Analysis of Q studies is a three-phase process consisting of centroid factor analysis to extract factors, varimax rotation of factors to provide maximum separation of factors which leads to the interpretation of the identified factors. Analysis began with producing a by-person correlation matrix that allowed a direct comparison of Q-sorts. Factor loadings represent the relationship between the person's Q-sort and the underlying perspective, or factor. Based on a Q-set of 49 statements, at a significance level of 0.01, the required factor loading must be at least 0.37 (Brown, 1980, p. 223). The strength of correlation was calculated by weighted averaging (z score). Varimax rotation was selected over judgemental rotation as all participants were anonymous and equal consideration was given to each viewpoint expressed in the Q-sorts. The weighted averages of individual Q-sorts contributed to a composite Q-sort called a factor array, which then forms the basis of interpretation.

2.7 | Factor validity and reliability

The trustworthiness of the qualitative data hinged on the representativeness of the original set of statements that participants sorted. The process of ensuring the value of that original Q-set is described below through the work of the international advisory group of expert nurses. Free-text comments were used as anonymously submitted, to assist in factor interpretation. The goal of interpretation was to understand the response-intentions represented in each factor array. In this study, there were three main sources of information to assess the meaning in these factors. The primary source was each factor's composite sort, along with statements that distinguished each factor. Secondly, the items in the extreme areas of the Q-sort (items ranked at +3 or −3) revealed areas of strongest intention in each factor. Thirdly, participant comments about the extreme statements often clarified the meaning or motivation for that concern. Participant quotes are identified by their study ID number (e.g., ID870), response options are identified by the statement number (1 to 49) and the cumulative ranking from +3 (highly ranked): −3 (e.g., 10: −2) refers to statement 10, which was negatively ranked.

The quantitative results displayed in the factor arrays in Appendix S1 are compared within and across each array in the following order: first, the highest ranking statements within each factor are identified (+3 or +2), then the lowest ranking statements (−3 or −2); second, items ranked higher or lower in one factor than in any other factor are identified. Where a statement in another factor is ranked identically with the ranking in the previous factor it will be extracted and included with factors ranking either higher or lower in the previous factor (Watts & Stenner, 2012). The statistical reliability of the factors was assessed when the eigenvalue was greater than 1.0 and the composite reliability of the four final factors, which ranged from 0.92 to 0.98, as per Table 1.

Working with members of the advisory group and among the authors, labels were constructed for each factor to summarize what intentions the factor represented, as indicated in Table 1. The labels were based on the apparent meaning of the most highly ranked distinguishing statements (ranked at +]3) for each factor. Tables 2–5 through 5 illustrate that there was more than one cluster of highly ranked distinguishing statements per factor, suggesting a duality that is reflected in the labels assigned.

3 | RESULTS

Seven factors were extracted initially. This extraction yielded five unrotated factors that accounted for 53% of the total variance in this study. Only four of these factors met these criteria for retention: each factor had an eigenvalue >1 and contained at least two significant Q sorts at 0.01 significance level. Application of Fuernttratt criterion further ensured that significance of the factor loading included communality, that is, 'the degree to which a Q-sort holds in common with the other Q-sorts' (Watts & Stenner, 2012, p. 114). These four factors were treated with varimax rotation to provide maximum distinction between them.

Construct validity for each factor was supported by the composite reliability coefficient (r_c), with all values exceeding the minimum acceptable threshold of 0.7 (Hair, Andersen, Tatham, & Black, 1998). The characteristics for these rotated factors are displayed in Table 1. Factor values and z-scores of each statement are presented in the factor array in Appendix S1.

3.1 | Interpretations

Interpretation engages an abductive approach to constructing the narrative for what that factor might mean; it begins to build the story of the viewpoints expressed in that factor. This is aided by the free-text comments by participants that explained their motivation for assigning a particular statement to the most extreme ends of the scale. A tentative description of the meaning of the factor was then reviewed and revised with the expert advisory group.

3.1.1 | Factor A: Refer/Support

Eleven participants loaded on this factor, with distinguishing statements listed in Table 2. The summary interpretation of factor A is that a request for assisted-dying would be met with encouragement to ensure that the physician was aware of the request (18:+3, 15: +2) and that assurance is given that regardless of the decision the person would not be abandoned (2: +3). Nurses whose Q-sorts loaded on factor A want the requesting person to feel assured of support regardless of their ultimate decision, but 'sometimes pts share more with nurses than they do with their doctors; [we should] encourage full disclosure of pts wishes to medical staff to enable them to have their wishes known fully' (ID870). The sentiment for ensuring the request be known to the treating physician was explained by one participant as an intention to 'advocate for patients, to refer the request to the person who can address their enquiry' (ID830). In the context of other participants' statements advocacy seemed to be limited to supporting the person to escalate the request. Factor A nurses would not dissuade the requestor from seeking an assisted death nor introduce fear or doubt into the conversation with responses from the concourse such as 'the process for approval for an assisted death may take a long time, maybe more time than you have available' (10: −2). Such a response was seen by other nurses as 'a futile attempt to absolve themselves of responsibility in this difficult situation' (ID874).

Even though statements ranked at '0', or 'not sure', are not distinguishing statements they can reveal interesting insights. Participants who Refer and Support are 'not sure' they would respond with statements 4 and 16: 'An assisted death is an option that might be available' (4) and 'I can give you some information about legal requirements for accessing an assisted death, but your doctor is likely to be the best person to assist you in deciding'. (16). These responses suggest ambivalence about acting to move the process forward, in contrast to the certainty in other viewpoints to avoid this type of response.

3.1.2 | Factor B: Object/deflect

Three participants loaded on this factor, with intended responses listed in Table 3. Nurses whose Q-sorts loaded on this factor intended to state their opposition to the request, 'Discussing this make

TABLE 1 Factor Characteristics, with interpretative labels

	Factors				
Characteristics	A 'Refer/ Support'	B 'Object/ Deflect'	C 'Engage/ Explore'	D 'Assess Needs/ Provide Info'	
Number of defining Q-sorts	11	3	8	8	
Composite reliability	0.98	0.92	0.97	0.97	
Standard error of factor scores	0.149	0.277	0.174	0.174	
Eigenvalue	8.9	2.9	8.9	2.8	
% Total variance	18.9	6.4	18.9	6.0	50.2% total

TABLE 2 Distinguishing response-intentions for Factor A

Rank	Statement no.	Statement item
'Would say'		
3	2	We will be here for you no matter what you decide.
3	18	Have you been able to discuss this with the doctor who is most involved in your care?
2	7	You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?
2	15	When you talk with your doctor about this, have you told your doctor what you have told me?
'Would not say'		
−1	5	Everyone has responsibility for their own life, that includes the type and the way in which they die.
−1	13	I have to be honest, I am not comfortable approaching this topic
−2	10	The process for approval for an assisted death may take a long time, maybe more time than you have available

me feel complicit in an action I cannot be involved in" (11: +3). Their opposition was unequivocal, "...it is equal to murder' (ID848), 'I am against assisted-dying and will never advocate for it' (ID835) and 'I do not believe it is a valid choice and I will not take part in any way' (ID848). These nurses would not tell the requestor that an assisted death might be legally available (4: −3). The intention in responding would be to deflect the requestor's attention to palliation (31: +3, 41: +2). These nurses felt that palliative care was the only alternative that could be discussed and that opting for assisted-dying was 'a failure of palliative care' (ID838). They were less interested than other nurses in exploring the requestor's fears or concerns in the moment (e.g., 20: +1). Nurses whose Q-sorts loaded onto this factor were more likely than others to involve medical staff, but only to enhance symptom control, not to discuss the request itself (19: +2; 41: +2).

Again we see how a statement ranked at '0' or 'not sure' can be illuminating even if it is not a distinguishing statement, Nurses in this factor were 'not sure' that they would say to the requestor that 'because of my own views about assisted-dying, I cannot encourage you to ask this question' (statement 12). In contrast to the other factors that rejected that response option, the uncertainty here underlines the sense that these nurses base their responses more explicitly on personal values.

3.1.3 | Factor C: Engage/explore

Eight participants loaded on this factor; their ranked intentions are listed in Table 4. The intentions identified here focussed on a promoting dialogue to explore the requestor's wishes and priorities, deep concerns and sense of meaning. These nurses were more willing to use open-ended questions and to explore what the requestor did not want (36: +3) 'to identify what the patient priorities are' (ID864). Nurses loading on this factor were more likely than other nurses to ask questions that encouraged the requestor to talk about concerns 'at the moment', or what their illness meant to them. They were somewhat willing to refer for symptom control (19: +1), but not specifically to escalate the request to the physician. This factor shares with factor A, Refer and Support, an assurance of non-abandonment and with factor D, Defer and Inform, a non-judgemental approach. The overall tenor of this intention was to engage with the requestor, but not necessarily with the request itself.

These nurses were the least willing among all participants to insert their personal views into the discussion (12: −3, 13: −3), because doing so 'is not going to improve the situation and may block the conversation' (ID841) and because 'it's not about me, it's about the person asking the question' (ID842). Possibly because of their willingness to use open-ended exploration of what the requestor was truly seeking they were the least likely to refer it to a colleague to manage (14: −2), but also not likely to advance the request to a resolution.

TABLE 3 Distinguishing response-intentions for Factor B

Rank	Statement No.	Statement Item
'Would say'		
3	11	Discussing this makes me feel complicit in an action that I cannot be involved in
3	31	I can't help you with that question, but what I can do is reassure you that I will do everything I can to support you being as comfortable as possible
2	19	If you are asking because you can't tolerate your pain, I'll let your doctor know so we can find ways to relieve that pain.
2	41	There are many options to control your symptoms and help you to feel better
1	20	I understand that you do not wish to be a burden to your family, but there are ways to achieve that without resorting to assisted-dying.
1	45	Death cannot be reversed. I am convinced that there is a reason to living
1	46	Some people make this statement when they're feeling really 'down'; then when circumstances change, they feel differently.
1	13	I have to be honest, I am not comfortable approaching this topic
'Would not say'		
−1	30	Let's talk about why you are asking me to help you die.
−2	2	We will be here for you no matter what you decide.
−2	16	I can give you some information about legal requirements for accessing an assisted death, but your doctor is likely to be the best person to assist you in deciding.
−2	49	What information do you have about assisted-dying?
−3	4	An assisted death is an option that might be available to you.
−3	5	Everyone has responsibility for their own life, that includes the type and the way in which they die.

TABLE 4 Distinguishing response-intentions for Factor C

Rank	Statement no.	Statement item
'Would say'		
3	2	We will be here for you no matter what you decide.
3	36	What do you not want?
2	33	What does your illness mean to you?
2	39	Can you tell me why you wish your life would end?
1	19	If you are asking because you can't tolerate your pain, I'll let your doctor know so we can find ways to relieve that pain.
'Would not say'		
−1	44	Are you aware of the impact of this procedure on any life insurance you might have?
−2	14	For a lot of reasons, I can't help you with that particular question. You will need to ask one of my colleagues.
−3	12	Because of my own views about assisted-dying, I cannot encourage you to ask that question.
−3	13	I have to be honest, I am not comfortable approaching this topic

3.1.4 | Factor D: Assess needs/provide information

Eight nurses participated in this factor. Here the request would be regarded impartially and would not be overtly addressed nor discouraged, per Table 5. Responses would promote discussion to assess requestor's information and support needs (48: +3, 32: +2).

While not overtly supporting the request, the emphasis in this factor is on ensuring the nurse understands what the requestor knows or needs to know about end-of-life options, 'to assist the person to have the information they need to consider their options' (ID844). This factor is distinct to factor A: Refer and Support, as these responses intend to defer further decisions to an informed patient, without specifically promoting involvement of the medical team. Responding to the request by asking, 'Can you tell me why you wish your life would end?' (statement 39) not only seeks 'to evaluate where the appropriate next support is for the patient' (ID885) but could also assess for suicidality (6: +1). These nurses would not say anything 'that sounds like fear-mongering' (ID877), nor block the conversation and would not interject their personal values into the discussion, 'I do not place personal overlays on my clients, I am an impartial resource' (ID844).

In summary, the results of this mixed-method analysis found elements of meaning in each factor that are distinct in most areas but with some overlap. Table 6, below, displays those relationships from the perspectives of assessment, approach to care and outcome for the requestor as key axes of differentiation.

4 | DISCUSSION

This study identified four factors that represent distinct viewpoints about responding to persons requesting an assisted death. Factor A

TABLE 5 Distinguishing response-intentions for Factor D

Rank	Statement No.	Statement Item
'Would say'		
3	39	Can you tell me why you wish your life would end?
3	40	What do you understand about your end of life care options?
2	32	What do I need to know about you to give you the best care possible?
2	41	There are many options to control your symptoms and help you to feel better
1	6	It seems like you have little hope. Have you found yourself thinking about taking your own life?
'Would not say'		
−1	10	The process for approval for an assisted death may take a long time, maybe more time than you have available
−1	13	I have to be honest, I am not comfortable approaching this topic
−2	5	Everyone has responsibility for their own life, that includes the type and the way in which they die.

(11 Q-sorts) focused on ensuring the treating physician was aware of the request and non-abandonment of the patient. Factor C (8 Q-sorts) focused on therapeutic communication with the patient to ensure the question was clear and motivations were known but did not advance or address the request. Factor D (8 Q-sorts) focused primarily on impartially soliciting information to assess patient needs, but again did not advance the request. The intention to assess for suicidality underpins the preference for neutrality and a level of detachment for an accurate assessment. Factor B (3 Q-sorts) represented a distinctive minority and focused on closing- down the discussion, while recommending palliative measures.

Our results suggest that there are clear differences in how nurses intend to enact their roles in end-of-life care when assisted-dying is requested. Comparing the intentions related to requests for assisted-dying with the typical enactments of nursing roles in end-of-life decision-making can be useful. Regardless of legality, assisted-dying tends to be distinct from usual care planning at end-of-life for ethical reasons related to the intent of the action (Royal College of Nursing, 2016).

In usual end-of-life care, nursing roles have a stronger focus on the triad of patient-family-physician. However, when assisted-dying requests are made, responses shift to a patient-nurse focus (see Figure 2, Adams et al. (2011). The shift of attention toward the patient in the assisted-dying context could be influenced by the requirement that the requestor is competent, as distinct to some end-of-life decisions that can be made on behalf of a patient who can no longer participate in the process. The focus on supporting or advising the patient (as opposed to family or physician) is consistent with international research on challenges to clinicians when presented with a request for assisted-dying (Fujioka, Mirza, McDonald, & Klinger, 2018).

Apart from the difference in the focus of role between the two contexts, there are two other areas of difference. The first difference is the presence of objection to participating in a discussion with a patient who requests access to assisted-dying; this is a nursing response which has no equivalent in usual end-of-life decision-making. The ethical ambiguities in end-of-life interventions are generally resolved in favour of good clinical practice, but this does not extend to participation in assisted-dying. The second difference is in the intention of nurses who would opt to Refer/ Support and relates to the role of advocacy (see Figure 3).

The Refer/Support response does not rise to the level of advocacy as identified in the end-of-life care literature, which is an active initiation of discussion, using 'a voice to speak up' to generate movement toward a care decision (Adams et al., 2011, p. 10). Where the practice of assisted-dying is legal, nursing guidelines for enacting an advocacy role range from promoting nursing involvement in developing practices that enable patient access to the provision of those resources that link the patient to the service they are requesting (Canadian Nurses Association, 2017; Oregon Nurses Association, 1997, 2015). A practical example of advocacy is found in the framework of the University of Toronto's Hospital Network where a nurse, on receiving a request, records it and

TABLE 6 Relationships of the factors to nursing actions[a]

Factor	What is assessed?	Approach to care	Likely outcome for request
A. Refer & Support	Patient readiness	Non-abandonment	Referral to doctor
C. Explore & Engage	Emotional state	Therapeutic alliance	Indeterminate
D. Assess Needs & Provide Information	Support and information needs	Non-judgemental	Indeterminate
B. Object & Deflect	Palliation needs	Comfort	Request is not advanced

[a]Factors arranged by number of Q-sorts loading onto each factor.

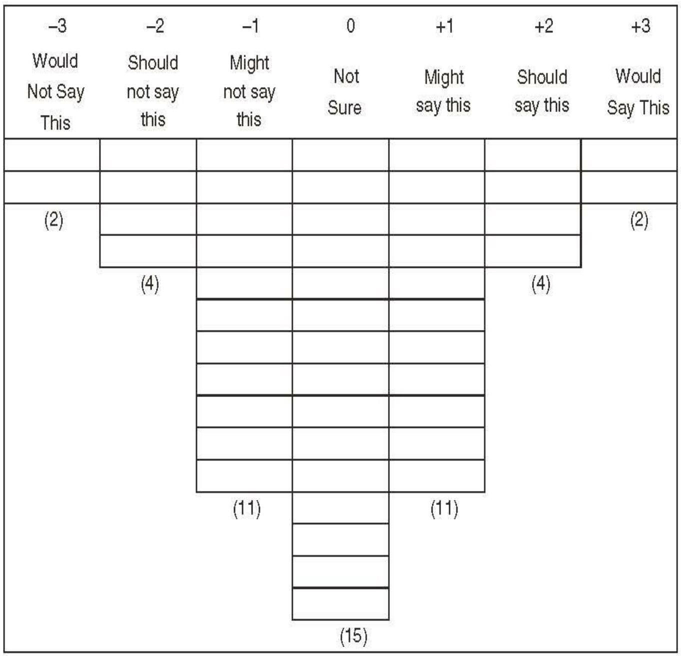
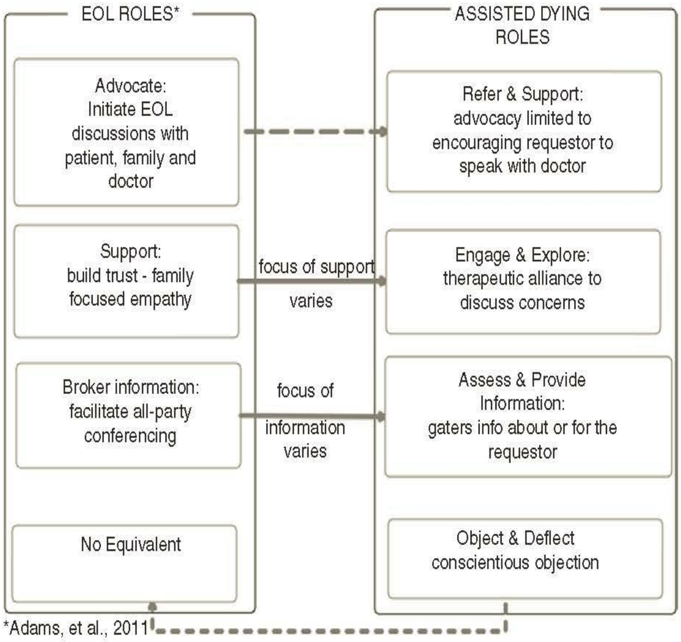


FIGURE 2 Sample Q-sort matrix



*Adams, et al., 2011

FIGURE 3 Comparison of EOL roles and assisted-dying role intentions

transmits it to the team. That act then initiates the processes of counselling, support and information brokerage that can result in a decision whether medical assistance in dying (MAiD) is an option. Until the nurse advocates the request with action everything else is just talk, often in a context where time is running out for the requestor. By way of contrast, in the UK where assisted-dying is not legal, advocacy is not within the scope of a nursing role (Royal College of Nursing, 2016). In the Australian context, it is clear in planned legislation that only referral to a physician would advance the request made by the patient for assisted-dying. Of the four groups of nurses in this study, the largest group (36%) adopted this approach as their intention.

Behavioural theory identifies intentions as a type of cognitive rehearsal for an action and these findings show that the dominant viewpoint in this sample might have begun to rehearse an advocacy role. The value of professional guidance for nurses in this regard is that it can provide a framework for those nurses to construct a script for that rehearsal. Professional guidance on how to advocate within the scope of nursing practice might require professional bodies to shift from a position of 'studied neutrality'. When the profession ends its silence on this issue, nurses might find their own voice (Monteverde, 2017). This study has identified an intention among practising nurses to have a voice in assisted-dying.

4.1 | Limitations

The cultural context of the study might restrict its findings. This study occurred eight months before implementation of assisted-dying legislation in one large (state) jurisdiction in Australia. While widely discussed in the end-of-life care nursing community across Australia, key legal requirements and administrative guidelines had not been widely distributed. The intentions expressed reflect the nurses' preferred actions, but not deep expertise in the new processes and procedures for assisted-dying. The development of the Q-set of sortable statements did not include advocacy for the requestor's access to this legal option and that may have created a 'ceiling effect' for intentionality. Participants did not have the option of intending to initiate a discussion with a patient and no clinical pathways to advance a request were suggested by any of the statements. This might have been appropriate for an Australian sample when the study was conducted, for the reasons just discussed. It would have been less meaningful if the study were conducted among Canadian nurses where there is a tacit expectation for healthcare providers to proactively explain this option (Downie, 2019).

From a technical perspective, Q-studies are most often conducted face-to-face, but the development of web-based platforms have increased the reach of collecting Q-sort data. The efficiency in the reach has come at some cost to the scope. The online format of this design restricted the exploration of the qualitative information collected at the end of the survey. Additionally, each item in the Q-set was presented as a de novo statement initially that had to be 'dragged and dropped' into a category. This feature, an inevitable restriction due to visual display limits of monitors, may have limited the respondent's understanding of that item. Any impact of these limitations was balanced by providing inclusive access to the views of experienced nurses across Australia.

5 | CONCLUSION

Behavioural theory suggests that intentions are subjective, involving cognitive, practical and moral evaluations. Using a method that focuses on the subjective viewpoints of participants, we have elicited nurses' distinctive approaches to requests for assisted-dying. This study has identified four types of nursing responses to requests for assisted-dying. While there are some similarities in informational approaches and patient centred care, the context of assisted-dying appears to trigger conscientious objection. The relatively low level of advocacy within the responses selected also is distinctly different from an established literature on nurse's engagement in end-of-life care.

These findings comprised the first of a two-stage research project and their practical significance might be limited. The second stage will build on these findings to model the influences that shape how nurses choose to respond to these requests. Understanding those influences can then provide evidence for policy, guidance and for developing realistic communication simulations for professional development modules. Together these might enable nurses to formulate responses to help persons at the end of life 'to consider valid alternatives and to open spaces of authentic moral negotiation' (Monteverde, 2017, p. 5).

ACKNOWLEDGEMENTS

Professor Cheri Ostroff and Dr Pam Oliver for critical advice and feedback. Advisory group members, for development of final data set and/or results interpretation: Dr Melissa Bloomer (Australia), Assoc Professor Rebecca Lehto (USA), Assoc Professor Phillpa Malpas (NZ), Laura Sheridan N.P. (Canada), Fran Tomlin, N.P. (Australia), Alison Walsh (Australia).

CONFLICT OF INTERESTS

The authors declare no conflicting or competing interests.

AUTHOR CONTRIBUTIONS

MW, RW, LC, and MW made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. MW, MW, RW, and LC involved in drafting the manuscript or revising it critically for important intellectual content. MW, RW, LC, and MW given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. MW, RW, LC, and MW agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ORCID

Michael R. Wilson https://orcid.org/0000-0002-6732-8508

TWITTER

Michael R. Wilson @mw108adelaide

REFERENCES

Adams, J. A., Bailey, D. E., Anderson, R. A., & Docherty, S. L. (2011). Nursing roles and strategies in end-of-life decision making in acute care: A systematic review of the literature. *Nursing Research and Practice*, *2011*, https://doi.org/10.1155/2011/527834

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl, & J. Beckmann (Eds.), *Action control: From cognition to behavior* (pp. 11–39). Berlin, Hedelberg, New York: Springer-Verlag.

Ajzen, I., & Fishbein, M. (2000). Attitudes and the attitude-behavior relation: Reasoned and automatic processes. *European Review of Social Psychology*, *11*, 1–33. https://doi.org/10.1080/14792779943000116

Akhtar-Danesh, N., Baumann, A., & Cordingley, L. (2008). Q-Methodology in Nursing Research: A Promising Method for the Study of Subjectivity. *Western Journal of Nursing Research*, *30*, 759–773. https://doi.org/10.1177/0193945907312979

Bagozzi, R. P., & Yi, Y. (1989). The degree of intention formation as a moderator of the attitude-behavior relationship. *Social Psychology Quarterly*, *52*(4), 266–279.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelkia, A. P. (2000). SPIKES – a six-step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, *5*, 302–311. https://doi.org/10.1634/theoncologist.5-4-302

Bannigan, K., & Watson, R. (2009). Reliability and validity in a nutshell. *Journal of Clinical Nursing*, *18*, 3237–3243. https://doi.org/10.1111/j.1365-2702.2009.02939.x

Bascom, P. B., & Tolle, S. W. (2002). Responding to requests for physician-assisted suicide: "These are Uncharterd Waters for Both of Us..". *JAMA*, *288*, 91–99. https://doi.org/10.1001/jama.288.1.91

Bloomer, M., Lee, S., & O'Connor, M. (2011). End of life clinician-family communication in ICU: A retrospective observational study - implications for nursing. *Australian Journal of Advanced Nursing*, *28*, 17–23.

Brown, S. R. (1980). *Political subjectivity: Applications of Q methodology in political science*. New Haven: Yale University Press.

van Bruchem-van de Scheur, A., van der Arend, A., van Wijmen, F., Abu-Saad, H. H., & ter Meulen, R. (2008). Dutch nurses' attitudes towards euthanasia and physician-assisted suicide. *Nursing Ethics*, *15*(2), 186–198.

Canadian Nurses Association (2017). *National nursing framework on medical assistance in dying in Canada*. Retrieved December 27, 2017, from https://cna-aiic.ca/~/media/cna/page-content/pdf-en/cna-national-nursing-framework-on-maid.pdf?la=en,.

Downie, J.@jgdownie. [Twitter post] (2019). Thankful that Canadian physicians and nurse practitioners have a duty to inform patients about option of #MAiD. Protection of vulnerable people includes protection from exclusion. #ICEL3. Retrieved March 14, 2019, from https://twitter.com/jgdownie/status/1103686643159126017

Elmore, J., Wright, D. K., & Paradis, M. (2016). Nurses' moral experiences of assisted death: A meta-synthesis of qualitative literature. *Nursing Ethics*, *23*, 1–18. https://doi.org/10.1177/0969733016679468

Emanuel, L. L. (2005). Facing requests for physician-assisted suicide: Toward a practical and principled clinical skill set. *JAMA*, *280*, 643–647. https://doi.org/10.1001/jama.280.7.643

Fujioka, J. K., Mirza, R. M., McDonald, P. L., & Klinger, C. A. (2018). Implementation of medical assistance in dying: A scoping review of health care providers' perspectives. *Journal of Pain and Symptom Management*, *55*, 1564–1576. https://doi.org/10.1016/j.jpainsymman.2018.02.011

Gamondi, C., Borasio, G., Oliver, P., Preston, N., & Payne, S. (2017). Responses to assisted suicide requests: An interview study with Swiss palliative care physicians. *BMJ Supportive and Palliative Care*, *9*, e7. Retrieved from https://doi.org/10.1136/bmjspcare-2016-001291

Godin, G., Bélanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008). Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories. *Implementation Science*, *3*, 36. Retrieved from https://doi.org/10.1186/1748-5908-3-36

Hair, J., Andersen, R., Tatham, R., & Black, W. (1998). *Multivariate data analysis*, Vol. 6. Upper Saddle River, NJ: Pearson.

Hudson, P. L., Schofield, P., Kelly, B., Hudson, R., O'Connor, M., Kristjanson, L. J., ... Aranda, S. (2006). Responding to desire to die statements from patients with advanced disease: Recommendations for health professionals. *Palliative Medicine*, *20*, 703–710. https://doi.org/10.1177/0269216306071814

Johnstone, M.-J. (2012). Organization position statements and the stance of "Studied Neutrality" on Euthanasia in palliative care. *Journal of Pain and Symptom Management*, *44*, 896–907. https://doi.org/10.1016/j.jpainsymman.2011.12.276

Joinson, A. (1999). Social desirability, anonymity and internet-based questionnaires. *Behavior Research Methods, Instruments, & Computers*, *31*, 433–438. https://doi.org/10.3758/BF03200723

Lavoie, M., Godin, G., Vezina-im, L.-A., Blondeau, D., Martineau, I., & Roy, L. (2014). Effect of knowing patients' wishes and health profession on euthanasia. *Journal of Palliative Care & Medicine*, *4*, https://doi.org/10.4172/2165-7386.1000169

Lavoie, M., Godin, G., Vézina-Im, L.-A., Blondeau, D., Martineau, I., & Roy, L. (2015). Psychosocial determinants of physicians' intention to practice euthanasia in palliative care. *BMC Medical Ethics*, *16*, https://doi.org/10.1186/1472-6939-16-6

Lavoie, M., Godin, G., Vezina-im, L., Blondeau, D., Martineau, I., & Roy, L. (2016). Psychosocial determinants of nurses' intention to practise euthanasia in palliative care. *Nursing Ethics*, *23*, 48–60. https://doi.org/10.1177/0969733014557117

Lehto, R., Olsen, D., & Chan, R. R. (2016). When a patient discusses assisted dying: nursing practice implication. *Hospice & Palliative Nursing*, *18*, 184–191. https://doi.org/10.1097/NJH.0000000000000246

Lo, B. (2018). Beyond legalization — Dilemmas physicians confront regarding aid in dying. *New England Journal of Medicine*, *378*, 2060–2062. https://doi.org/10.1056/NEJMp1802218

Monteverde, S. (2017). Editorial: Nursing and assisted dying: Understanding the sounds of silence. *Nursing Ethics*, *24*(1), 3–8. https://doi.org/10.1177/0969733016684967

Ohnsorge, K., Keller, H. R. G., Widdershoven, G. A., & Rehmann-Sutter, C. (2012). 'Ambivalence' at the end of life: How to understand patients' wishes ethically. *Nursing Ethics*, *19*, 629–641. https://doi.org/10.1177/0969733011436206

Oliver, P. (2016). Another week? Another week! I can't take another week' Addressing barriers to effective access to legal assisted dying through legislative, regulatory and other means (Doctoral thesis). Auckland, NZ: University of Auckland.

Oregon Nurses Association (1997). Assisted Suicide: The debate continues. The Oregon Nurse, 62. Retrieved from https://hawaiinursescontinuingeducation.com/wp-content/uploads/2018/03/ONA_AssistedSuicide_2015-06-.pdf

Oregon Nurses Association(2015). Oregon nurses association position statement: assisted suicide. Retrieved from https://cdn.ymaws.com/www.oregonrn.org/resource/resmgr/Docs/ONA-PosState_AsstSuicide.pdf

Quill, T. E., Back, A. L., & Block, S. D. (2016). Responding to patients requesting physician-assisted death: Physician involvement at the very end of life. *JAMA*, *315*, 245–246. https://doi.org/10.1001/jama.2015.16210

Royal College of Nursing (2016). *When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death* (2nd ed). Royal College of Nursing. Retrieved from https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/december/005822.pdf.

Scherrens, A.-L., Beernaert, K., Robijn, L., Deliens, L., Pauwels, N. S., Cohen, J., & Deforche, B. (2018). The use of behavioural theories in end-of-life care research: A systematic review. *Palliative Medicine*, *32*, 1055–1077. https://doi.org/doi/10.1177/0269216318758212

Sheridan, L. (2017). *When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying* (Masters Thesis). University of Western Ontario, Electronic Thesis and Dissertation Repository 5041. Retrieved from https://ir.lib.uwo.ca/etd/5041

Thompson, C., & Baker, R. (2008). In Q methodology in nursing research. R. Watson (Eds.) *Nursing Research: Designs and Methods* (p. 412). China: Elsevier.

Turner, J., Zapart, S., Pedersen, K., Rankin, N., Luxford, K., & Fletcher, J. (2005). Clinical practice guidelines for the psychosocial care of adults with cancer. *Psycho-Oncology*, *14*, 159–173. https://doi.org/10.1002/pon.897

Vézina-Im, L.-A., Lavoie, M., Krol, P., & Olivier-D'Avignon, M. (2014). Motivations of physicians and nurses to practice voluntary euthanasia: A systematic review. *BMC Palliative Care*, *13*(1). https://doi.org/10.1186/1472-684X-13-20

Watts, S., & Stenner, P. (2012). *Doing Q methodological research, theory, method and interpretation*. London: Thousand Oaks. Retrieved from https://books.google.com/books/about/Qualitative_Research_in_Clinical_and_Hea.html?xml:id=mpe7BgAAQBAJ

Wright, D. K., Chirchikova, M., Daniel, V., Blitzas, V., Elmore, J., & Fortin, M.-L. (2017) Engaging with patients who desire death: Interpretation, presence and constraint. *Canadian Oncology Nursing Journal*, *276*, 56–64. https://doi.org/DOI:10.5737/236880762715664

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Wilson MR, Wiechula R, Cusack L, Wilson M. Nurses' intentions to respond to requests for legal assisted-dying: A Q-methodological study. *J Adv Nurs*. 2020;76:642–653. https://doi.org/10.1111/jan.14257

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

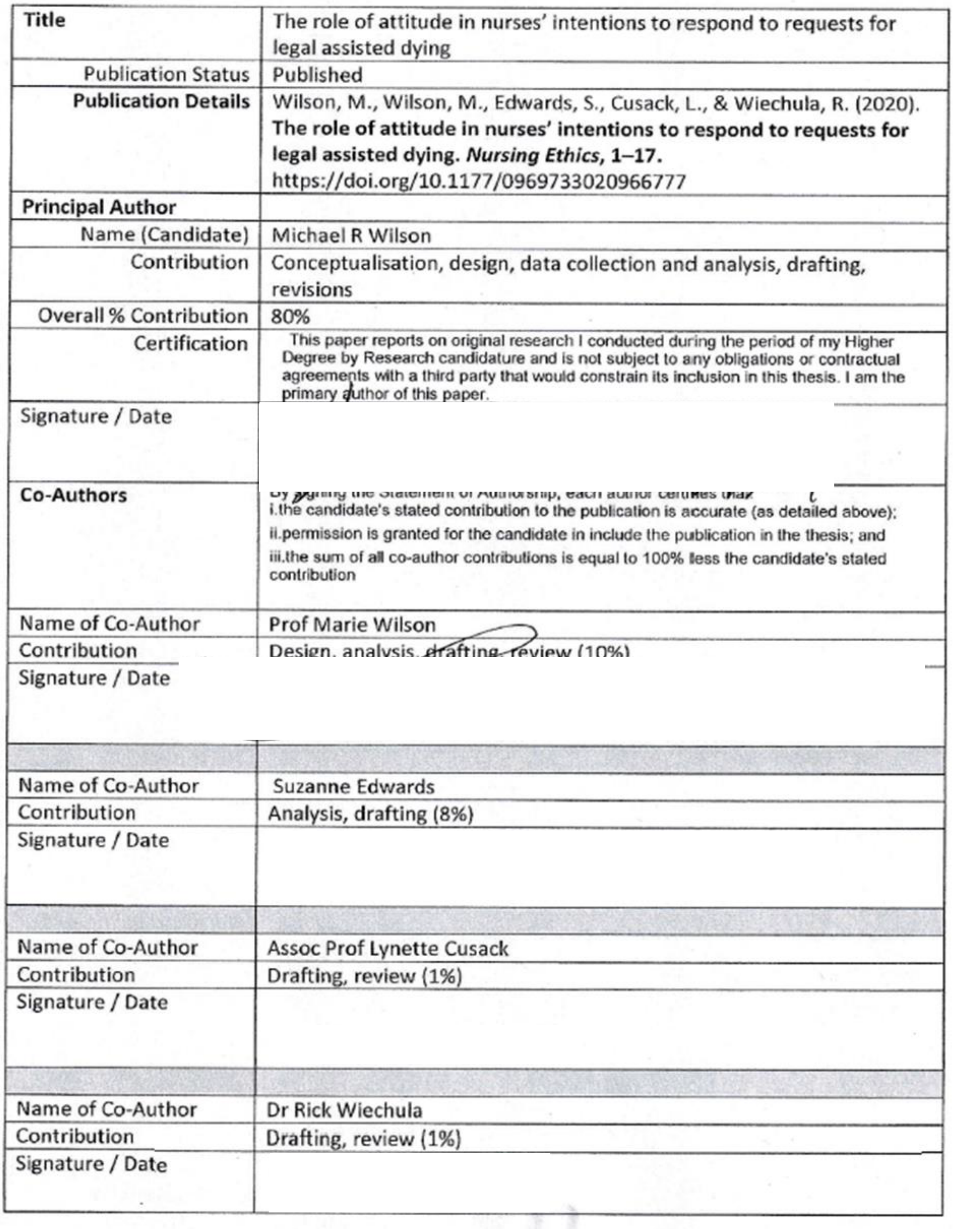
- **High-impact forum:** the world's most cited nursing journal, with an Impact Factor of 1·998 – ranked 12/114 in the 2016 ISI Journal Citation Reports © (Nursing (Social Science)).
- **Most read nursing journal in the world:** over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 3,500 in developing countries with free or low cost access).
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).

Chapter Five: The role of attitude in nurses’ intentions to respond to requests for legal assisted dying

This chapter consists of the following manuscript:

Wilson, M., Wilson, M., Edwards, S., Cusack, L., & Wiechula, R. (2020b). The role of attitude in nurses’ intentions to respond to requests for legal assisted dying. *Nursing Ethics*, *28*(5), 670–686. https://doi.org/10.1177/0969733020966777

Statement of Authorship



Title	The role of attitude in nurses' intentions to respond to requests for legal assisted dying
Publication Status	Published
Publication Details	Wilson, M., Wilson, M., Edwards, S., Cusack, L., & Wiechula, R. (2020). **The role of attitude in nurses' intentions to respond to requests for legal assisted dying. *Nursing Ethics*, 1–17.** https://doi.org/10.1177/0969733020966777
Principal Author	
Name (Candidate)	Michael R Wilson
Contribution	Conceptualisation, design, data collection and analysis, drafting, revisions
Overall % Contribution	80%
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature / Date	
Co-Authors	By signing the Statement of Authorship, each author certifies that: i.the candidate's stated contribution to the publication is accurate (as detailed above); ii.permission is granted for the candidate in include the publication in the thesis; and iii.the sum of all co-author contributions is equal to 100% less the candidate's stated contribution
Name of Co-Author	Prof Marie Wilson
Contribution	Design, analysis, drafting, review (10%)
Signature / Date	
Name of Co-Author	Suzanne Edwards
Contribution	Analysis, drafting (8%)
Signature / Date	
Name of Co-Author	Assoc Prof Lynette Cusack
Contribution	Drafting, review (1%)
Signature / Date	
Name of Co-Author	Dr Rick Wiechula
Contribution	Drafting, review (1%)
Signature / Date	

Original Manuscript

Nursing Ethics
1–17
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
10.1177/0969733020966777
journals.sagepub.com/home/nej
SAGE

Role of attitude in nurses' responses to requests for assisted dying

Michael Wilson
The University of Adelaide, Australia

Marie Wilson
University of South Australia, Australia

Suzanne Edwards, Lynette Cusack and Richard Wiechula
The University of Adelaide, Australia

Abstract

Background: Legal assisted dying is a rare event, but as legalisation expands, requests for it will likely increase, and the nurse most often receives the informal, initial request.

Objectives: To assess the effects of attitude in interaction with normative and control beliefs on an intention to respond to a request for legal assisted dying.

Ethical considerations: The study had the lead author's institutional ethics approval, and participants were informed that participation was both anonymous and voluntary.

Methodology: This was a cross-sectional correlational study of 377 Australian registered nurses who completed an online survey. Generalised linear modelling assessed the effects of independent variables against intended responses to requests for legal assisted dying.

Results: Compared to nurses who did not support legal assisted dying, nurses who did had stronger beliefs in patient rights, perceived social expectations to refer the request and stronger control in that intention. Nurses who did not support legal assisted dying had stronger beliefs in ethics of duty to the patient and often held dual intentions to discuss the request with the patient but also held an intention to deflect the request to consideration of alternatives.

Discussion: This study advances the international literature by developing quantified models explaining the complexity of nurses' experiences with requests for an assisted death. Attitude was operationalised in interaction with other beliefs and was identified as the strongest influence on intentions, but significantly moderated by ethical norms.

Conclusion: The complex of determinants of those intentions to respond to requests for an assisted death suggests they are not isolated from each other. Nurses might have distinct intentions, but they can also hold multiple intentions even when they prioritise one. These findings present opportunities to prepare nurses in a way that enhances moral resilience in the face of complex moral encounters.

Keywords

Assisted dying, attitude, clinical ethics, nurses, theory of planned behaviour (TPB)

Corresponding author: Michael Wilson, Level 4, Adelaide Health & Medical Sciences Building, Cnr North Terrace & George Street, Adelaide, South Australia 5000, Australia.
Email: michael.r.wilson@adelaide.edu.au

Introduction

Choices in end-of-life care are expanding internationally, from advanced directives that specify the patient's preferred and excluded measures to prolong life, to include medical interventions that cause death. In the past 15 years, the number of jurisdictions that regulate assisted dying[i] has more than doubled to 19. Australia has been active in legislating for medically assisted dying for over two decades, having been the first nation to legalise euthanasia (albeit briefly) in 1994. Six of eight states and territories in Australia have previously or currently proposed legislation, and two states now regulate assisted dying.

Australian nurses have historically shown support for legal assisted dying. Some of the earliest research into nurses' attitudes towards assisted dying occurred in Australia and showed strong nursing support for its legalisation, at rates as high as 75% in 1993.[1,2] Australian nursing associations had begun to support access to legal assisted dying since 2016.[3,4] The momentum of legislation across Australia for legalisation of assisted dying and increasing awareness through the public debate that accompanies legislative action suggest it is likely that Australian nurses will be presented with more requests for access to assisted dying, and more frequently, than in the past.

Australian legislation permitting access to assisted dying prohibits healthcare professionals from initiating a discussion about assisted dying,[5] but professional guidance is clear that any role includes a response to the initial, informal, request relating to assisted dying.[4,6] Understanding how nurses intend to respond is important for two reasons: First, the response can have an implicit gatekeeping effect on a patient's outcome, sometimes at a point in an illness where time is critical;[7] second, responding to a request can generate moral distress if nurses feel they cannot act in ways that are personally morally appropriate.[8]

This study seeks to clarify two important questions in relation to the nurse's response to such a request: what response does the nurse intend, and can differences in intended responses be explained by the nurse's attitudes and beliefs? The significance of this research is that it explores a nuanced understanding of how – and why – nurses may respond in situations that are relatively rare, often private and that can impact the nurse–patient relationship. For the patient, the request for assisted dying may be both urgent and profoundly difficult to make; for the nurse, it can be difficult to answer in a busy environment where the nurse may be unprepared on a number of levels.[7,9]

Background

The role of the nurse as an information broker between patient, physician and family in most end-of-life decisions[10,11] may be challenged when a patient requests access to assisted dying. Nurses may respond to such requests about assisted dying in various ways. Canadian and Australian research has identified distinct types of nurses' responses as an information broker that includes directly aiding the request for assisted dying by escalating it to the medical team, delaying the request by withdrawing from the discussion or responding in a way that neither advances nor impedes the request.[12,13]

This study examines assisted dying as a healthcare situation that is complex and is not a matter of saying: 'yes' or 'no' to undertake a certain action. A request for assisted dying elicits a broader range of responses by nurses which, at the extremes, includes full support or objection, as well as other options that may result in barriers for requestors.

The trajectory of research on nurses' overall participation in assisted dying has posited attitude as a primary determinant of involvement.[14] Attitude is often expressed as an agreement with or willingness to participate in legal assisted dying and is usually described in relation to demographic features.[15,16] A systematic review of studies of nurses' motivations to participate in some form of assisted dying showed that willingness was often a function of clinical speciality, previous experience with assisted dying and the patient's condition or prognosis.[17] Other studies have shown that religious beliefs also shape attitude towards assisted dying.[18,19] While attitude seems to be a necessary condition for a decision regarding assisted dying, it is not always sufficient. Even a supportive attitude does not fully explain the degree of willingness to participate in differing processes related to assisted dying. For example, New Zealand nurses who supported legal assisted dying would perform information-sharing activities more so than advanced clinical procedures (e.g. cannulation or equipment setup).[20] The gradient of willingness suggests that other factors might explain intentions and reinforces the importance of looking at both what responses are intended and the profile of the nurse in a more nuanced way.

Recent research has begun to explore the interaction of psychosocial variables that may have more influence on intentions to participate in assisted dying than demographic factors. A review of studies of clinicians' behaviour in facilitating end-of-life planning with patients, including assisted dying, identified that various behavioural theories have guided research. The most frequently used framework is the Theory of Planned Behaviour (TPB).[21] Dozens of studies have used TPB to explain the variance in healthcare-related behaviours.[22] TPB's effectiveness comes in part from identifying intention as the proximate predictor of behaviour, where intention mediates three belief-based constructs of attitude, social expectations (subjective norms) and perceived control over an intended behaviour.[23]

While TPB has not yet been used extensively in assisted dying–related research, this framework guided the study by Lavoie et al.[24] of intentions of palliative care nurses in Québec to participate in 'an act of euthanasia' (p. 48), in the period leading to its legalisation in that province. That study expanded TPB to include the role of moral norms as an additional explanatory variable for intentions. In the TPB literature, moral norms are constructed as personal convictions about the rightness or wrongness of an action without regard to results.[25]

This study expanded on the TPB model by including bioethical norms in addition to the core TPB constructs of attitude, subjective norms and perceived behavioural control (PBC). Extending the TPB model to include ethical norms has been shown to enhance its explanatory power when the question at hand has a strong moral or ethical component.[25,26]

This study also included two sociodemographic factors: experience and religious affiliation which have been a focus in earlier assisted dying research.[17] Previous experience with similar requests might prepare nurses to be more accepting of these requests. The influence of religion, particularly in cultures with majority or state religions, for example,[18,27] has featured prominently in studies of attitude towards assisted dying across Western and non-Western cultures, despite criticisms of simplistic or ambiguous measurement.[19] Given the impact of bioethical norms in the study by Lavoie et al. and the use of religious affiliation in numerous studies of nursing attitude to assisted dying, religious affiliation was included, acknowledging that this is a demographic feature and does not measure the impact that affiliation has on daily moral decision-making.

Aim

This study assessed the contribution of nurses' attitudes towards an intention to respond to a request for a legal assisted death in interaction with moderating influences of normative, control and ethical beliefs.

Method

The design of the research was a cross-sectional correlational study.

Sample

The study recruited Australian nurses through invitations to complete an anonymous online survey advertised to members of Australian nursing professional associations. Inclusion criteria were the following: (1)

nurse registered with the Nursing and Midwifery Board of Australia, and (2) primary work setting is with adult clients or patients. The survey attracted 470 respondents. Excluded respondents were non-nursing professionals (n = 40), nurses who did not work with adult clients (n = 14) and those who exceeded 25% of items in their missing response rate (n = 39). A sample of 377 nurses was retained for analysis. The rate of missing responses from retained cases did not exceed 4%.

Ethical considerations

The study was approved by the lead author's institutional Human Research Ethics Committee (ref: HREC 2018-234), which subscribes to the Helsinki Declaration. Participants were advised in the participant information sheet that participation was voluntary and anonymous.

Instrumentation

The questionnaire contained 53 items and was administered from July to December 2019. The participant information sheet with the questionnaire defined assisted dying as follows: '… the provision or administration of a lethal substance to an adult, competent person with an illness that makes their death reasonably foreseeable, at that person's own request, and where all legal requirements have been met'.[ii]

The survey included 16 questions regarding the nurse's intended responses to a request for assisted dying. Participants were asked to indicate their intended responses by referring to the following brief scenario: 'Assume that voluntary, medically assisted dying is legal where you practice nursing. You have developed a rapport with an adult patient who has an illness with a terminal diagnosis. Today this patient asks you, for the first time, for your help to access medical assistance to die'.

Participants were also asked to respond to 10 questions on demographic and professional profile (e.g. gender and years of experience) and 25 questions regarding attitude and beliefs. One question assessed the single most personally important response type.

With the exception of demographic information, and one categorical intention question, all items were measured with a 5-point Likert-type scale (e.g. strongly agree/somewhat agree/neither disagree nor agree/somewhat disagree/strongly disagree). Measures of attitude, subjective norms and PBC were refined using a panel of seven advanced practice nurses working in end-of-life care settings across Australia to adapt the language of existing scales, following standard guidelines for designing TPB-based instruments.[29] For example, a question on subjective norms would ask about the expectations of a 'significant other', but the responses elicited from this expert group included 'colleagues' as the significant other, and the question was adapted to that stem.

Psychometric properties of the scales were assessed through a pilot study of the survey items. Forty-five US nurses, sourced through the Amazon Mechanical Turk service[iii] from their healthcare professionals database, completed the pilot survey. All items demonstrated acceptable internal consistency (measured by Cronbach's alpha) at .78 and higher.

Table 1 reflects the construction and reliability testing (Cronbach's alpha) for the variables of interest.

The instrument was validated in several ways. The dependent variables (for intention) were drawn from a previous study that established a range of Australian nursing responses to a request for assisted dying.[13] Responses to questions relating to the dependent variables in this study also displayed concurrent validity with a triangulation measure of singular intention. The contextual language of the predictor variables was refined through interviews with an expert panel. This followed the standard protocol for developing items related to TPB-based questionnaires, with further pilot testing for internal consistency of measures. Correlational analysis also provided additional check measures of convergent and divergent validity between measures.

Table 1. Instrumentation.

	Variable of interest	Items	Source	Sample item	Treatment	Cronbach's α
Dependent variables: Response type	REFER to the treating physician	4	Wilson et al.[13]	'Have you been able to discuss this with the doctor who is most involved in your care?'	Summed, averaged	.65
	DISCUSS the request with the patient	8	Wilson et al.[13]	'Can you tell me why you wish your life would end?'	Summed, averaged	.78
	DEFLECT the request to alternatives	4	Wilson et al.[13]	'If you are asking because you can't tolerate your pain, I'll let your doctor know so we can find ways to relieve that pain'	Summed, averaged	.63
	Primary intended response	5	n/a	Set of options reflecting the range of intended responses; respondent selects the one item most likely to be performed (triangulation item)	n/a	n/a
Independent variables	Attitude (ATT)	3	Lavoie et al.[24] Howe and Krosnick[30] Oliver[7]	'I believe that voluntary assisted dying should be legal in the state/jurisdiction where I work' 'I would choose legal AD as an option for my end of life care'	Summed, averaged	.93
	Rights norm (RN)	3	Quaghebeur et al.[31] Torres-Harding et al.[32]	'This patient should be able to define solutions to their problems' (autonomy item) 'This patient has a right to make decisions in own best interests' (justice item)	Summed, averaged	.83
	Duty norm (DN)	2	Gorsuch[33]	'I would help this patient to find ways to live as well as possible instead of seeking assisted dying' (beneficence item)	Summed, averaged	.66
	Subjective norms (SN)	8	Adapted from Francis et al.[29] for the assisted dying context	'My professional colleagues would expect me to help this patient to access legal assisted dying' (injunctive item) 'How important to you are the views of your colleagues about assisted dying?' (compliance item)	Scales (injunctive and compliance); summed, multiplied and averaged	Injunctive scale = .81; Compliance scale = .72
	Perceived behavioural control (PBC)	4	Adapted from Francis et al.[29] for the assisted dying context	'Overall, how I respond to this request would be up to me' (self-efficacy item)	Scales (self-efficacy and barriers) summed, multiplied and averaged	Self-efficacy scale = .66; Barriers scale = 72
Socio-cultural	Religious Affiliation	1	n/a	'Do you identify with a religious or faith community?'	Yes / No	
	Previous experience with similar request	1	n/a	'In your professional nursing practice has a patient asked you to help them to die?'	Yes / No; if yes, how many times?	n/a

AD: assisted dying.

Measures

Intention. This study drew 16 intended responses from a recent Q-method study among Australian nurses.[11] These items presented possible responses along a gradient from referring the request to the treating physician, to objecting to the request, to having discussing the request in a variety of ways. For each statement, the nurse indicated that a suggested response is something 'I would say' (1) to 'I would not say' (5).

The researchers used confirmatory factor analysis to establish typologies of intention: Refer, Discuss and Deflect. Consistent with the more unitary approach of TPB, the analytical plan also included a weighted composite variable, Enactment, which gave lower weightings (1) to referral-linked behaviours and higher weightings (5) to responses that blocked referral, including deflection to palliation and objection to the request.

In addition, the survey asked which 'one action' the nurse felt personally obligated to perform in response to this hypothetical request: (1) Refer, either directly or by supporting the patient to self-refer; (2) Discuss, either through assessing needs or exploring motivation; or (3) Deflect, by recommending enhanced palliation instead of seeking an assisted death. These options were added as a check on concurrent validity.

Attitude. Two questions asked about the general acceptability of legal assisted dying and whether the hypothesised patient should have access to that service. The third item assessed the strength of the attitude with a measure of personal importance[30] of assisted dying, asking whether the respondent would consider an assisted death as an option for their own end-of-life care.

Subjective norms. The study measured subjective norms in relation to beliefs about the expectations of significant others to assist this (hypothesised) patient, using the standard TPB approach.[29] Interviews of advanced practice nurses that elicited the measures identified significant others as (1) one's own family, (2) work colleagues, (3) employer and (4) professional associations. Four items assessed whether or not the respondent believed the significant other would expect them to help this patient access an assisted death.

PBC. The study measured PBC with four items derived from the standard TPB survey structure,[29] adapted to an assisted dying request: two questions assessed the respondents' sense of self-efficacy, and two questions assessed the perception of barriers to performance.

Ethical norms. Eight items were developed to assess the four ethical principles common to healthcare (beneficence, non-maleficence, personal autonomy, justice) in the context of assisted dying.

Using survey data, exploratory factor analysis identified two distinct bioethical factors across five of the original eight items. One construct combined patient autonomy with two items on justice. This factor was labelled 'rights norm'. The other construct had one item measuring beneficence and one for non-maleficence and was labelled 'duty norm'. This result was consistent with Snelling's research that identified attitudes towards euthanasia centred around norms of autonomy and beneficence/non-maleficence.[34]

Analysis

Prior to analysis, the researchers inspected the variables for multicollinearity, homoscedasticity and normality of distributions. SPSS' generalised linear model function analysed the relationships of intentions and other variables (SPSS version 26; IBM SPSS, NY). The researchers found their assumptions of a linear model were upheld by inspection of histograms and scatter plots of residuals and predicted values.

The confirmatory factor analysis of the 16 intention items (dependent variables) was constrained to a three-factor solution. Two decision rules were used for factor extraction: first, variables should yield an eigenvalue >1, indicating that a factor explained more variance than a single item; second, using the Rotated Factor Pattern results, items loading at >0.50 on one factor and <0.40 on all others were considered for inclusion. The three extracted factors comprised items that related to three distinct types of response. These were (1) *Refer the request* to the treating physician; (2) *Discuss the request* with the patient; and (3) *Deflect the request* towards symptom control.

Concurrent validity assessment found a significant correlation between two different sets of items measuring intended responses. The proportion of nurses who reported a sense of obligation to Refer the request did not differ from their responses to the Refer intention items, $\chi^2\,(2, N = 204) = 42.95, p < .0001$. Similar relationships were found for the Discuss variable, $\chi^2(2, N = 144) = 8.023, p = .018$, and the Deflect variable, $\chi^2(2, N = 5) = 7.56, p = .023$. This provided additional assurance of the robustness of the intention measures.

The distribution of data and the research on nurses' attitudes supported the decision to dichotomise the attitude variable between those who agreed or strongly agreed with legal assisted dying (a summed score of ratings of 1 or 2 across the items), labelled 'positive' attitude, and those who were neutral or disagreed (a summed score of ratings of 3, 4, or 5), labelled 'neutral or negative' attitude. It should be noted again that lower scores indicated higher agreement.

Results

Data from this study are publicly available under a Creative Commons licence.[35]

Sample

Table 2 presents the respondents' characteristics. Relevant findings are as follows: most nurses had previous experience with similar requests, even though assisted dying at the time of the study had not been legalised. Consistent with the finding of a 2002 survey,[36] most Australian nurses were secular, claiming no religious affiliation (n = 243, 65%). Most nurses agreed in principle with legalised assisted dying (n = 309, 83%), while 4% (n = 17) were not sure and 14% (n = 58) disagreed with legal assisted dying.

Table 3 presents the range of scores, mean scores and standard deviations for variables of interest.

Most independent variables correlated significantly with intentions to Refer and Deflect, while intention to Discuss correlated less well with psychosocial variables. The Duty norm correlated negatively with the Refer intention but positively with Discuss and Deflect intentions. Table 4 presents the correlation matrix of variables of interest.

Dependent variables

Before conducting the generalised linear model analyses, the researchers computed a new variable to encompass the range of the three already identified intentions (Refer, Discuss and Deflect). This new continuous variable labelled 'Enablement' was defined as the range of responses that served to enable the patient's request from full support in referral to an intention not to advance the request. This variable was proposed to make the analysis consistent with most studies using TPB, where the dependent variable is a single construct.

Table 5 presents the generalised linear models of intention to respond. Where interactions were not significant, the table presents the results of the main effects model. The estimates, 95% confidence interval and p values are listed along with brief interpretative notes.

Table 2. Sample characteristics.

Measure	Frequency	%
Gender (n = 369)		
Female	335	91
Male	33	9
Other	1	.2
Total %	–	99
Experience (years) (n = 371)		
<11	108	29
11–20	60	16
21–30	76	20
>30	127	34
Total %	–	99
Clinical setting (n = 372)		
Freq EOL care[a]	137	36
Tertiary care	131	36
Community	38	10
Other[b]	66	18
Total %	–	100
Religious affiliation (n = 373)		
No affiliation	243	65
Affiliated	130	35
Total %	–	100
Previous experience with a similar request (n = 373)		
None	111	30
<10 times	188	50
>10 times	74	20
Total %	–	100

ICU: intensive care unit; EOL: end of life.

Totals other than 100% due to rounding.

[a] Freq EOL care settings: ICU, Oncology, Palliative, Aged care.

[b] Other settings include education, research and management.

Table 3. Score ranges, means and standard deviations of variables.

Variable	Range[a]	M	SD
Intention: Refer	1–5	1.36	0.532
Intention: Discuss	1–5	1.87	0.683
Intention: Deflect	1–5	2.85	0.754
Attitude	1–15	5.18	3.39
Subjective norms	1–40	7.06	3.77
PBC	1–20	5.42	4.69
Rights norm	1–15	1.39	0.490
Duty norm	1–10	3.28	1.127

SD: standard deviation; PBC: perceived behavioural control.

[a] Lower scores indicate higher agreement.

Table 4. Inter-correlations (Pearson's r) for the study variables (n = 373).

	Attitude	Rights norm	Duty norm	Subjective norms	PBC	Enablement intention	Refer intention	Discuss intention	Deflect intention
Attitude	1	.489**	−.556**	.288**	.529**	.014	.384**	−.003	−.241**
Rights norm	–	1	−.255**	.246**	.374**	.08	.350**	.097	−.183**
Duty norm	–	–	1	−.106*	−.372**	.299**	−.188**	.232**	.495**
Subjective norms	–	–	–	1	.262**	.142**	.264**	.143**	−.045
PBC	–	–	–	–	1	.047	.336**	.068	−.207**
Enablement	–	–	–	–	–	1	.551**	.824**	.775**
Refer	–	–	–	–	–	–	1	.291**	.085
Discuss	–	–	–	–	–	–	–	1	.464**
Deflect	–	–	–	–	–	–	–	–	1

PBC: perceived behavioural control.
*Correlation is significant at the .05 level (two-tailed); **Correlation is significant at the .01 level (two-tailed).

Intention to enable the request. Positive attitude towards assisted dying supported the aggregated intention to enable the request. Subjective norms were a weak but statistically significant contributor to the intention to enable (estimate = .019; p = .005). However, for nurses with a neutral or negative attitude, duty norms reduced nurse intention to enable the request (p < .0001).

Intention to Refer the request. The intention to Refer the request is explained by the interaction of attitude with rights norms and PBC. Compared to nurses with a positive attitude, those with a neutral or negative attitude have a stronger relationship between an intention to Refer and rights norm (p = .001) as well as PBC (p < .0001). However, where attitude is positive, and there is a stronger agreement with duty norm (p < .0001), there is a slightly increased intention to Refer the request. Those with a positive attitude who might intend to Refer are more influenced by subjective norms than those with a neutral or negative attitude. While statistically significant, subjective norms have a weak impact on intention to Refer (estimate = .049; p = .001).

Intention to Discuss the request. The intention to Discuss the request with the patient is not explained by the interaction between attitude and duty norm, and a main effects model has greater explanatory power. There is a statistically significant association between discuss and attitude, controlling for duty norm (p < .0001). Nurses with neutral or neutral or negative attitude are less likely to Discuss the request with the patient than nurses with positive attitude. In addition, there is a significant statistical association between intention to Discuss and duty norm scores, controlling for attitude (p = .003). However, for nurses with a neutral or negative attitude, there is a weak but significant relationship between rights norm and intention to Discuss (p = .024), where the lower the agreement with the rights norm value, the lower the agreement that nurses indicate with an intention to Discuss the request. Controlling for attitude, dubjective norms have a weak, but statistically significant effect, reducing the intention to Discuss (estimate = .026; p = .006). PBC has no significant effect on the intention to Discuss the request.

Intention to Deflect the request. The intention to Deflect the request is explained primarily by a highly significant interaction of attitude and ethical norms (rights norm: p = .001 and duty norm: p < .0001). Nurses with a neutral or negative attitude agree more with an intention to Deflect the request away from assisted dying and have the intention reduced as agreement with duty norm increases, compared to those

Table 5. Generalised linear model of intentions to respond, by attitude.

Intended response	Interaction with attitude (ATT)	Comparison	Estimate (95% CI)	p value	Interpretation
ENABLEMENT	Duty norm (DN)	Neutral or negative (N/N) ATT vs positive (Pos)	1.623 (1.122, 2.124)	<.0001	The association between Enablement and DN is stronger in nurses with N/N ATT than in those with a Pos ATT.
	Subjective norms (SN)	N/N ATT vs Pos SN	0.031 (–0.162, 0.099)	.639 *ns*	There is no significant interaction (*ns*) between ATT and SN, but there is a significant association between Enablement and SN, adjusting for ATT.
	Main effects only		0.019 (0.006, 0.032)	.005	
REFER request to the medical team	Rights norm (RN)	N/N ATT vs Pos	0.396 (0.164, 0.629)	.001	The association between intention to Refer and RN is stronger in those with an N/N attitude than in those with a Pos attitude.
Refer (cont'd)	DN	N/N ATT vs Pos	–0.269 (–0.404, –0.135)	<.0001	The association between intention to Refer and DN is stronger in those with a Pos attitude than in those with an N/N attitude.
	SN	N/N ATT vs Pos	0.049 (0.019, 0.078)	.001	The association between intention to Refer and SN is slightly stronger in those with an N/N attitude than in those with a Pos attitude.
	Perceived behavioural control (PBC)	N/N ATT vs Pos	0.408 (0.271, 0.545)	<.0001	The association between intention to Refer and PBC is stronger in those with an N/N attitude than in those with a Pos attitude.

(continued)

Table 5. (continued)

Intended response	Interaction with attitude (ATT)	Comparison	Estimate (95% CI)	p value	Interpretation
DISCUSS request with the patient Discuss (cont'd)	RN	N/N ATT vs Pos	0.069 (−0.280, −0.141)	.518 *ns*	Controlling for ATT, for every 1 unit increase away from agreement with RN, the intention to not Discuss increases by 0.255 units. The higher the RN score, the less likely to Discuss.
	Main effects only	RN	0.255 (0.034, 0.475)	.024	
	DN	N/N ATT vs Pos	0.307 (0.105, 0.508)	.003	Controlling for DN, those with N/N ATT are 0.307 units more likely to not discuss than those with pos ATT. Controlling for ATT, for every 1 unit increase away from agreement with DN, intention to not Discuss increases by 0.190 units.
	Main effects only	DN	0.190 (0.122, 0.257)	<.0001	
	SN	N/N ATT vs Pos	1.670 (1.438, 1.902)	<.0001	Controlling for ATT, as SN score increases (less importance attached to others' expectations), the more likely it is to not Discuss. ATT has a significant effect on intention to not discuss, controlling for SN. Those with N/N ATT are more likely to not Discuss than those with positive ATT.
	Main effects	SN	0.026 (0.008, 0.045)	.006	
	PBC	N/N ATT vs Pos	−0.270 (−0.422, −0.177)	.001	Adjusting for PBC, those with N/N ATT have lower mean Discuss score (more likely to discuss) than those with a Pos ATT.
	Main effects only	PBC	0.011 (−0.006, 0.027)	.210 *ns*	
DEFLECT the request	RN	N/N ATT vs Pos	−0.270 (−0.422, −0.117)	.001	Those with N/N ATT have a weaker association between Deflect and RN than those with a Pos ATT.
	DN	N/N ATT vs Pos	0.365 (0.255, 0.475)	<.0001	Those with N/N ATT have a stronger association between Deflect and DN than those with a Pos ATT.
	SN	N/N ATT vs Pos	−0.029 (−0.053, −0.006)	.013	Those with N/N ATT have a weaker association between Deflect and SN than those with a Pos ATT.
	PBC	N/N ATT vs Pos	−0.037 (−0.053, −0.020)	<.0001	Those with N/N ATT have a weaker association between Deflect and PBC than those with a Pos ATT.

CI: confidence interval.

with a positive attitude. The opposite applies to agreement with rights norm. In comparison to those with a positive attitude, nurses with a neutral or negative attitude may experience a slightly weaker but significant impact of PBC in this situation (estimate = .037; $p < .0001$). Subjective norms have a marginal interaction with attitude in explaining nurses' intentions to Deflect the request ($p = .013$).

Effects of previous experience and religious affiliation

Table 6 presents the generalised linear models adjusting for effects of previous experience with similar requests and religious affiliation. Neither previous experience nor religious affiliation has any effects on an intention to Refer the request. The intention to Discuss the request is significantly associated with neither attitude nor previous experience in the same model. However, there is a significant interaction between attitude and religious affiliation for the mean Discuss score. For nurses with a neutral or negative attitude, those who did not indicate a religious affiliation are less likely to intend to Discuss the request than those who indicated a religious affiliation.

The intention to Deflect the request has no direct or interaction effects with previous experience. However, religious affiliation has a significant interaction with attitude for intention to Deflect the request. For nurses with a religious affiliation, those with a neutral or negative attitude are more likely to intend to Deflect the request than those with a positive attitude.

Discussion

The purpose of this article is to present a study that assessed the contribution of nurses' attitudes towards an intention to respond to a request for a legal assisted death in interaction with moderating influences of normative, control and ethical beliefs. This study has identified a typology of intended responses that are qualitatively and statistically distinct.[12,13] However distinct these response intentions are, they are not necessarily exclusive. Nurses often have complex and overlapping intentions for responding to requests for assisted dying, including those who intend to Refer the request.

The majority of Australian nurse participants have a positive attitude towards legal assisted dying judged by their in-principle agreement with it. That agreement is closely associated with an intention to enable a request for assisted dying, with most nurses agreeing that they would Refer the request to the physician or support the patient to do so. However, even those with lower levels of agreement with legal assisted dying are still likely to Refer the request depending on their ethical beliefs, and to a lesser extent, their affiliation with a religion. Regardless of whether the nurse refers the request to the treating physician willingly or ambivalently, referral is a basic professional expectation of a nurse who receives a request of this type.

The critical issue is the impact on the outcome for the patient in a time-limited situation, and the moral burden[37] for the nurse when an intention to Refer competes with intentions to Discuss and/or Deflect. This study took a nuanced view of intentions and found that they had unique relationships with attitude and ethical beliefs.

Consistent with most TPB-based studies, this research found that attitude was a primary driver of intention and measurable on a single scale.[38] Most nurses agreed with legal assisted dying, as would be expected, given the long history of support for legal assisted dying among Australian nurses. Despite a positive attitude, intentions varied, suggesting that ambiguity in intention did not derive from ambivalence in attitude, but rather from its interaction with other psychosocial influences.

The TPB literature posits that attitude is moderated by subjective norms and PBC. Consistent with most TPB-based studies, subjective norms interacted weakly with attitude in this study.[39] The dominance of attitude and the weakness of social expectations in this sample contrast with the findings of the Québec

Table 6. Linear regression models adjusted for previous experience and religious affiliation with attitude.

Response intention	Predictor/interaction term	Comparison	Estimate (95% CI)	p value	Interpretation
the request to the doctor	Previous experience (PE)	No PE vs PE	0.034 (−0.080, 0.147)	.561	Controlling for PE, those with an N/N ATT have a significantly higher mean Refer score than those with a positive ATT (less likely to refer).
	Attitude (ATT)	Neutral or negative (N/N) ATT vs Positive (Pos)	0.404 (0.267, 0.541)	<.0001	
	Religious affiliation (REL)	No affiliation vs affiliated	−0.050 (−0.163, 0.163)	.386	Controlling for claimed REL, those with an N/N ATT have a significantly higher mean Refer score (less likely to refer) than those with a positive attitude.
	ATT	N/N ATT vs Pos	0.390 (0.248, 0.533)	<.0001	–
DISCUSS the request with the patient	PE	No PE vs PE	0.08 (−0.07, 0.23)	.285	There is no significant association between the mean Discuss score and ATT or PE, controlling for each other.
	ATT	N/N ATT vs Pos	0.02 (−0.16, 0.21)	.791	–
	REL* ATT	N/N ATT: No affiliation vs affiliated	0.38 (0.04, 0.73)	.030	There is a significant interaction between REL and ATT for the mean Discuss score. For those with an N/N ATT, those with no claimed religious affiliation have a significantly higher discuss score (are less likely to discuss) than those who claim a religion. For those with no claimed REL, those with an N/N ATT are more likely not to discuss than those with a positive ATT.
		No affiliation: N/N ATT vs Pos	0.30 (0.01, 0.59)	.045	
DEFLECT the request	PE	No PE versus PE	−0.01 (−0.18, 1.5)	.887	Controlling for PE, those with an N/N ATT have a significantly lower mean Deflect score than those with a positive ATT (more likely to deflect).
	ATT	N/N ATT vs Pos	−0.40 (−62, −0.22)	<.0001	–
	REL*ATT	No affiliation: N/N ATT vs Pos	0.436 (.021, −0.851)	.039	There is a significant interaction between REL and ATT for the mean Deflect score. Among those who claim a religious affiliation, those with an N/N ATT are more likely to deflect than those with a positive ATT.
		Affiliated: N/N ATT vs Pos	−0.62 (−0.89, −0.35)	<.0001	

CI: confidence interval.

study of intentions to participate in euthanasia. That study found no effect of attitude but that subjective norms were the dominant predictor of intention.[24] This difference might be explained by the different contexts of these two research samples. The Québec study was conducted among palliative care nurses, most of whom had a religious affiliation (65%), in a jurisdiction prior to legalisation. This Australian study sampled nurses from a range of clinical settings, most of whom had no religious affiliation (65%), in a nation where legal assisted dying had become established.

It should be noted that a potential limitation on this study might have arisen from dichotomising the attitude variable. To facilitate the interpretation of results, attitude was split between those who agree and those who do not agree or are neutral towards assisted dying; this included the very few respondents (4%) who were 'not sure'. This may have introduced a risk of bias in the results, but eliminating them would have jeopardised statistical power which would have been a more significant risk.

In the context of assisted dying, attitude is an evaluative process of the rightness or wrongness of an act;[25] as such, this evaluation is deeply connected to professional ethics. The study by Lavoie et al.[24] found that the professional duty of beneficence predicted an intention to participate in an act of euthanasia, but in this sample beneficence/non-maleficence reduced the intention to Refer the request. Regardless of the difference in findings, ethical beliefs in research related to assisted dying has been shown to have substantial explanatory power.

The role of ethical norms in relation to assisted dying has been a focus of research since 1987,[31] predating empirical studies of nurses' attitudes by more than 5 years.[40] The literature of nurses' ethical decision-making shows that when nurses are confronted with ethically challenging situations, their choices are often shaped by social expectations,[34,41,42] 'without any conscious awareness of having gone through steps of search[ing], weighing evidence, or inferring a conclusion'.(p. 11).[43] This phenomenon of moral intuition is seen in this research among nurses who intend to Discuss the request with the patient.

It is only in the case of an intention to Discuss the request that both Rights norms (autonomy/justice) and Duty norms (beneficence/non-maleficence) have an effect. Some of these nurses, however, may have a dual intention to Discuss and Deflect since their intention to Discuss also comes from two social influences: expectations of significant others to assist this patient and a religious affiliation. Discussing the request might be a compromise to mitigate the moral burden or distress the nurse experiences,[39] but it might also – intentionally or inadvertently – construct a barrier to the requestor.[6] The barrier could take the form of deliberate or unconscious desire to delay or design choices for the patient without the patient's awareness.[44] The tension between social expectations and personal beliefs can lead to an intention to spend time in dilatory discussion. The motivations of nurses who intend to Discuss the request illustrate a point made by Pesut[42] that the choice of supporting or not supporting a request for assisted dying is shaped by sociocultural factors and is not a binary decision.

These data reveal that expectations of others serves to nudge those who agree with legal assisted dying to escalate the request to the medical team, while those who do not agree are less influenced by the expectations of others and would propose alternatives to the patient. Most nurses would be able to assist the patient's request 'even if it conflicted with my personal values', but some would not. This disparity in nurses' intentions suggests the need for specific preparation in healthcare ethics, particularly for student nurses, in a way that develops what Monteverde describes as 'moral resilience' so that their first experience of such a request is not a 'moral stressor'.[45] Pesut proposes preparation that requires searching 'for reasons that support alternative positions' (p. 4),[42] rather than seeking post hoc justifications for a belief. Engaging in these cognitive rehearsals can help nurses become aware of how their intentions impact their network of social relations and might enhance their own moral resilience in order to manage complex moral demands[45] that will no doubt arise as the option of legal assisted dying expands.

Conclusion

This study has shown that attitude can drive diverse responses to requests for assisted dying, and that it interacts with ethical beliefs and, to a lesser extent, religious affiliation. Beyond that, this study extends the line of research that examines the ethical foundations in end-of-life care and bridges the psychosocial, demographic and ethical approaches to practice. The impact of ethical beliefs, or moral intuitions, provides the starting point for practice implications, particularly in preparing nurses for a work life where such requests will become more common. In addition, this more nuanced and inclusive model has implications for future research. Longitudinal research can shed light on the stability of intentions, their impact on behaviour, and the impact of interventions, such as practice guidelines and/or changes in training and support models.

Acknowledgements

For assistance with survey dissemination, the authors would like to thank the Australian Nursing and Midwifery Federation, Cancer Nurses Society Australia, and Australian College of Nursing.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article: Funding was provided by the Australian Government Research Training Program. Editing support was provided by Laura Bassi Scholarship (Editing Press).

ORCID iD

Michael Wilson https://orcid.org/0000-0002-6732-8508

Notes

i. Assisted dying is a generic term encompassing a range of practices from active voluntary euthanasia to medically assisted suicide and is usually restricted to adults assessed as mentally competent who have a terminal illness and whose death is reasonably foreseeable, although these components have national or regional variations.

ii. This definition was modelled on the language of the Australian State of Victoria's Voluntary Assisted Dying Act 2017,[28] which was implemented in June 2019, just before data collection commenced.

iii. A non-Australian sample was sought to avoid potential cross-posting and contamination of the population participating in the research project. The United States was a preferred site because, like Australia, the United States has a federal system, and a similar percentage of states in both countries have legislated to permit assisted dying.

References

1. Stevens CA and Hassan R. Nurses and the management of death, dying and euthanasia. *Med Law* 1994; 13(5 6): 541 554.
2. Kuhse H and Singer P. Voluntary euthanasia and the nurse: an Australian survey. *Int J Nurs Stud* 1993; 30: 311 322.
3. Australian Nursing and Midwifery Federation. ANMF position statement: assisted dying, http://anmf.org.au/documents/policies/PS_Assisted_Dying.pdf (2016, accessed 15 January 2018).

4. Australian College of Nursing. Voluntary assisted dying in Victoria. https://www.acn.edu.au/wp-content/uploads/2018/10/Voluntary-Assisted-Dying-in-Victoria.pdf (2018, accessed 26 September 2018).
5. Hewitt J, White B, Del Villar K, et al. Voluntary assisted dying in Victoria: why knowing the law matters to nurses. *Nurs Ethics*. Epub ahead of print 1 September 2020. DOI: 10.1177/0969733020944457.
6. American Nurses Association. The nurse's role when a patient requests medical aid in dying, https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf (2019, accessed 3 December 2019).
7. Oliver P. *Another week? Another week! I can't take another week' Addressing barriers to effective access to legal assisted dying through legislative, regulatory and other mean.* Doctoral Thesis, The University of Auckland, Auckland, New Zealand, 2016.
8. McCarthy J and Monteverde S. The standard account of moral distress and why we should keep it. *HEC Forum* 2018; 30(4): 319 328.
9. Elmore J, Wright DK and Paradis M. Nurses' moral experiences of assisted death: a meta-synthesis of qualitative research. *Nurs Ethics* 2016; 25: 955 972.
10. Adams JA, Bailey DE Jr, Anderson RA, et al. Nursing roles and strategies in end-of-life decision making in acute care: a systematic review of the literature. *Nurs Res Pract* 2011; 2011: 527834.
11. Inghelbrecht E, Bilsen J, Mortier F, et al. Factors related to the involvement of nurses in medical end-of-life decisions in Belgium: a death certificate study. *Int J Nurs Stud* 2008; 45(7): 1022 1031.
12. Beuthin R, Bruce A and Scaia M.Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nurs Forum* 2018; 53(4): 511 520.
13. Wilson M, Wiechula R, Cusack L, et al. Nurses' intentions to respond to requests for legal assisted dying: a Q-methodological study. *J Adv Nurs* 2020; 76(2): 642 653.
14. Holt J. Nurses' attitudes to euthanasia eleven years on: has anything changed? *Nurs Philos* 2019; 20(3): e12249.
15. Evans L. Nurses' attitudes to assisted suicide: sociodemographic factors. *Br J Nurs* 2015; 24: 623 632.
16. Berghs M, Dierckx de Casterle B and Gastmans C. The complexity of nurses' attitudes toward euthanasia: a review of the literature. *J Med Ethics* 2005; 31(8): 441 446.
17. Vézina-Im L-A, Lavoie M, Krol P, et al. Motivations of physicians and nurses to practice voluntary euthanasia: a systematic review. *BMC Palliat Care* 2014; 13: 20.
18. Danyliv A and O'Neill C. Attitudes towards legalising physician provided euthanasia in Britain: the role of religion over time. *Soc Sci Med* 2015; 128: 52 56.
19. Gielen J, van den Branden S and Broeckaert B. Religion and nurses' attitudes to euthanasia and physician assisted suicide. *Nurs Ethics* 2009; 16: 303 318.
20. Oliver P, Wilson M and Malpas PJ. New Zealand doctors' and nurses' views on legalising assisted dying in New Zealand. *N Z Med J* 2017; 130: 6 15.
21. Scherrens A-L, Beernaert K, Robijn L, et al. The use of behavioural theories in end-of-life care research: a systematic review. *Palliat Med* 2018; 32(6): 1055 1077.
22. Godin G and Kok G. The theory of planned behavior: a review of its applications to health-related behaviors. *Am J Health Promot* 1996; 11(2): 87 98.
23. Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process* 1991; 50: 179 211.
24. Lavoie M, Godin G, Vezina-im LA, et al. Psychosocial determinants of nurses' intention to practise euthanasia in palliative care. *Nurs Ethics* 2016; 23(1): 48 60.
25. Manstead ASR. The role of moral norm in the attitude behavior relation. In: Terry DJ and Hogg MA (eds) *Applied social research. Attitudes, behavior, and social context: the role of norms and group membership*. Mahwah, NJ: Lawrence Erlbaum Associates, 2000, pp. 11 30.
26. Godin G, Conner M and Sheeran P. Bridging the intention-behaviour gap: the role of moral norm. *Br J Soc Psychol* 2005; 44(Pt 4): 497 512.

27. Bendiane MK, Galinier A, Favre R, et al. French district nurses' opinions towards euthanasia, involvement in end-of-life care and nurse patient relationship: a national phone survey. *J Med Ethics* 2007; 33(12): 708 711.
28. Government of Victoria. Voluntary Assisted Dying Bill 2017 Explanatory Memorandum. Victorian Bills Explanatory Memoranda. http://classic.austlii.edu.au/au/legis/vic/bill_em/vadb2017312/vadb2017312.html (2017, accessed 5 July 2018).
29. Francis J, Eccles M, Johnston M, et al. *Constructing questionnaires based on the theory of planned behaviour: a manual for health services researchers*. Newcastle upon Tyne: University of Newcastle upon Tyne.
30. Howe LC and Krosnick JA. Attitude strength. *Ann Rev Psych* 2017; 68: 327 351.
31. Quaghebeur T, Dierckx de Casterle B and Gastmans C. Nursing and euthanasia: a review of argument-based ethics literature. *Nurs Ethics* 2009; 16(4): 466 486.
32. Torres-Harding SR, Siers B and Olson BD. Development and psychometric evaluation of the Social Justice Scale (SJS). *Am J Community Psychol* 2012; 50(1 2): 77 88.
33. Gorsuch NM. *The future of assisted suicide and euthanasia*. Princeton, NJ; Oxford: Princeton University Press, 2006.
34. Snelling PC. Consequences count: against absolutism at the end of life. *J Adv Nurs* 2004; 46(4): 350 357.
35. Wilson M. The University of Adelaide my data. Figshare, https://doi.org/10.25909/5ef147c894344 (2020, accessed 23 June 2020).
36. Tanida N, Asai A, Ohnishi M, et al. Voluntary active euthanasia and the nurse: a comparison of Japanese and Australian nurses. *Nurs Ethics* 2002; 9: 313 322.
37. Lutzen K, Dahlqvist V, Eriksson S, et al. Developing the concept of moral sensitivity in health care practice. *Nurs Ethics* 2006; 13(2): 187 196.
38. Eagly AH and Chaiken S. *The psychology of attitudes*. Fort Worth, TX: Harcourt Brace Jovanovich College Publishers, 1993.
39. Armitage CJ and Conner M. Efficacy of the theory of planned behaviour: a meta-analytic review. *Br J Soc Psychol* 2001; 40(Pt 4): 471 499.
40. Verpoort C, Gastmans C, De Bal N, et al. Nurses' attitudes to euthanasia: a review of the literature. *Nurs Ethics* 2004; 11: 349 365.
41. Goethals S, Gastmans C and de Casterlé BD. Nurses' ethical reasoning and behaviour: a literature review. *Int J Nurs Stud* 2010; 47(5): 635 650.
42. Pesut B, Thorne S and Greig M. Shades of gray: conscientious objection in medical assistance in dying. *Nurs Inq* 2020; 27: e12308.
43. Graham J, Haidt J, Koleva S, et al. Chapter two moral foundations theory: the pragmatic validity of moral pluralism. *Adv Exp Soc Psychol* 2013; 47: 55 130, https://doi-org.proxy.library.adelaide.edu.au/10.1016/B978-0-12-407236-7.00002-4
44. Gelinas L and Miller FG. Nudging, autonomy and valid consent: context matters. *Am J Bioeth* 2013; 13(6): 12 13.
45. Monteverde S. Caring for tomorrow's workforce: moral resilience and healthcare ethics education. *Nurs Ethics* 2016; 23(1): 104 116.

Chapter Six: Profiles of nurses’ intentions to respond to requests for legal assisted dying

This chapter consists of the following manuscript:

> Wilson, M., Ostroff, C., Wilson, M., Wiechula, R., & Cusack, L. (2021). Profiles of nurses’ intentions to respond to requests for legal assisted dying: a cross-sectional study. *International Journal of Nursing Studies*, *in press*. Journal page proof. https://doi.org/10.1016/j.ijnurstu.2021.104069

Statement of Authorship

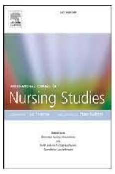
Title	Profiles of nurses' responses to requests for legal assisted dying
Publication Status	In press
Publication Details	Wilson, M., Ostroff, C., Wilson, M., Wiechula, R., & Cusack, L. (2021). **Profiles of nurses' intentions to respond to requests for legal assisted dying.** ***International Journal of Nursing Studies, in press.*** https://doi.org/10.1016/j.ijnurstu.2021.104069
Principal Author	
Name (Candidate)	Michael R Wilson
Contribution	Conceptualisation, design, data collection and analysis, drafting, revisions
Overall % Contribution	70%
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature / Date	
Co-Authors	By signing the Statement of Authorship, each author certifies that: i.the candidate's stated contribution to the publication is accurate (as detailed above); ii.permission is granted for the candidate in include the publication in the thesis; and iii.the sum of all co-author contributions is equal to 100% less the candidate's stated contribution
Name of Co-Author	Prof Cheri Ostroff
Contribution	Conceptualisation, analysis plan, drafting, review (15%)
Signature / Date	8 Sept 2021
Name of Co-Author	Prof Marie Wilson
Contribution	Conceptualisation, drafting (10%)
Signature / Date	
Name of Co-Author	Dr Rick Wiechula
Contribution	Review (4%)
Signature / Date	
Name of Co-Author	Dr Lynette Cusack
Contribution	Review (1%)
Signature / Date	

International Journal of Nursing Studies 124 (2021) 104069

Contents lists available at ScienceDirect

International Journal of Nursing Studies

journal homepage: www.elsevier.com/ijns



Profiles of intended responses to requests for assisted dying: A cross-sectional study

Michael Wilson[a,*], Cheri Ostroff[b], Marie E. Wilson[c], Richard Wiechula[d], Lynette Cusack[d]

[a] Adelaide Nursing School, University of Adelaide, North Terrace, Adelaide, South Australia 5000, Australia
[b] UniSA Business, University of South Australia, City West Campus, Adelaide, South Australia 5000, Australia
[c] The Chancellery, University of South Australia, City West Campus, Adelaide, South Australia 5000, Australia
[d] Adelaide Nursing School, Medical and Health Sciences Faculty, North Terrace, Adelaide, South Australia 5000, Australia

ARTICLE INFO

Article history:
Received 15 April 2021
Received in revised form 7 July 2021
Accepted 16 August 2021

Keywords:
Nursing
Intention
Euthanasia active
Cluster analysis
Logistic regression

ABSTRACT

Background: Responding to legal medically assisted dying requests may become the most frequent form of nurses' participation in that service. Recent research has explored nurses' discrete responses to requests about or for assisted dying; however, nurses likely hold intentions for multiple responses to these requests. These intentions form patterns shaped by individual factors such as attitude and beliefs. No research has investigated patterns of multiple responses to requests for assisted dying, how these patterns form profiles of nurses and factors that might explain these response profiles.
Objectives: Identify patterns of multiple responses that nurses intend for requests for assisted dying. Explore how these patterns form profiles of nurses' who share similar patterns of intended responses. Finally, investigate how attitude, norms and beliefs distinguish response profiles.
Design: Cross-sectional survey
Settings: Online survey of Australian nurses
Participants: 365 experienced registered nurses (years in nursing mean = 23, SD = 14.21) working primarily with adults across various practice settings.
Methods: Principal components analysis identified five types of intended responses. K-means cluster analysis was then used to develop profiles of nurses' intended responses across these five responses. Multinomial logit regression was utilised to examine psychosocial variables that distinguished different profiles
Results: Cluster analysis resulted in five profiles that reflect different patterns of intended responses by nurses - Facilitator, Complier, Expediter, Objector, and Detached. Logit regressions of explanatory variables indicated that nurses' attitude toward assisted dying, ethical beliefs, and social norms predicted nurses' membership in intended response profiles. The overall model was statistically significant, $\chi^2(20) = 106.527$, $p < .001$, and the predictors accounted for 25.3% of the variance in the profiles (Cox and Snell test: Pseudo $R^2 = 0.253$).
Conclusion: Nurses intended responses have been usefully constructed as five patterns or profiles of multiple responses. These profiles represent different types and levels of engagement with requests. Further, attitude and social expectations distinguish profiles with stronger intentions to engage positively. Using a cluster analysis methodology provides a more holistic understanding of nurses' intended responses to assisted dying requests by focusing on various responses and demonstrating that nurses have distinctive patterns of responses.

What is already known

- Most nurses view participation in legal assisted dying as an extension of professional practice and are engaged with making sense of that new practice area
- Nurses are increasingly asked about assisted dying and respond in a variety of different ways
- Nurses' attitudes, psychosocial factors, norms, religion, ethical beliefs have been associated with singular types of intended responses to requests, e.g., either refer the request or object to it.

---

[*] Corresponding author.
E-mail addresses: michael.r.wilson@adelaide.edu.au (M. Wilson), cheri.ostroff@unisa.edu.au (C. Ostroff), marie.wilson@unisa.edu.au (M.E. Wilson), rick.wiechula@adelaide.edu.au (R. Wiechula), lynette.cusack@adelaide.edu.au (L. Cusack).

https://doi.org/10.1016/j.ijnurstu.2021.104069
0020-7489/

What this paper adds

- When contemplating a request about assisted dying, nurses intend to respond in multiple ways, to varying degrees.
- Using cluster analysis, profiles of nurses with similar patterns of intended responses were developed, and attitude, norms and beliefs explained membership in a profile.
- Viewing nurses as relying on multiple types of responses, rather than intending to utilise a single response, advances understanding of how nurses interact with requests about or for assisted dying

1. Introduction

Where it is legal, the process that can lead to receiving medical assistance to die begins with a person making a formal request. However, before the formal request, the person seeking assistance in dying may make informal, exploratory enquiries (Oliver, 2016). Due to their unique role as information brokers in end-of-life care, nurses are often the professionals to hear and respond to these exploratory requests (Fujioka et al., 2018). Understanding the influences at work in these responses can help nurses optimise care for someone at the end of their life.

Assisted dying is a generic term (Holt, 2019) for the legal administration of a substance to cause a mentally competent person's death, usually at the end stage of a terminal illness. While details of legislation vary by jurisdiction, a common feature is that the request must be assessed as voluntary and delivered to a healthcare professional qualified to act on the request, usually a doctor. Registering that formal request is usually considered the "initial" request, although conversations between a person and a clinician often occur in advance of that event (Oliver, 2016).

In Australia, assisted dying legislation had been passed in one State at the time of study but not yet implemented, and only one other State was developing a similar Bill. At the same time, public momentum of support of assisted dying was surging (Kirchhoffer and Lui, 2021). In this context, nurses will likely receive inquiries from patients and family members about assisted dying but are often left unprepared to respond (Elmore et al., 2016). It is important to understand nurses' anticipated responses to request given the increasing attention worldwide to enacting legislation in this context.

Emerging research into these private, sometimes brief discussions (Dierckx de Casterlé et al., 2010) is important because the type of response at this early stage of the process can influence the requestor's subsequent choices and decisions (Cohen, 2019). The complexities in caring for persons who request assisted dying as part of end-of-life care include the larger issues about the legal and professional scope of practice and the more focussed issues about managing a complex situation (Elmore et al., 2016). These complexities require the relational skills to "hear the clues" in the request to discern what the person truly wants and the ability to finesse the cognitive and affective shift from curative to palliative care (Wright et al., 2017), particularly if the scope of palliative care controversially includes the practice of assisted dying (Bernheim and Raus, 2017; Sheahan, 2016). Coping with the quotidian pressures of clinical requirements that restrict the time to manage these complexities is another (Kuhse and Singer, 1993; Stevens and Hassan, 1994) well-known complicating factor in this (Dierckx de Casterlé et al., 2010). The mix of pressures and influences suggests that responding to a request about assistance to die is not a discrete act, and intentions to respond may not be not discrete either.

Recent research has explored what nurses have recalled of prior requests and their responses to them. For example, North American researchers have examined nurses' moral experiences (Elmore et al., 2016) and the complexity of deciding to support the requestor or object to the request (Pesut, 2019; Schwarz, 2003). The core complexity lies beyond the decision poles of support or objection; for most nurses that involves a space 'in-between' of active sensemaking about how participation in assisted dying is part of nursing practice (Beuthin et al., 2018). This body of research has provided important insights into the range of nurses' responses in situations where assisted dying is legal. Given the increasing impetus for assisted dying legalisation and implementation, it is important to clarify how nurses intend to respond to these requests. This information can be used to enhance preparation for these encounters in jurisdictions where legalisation is pending.

The little research that has been conducted into nurses' intentions to respond to a request for assisted dying identified psychosocial factors that impact their intended response. Shortly before it was legalised in Québec in 2014, researchers used the theory of planned behaviour to examine nurses' motivations to participate in euthanasia. They showed that nurses' views of their own family's approval and that of their colleagues, as well as the moral norm of beneficence, were important in predicting their intention to participate in assisted dying (Lavoie et al., 2016). Similarly, in an Australian study, psychosocial variables, including attitude and moral norms, predicted nurses' response intentions, with attitudes towards assisted dying playing a complex role (Wilson et al., 2020b). Prior research has generally assumed that different nurses may respond differently, but the focus has been on predicting or understanding a nurse's single response. However, social psychologists have long documented that a given person does not respond the same way across different situations or people. Rather, people have multiple behavioural options and different profiles or behavioural signatures (Mischel et al., 2002) that capture their array of responses. Thus, it may be more fruitful to examine multiple types of nurses' response intentions together as a profile. This approach moves beyond dichotomies, such as supporting or objecting to a request and takes a more holistic view of nurses' responses. A profile approach takes into account that a given nurse's responses are not singular, and the array of different responses a nurse uses or intends to use may reinforce one another.

Thus, in the current study, response intentions were examined as patterns or profiles that capture the range of responses is more or less likely to rely upon. For example, some nurses might intend to explore the request in more detail with strong intentions to refer the request to a doctor; others may intend to undertake a broad array of activities with weaker intentions to refer the request. We also examined the extent to which psychosocial variables, consistent with the theory of planned behaviour, differentially explain nurses' intended response profiles. Examining response profiles rather than discrete responses is important for theoretical reasons, particularly as it expands the theory of planned behaviour and allows us to consider how psychosocial factors can predict complex intentions. This study also opens up new research questions about how profiles of intentions translate into actual behaviours. Practically, these findings suggest opportunities for organisational policy to prepare and support nurses who work in jurisdictions where assisted dying is legal or pending.

2. Method

2.1. Design

The design of this study is a cross-sectional survey. This study's dataset was used in a prior publication that examined the role of attitude in interaction with psychosocial variables to understand an individual nurse's discrete intended response (Wilson et al., 2020b). While drawing on the same dataset, this study applied a new methodological approach (cluster analysis) to understand

Table 1
Sample characteristics.

		n	%
Gender	Female	335	90.7
	Male	33	9.0
	Other	1	.3
		369	100
Practice Setting	Common EOL*	136	37.0
	Tertiary Care**	130	35.3
	Community	37	10.1
	Other***	65	17.7
		369	100
Years Nursing Experience			
	0–5	55	14.9
	6–10	53	14.4
	11–20	60	16.3
	21–30	76	20.6
	>30	125	33.9
		369	100

* EOL care settings: ICU, Oncology, Palliative, Aged care.
** Tertiary care settings include general med-surg and specialist settings (e.g., midwifery, adult MH).
*** Other settings include education, research, management.

further how nurses intend to respond by focusing on profiles of responses rather than individual discrete responses and examining how profiles may be differentially predicted.

2.2. Sample

Participants were recruited through invitations to complete an anonymous online survey advertised to members of Australian nursing professional associations. Inclusion criteria were (1) nurse registered with the Nursing and Midwifery Board of Australia, and (2) primary work is with adults. Among 470 responses received, 40 were excluded because they were non-nursing professionals, 14 did not work with adult clients, 39 had missing responses for more than 25% of items, and 8 had missing data on the intention measures. The final sample was 369 nurses. There were no more than 4% missing responses from any survey in the final sample for analysis.

Sample characteristics appear in Table 1. The study was approved by the first author's institutional ethics committee (ref. HREC 2018-234).

2.3. Instrumentation

The survey of 53 items was administered online from July to December 2019. The definition of assisted dying was provided in the participant information sheet using the language of the Victoria (Australia) Voluntary Assisted Dying Act 2017. Participants were asked to answer questions in response to a hypothetical scenario where assisted dying was legal in the jurisdiction where they practice, and a person in the nurse's care asked for the nurse's help to access medical assistance to die. Nurses responded to six categories of items: response intentions; attitude toward assisted dying; subjective norms; perceived behavioural control; and ethical principles of respect for autonomy and beneficence.

2.4. Measures

Information on the reliability and validity of the measures is provided in the following sections. For a more detailed discussion on the choice of measures relevant to the underlying theory of planned behaviour framework, please see Wilson et al. (2020b).

2.4.1. Response intentions

Intended responses to a request for assisted dying were measured with 16 statements drawn from recent Australian research (Wilson et al., 2020a). Nurses rated each statement on a 5-point Likert-type scale ranging from 1='I would not say this' to 5='I would say this'. Sample statements of intended responses included, "You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?" [Assess], "Have you been able to discuss this with the doctor who is most involved in your care?" [Refer], and "Can you tell me about the things that frighten or concern you the most at the moment?" [Explore].

Exploratory principal components factor analysis extended earlier work and examined the response intentions without imposing a preconceived factor structure on the variables. An eigenvalue of > 0.95 was used to retain a factor. A response intention was included if the factor loading was at least 0.6 but no higher than 0.4 on any other factor (Ramlo, 2016). These inclusion criteria reduced the pool of 16 response statements to 12 statements. The analysis resulted in five factors or types of responses: 1) "Explore", where the responses probed for the meaning of the request ($\alpha = 0.73$), 2) "Deflect", where the responses redirected the request to a consideration of palliative alternatives ($\alpha = 0.66$), 3) "Assess", where the responses sought to determine the requestor's mental status ($\alpha = 0.73$), 4) "Refer", where the response queried the person's efforts or desires to escalate the request to the doctor ($\alpha = 0.66$), and 5) "Object" to the request due inability or unwillingness to assist ($\alpha = 0.52$). There were two to four items per factor. Items within a factor were averaged to create five scale scores that were used in subsequent analyses. Despite the lower reliability of the "Object" scale, it was retained for analysis due to the strong factor loadings (0.73 and 0.85) and the nuance it provides to the array of possible responses. The "object" response type indicates both ethical objection and a commitment to non-abandonment of care and is distinct from an intention to deflect the request to discuss palliative alternatives to an assisted death.

Factor loadings of each response intention are presented in Table 2.

2.4.2. Psychosocial measures

The theory of planned behaviour has guided prior research into nurses' encounters with assisted dying (Lavoie et al., 2016; Wilson et al., 2020b). This study assessed nurses' attitudes towards legal assisted dying, subjective norms (perceptions of the expectations of other), perceived behavioural control (the degree to which they believe they have control in the situation), and two dimensions of ethical principles, namely autonomy (incorporating justice) and beneficence (incorporating non-maleficence). A 5-point Likert-type scale, where 1=strongly disagree to 5=strongly agree, was used for all items. For each measure, responses to items were averaged.

Attitude toward assisted dying was measured with three items, two about the acceptability of assisted dying and one about the likelihood that assisted dying would be chosen as the respondents' own end-of-life care option ($\alpha = 0.93$). Subjective norms, or expectations of others, was measured with eight items reflecting perceptions of others' expectations to assist this person's request ($\alpha = 0.72$). Here, others included the nurse's family, the care team members, the employer, and professional associations. Perceived behavioural control consisted of two items that assessed self-efficacy ("I can do this") and two items that assessed the barriers of a lack of time or insufficient training to be able to respond ($\alpha =0.73$). Ethical beliefs, focusing on bioethical principles were assessed through three items measuring respect for autonomy and justice, labelled "Autonomy" ($\alpha = 0.83$), and a two-item mea-

Table 2
Rotated component matrix of factor loadings and statements for each response intention scale.

Intention Scale	1. Explore Request	2. Deflect Request	3. Assess needs	4. Refer Request	5. Object	Response statements
Explore Request	**0.82**	0.008	−0.009	0.034	0.093	What do I need to know to give you the best care?
	0.705	0.182	0.021	0.172	−0.126	What do you not want?
	0.674	0.139	0.248	0.137	0.031	Can you tell me about the things that frighten or concern you the most at the moment?
	0.606	0.124	0.421	−0.003	0.084	What does your illness mean to you?
Deflect Request	0.038	**0.814**	0.175	0.114	0.117	If you are asking because you can't tolerate your pain, I'll let your doctor know so we can find ways to relieve that pain
	0.293	**0.687**	0.221	0.047	0.249	There are many options to control your symptoms and help you to feel better
Assess Needs	0.281	0.106	**0.787**	0.133	0.022	You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?
	0.144	0.328	**0.759**	0.055	0.055	Can you tell me why you wish your life would end?
Refer Request	0.155	0.011	0.012	**0.874**	−0.012	Have you been able to discuss this with the doctor who is most involved in your care?
	0.052	0.103	0.157	**0.791**	−0.019	When you talk with your doctor about this, have you told your doctor what you have told me?
Object	−0.01	−0.024	0.149	−0.044	**0.853**	I can't help you with that question, but what I can do is reassure you that I will do everything I can to support you being as comfortable as possible
	0.001	0.341	−0.075	−0.083	**0.73**	Discussing this makes me feel complicit in an action that I cannot be involved in.

Table 3
Means, standard deviations, reliability (and intercorrelations of scales).

	Mean score	SD	Cronbach's α	Attitude	Autonomy	Beneficence	Subjective norms	Perceived control	Explore	Deflect	Assess	Refer	Object
Attitude	4.27	1.13	0.93	–									
Autonomy	4.61	0.49	0.83	.562**	–								
Beneficence	2.72	1.13	0.66	−0.488**	−0.254**	–							
Subjective norms	3.36	0.70	0.72	−0.288**	−0.106*	.248**	–						
Perceived control	3.55	1.18	0.73	−0.529**	−0.375**	.372**	.262**	–					
Explore	4.27	0.76	0.73	.123*	−0.098	−0.191**	−0.193**	−0.141**	–				
Deflect	3.75	1.02	0.66	−0.104*	−0.373**	.112*	0.012	.109*	.328**	–			
Assess	4.04	1.01	0.74	−0.148**	−0.267**	0.015	−0.019	0.078	.333**	.408**	–		
Refer	4.69	0.53	0.66	.243**	0.099	−0.276**	−0.194**	−0.254**	.266**	.176**	.169**	–	
Object	1.95	1.01	0.52	−0.331**	−0.455**	.220**	.144**	.306**	0.027	.345**	.125*	−0.077	–

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

sure of beneficence and non-maleficence, labelled "Beneficence" ($\alpha = 0.66$) (Wilson et al., 2020b).

Table 3 contains descriptive statistics, alphas, and intercorrelations of the measures.

2.5. Analysis

K-means cluster analysis was used to identify different profiles of nurses' intended responses across the five response types (explore, deflect, assess, refer, object). Subsequent analysis used multinomial logistic regressions to identify the psychosocial variables that differentially explain membership in those profiles.

All analyses were performed using SPSS v.26 (IBM, NY).

3. Results

The k-means cluster analysis results are presented first, including the description and content of the patterns or response intentions. Following that, the results of the multinomial logistic regression are presented.

3.1. Cluster analysis

Cluster analysis is an analytical technique that identifies homogenous groups based on similarity in responses in set variables – the pattern or profile across measures. Cluster analysis is a valuable exploratory analytic approach because it can reveal relationships in the data that had gone unnoticed (Beckstead, 2002). In inductive cluster analysis approaches, profiles are determined based on empirical analysis of the data and the resulting profiles are labelled and interpreted (Ketchen et al., 1993). In this case, k-means cluster analysis groups nurses based on their intended responses across the five intended responses: explore, deflect, assess, refer, or object to the request. Nurses in the same cluster have similar patterns of intended responses and differ from those in other groups.

Results from the analysis and examination of scree plots (Kaufman and Rouseeuw, 2008) revealed a 5-group solution. Scores for each category of response type were standardised to facilitate interpretation. During a series of three brief 'world-café' workshops, the profiles were presented to practice nurses, nurse educators and senior nursing researchers to ensure the profiles made sense and could be labelled appropriately. The profiles were labelled as "Facilitator", "Objector", "Expediter", "Complier", and "Detached" (see Fig. 1).

3.2. Profiles

The profiles varied across most response intentions. The exception to this is the profile labelled "Detached", which had the weakest intentions to engage or refer. The other profiles can be

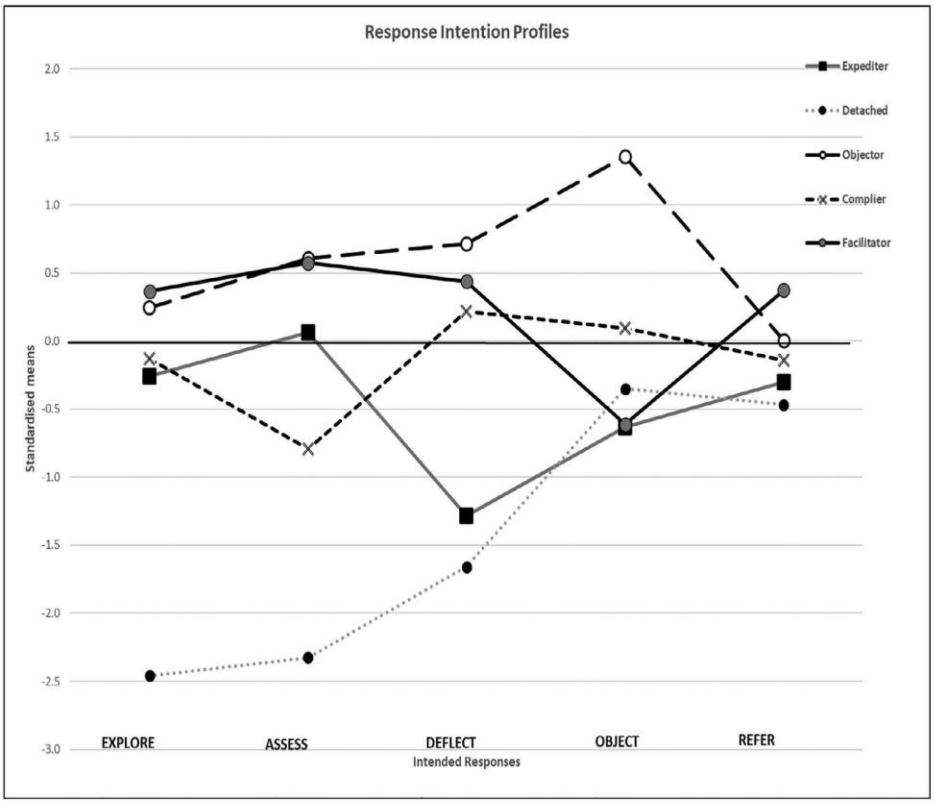


Fig. 1. Pattern of response profiles.

categorised into two groups by the relative strengths of their pattern of intentions. Patterns of Facilitators and Objectors share relatively strong intentions to explore, assess, and deflect to discuss alternatives, but they diverged in their intention to object to the request. While they shared a similar strength of intention to explore and refer, Expediters and Compliers' patterns diverged in their intentions to assess, discuss alternatives, and express some objection to the request.

Facilitator. This profile contains 31% of the sample ($n = 116$). Nurses in this profile intended to use a range of responses and engage actively with requestors in several ways. They hold these intentions with a weak intention to express an objection or commit to non-abandonment of care.

Objector. This profile contains 22% of the sample ($n = 83$). Nurses in the Objector profile were largely defined by their relatively high intentions to state their objection while assuring the requestor of their commitment to ongoing care. Consistent with that commitment, they also intended to provide a range of responses and have fairly strong intentions to explore the request, assess the person's mental status, deflect to palliative alternatives, and refer to a doctor.

The label "Objector" should not be confused with the term 'conscientious objector' as discussed in practice. Here, those in the Objector profile intended to engage with a requestor and discuss the request, whereas conscientious objectors have legal and professional exemptions from engaging.

Expediters This profile contains 18% of the sample ($n = 66$). Expediters had moderately strong intentions to assess the person's mental status, explore the meaning of the request, and refer to a doctor. Nurses in this profile are relatively less likely to deflect the request or object to it. Thus, nurses in this profile intended to clarify what the requestor asks and refer the request.

Complier. This profile contains 28% of the sample ($n = 78$). In this profile, nurses intended to explore the request, deflect, object, and refer, but the strength of intentions was moderate and close to the standardised mean response score. This pattern, coupled with the relatively weak intention is to assess the requestor's mental status, suggests they comply with nursing practice to engage with requestors but are less inclined to delve more deeply into why the patient's request was made.

Detached. This profile contains a minority of nurses at 7% of the sample ($n = 26$). Nurses in this profile are the least interactive with the requestor, with relatively weak intentions to explore the request, assess mental status, or deflect to a discussion of alternatives. They are more likely to object to the request, but that intention is relatively weak, as is their intention to refer it to the doctor.

Fig. 1 presents the labels and patterns of the five clusters produced by the k-means cluster analysis.

3.2. Association of predictor variables and nurses intended response profiles

To examine the association between potential predictors and the profiles, the five profiles were regressed on attitude toward assisted dying, subjective norms (expectations of others about how to respond), perceived behavioural control (feelings of self-efficacy and control over the situation), and ethical beliefs regarding autonomy and beneficence.

Table 4 presents the multinomial logit regressions results when the referent profile was "Detached". B represents the log odds. The

Table 4
Comparison of clusters when reference cluster = "Detached".

Expediter					95% CI	
Predictor	B	SE	Sig.	Exp(β)	Lower	Upper
Intercept	−5.608	3.120	.072			
Attitude	−0.065	.353	.854	.937	.469	1.873
Autonomy	.588	.602	.328	1.801	.554	5.858
Beneficence	.461	.336	.171	1.585	.820	3.066
Subj Norms	.949	.356	*.008*	2.583	1.285	5.193
PBC*	.007	.218	.973	1.007	.657	1.544

Objector					95% CI	
Predictor	B	SE	Sig.	Exp(β)	Lower	Upper
Intercept	−7.098	2.924	.015			
Attitude	.469	.346	.175	1.599	.812	3.150
Autonomy	−0.135	.581	.816	.873	.280	2.727
Beneficence	1.952	.346	*.000*	7.044	3.578	13.869
Subj Norms	.545	.368	.139	1.725	.838	3.551
PBC*	−0.016	.222	.943	.984	.637	1.520

Complier					95% CI	
Predictor	B	SE	Sig.	Exp(β)	Lower	Upper
Intercept	−4.181	2.866	.145			
Attitude	.563	.354	.112	1.756	.877	3.516
Autonomy	−0.387	.565	.493	.679	.224	2.056
Beneficence	1.205	.331	*.000*	3.337	1.743	6.389
Subj Norms	.682	.355	*.055*	1.978	.986	3.970
PBC*	−0.111	.215	.608	.895	.587	1.366

Facilitator					95% CI	
Predictor	B	SE	Sig.	Exp(β)	Lower	Upper
Intercept	−6.403	2.880	.026			
Attitude	.444	.342	.194	1.559	.797	3.048
Autonomy	.284	.561	.612	1.329	.443	3.986
Beneficence	1.093	.321	*.001*	2.982	1.590	5.595
Subj Norms	.744	.339	*.028*	2.104	1.082	4.090
PBC*	−0.071	.207	.730	.931	.621	1.397

* PBC = perceived behavioural control.

greater the value of B, the higher the odds that the explanatory variable distinguishes the named focal profile from the referent Detached profile. Exp(β) provides the ratio of probabilities among two profiles, often termed the predicted odds ratio or the relative risk ratio. When Exp(β) is 1, the explanatory variable does not distinguish between the two profiles, and there is an equal likelihood of being in the focal profile or the referent profile. The magnitude of the coefficient represents how much more (or less) likely it is that the explanatory variable is related to the focal profile relative to the reference or omitted profile. For example, using data drawn from Table 4, an Exp(β) of 2.98 indicates that increasing the variable beneficence by 1 scale point increases the predicted odds ratio by 2.98 that the nurse will have the focal profile of Facilitator instead of the Detached reference profile. For a given explanatory variable, comparisons between all pairs of clusters can be mathematically derived from the information in Table 4. However, for ease of interpretation, each profile was sequentially omitted, and the full set of comparisons are presented (online) in a supplemental table. Given the sheer number of comparisons between pairs of profiles, our decision rule for which results to highlight below was based on those with a p-value $\leq$0.05. All point estimates and confidence intervals are contained in the tables.

The chi-square for the model was statistically significant X^2 (27) = 106.527, p = .000, indicating that psychosocial variables were related to the set of nurses' response profiles. The set of explanatory variables accounted for an estimated 25.3% of the variance in the set of nurses' profiles based on Pseudo R^2 (Cox and Snell test). The goodness-of-fit statistic (Deviance measure) was X^2 (1400) = 984.261, p = 1.000, indicating the data fit the model well.

The mean score for attitude measure was 4.27 (SD = 1.13), suggesting an overall strong agreement toward legal assisted dying, a finding in line with historical survey data among Australian nurses that have shown a high level of support for the practice (Kuhse and Singer, 1993; Stevens and Hassan, 1994).

The multinomial logit indicated that nurses' attitudes toward assisted dying distinguished between membership in some profiles. Nurses with a more positive attitude were statistically significantly more likely to have an Objector, Complier or Facilitator profile than an Expediter profile (see Table S1). Objectors, Compliers and Facilitators were not well distinguished from each other, and further, attitude did not strongly distinguish the Detached profile from other profiles. The pattern of results indicates that attitude is particularly important for profiles with relatively stronger intentions to engage with the requestor by exploring the meaning of the request, discussing palliative alternatives, assessing mental status, or referring the request to a doctor.

Subjective norms reflect the extent to which nurses believe that others would expect them to assist this requestor. Nurses with higher subjective norms scores were statistically significantly more likely to be Expediters, Facilitators, or Compliers than Detached (see Table 4 for estimates and confidence intervals). Expectations of others seem particularly important for profiles that involve positive engagement with the request in some way, such as explore, assess, or refer requests and distinguish these profiles from one in which there is little direct engagement with the request (Detached). However, subjective norms did not result in meaningful odds differences between the Objector profile and other profiles (see supplementary table for point estimates and confidence intervals), suggesting that expectations of others is not particularly useful for determining if nurses are more or less likely to have a profile of Objector.

There were several findings worth highlighting with respect to the two ethical variables of autonomy and beneficence. The mean value of the autonomy variable was 4.6 (SD = 0.49), indicating that most nurses in this sample strongly believe that the requester has the right to make decisions about assisted dying. The low variance for autonomy limits the ability to find significant results. An increase in autonomy beliefs statistically significantly differentiated the Expediter profile from the Complier profile, but all other comparisons revealed weak or small odds differences.

In contrast to autonomy, the mean score of beneficence was 2.7 (SD = 1.13), indicating that, in general, nurses had somewhat weak beliefs about helping the person live as well as possible instead of choosing an assisted death. However, the relatively high variance indicates that nurses differed substantially in their beneficence beliefs. Higher beneficence beliefs statistically significantly distinguished the Objector profile from the Facilitator and Complier profiles, and in turn, Facilitator and Complier were statistically significantly more likely than the Expediter or Detached profiles (see confidence intervals in supplementary table). Overall, this pattern of results indicates that a higher beneficence score makes it less likely that nurses will have a profile of Expediter or Detached, and more likely that nurses will have a profile of Objector.

Perceived behavioural control did not meaningfully distinguish between nurses' membership in any profile.

In summary, we found five patterns, or profiles, of intended responses to requests for assisted dying through cluster analysis. These profiles presented behavioural signatures of different engagement levels with requests about assisted dying. Further, logistic regression produced meaningful models of the influence of individual attitudes and beliefs in explaining membership in different profiles of response intentions.

4. Discussion

This research was designed to explore whether nurses had identifiable patterns of intentions to respond to assisted dying requests rather than a single or dichotomous intention. The shift from examining discrete response intentions to patterns of intentions is based on theories of social psychologists (e.g., Shoda and Mischel, 1994), who indicate that individuals vary in their behaviours over situations. This pattern of variability forms behavioural signatures or profiles. Using cluster analysis, we identified five profiles of nurses who held distinctive patterns of response intentions. Multinomial logit models further revealed that individual attitudes and beliefs were associated with those profiles. By demonstrating that nurses have distinctive behavioural signatures in the combinations of possible responses, we gain a more nuanced understanding of the pattern of nurses' intentions to respond and the implications for professional practice in this emerging area.

The five profiles were labelled to reflect the overall pattern of underlying behavioral intentions. As is evident in Fig. 1, different nurses have distinct combinations of intentions, highlighting this procedure's utility compared to examining behaviours or intentions independently. To varying degrees, nurses intended to engage in activities that are consistent with professional guidance for responding to these requests (e.g., Royal College of Nursing, 2016): explore the meaning of the request, assess the requestor, discuss palliative alternatives, commit to non-abandonment of care where they object to the request itself, and refer the request to a doctor. However, a small portion of nurses in the Detached profile had relatively low intentions to explore the meaning of the request, assess the requestor, assess the patient's needs, and their intention to refer was the weakest of all profiles.

The two profiles that constitute about half of this sample, Facilitators and Objectors, have a similar mix of relatively strong intentions that reflect greater engagement with a requestor (but differ in their intention to object). In contrast, those with a Complier profile have patterns of relatively weaker intentions to assess the requestor, while Expediters have moderate intentions to explore and assess and weak intentions to discuss palliative alternatives. Nurses often feel they failed the person in their care when confronted with a request to die and wonder if it is due to something they are not providing or if it is truly a well-considered request (Wright et al., 2017). These feelings highlight that assessing needs and mental state is important for both requestors and nurses. An avenue for future research would be to examine if nurses with profiles that include greater degrees of exploring and assessing needs, such as Facilitator and Objector, have more satisfied patients and carers and feel more satisfied themselves.

The small cohort of nurses whose profile of response intentions was labelled as Detached is markedly weaker in intended responses that involve interaction with the requestor. These nurses seem ambivalent about enacting personally engaging or time-intensive responses, perhaps because they experience personal conflicts or moral uncertainty in caring for persons who request assisted dying (De Bal et al., 2008; Elmore et al., 2016; Pesut, 2019). Possibly, the Detached cohort has not yet self-identified as conscientious objectors, in contrast to nurses in this study who will engage despite ethical objections. Studies have shown that some nurses may not understand what conscientious objection is and that professional ethics codes do not provide clear guidance on this option (Pesut, 2019). Alternatively, these nurses may need organisational support in the form of collegial support, training, or resources to engage more effectively with such requests.

Examining the influences that can explain the profiles opens new research questions and new considerations for practice guidance. We demonstrated that psychosocial variables are differentially associated with nurses' intention profiles. Research using the theory of planned behaviour (Ajzen, 1991) to examine the relative importance of end-of-life decision-making frequently identifies psychosocial variables for explaining intentions in this setting (Scherrens et al., 2018) and has generally found that attitude is a stronger and more proximal predictor of intentions (Armitage and Conner, 2001; Godin and Kok, 1996). In the assisted dying literature, recent research has shown both minimal effects of attitude on nurses' intentions to participate in assisted dying (Lavoie et al., 2016) and complex relationships between attitude and intentions to respond to requests (Wilson et al., 2020b). When viewed through the lens of profiles of intentions, our findings suggest that attitudes make it more likely to have some profiles of responding than others. In particular, attitude distinguished the Complier, Facilitator and Objector profiles from the Expediter profile. As noted earlier, Expediters have only modest intentions to engage. It may be that a positive attitude toward assisted dying is particularly important for profiles of intentions that include higher levels of interaction with requestors. Attending to nurses' attitudes may be useful for continuing the professional development of nurses who care for persons at the end of life in jurisdictions where assisted dying is a legally available option.

Subjective norms – the perceived expectations of others - generally have been weak predictors of behavioural intentions (Armitage and Conner, 2001). However, they were shown to be strong predictors of intentions to participate in assisted dying (Lavoie et al., 2016). Here, subjective norms distinguished Expediter, Complier, and Facilitator profiles from the Detached, meaning that the influence of others' expectations makes it more likely a nurse will have a profile of behaviour that includes exploring and assessing. This finding of the influence of others' beliefs is reinforced by Australian polling data in 2017, showing support among nurses at 79% (Smith, 2021). The implication is that nurses' can draw upon significant others, particularly colleagues, when dealing with requests. Fostering an environment of collegial support could be useful where the objective is to encourage nurses to engage more deeply with assisted dying requests.

The influence of ethical beliefs on profile membership produced some interesting findings. Beneficence, defined as working for the person's best interest (Savulescu, 2015), has an ambiguity that justifies multiple positions. A review of ethics literature about nurses' participation in assisted dying found that beneficence was used to support arguments for and against their participation (Quaghebeur et al., 2009). Consistent with the study by Lavoie et al. (2016) that beneficence was the sole moral norm that predicted an intention to participate in assisted dying, we also found beneficence was related to intentions to engage with requests for assisted dying. In this study, beneficence was operationalised as a belief that "I would help this patient to find ways to live as well as possible instead of seeking assisted dying", and higher levels of beneficence made it more likely to be an Objector relative to all other profiles. An increase in beneficence also made it more likely to be in the Facilitator or Complier profiles than Expediter or Detached. Together, these results suggest that beneficence has a role in intentions to engage with the request and makes it more likely that nurses will have profiles where discussing palliative alternatives is an intention.

In contrast, the findings for autonomy were weaker than those for beneficence. Autonomy distinguished between Expediters and Compliers but did not result in large odds differences among other profiles. Expediters and Compliers differ primarily in their intention to deflect the request to discuss palliative alternatives; hence respect for autonomy may be relevant for patterns of behaviour that do not include deflecting. Given that dimensions of ethical beliefs have been deemed important for understanding nurses engagement in assisted dying (Lavoie et al., 2016; Wilson et al., 2020b), the overall weak results we found implies that nurses' views of autonomy may be more important for understanding individual behaviours than the profiles of behaviours as examined in this study. The same is likely true of perceived behavioural control. While useful in explaining discrete intentions, our findings suggest it does not well distinguish among profiles of intentions.

4.1. Implications

These findings have implications for policy and clinical practice in Australia and research into nursing engagement with legal assisted dying generally. While not widespread at the time of data collection in 2019, by mid-2021 four of the six Australian States had passed assisted dying legislation. One feature across all of these Acts is the prohibition against any healthcare professional initiating a discussion of assisted dying. As nurses cannot raise this option with a patient, attention is focused on how the nurse responds to informal, often ambiguous requests for or about assisted dying. Thus, the findings of this study are particularly informative for contexts in which legislation is anticipated and highlights the emphasis on understanding informal requests. The current practice in Australia is a prospective system of approvals where doctors who receive the initial formal request begin a sequence of applications and responses from an oversight committee before the drug can be administered (White et al., 2021). The effect of this system is to create delays for requests that might be urgent. These requirements that prohibit the initiation of discussion and time delays may impact nurses' patterns of responses in the future as laws become implemented in more States in Australia. In particular, nurses whose response tendencies currently favour exploring and assessing, such as those in the Facilitator profile, may temper their responses to protect against seeming to initiate conversations about assisted dying or delaying a decision.

Further, while the range of intended responses in this study was similar to those in other studies (e.g., Beuthin et al., 2018), the profiles and the percentage of nurses within each profile could differ where laws have been in place for some time. Different countries enact different legal requirements. For example, Canada has no legal provision that prohibits initiating this discussion (although professional guidelines restrict this to qualified practitioners) (Daws et al., 2020). In the Benelux countries, across federal Canada and in the United States, an assisted dying request is negotiated with the qualified practitioner and reviewed retrospectively for compliance. Given differences in culture and legal context, substantially more research is needed to understand better the contextual differences that might impact the type and propensity of different response profiles. We hope our study provides the impetus for using profiles to understand the phenomenon better.

Understanding that nurses have different profiles of intentions to respond, healthcare providers and professional bodies can take steps to support how nurses approach these encounters. For example, providers can be explicit about what end-of-life services they do and do not provide; they can offer information about other services to assist clients in their end-of-life choices, and for conscientious objectors, scripts can be developed to respectfully exit the discussion (McDougall et al., 2021). These are simple acts that can resolve issues for nurses, persons in treatment and their families. Professional bodies can refine their guidance to help nurses understand how people make these requests and encourage nurses to reflect upon how their response can significantly impact the outcome for requestors and their families. Nursing managers can facilitate explicit collegial support, mentoring or development for nurses who have weak intentions to engage more confidently with requestors. This practical leadership can help ambivalent or uncertain nurses clarify their intentions and understand what requestors might need.

4.2. Limitations

This study represents an initial foray into using profiles to understand nurses' responses to requests for assisted dying. As such, a deductive approach was used to identify the profiles. The results demonstrate how researchers might think differently by focusing on whole patterns of responses rather than aggregating "participation" as a singular intention. Moving forward, future work is needed to develop a deeper theoretical underpinning that can be used to predict and explain the expected profiles across different contexts. Future research is needed to address additional predictors such as organisational configurations for providing or restricting access to assisted dying. Our study focused on intentions to respond as opposed to actual responses. Given that intentions have strong relationships to subsequent action (Bagozzi and Yi, 1989), future research could examine how patterns of intentions translate into nurses' actual behaviours when people request assisted dying and how this relates to requestor satisfaction.

A further limitation pertains to the sampling strategy, which was based on advertising the survey and relying on nurses to volunteer to participate. As such, the sample could likely be biased toward those with more extreme or well-defined attitudes for or against assisted dying. The high mean for attitudes towards assisted dying indicates that the sample has a favourable attitude, but the high standard deviation also indicates variability in the sample towards unfavourable attitudes. Future research is needed to address this possibility and ensure the sample is fully representative. Further, nurses in our study had a mean of 22 years of work experience; hence we could not assess how early-career nurses' intend to engage with these requests. A stratified sample across career stages would allow for assessing the impact of ongoing professional development and professional practice maturation on profiles of response intentions.

In terms of the scales used in the study, we acknowledge that the internal reliability coefficients (Cronbach's α) were on the lower end of acceptable, which makes it less likely to detect statistically significant results. Future research could further refine measures, including scales with more items which generally increases internal reliability.

5. Conclusion

In this study, we add to the existing international research by elaborating five combinations of responses, or profiles, that nurses intended to deploy to respond to assisted dying requests. We further demonstrated that different attitudes and beliefs are more predictive of some profiles than others, with particular importance evident for nurses' attitudes, ethical beliefs, and normative expectations of others.

Examining assisted dying through the lens of behavioural profiles allows for a more nuanced depiction of how nurses form different patterns of responses that have implications for organisational policy and practice to support nurses who may increasingly become engaged with these requests.

Declaration of Competing Interest

None.

CRediT authorship contribution statement

Michael Wilson: Conceptualization, Resources, Data curation, Formal analysis, Writing – original draft. **Cheri Ostroff:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Marie E. Wilson:** Conceptualization, Writing – review &

editing. **Richard Wiechula:** Supervision, Writing – review & editing. **Lynette Cusack:** Supervision, Writing – review & editing.

Acknowledgments

Suzanne Edwards, Senior Statistician, for assistance in data tabulation. Dr Pam Oliver for advice on barriers to access. Australian Nursing and Midwifery Federation and Australian College of Nursing for assistance with recruitment of participants. We wish to thank the anonynmous reviewers for their work in improving the draft of this article. This research was funded by the Commonwealth of Australia Research Training Scholarship.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.ijnurstu.2021.104069.

References

Ajzen, I., 1991. The theory of planned behavior. Organ. Behav. Hum. Decis. Process. 50, 179–211.

Armitage, C.J., Conner, M., 2001. Efficacy of the theory of planned behaviour: a meta-analytic review. Br. J. Soc. Psychol. 40, 471–499.

Bagozzi, R.P., Yi, Y., 1989. The degree of intention formation as a moderator of the attitude-behavior relationship. Soc. Psychol. Q. 52, 266–279. doi:10.2307/2786991.

Beckstead, J.W., 2002. Using hierarchical cluster analysis in nursing research. West. J. Nurs. Res. 24, 307–319.

Bernheim, J., Raus, K., 2017. Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care. J. Med. Ethics 43, 489–494. doi:10.1136/medethics-2016-103511.

Beuthin, R., Bruce, A., Scaia, M., 2018. Medical assistance in dying (MAiD): Canadian nurses' experiences. Nurs. Forum (Auckl.) 53, 511–520. doi:10.1111/nuf.12280.

Cohen, S., 2019. The logic of the interaction between beneficence and respect for autonomy. Med. Health Care Philos. 22, 297–304. doi:10.1007/s11019-018-9876-4.

Daws, T., Landry, J., Viens, P., Beuthin, R., Maynard, E., Regglar, J., 2020. Bringing up medical assistance in dying (MAiD) as a clinical care option.

De Bal, N., Gastmans, C., Dierckx de Casterle, B., 2008. Nurses' involvement in the care of patients requesting euthanasia: a review of the literature. Int. J. Nurs. Stud. 45, 626–644. doi:10.1016/j.ijnurstu.2007.06.009.

Dierckx de Casterlé, B., Denier, Y., De Bal, N., Gastmans, C., 2010. Nursing care for patients requesting euthanasia in general hospitals in Flanders, Belgium. J. Adv. Nurs. 66, 2410–2420. doi:10.1111/j.1365-2648.2010.05401.x, https://doi-org.proxy.library.adelaide.edu.au/.

Elmore, J., Wright, D.K., Paradis, M., 2016. Nurses' moral experiences of assisted death: a meta-synthesis of qualitative research. Nurs. Ethics 25, 955–972. doi:10.1177/0969733016679468.

Fujioka, J.K., Mirza, R.M., McDonald, P.L., Klinger, C.A., 2018. Implementation of medical assistance in dying: a scoping review of health care providers' perspectives. J. Pain Symptom Manag. 55, 1564–1576. doi:10.1016/j.jpainsymman.2018.02.011.

Godin, G., Kok, G., 1996. The theory of planned behavior: a review of its applications to health-related behaviors. Am. J. Health Promot. 11, 87–98.

Holt, J., 2019. Nurses' attitudes to euthanasia eleven years on: has anything changed? Nurs. Philos. 1–3. doi:10.1111/nup.12249.

Kaufman, L., Rouseeuw, P.J., 2008. Finding Groups in Data: An Introduction to Cluster Analysis, Wiley Series in Probability and Statistics. John Wiley & Sons, Ltd doi:10.1002/9780470316801.fmatter.

Ketchen, D.J., Thomas, J.B., Snow, C.C., 1993. Organisational configurations and performance: a comparison of theoretical approaches. Acad. Manag. J. 36, 1278–1313. doi:10.5465/256812.

Kirchhoffer, D., Lui, C.W., 2021. Public reasoning about voluntary assisted dying: an analysis of submissions to the Queensland Parliament, Australia. Bioethics 35, 105–116. doi:10.1111/bioe.12777.

Kuhse, H., Singer, P., 1993. Voluntary euthanasia and the nurse: an Australian survey. International Journal of Nursing Studies 30 (4), 311–322. doi:10.1016/0020-7489(93)90103-2.

Lavoie, M., Godin, G., Vezina-im, L., Blondeau, D., Martineau, I., Roy, L., 2016. Psychosocial determinants of nurses' intention to practise euthanasia in palliative care. Nurs. Ethics 23, 48–60. doi:10.1177/0969733014557117.

McDougall, R., White, B., Ko, D., Keogh, L., Willmot, L., 2021. Junior doctors and conscientious objection to voluntary assisted dying: ethical complexity in practice. J. Med. Ethics 0, 1–5. doi:10.1136/medethics-2020-107125.

Mischel, W., Shoda, Y., Mendoza-Denton, R., 2002. Situation-behavior profiles as a locus of consistency in personality. Curr. Dir. Psychol. Sci. 11, 50–54. doi:10.1111/2F1467-8721.00166.

Oliver, P., 2016. Another week? Another week! I can't take another week' Addressing barriers to effective access to legal assisted dying through legislative, regulatory and other means (Doctoral thesis). University of Auckland, Auckland, NZ.

Pesut, B., 2019. Shades of gray: conscientious objection in medical assistance in dying. Nurs. Inq. 00, 8. doi:10.1111/nin.12308.

Quaghebeur, T., Dierckx de Casterle, B., Gastmans, C., 2009. Nursing and Euthanasia: a review of argument-based ethics literature. Nurs. Ethics 16, 466–486. doi:10.1177/0969733009104610.

Ramlo, S., 2016. Centroid and theoretical rotation: justification for their use in Q methodology research. West. Educ. Res. 28, 73–92.

Royal College of Nursing, 2016. When Someone Asks For Your Assistance to Die: RCN Guidance On Responding to a Request to Hasten Death, 2nd ed Royal College of Nursing.

Savulescu, J., 2015. Autonomy, interests, justice and active medical euthanasia. In: International Library of Ethics, Law, and the New Medicine, 64. Springer, Cham, pp. 41–58.

Scherrens, A.L., Beernaert, K., Robijn, L., Deliens, L., Pauwels, N.S., Cohen, J., Deforche, B., 2018. The use of behavioural theories in end-of-life care research: a systematic review. Palliat. Med. 32, 1055–1077. doi:10.1177/0269216318758212.

Schwarz, J.K., 2003. Understanding and responding to patients' requests for assistance in dying. J. Nurs. Scholarsh. 35, 377–384. doi:10.1111/j.1547-5069.2003.00377.x.

Sheahan, L., 2016. Exploring the interface between 'physician-assisted death' and palliative care: cross-sectional data from Australasian palliative care specialists. Intern. Med. J. 46, 443–451. doi:10.1111/imj.13009.

Shoda, Y., Mischel, W., 1994. Intraindividual stability in the organisation and patterning of behavior: incorporating psychological situations into the idiographic analysis of personality. J. Pers. Soc. Psychol. 67, 674–687.

Smith, P., 2021. Many doctors support VAD but would they administer the lethal drug? Aust. Dr. 3.

Stevens, C.A., Hassan, R., 1994. Nurses and the management of death, dying and euthanasia. Medicine and Law 13, 541–544.

Wilson, M., Wiechula, R., Cusack, L., Wilson, M., 2020a. Nurses' intentions to respond to requests for legal assisted dying: a Q-methodological study. J. Adv. Nurs. 76, 642–653. doi:10.1111/jan.14257.

Wilson, M., Wilson, M., Edwards, S., Cusack, L., Wiechula, R., 2020b. The role of attitude in nurses' intentions to respond to requests for legal assisted dying. Nurs. Ethics 1–17. doi:10.1177/0969733020966777.

Wright, D.K., Chirchikova, M., Daniel, V., Blitzas, V., Elmore, J., Fortin, .M.-L., 2017. Engaging with patients who desire death: interpretation, presence, and constraint. Can. Oncol. Nurs. J. 276, 56–64. doi:10.5737/236880762715664.

Chapter Seven: Contributions of this research

> "It is time for all professionals within the health industry… to consider what their response will be should the question of voluntary assisted dying arise in their workplace." (Western Australia VAD Implementation Leadership Team, Communique May 2021)

7.1. Reflection

This research project began shortly after the Australian state of Victoria legalised AD in November 2017, but before that law was implemented. That timing facilitated the collection of data of nurses' intentions to respond to requests for that service as a way to gain insight into how nurses might adjust to this new practice environment. The Victorian legislation emerged in Australia as part of a global trend toward legalising AD. What began in Uruguay in1934 as a judicial decision not to prosecute 'honourable' doctors for the act of 'compassionate homicide' (BBC News, 2012) became a tentative movement across western democracies. In the first decade of this century, legalisation began to accelerate as several more jurisdictions in Europe and North America (and in the 1990s, very briefly, in the Northern Territory of Australia) began to regulate that practice. The researcher's view was that the new Victorian law would be the first among other Australian states and that increasing legalisation of AD would have an untested impact on nursing practice as laws evolved to meet distinct demographic and regional needs.

While the language of the Victorian legislation regulated the actions of healthcare professionals generally, the focus of the statute was on doctors' activities. Its focus on doctors was not surprising, as its legal structure was consistent with earlier statutes in the US specifically legalising 'physician-assisted dying', which mandated that only doctors could assess eligibility and prescribe the lethal drug(s). However, recent nursing research has begun to elaborate a pivotal role in providing AD in responding to informal requests (Fujioka et al., 2018). These informal requests are distinct from the legal requirement of the formal request that is required by the statutes. The requirement of the 'first' request in Australia is that it be formally delivered to a health professional qualified to receive it (Government of Victoria, 2017). The requests considered in the context of the present research are often tentative, exploratory and ambiguous, as patients might know there is a legal option but may not know how to ask about it, and nurses are frequently the health professionals to receive these requests (Beuthin et al., 2018; Fujioka et al., 2018).

Responding to the informal request can be pivotal to patient outcomes because the nurse's response to an exploratory request can influence the patient's subsequent choices. As de Beer et al. (2004) observed, nurses do not always interpret the euthanasia request in the way the patient intended. "Precisely as a result of their immense personal involvement and long-standing relationship with the patient, in some cases, nurses go by their feelings regarding the request" (De Beer et al., 2004, p. 496). Responding to these requests may be a source of moral distress for nurses who realise the gravity of the request but might feel under-prepared to respond or whose work pressures do not allow time to respond adequately (Elmore et al., 2016). Beuthin et al. (2018) found that while most nurses accepted AD as an extension of nursing practice, their evaluation of it occupied a 'middle ground' of sense-making between support and objection.

After reviewing the literature on nurses' participation in AD, the research question came to be clarified as: How do Australian nurses intend to respond to informal requests for legal AD, and what underlying influences shape those intended responses?

The first step to answering that question required an analysis of nurses' subjective views on responding to AD requests to set the foundation for normative analysis of how attitude and other beliefs of a sample of Australian nurses predicted a discrete response. However, that analysis revealed an interaction of beliefs and intention that was more complex and ambiguous than expected and that intentions were not discrete, but that multiple intentions could co-exist. Experimental research on intentions has demonstrated that some intentions are stronger than others and that a stronger intention is a more reliable predictor of a behaviour (Bagozzi & Yi, 1989). Taken together, the insights about co-existing intentions of varying strengths prompted a pivot away from a normative view of the sample as a whole, back to the intentions of individual nurses. That pivot tried to identify, firstly, the profiles of nurses who shared patterns of co-existing intentions, and secondly, which beliefs predicted membership of those profiles.

The literature review that opened up the research question was clear that nurses' participation in AD was a complex decision, and those decisions usually – but not always – resulted in one response or another. Hence the theoretical framework that guided the implementation of this research and the analysis of the data, the TPB, was suited to the research question, as most research supporting that theory was based on a relative binary intention (to participate or not). However, as each component of this project resulted in unique findings and contributed to a subsequent component, the project as a whole led to an unexpected finding that the complexity of intentions can be more easily understood as clusters of shared patterns of intention-strength by different groups of nurses.

The evolution of the project also identified some weaknesses that limit these findings. However, even within those limitations, there are implications for nursing practice and policy consistent with the most recent literature on the emerging regulatory environment as Australia opens up access to legal AD. The following sections discuss the implications of these findings for Australian nursing practice and policy.

7.2. Implications for policy and practice

In responding to requests for AD, the nurse's role is complicated by professional and ethical constraints and time pressures often related to the urgency of these requests. The findings from the published studies generated by this project have practical implications that can help professional bodies and healthcare providers support nurses to care for patients who request AD. The following subsections highlight new challenges as the features of the various Australian AD laws become clearer. In these situations, the structures that present barriers to patient-centred care include 1) the prohibition against initiating discussion of AD with a patient, 2) the right of non-referral for nurses who conscientiously object, and 3) the urgency created by Australia's system of prospective approval of requests.

1. Prohibition against initiating a discussion about AD. Clause 8 of the Victorian legislation prohibits healthcare professionals from initiating a discussion about 'VAD' (Government of Victoria, 2017), including suggesting it as part of a range of treatment options. While Clause 8 is primarily directed toward the medical practitioner who receives and records a formal request, a similar problem arises for the nurse who hears an informal, exploratory request. That is, the requesting patient may hold multiple questions about desiring to die, hastening death, having suicidal thoughts, or asking frankly about AD (Willmott et al., 2020). Most nurses in the present research intended to explore the meaning of the request, but this exploring

can be especially difficult if a patient asks what treatment options are available at the end of life. Nurses in Tasmania and Queensland, like nurses in some Canadian provinces, can present AD as a treatment option, but only with the proviso that the person must speak with the doctor if they have any further questions. However, raising AD in such an encounter is not an option in three other Australian states that now have legislation (Victoria, Western Australia, South Australia).

Possibility for change. The variations of regulations around raising the topic of AD with potentially eligible patients who make exploratory requests or ‘desire-to-die’ statements create inequitable routes of access to a legal end-of-life option. It might not be realistic for nurses to know legal requirements related to every treatment option, but nurses should know at least the eligibility requirements for AD in their jurisdiction to reduce harm by discussing AD with patients who clearly would not be eligible (Hewitt et al., 2020). Beyond that basic shared requirement, there are sound reasons for consistent national policy in this regard. It is clear that an ‘Australian model’ has emerged around AD, but with sufficient variations to meet the unique needs of a given jurisdiction. However, the question must be asked about whose needs are met by including this prohibition in law? This particular prohibition, described as a ‘safeguard’, appears to be an ad-hoc insertion into law that leads to inconsistency without improving patient safety (ACHLR, 2021). Australian researchers have developed strategies for responding to requests that help a patient explore the request; to understand what is being requested. However, these strategies are acknowledged as “at best, workarounds” to these prohibitions (Willmott et al., 2020, p.109) and can still expose some nurses to criminal penalties.

It seems that systemic action might be required to protect nurses and focus concern on the requesting patient. Nursing professional bodies could collaborate with patient advocacy groups to pressure legislators to repeal clauses that prohibit the initiation of this discussion. The opposite position could also be taken, of course. Professional groups could lobby for the prohibition of raising the topic of AD to be across all laws. However, that latter position would not be tenable since counselling patients at the end of life about all legal options is a generally understood expectation of ethical nursing practice (Daws et al., 2020).

2. The right of non-referral. Clause 7 of the Victorian legislation codifies the right of non-referral as *"There is no obligation to refer in circumstances where a practitioner conscientiously objects"* (Government of Victoria, 2017). Western Australia has a similar protection "to not participate in the request" (Voluntary Assisted Dying Act 2019). South Australia's law states that conscientious objectors are not required to "provide information about voluntary assisted dying" (Voluntary Assisted Dying Bill 2020, 2021).[2]

There are two features of nursing practice that are not recognised sufficiently in laws that provide legal protection for non-referral to another practitioner or withholding information about AD for reasons of conscience. First, conscientious objection is not a binary decision for most nurses but often a layered one influenced as much by context as an ethical stance (Pesut, 2019). Further, not all objections are conscience-based; some objections may be based in emotion (e.g., concern about liability or competency). The complexity of identifying one’s objection and how that is registered in advance of such an encounter is under-researched (Brown et al., 2021).

Second, the right to non-referral can put nurses who object in an invidious situation as Australian nursing professional standards are clear that nurses must:

> "… responsibly use their right not to provide, or participate directly in, treatments to which they have a conscientious objection. In such a situation, nurses must respectfully inform the person, their employer and other relevant colleagues of their objection and ensure the person has alternative care options". (Nursing and Midwifery Board of Australia, 2018, clause 4.4.b)

In short, while the law protects the nurse who conscientiously objects, invoking that protection can put a nurse at odds with practice expectations.

Protection for conscientious objectors to neither refer nor provide information about AD options privilege some healthcare professionals at the expense of patients' agency and equitable access to a legal end-of-life option (McDougall & Pratt, 2020). That protection conflicts with professional guidance that expects requests for AD to be referred, a conflict that can be difficult to resolve. A recent study among Canadian healthcare providers who would not participate in MAiD concluded that referral in the

---

[2] Tasmanian law is silent on this matter, but the Queensland law specifically requires conscientious objectors to refer the request to a colleague.

context of the emotional labour of end-of-life care is complex but is nonetheless "essential to support the social contract of care" (Brown et al., 2021, p.1795). That study found that referral pathways must accommodate patient needs while protecting the moral space of objectors. Examples of referral pathways have been developed in Ontario, Canada and Victoria, Australia.

Reports of early experiences of hospital-based delivery of MAiD in Canada reveal how preparation and organisation can deliver patient-centred care in responding to an informal request. The largest hospital network, belonging to the University of Toronto, organised a three-tier team approach to MAiD requests and an organisational framework that ensured staff were prepared to respond to requests. The front-line tier are clinicians involved with the patient (doctors, nurses, allied health). That front-line tier of service has one responsibility on hearing that request "All staff to notify most responsible physician (MRP) same day" (Li et al., 2017, p. 2084). A similar three-tier model has been adopted by the Saint Vincents Hospital Melbourne (Australia), where the staff member who hears the request follows a distinct four-step 'CARE' protocol: Clarify, Acknowledge, Respond, Escalate (Boughey, 2020). A specially-trained team whose members have volunteered for the role take over responsibility for all further discussions with the patient. Because volunteers assume assessment, counselling and legal compliance, the issue of conscientious objection does not arise. This emerging organisational structure can minimise the participation of objecting nurses in the more direct aspects of delivering AD services, but it does not address the problem of the nurse who will hear but not refer the request.

Possibility for change. In the Australian context, where non-referral is a right for any objecting healthcare professional, employers could address the conflict with protocols to quickly and appropriately escalate requests while maintaining the nurse's right to object. McDougall et al. (2021) have proposed that a script be prepared to allow a respectful exit from the discussion should a request arise. Another practice that could escalate the request without the nurse having to refer it to another professional to manage might require that an objecting nurse formally notifies the unit manager that a patient has made the request, with a statement of conscientious objection to responding to it. These are just work-day suggestions that represent a compromise that recognise the limits of the practitioner's moral integrity and the patient's rights. Nonetheless, this could be considered in future guidance and perhaps explicitly stipulated in professional standards and code of conduct for nurses.

3. Prospective approval**.** A significant feature of Australia's emerging legal framework, a core component of the emerging Australian model, is a system of prospective approval for a medically assisted death. That prospective approval feature is unique among AD regulations globally. European, Canadian and US jurisdictions allow AD to be a medical decision reviewed retrospectively with sanctions for procedural failures. The Australian prospective approval system requires each step to be reviewed by a state-level Commission before the next step in the process can occur (White et al., 2021). Research among doctors in Victoria who have participated in providing that state's VAD programme has described their frustration with the legalistic, ‘byzantine’ process that creates unnecessary delays for people making a request (e.g., reviews are not available on weekends or are returned for typographical errors) (White et al., 2021). That claim of unnecessary delays is supported by the reported ratio of 43.5% of all 2020 applicants in Victoria who died while waiting for a decision on their request (State of Victoria, 2021). That rate is twice that of California in the first year of its AD law (Huong et al., 2018).

These findings demonstrate the need for timeliness often attached to requests for an assisted death, and that urgency highlights a basic challenge for nurses in Australia to respond effectively. Nursing guidelines (e.g., Australian Nursing and Midwifery Federation, 2016) are clear that patient-centred care requires a response that clarifies what the person is requesting and referring the request according to protocol. However, the findings from this study align with findings from European research (Gamondi et al., 2019) that suggest nurses intend to respond in ways that might frustrate a patient's need for urgent action on the request.

Of the 369 nurses included in the cluster analysis in this present research (described in Chapter Six), all nurses reported an intention to refer the request. However, only a minority of nurses (‘Expediters’, 18%, n = 66) intended to ensure the request was understood and that the requestors' immediate needs were assessed, and the referral was enacted. All other profiles had stronger intentions to discuss palliative alternatives to AD. The finding that most nurses had a strong intention to discuss alternatives to AD is not surprising. These data were collected before the first AD law in Victoria was implemented, so nurses responded to a type of request – a desire to die statement – with which 70% of this sample claimed prior experience. Hence, these nurses likely approached the survey’s hypothetical scenario from a business-as-usual mindset that might have regarded such a request as a more generic ‘desire-to-die’ statement, where assessing palliation needs would have been expected practice (Hudson et al., 2016). However, anecdotal evidence is emerging from nurse 'navigators' for VAD in Victoria and Western Australia, indicating that people who make specific AD requests are less likely to be making exploratory requests because they have been considering this option even before it became legal (Hudson, 2021). There seems to be a mismatch between what nurses are used to providing and what patients at the end of life seem to expect for themselves in light of this new legal option. That mismatch has the potential for exacerbating an already burdensome delay.

<u>Possibility for change</u>. Nurses can have an important role in mitigating the delays caused by the system of prospective approval. Findings from this study, described above, suggest that Australian nurses are not yet prepared for that role, which has implications for professional preparation. Professional preparation can be managed through role clarification, educational preparation and collegial support.

Role clarification. International data (Hendry et al., 2012), including recent data from Canada (Wiebe et al., 2018), demonstrate that the main reason people requested AD "was to relieve distress over the loss of autonomy and to experience a sense of personal control over the circumstances of dying" (Li et al., 2017, p.2088). Symptom management is commonly a less urgent concern. In a time-pressured context, particularly when a person is at the end of life, discussing alternatives to what the patient requested might not just be a disservice to the person but also might stray from the nurse's scope of practice in this situation. The position statement of the Australian College of Nursing about the Victorian law states that "[l]egislation requires that *medical practitioners* ensure that the individual is properly informed of all treatment and care options and likely outcomes, including palliative care" (emphasis added) (Australian College of Nursing, 2018, n.p.). However, the scope of nurses' practice in responding to informal requests might benefit from understanding that it falls within the ambit of ascertaining the meaning of the request (Explore) and referring it (Refer). Like the tiered system that operates in the St Vincent's Melbourne hospital, other professionals qualified to further the request have the responsibility to ensure all treatment options are explained. Clarifying and referring the request could manifest respect for the autonomy of the requesting patient, particularly when the patient presents a well-considered request.

Professional preparation for new responses. Because intention is a cognitive activity, there is an obvious link with the developmental practice of cognitive rehearsal as a way to clarify an intention to respond (Griffin & Clark, 2014). When a response is being considered in advance of the actual request – against the complex background of competing interests, such as ethical principles, the duty of care, the outcomes for the patient, the nurse's attitude, or social constraints - intention can be focussed on the deliberate practice of a response. Like scripts that conscientious objectors can use to respectfully navigate an exit from a discussion (McDougall et al., 2021), guided practice in formulating a confident response based on evidence of patient expectations and relevant legislation can minimise problems for nurses who find themselves engaging with requests for AD. Preparing one's script for responding can be supported by including feedback from colleagues who are more familiar with the law and organisational policy. Simulated conversations that include that feedback might reinforce the expectations of trusted others. This research has shown that Facilitators and Compliers were distinguished by their reliance on the expectations of others to assist with a request, but nurses in the Detached profile might simply be ambivalent and could be well-supported by clear feedback about the team's culture.

7.3. Contributions to knowledge

The focus of this research project was the identification, measurement, and explanation of influences on intention to respond to requests for AD. The literature review in Chapter Two and the methods in Chapter Three laid out the scientific rationales for the role of intention as a reliable predictor of future behaviour. Because intention is essentially a construct about the future, the focus on intention is appropriate to the prospective analysis of nurses' likely behaviour in the face of an imminent cultural and legal shift in end-of-life care delivery. The level of analysis for intention is the individual. The TPB has demonstrated its value for analysing degrees of influence of individual intentions on a single behaviour (for example, how strongly one intends to wash hands before attending to a patient). However, in the nurse's interaction with a patient who requests AD, understanding ethical influences on intention extended the TPB into a unique area of inquiry. Further, this research project asked nurses to (1) identify and scale their intentions to act in multiple ways and (2) to express the relativities of intention between alternative response options; that distinction is elaborated below.

7.3.a Theoretical contribution.

This research demonstrated that, in general, nurses held intentions to refer the request, explore the meaning of the request, assess the patient's informational and other needs, and promote the consideration of alternatives. A few nurses held some level of objection to participating in the discussion of the request.

The relevant findings described in Chapter Five revealed a complex interaction of attitude with other influences on response intentions. The strongest interactions (in statistical terms) were between attitude and two bioethics beliefs – autonomy and beneficence – such that stronger agreement with patient autonomy supported an intention to refer. In comparison, a stronger agreement with beneficence supported an intention to discuss alternatives or conscientiously object to the request (Wilson et al., 2020). Those interactions add a new dimension to TPB, which hitherto has seldom included the interaction of ethical beliefs with other psychosocial variables, and distinguishes it from other studies of AD where either only ethics are considered (e.g., Pesut, 2019; Quaghebeur et al., 2009; McCabe, 2007) or where these are not seen as interacting or additive (e.g., Lavoie et al., 2016).

Regardless of the nurse's ethical or attitudinal evaluation of the request, nurses generally agreed with the relevant survey items that they would refer the request. That intention to refer the request is consistent with practice expectations for responding to requests for AD (e.g., Australian Nurses and Midwives Federation position statements of 2016, 2019). However, nurses who perceived strong expectations from significant others to assist AD requests, such as colleagues or family members, were more likely to intend to have an intention to refer the request. The intention to refer regardless of attitude is consistent with a view that moral choices are often determined in response to the 'top-down' pressure of social expectations (Gaus, 2017).

The research on nurses' intentions to participate in AD has described complex, sometimes conflicting decisions (e.g., Beuthin et al., 2018; Elmore et al., 2014; Berghs et al., 2005). However, no prior research had measured co-existing intentions or the relative strengths of those intentions. Therefore, the results reported in Chapter Six offer a novel perspective on the latent complexity of intention and action in this domain and the moral and professional complexity that underpins nursing practice in this area. The primary inference drawn from these findings was that each nurse might have distinct intentions that form 'behavioural signatures' or profiles (Mischel et al., 2002).

Further, the findings from the study in Chapter Six suggested that attitude and ethical beliefs might shape those patterns. Thus, examining complex, individual patterns of response intentions across cohorts of nurses who share similar ‘profiles’ can offer insights into diverse profile dynamics and the psychosocial predictors of these intention signatures.

The realisation that multiple types of intentions can be differentially predicted supported a return to the theoretical grounding of intentions at the level of the individual. That return to the individual nurse's intentions was a pivot from the normative, list-wise approach of mean response intentions of the entire sample to a case-wise view of the data from individual nurses, aggregated into similar profiles. That pivot allowed a view of the distinctive characteristics and drivers of nurses’ intentions in this emerging clinical area. That pivot from the entire sample back to a more finely-grained analysis of individuals who shared similar intentions facilitated identifying the patterns of intentions and cohorts of nurses who shared similar patterns on intended responses.

The multiplicity of intentions, and the identification of cohorts within a sample or population that share similar intention profiles, allows a more nuanced approach to predictors and correlates. While aggregated models tend to wash out important factors to distinct subgroups, focusing on cohorts enables a conclusion that nurses with similar intentions may share attitudes and beliefs. Profiling moves us beyond considering an aggregate relationship to understand that different factors and beliefs may dominate intentionality for different groups.

7.3.b. Methodological contribution

This research project has also made a methodological contribution by using Q-methodology, cluster analysis and logit modelling of membership of response profiles by psychosocial variables. The use of Q-methodology, which creates factors that are true to individual respondents through case-wise solutions, is reinforced through cluster analysis which again uses a case-wise approach. The clusters present similarities within the group of respondents without any pre-determination by the researcher. Further multinomial regression allowed simultaneous consideration of the natural complexity of a clinical intention. These steps developed a closer approximation of the individual focus of the TPB framework than was possible through aggregated linear correlational analyses alone.

7.4. Limitations

The process of doing this research revealed some important limitations related to the ambiguity of a nurse's level of support for or objection to a request for AD, a weakness in the TPB model related to the sample or the type of analysis, and the limited ambit of the hypothetical scenario. The limitations described below are unique to the overall project; the limitations specific to the published studies are described in the relevant manuscripts in Chapters Four through Six.

The ambiguity of ‘objection’. While one of the strengths of the TPB model is that it is built 'from the ground up' by elicitation studies, it can also have its weaknesses. One type of response that did not appear in the range of intended responses for the survey phases of the research was conscientious objection. Conscientious objection is a protected status in the laws of most jurisdictions, exempting a health professional from any participation in AD services, including the referral of a request or the provision of any information about the service (in some Australian States) (McDougall & Pratt, 2020). Even though the legal protection seems unambiguous, understanding what constitutes conscientious objection is not straightforward and was difficult to capture in the elicitation study. Pesut et al. (2019) observe that conscientious objection for some nurses may be a binary decision that can be declared to an employer on commencing employment, but for most nurses, an intention to assist with a request might depend as much on context as an ethical stance. Some of that context includes the patient’s condition (Vezina-Im et al., 2014), but also, as seen in the predictors of profiles of response patterns in Chapter Six, the context includes what others expect of us. Some nurses might refer the request or provide information because they see referral as expected behaviour, despite their disagreement.

Those ambiguities may have restricted the typology of intentions in each of the three studies in this project. In the Q-method survey, nurses could elect extreme response options as something they would say to a patient that reflected conscientious objection. One example of that type of response was: ‘Discussing this makes me feel complicit in an action that I cannot be involved in’. These more extreme response items were rated highly as an intended response by few nurses (n=4; 8%) and did not rise to the level of statistical significance that loaded onto a factor. As a result, they were not included in subsequent survey research, though there were proxies for those more extreme intentions in the ‘Object’ type of responses. The relatively low reliability coefficients of the ‘Object’ scales were discussed in Chapters Five and Six.

Cluster sizes. The sample sizes of the profiles derived from the cluster analysis were divided into smaller datasets of five separate clusters, with each cluster being a sub-sample, the smallest of which contained only 26 respondents. As the research project progressed and analyses became finely grained, it was likely that weaker effects were no longer statistically significant. The level of analysis with smaller sub-samples may have contributed to a nil finding for perceived behavioural control (PBC) as a predictor of intention. Experimental research has shown that PBC can be neutralised as a predictor in studies with smaller sample sizes where other predictor variables are clustered or skewed (Yzer, 2012). While PBC normally interacted with attitude in studies of intention and did so weakly in the normative analysis in Chapter Five, the positive skew of responses to the 5-point attitude scale (x=4.6; sd=.53) combined with the reduced sample size through clustering may have eroded any reliable findings.

Limited contextual richness. Finally, using a single hypothetical scenario that aligned with the language of the recently passed Act in Victoria helped focus responses from survey participants. However, the hypothetical scenario would not have captured the complex social interactions in these nurse-patient exchanges (Gould, 1996). A set of scenarios could have provided more nuanced information, as it did for the study by Lavoie et al. (2016); however, doing that in the present research might have been at the cost of a reduced number of respondents due to the fatigue from participating in a lengthy survey. However, it seems on the face of it that developing profiles of patterns of intended responses might have mitigated that limitation since it evoked identifiable sets of multiple response options that might reflect real-world variations, particularly given the experience levels and tenure of the sample, and the reported prior experience of requests by 70% of the sample.

7.5. Future research

Since this research project began, a broad consensus around the legal framework for AD has emerged in Australia, although each of the five states that have passed legislation has varied that framework to suit their unique circumstances (ACHLR, 2021). That consensus allows future research to understand better situational triggers that promote different responses, particularly the objector who would not discuss AD. This study did not measure whether a refusal to participate in this discussion was conscience-based (i.e., derived from a religious or moral stance) or non-conscience based (e.g., concerns about competency or liability) (Brown et al., 2021). Future research could include a simple prompt for questions about objection-related intentions connected to specific situations that might evoke different types of objection.

A related area for future research that could be especially helpful for professional development providers might focus on factors that prompt a nurse to shift into a different profile. For instance, in Chapter Six, we saw that subjective norms – the expectations of others – influenced nurses in some profiles to have a stronger intention to refer the request than nurses in the 'Detached' profile. That finding led to an inference that if the 'detached' nurse had collegial support, then supporting the patient's request might promote alignment with another profile. However, that was only an inference. Future research could operate under the assumption that an intention to participate in AD is not only non-binary but also fluctuates for an individual across time and place. The respondents in this study gave their views at a point in time, and research shows that the willingness of practitioners to engage in AD changes over time, depending on the general acceptance of the practice (Gamondi et al., 2019). Most nurses in this study's sample held some measure of ambivalence despite a largely positive attitude toward the legalisation of AD. Understanding the role of ambivalence in intention to participate in AD, particularly in intending to exercise the right to non-referral, could be uncovered through qualitative research. Those findings could help nurses work in this new environment by identifying beliefs and ambivalences about AD.

7.6. Concluding remarks

This research examined the intention to respond to a request for AD. Different analytical approaches identified different types of intentions and differing influences of psychosocial variables. Examining intentionality through mixed-method perspectives has shown that nurses indicate common patterns of intentions, where some intentions are stronger than others, and those patterns are distinguished by the psychosocial characteristics of cohorts of nurses who share them.

The finding of shared patterns of intentions has extended nursing research in the growing area of inquiry into nurses' participation in AD. Moreover, by focusing narrowly on intentions to respond to requests, this project has extended research that has considered participation as a unitary construct towards a multi-faceted consideration relevant to most nurses, whose only participation may be in responding to patient questions and requests. This project began as a quest to identify the likely responses nurses might have to such requests. Exploring the predictors of discrete responses led to discovering the complexity of intentions and judgements related to attitudes and ethics. This project has found that nurses, even those without prior experience hearing AD requests, can articulate a range of potential intended responses to those.

This research was informed by the interacting dynamics of the social ecology model that suggested multiple influences can help nurses find their paths through this new practice environment. The relevance of this research for Australian nurses is for their preparation to manage AD request encounters, the usefulness of collegial support, and organisational processes to enable both of those. This research can inform modules of professional preparation to support effective practice. Based on the findings of this project, such preparation should include recommended limits to the nurse role in these unique, preliminary end-of-life conversations, the evidence about the usual reasons people might request AD, the implications of urgency for formulating an effective response, and the cognitive rehearsal of those responses based on if-then scenarios. Apart from individual preparation, organisational support could include protocols aligned with the Nursing and Midwifery Board of Australia's professional standards (clause 4.4.b) for conscientious objectors to respectfully exit the discussion while notifying a manager that a request has been encountered. Knowing that collegial support plays a significant role in helping nurses to respond effectively, organisations that provide AD can structure practices that support team cohesion in those units where it will most likely occur.

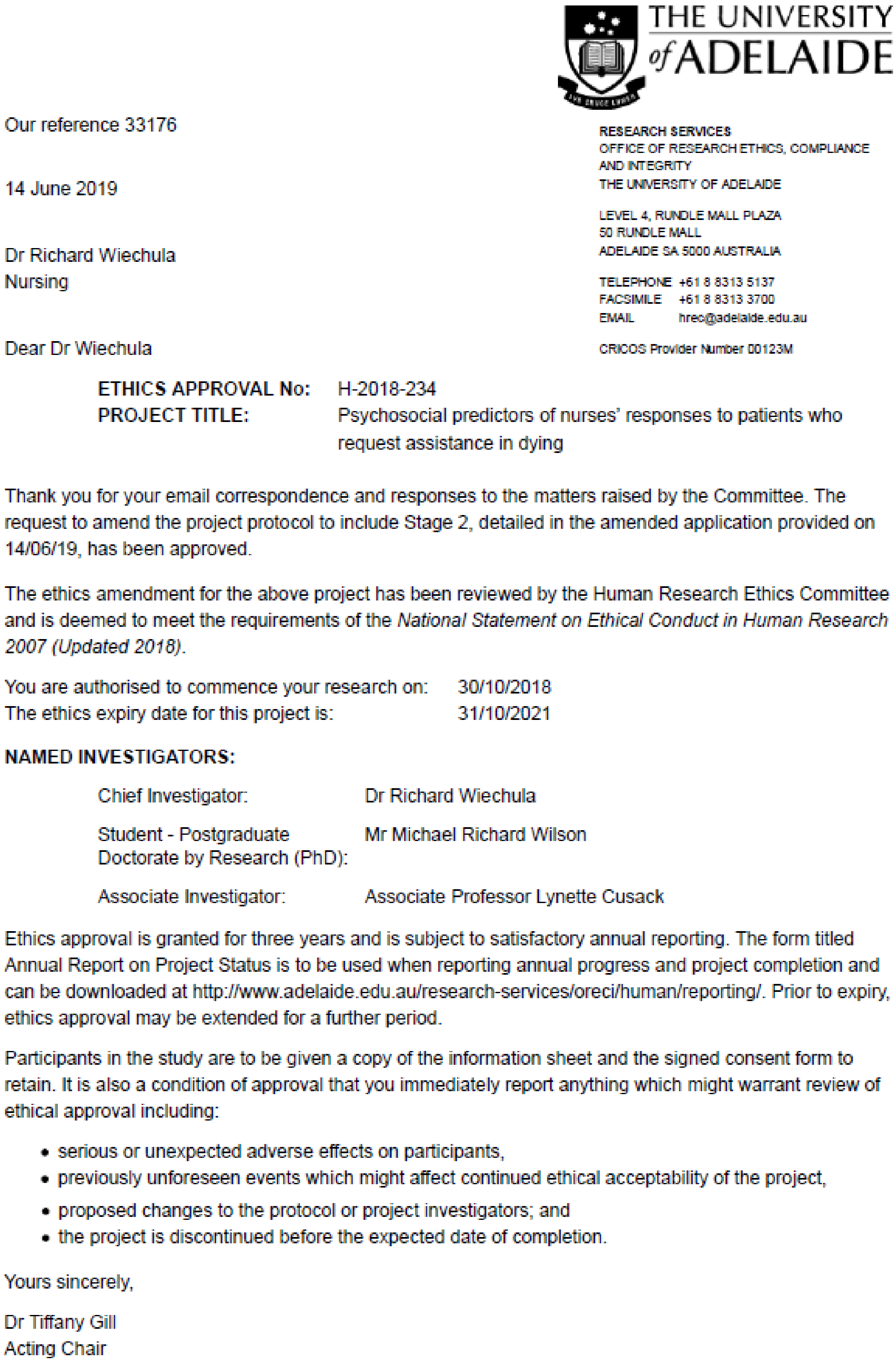
Appendix 2.1: Themes of suggested responses

Reference	**Response Suggestions**	**Theme**
Bascom & Tolle, 2002, JAMA	What do you understand about your end of life care options?	Assess Info
	How specifically would you like me to help you?	Assess need
	How will your family react if you proceed with an assisted death?	Elide
Hudson, et al., 2006, Pall Med	Can you tell me about the things that frighten or concern you the most at the moment?’’	Explore
	‘‘Some people make this statement when they’re feeling really ‘down’; then when circumstances change they feel differently. What do you think things might look like tomorrow?	Explore
	What do you feel could be improved in your care and treatment?’	Explore
	Can you tell me about how others have reacted to you being ill like this. . . who would you say understands best what you are going through?	Explore
	We should talk a lot more about this. Before we can know what way to proceed, let’s talk about why you are asking me to help you die	Explore
	Can you tell me how you’ve come to feel like this and why you want to take this action?’’	Explore
	‘Who else knows that you have expressed this wish to end your life?’	Explore
	Have you found yourself thinking about taking your own life?	Assess mental state
	We should talk a lot more about this, before we know what to do. Let's talk about why you are asking me to help you die.	Explore meaning
	Can you tell me how you've come to feel like this and why you want to take this action?	Explore meaning
	Have you been able to discuss this with the doctor who is most involved in your care?	Assess referral
	You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?	Explore meaning
	Can you tell me why you wish your life would end?	Assess mental state
	You sound like you are feeling quite hopeless. Have you found yourself thinking about taking your own life?	Assess mental state
	Is this something you've been thinking about for awhile, or is it something you've thought about today or recently for the first time?	Assess mental state
Lehto, et al. 2016 Hosp & Pall Nrs	Is this something that is an actual, complete, urgent wish for you?	Assess mental state
	We have many options to control your symptoms and help you to feel better	Promote alt

Reference	**Response Suggestions**	**Theme**
	We will be here for you no matter what you decide	Non-abandon
B. Lo, 2018 NEJM	Discussing AD makes me feel complicit in an action that I cannot be involved in	object
	The medicines used can affect people differently, and sometimes there can be very unpleasant events	Dissuade
	I can't answer that question, but I'll talk with other members of our team to find someone who can	Elide
	For a lot of reasons I can't help you with that particular question. You will need to ask one of my colleagues.	Elide
	I can't help you with that question, but what I can do is reassure you that I will do everything I can to support you being as comfortable as possible	Non-abandon
Ohnsorge et al., 2012, Nrs Ethics	When you talk with your doctor about this, have you told her what you have told me?	Assess referral
Oliver, 2016, Dissertation	I imagine your reasons for asking this are complex, but my job here is to provide you with factual information and identify alternatives	Inform
	I would never choose that for myself, but I want you to know that I will accompany you on this path if it is open to you.	Non-abandon
	Can I have your permission to consult with your family before taking the conversation further?	Elide
	Has anyone explained other options that can be available to keep you comfortable as your illness progresses?	Assess info
	The assisted dying option is not available at this facility - it's just our policy.	Object
	My views about assisted dying are that it would breach my own values/religion to encourage you to have that question	Object
	An assisted death is a real option that might be available to you.	Affirm
	I understand what you must be feeling, and I want you to know that I respect your wish to control the timing and manner of your death.	Affirm
Gamondi, et al. 2017, BMJ Supportive and Palliative Care	I can give you some information about legal requirements for accessing an assisted death, but your doctor will be the person who will help you decide.	Affirm
	I hope you will discuss this request with your family, but I want you to know that I won't do that without your permission	Non-abandon
	Is it okay with you if I speak with your doctor about this request? She will be able to discuss ways to manage pain with you.	Assess referral
	I need to share this request with the rest of your team, but you should know that not everyone supports such requests.	Assess referral
	The process for approval for an assisted death may take a long time, maybe more time than you have available	Dissuade
	Sometimes the procedure can be difficult, it has been known to fail.	Dissuade
	Are you aware of the impact of this procedure on any life insurance you might have?	Dissuade
	It can not be reversed. I am convinced that there is a reason to living	Dissuade

Reference	**Response Suggestions**	**Theme**
	Everyone has responsibility for their own life, that includes the type and the way in which they die	Affirm
Quill, et al., 2016, JAMA	What are you most worried about?	Explore
	Tell me more about exactly what frightens you.	Explore
	What kinds of deaths have you seen in your family?	Explore
	How are you hoping I can help you?	Explore
	What makes your situation most intolerable right now?	Explore
	Tell me more about the worst part.	Explore
	How do you think your family feels or would feel about your wish?	Elide
	Exactly how are you hoping I can help you?	Explore
Canadian Cancer Society, 2013	What do I need to know about you as a person to give you the best care possible	Explore
L. Emanuel, 2005, JAMA	I know from talking with you that your goals for personal dignity and not being a burden to your family are strong, but there are ways to achieve that without resorting to assisted dying.	Dissuade
Wright et al., 2016, Can Onc Nrs J	I have to be honest, I am not the most comfortable approaching the subject	Object

Appendix 3.1. Evidence of Ethics Approval



THE UNIVERSITY of ADELAIDE

RESEARCH SERVICES
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY
THE UNIVERSITY OF ADELAIDE

LEVEL 4, RUNDLE MALL PLAZA
50 RUNDLE MALL
ADELAIDE SA 5000 AUSTRALIA

TELEPHONE +61 8 8313 5137
FACSIMILE +61 8 8313 3700
EMAIL hrec@adelaide.edu.au

CRICOS Provider Number 00123M

Our reference 33176

14 June 2019

Dr Richard Wiechula
Nursing

Dear Dr Wiechula

ETHICS APPROVAL No: H-2018-234
PROJECT TITLE: Psychosocial predictors of nurses' responses to patients who request assistance in dying

Thank you for your email correspondence and responses to the matters raised by the Committee. The request to amend the project protocol to include Stage 2, detailed in the amended application provided on 14/06/19, has been approved.

The ethics amendment for the above project has been reviewed by the Human Research Ethics Committee and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)*.

You are authorised to commence your research on: 30/10/2018
The ethics expiry date for this project is: 31/10/2021

NAMED INVESTIGATORS:

Chief Investigator: Dr Richard Wiechula

Student - Postgraduate Doctorate by Research (PhD): Mr Michael Richard Wilson

Associate Investigator: Associate Professor Lynette Cusack

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled Annual Report on Project Status is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the information sheet and the signed consent form to retain. It is also a condition of approval that you immediately report anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol or project investigators; and
- the project is discontinued before the expected date of completion.

Yours sincerely,

Dr Tiffany Gill
Acting Chair

Appendix 3.2. Q-set of response items

#	Statements
1	I would never choose that for myself, but I want you to know that I will accompany you on this path if it is open to you.
2	We will be here for you no matter what you decide.
3	I imagine your reasons for asking this are complicated. I can help by providing you with factual information and identify alternatives.
4	An assisted death is an option that might be available to you.
5	Everyone has responsibility for their own life, that includes the type and the way in which they die.
6	It seems like you have little hope. Have you found yourself thinking about taking your own life?
7	You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?
8	The medicines used can affect people differently, and sometimes there can be very unpleasant side effects.
9	Sometimes the procedure that actually ends the life can be difficult, it has been known to fail.
10	The process for approval for an assisted death may take a long time, maybe more time than you have available
11	Discussing this makes me feel complicit in an action that I cannot be involved in
12	Because of my own views about assisted dying, I cannot encourage you to ask that question.
13	I have to be honest, I am not comfortable approaching this topic
14	For a lot of reasons, I can't help you with that particular question. You will need to ask one of my colleagues.
15	When you talk with your doctor about this, have you told your doctor what you have told me?
16	I can give you some information about legal requirements for accessing an assisted death, but your doctor is likely to be the best person to assist you in deciding.
17	I can't answer that question, but I'll talk with other members of our team to find someone who can
18	Have you been able to discuss this with the doctor who is most involved in your care?
19	If you are asking because you can't tolerate your pain, I'll let your doctor know so we can find ways to relieve that pain.
20	I understand that you do not wish to be a burden to your family, but there are ways to achieve that without resorting to assisted dying.
21	How will your family react if you proceed with an assisted death?
22	I hope you will discuss this request with your family, but I want you to know that I won't do that without your permission

23 How long have you been thinking about this?
24 Are you very sure you want to do this?
25 What makes your situation intolerable?
26 Tell me more about the worst part.
27 Tell me more about exactly what frightens you.
28 Can you tell me about the things that frighten or concern you the most at the moment?
29 How are you hoping I can help you?
30 Let's talk about why you are asking me to help you die.

31 I can't help you with that question, but what I can do is reassure you that I will do everything I can to support you being as comfortable as possible
32 What do I need to know about you to give you the best care possible?
33 What does your illness mean to you?

34 Can you tell me about how others have reacted to you being ill like this. . . who would you say understands best what you are going through?
35 Who else knows that you have expressed this wish to end your life?
36 What do you not want?

37 What do you feel could be improved in your care and treatment?
38 Can you tell me why you want to take this action?
39 Can you tell me why you wish your life would end?
40 What do you understand about your end of life care options?

41 There are many options to control your symptoms and help you to feel better
42 Has anyone explained other options?
43 What other deaths have you encountered?
44 Are you aware of the impact of this procedure on any life insurance you might have?

45 Death cannot be reversed. I am convinced that there is a reason to living
46 Some people make this statement when they're feeling really ‘down'; then when circumstances change, they feel differently.
47 The assisted dying option is not available at this facility – it's just our policy.
48 I know you live alone and have no family. Is this part of why you want this option?

49 What information do you have about assisted dying?

Appendix 3.3: Elicitation study Interview questions

INTERVIEW QUESTIONS

➢Prior to asking specific questions, the consent form was reviewed and any remaining questions were discussed.

1. Do I have your permission to begin recording this conversation?

    1.a. If "**no"**, "I cannot proceed with the interview unless it is recorded, but thank you for participating in the online survey."

    1.b. If "**yes"**, Thank you. I have read the consent form to you. Do you freely consent to commence the interview? Please understand there are no right or wrong answers to these questions. What the project needs to know is whatever you think are your own answers".

---

2. Are you a registered nurse with 12 or more months of clinical experience since your registration?

3. What specialty care area do you work in?

4 What do you believe are the **advantages** of engaging in a discussion initiated by a patient where a request is made for an assisted death?

5. What do you believe are the **disadvantages** of engaging in a discussion initiated by a patient where a request is made for an assisted death?

6 Is there anything else you associate with your own views about engaging in a discussion initiated by a patient where a request is made for an assisted death?

7. Are there any individual or groups who would **approve** of you engaging in a discussion initiated by a patient where a request is made for an assisted death?

8. Are there any individual or groups who would **disapprove** of you engaging in a discussion initiated by a patient where a request is made for an assisted death?

90. Is there anything else you associate with other people's views about engaging in a discussion initiated by a patient where a request is made for an assisted death?

101. What factors or circumstances would **enable** you to engage in a discussion initiated by a patient where a request is made for an assisted death?

11. What factors or circumstances would **make it difficult** or impossible for you to engage in a discussion initiated by a patient where a request is made for an assisted death?

12. Are there any other issues that come to mind when you think about engaging in a discussion initiated by a patient where a request is made for an assisted death?

Appendix 3.4. Survey Items

Variable Name	Item no.	Item text
RN?	Q27	Are you a nurse or midwife currently registered with AHPRA?
Non_RN?	Q28	Are you a non-nursing healthcare professional currently registered with AHPRA?
ClinArea	Q39	In which one of these clinical areas do you primarily work ? - Selected Choice
Gender	Q34	Are you: (F,M,Other)
Years Exp	Q35	How many years have you been working as a nurse? (please enter a number in the box below)
State	Q37	In which state or territory do you primarily work as a nurse? - Selected Choice
Geography	Q38	What is the geographical setting where you work ?
Prev Experience	Q40	In your professional nursing practice has a patient asked you to help them to die?
Religion	Q36	Do you identify with a religious or faith community?
Religiosity	Q41	To what extent do the social or moral teachings of your religious or faith community influence your daily life (e.g., dietary practices, lifestyle choices, etc)
PersOblig	Q43	In this scenario, which ONE of the following actions would you feel most personally obligated to perform
Confidence	Q44	How confident are you that this is the ONE action you would take in this situation?
Behavioural Intentions	Q45	Please rate the following statements according to how likely it is that you would use that statement as you respond to this patient in this scenario:
BI_O&D3	a.	
BI_R&S1	b.	We will be here for you no matter what you decide
BI_O&D1	c.	I can't help you with that question, but what I can do is reassure you that I will do everything I can to support you being as comfortable as possible
BI_O&D2	d.	Discussing this makes me feel complicit in an action that I cannot be involved in.
BI_A&I1	e.	Can you tell me why you wish your life would end?
BI_R&S4	f.	You've referred several times to wishing it were all over. Can you tell me what you're thinking about when you say that?
BI_A&I2	g.	What do you understand about your end of life care options?
BI_R&S2	h.	Have you been able to discuss this with the doctor who is most involved in your care?
BI_R&S3	i.	When you talk with your doctor about this have you told your doctor what you have told me?
BI_E&E4	j.	The medicines used can affect people differently, and sometimes there can be very unpleasant side effects.
BI_E&E3	k.	What does your illness mean to you?
BI_A&I3	l.	What do I need to know about you to give you the best care possible?

BI_E&E1	m.	What do you not want?
BI_E&E2	n.	Can you tell me about the things that frighten or concern you the most at the moment?
BI_O&D4	o.	There are many options to control your symptoms and help you to feel better
BI_A&I4	p.	What do you feel could be improved in your care and treatment?
Auto1	Q8	This patient should be able to define solutions to their problems
Global	Q9	I believe that people who meet legal criteria should have the choice of medically-assisted dying
Bene1	Q45	When another's suffering cannot be eliminated I must work to minimise it, at least
NonMal1	Q10	Human life should never be violated, regardless of the person's situation.
Just1	Q11	This patient has a right to make decisions in own best interests
Auto2	Q12	This patient should have meaningful input into own decisions about assisted dying
Just2	Q13	This patient has a right to speak and be heard about their decisions about an assisted death
Bene2	Q15	I would help this patient to find ways to live as well as possible instead of seeking assisted dying
Global	Q16	I believe that voluntary assisted dying should be legal in the state/jurisdiction where I work
NonMal2	Q17	If this patient chooses an assisted death I would withdraw as a member of the care-team
Pers	Q19	Is legal assisted dying something that you would consider for yourself?
SN_Comp1	Q29	How important to you are the views of your colleagues about assisted dying?
SN_Comp2	Q30	How important to you are the views of your own family about assisted dying?
SN_Comp3	Q32	How important to you is your employer's position about assisted dying?
SN_Comp4	Q34	How important to you is your professional association's position on assisted dying?
SN_Inj1	Q4	My professional colleagues would expect me to help this patient to access legal assisted dying
SN_Inj2	Q5	My family would expect me to help this patient to access legal assisted dying
SN_Inj3	Q6	My employer would expect me to help this patient to access legal assisted dying
SN_Inj4	Q7	My professional association would expect me to help this patient to access legal assisted dying
PBC_SelfEffic1	Q20	Overall, responding to this request would be:
PBC_SelfEffic2	Q21	Overall, how I respond to this request would be up to me
PBC_SelfEffic3	Q23	I could help this patient with this request even if it conflicted with my personal values
PBC_SelfEffic4	Q22	Responding to this request is beyond my ability
PBC_Barriers1	Q24_1	I could adequately respond to this request: - Even if I feel like I'm too busy to take the time I need to discuss this with this patient
PBC_Barriers2	Q24_2	I could adequately respond to this request: - Even if I had not been specifically trained to handle this situation

Appendix 6.1 Logit models of profile membership

The overall model was significantly significant, $\chi^2(20) = 106.527$, $p < .001$, and the predictors accounted for 25.3% of the variance in the outcome variable (Cox and Snell test: Pseudo $R^2 = .253$). The Deviance goodness-of-fit test was non-significant, $\chi^2(1400) = 984.261$, $p = 1.000$, suggesting the model was a good fit for the data. Tables 1 to 5 present the details of this classification model.

Reference Criterion: *Expediter*

Detached. As Subjective Norms scores increased by 1, the likelihood that the cluster will be Detached *decreased* by 61.3%, in comparison to Expediter ($p = .008$). Perceived control, attitude, autonomy and Beneficence were not significant predictors for the Detached cluster (all *p values* > .05).

Objector. As Attitude scores increased by 1, the likelihood that the cluster will be Objector increased by 1.706 times in comparison to Expediter ($p = .013$). As Beneficence scores increased by 1, the likelihood that the cluster will be Objector increased by 4.443 times, in comparison to Expediter ($p < .001$). Perceived control, subjective norms and autonomy were not significant predictors for the Objector cluster (all *p values* > .05).

Complier. As Attitude scores increased by 1, the likelihood that the cluster will be Complier increased by 1.874 times, in comparison to Expediter ($p = .007$). As Beneficence scores increased by 1, the likelihood that the cluster will be Complier increased by 2.105 times, in comparison to Expediter ($p < .001$). As Autonomy increased by 1, the likelihood that the cluster will be Complier *decreased* by 62.3%, in comparison to Expediter ($p =.027$). Perceived control and subjective norms were not significant predictors for the Complier cluster (all *p values* > .05).

Facilitator. As Attitude scores increased by 1, the likelihood that the cluster will be Facilitator increased by 1.664 times, in comparison to Expediter ($p = .017$). As Beneficence scores increased by 1, the likelihood that the cluster will be Facilitator increased by 1.881 times, in comparison to Expediter ($p = .001$) Perceived control, subjective norms and autonomy were not significant predictors for the Facilitator cluster (all *p values* > .05).

Table 1: *Comparison of Clusters with Reference Criterion: Expediter*

Reference: **EXPEDITER**

Cluster								95% CI	
Detached	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	5.608	3.120	3.231	1	.072			
	Attitude	.065	.353	.034	1	.854	1.067	.534	2.133
	Autonomy	-.588	.602	.956	1	.328	.555	.171	1.806
	Beneficence	-.461	.336	1.876	1	.171	.631	.326	1.220
	Subj Norms	**-.949**	.356	7.095	1	**.008**	.387	.193	.778
	PBC*	-.007	.218	.001	1	.973	.993	.648	1.521

Cluster								95% CI	
Objector	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-1.491	2.213	.454	1	.501			
	Attitude	.534	.214	6.224	1	**.013**	1.706	1.121	2.597
	Autonomy	-.724	.448	2.608	1	.106	.485	.202	1.167
	Beneficence	1.491	.229	42.481	1	**.000**	4.443	2.837	6.958
	Subj Norms	-.404	.278	2.115	1	.146	.668	.388	1.151
	PBC*	-.023	.163	.021	1	.886	.977	.710	1.344

Cluster								95% CI	
Complier	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	1.426	2.182	.427	1	.513			
	Attitude	.628	.234	7.189	1	**.007**	1.874	1.184	2.966
	Autonomy	**-.976**	.441	4.892	1	**.027**	.377	.159	.895
	Beneficence	.744	.210	12.510	1	**.000**	2.105	1.393	3.179
	Subj Norms	-.267	.261	1.042	1	.307	.766	.459	1.278
	PBC*	-.118	.158	.559	1	.455	.889	.652	1.211

Cluster								95% CI	
Facilitator	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-.796	2.154	.137	1	.712			
	Attitude	.509	.213	5.736	1	**.017**	1.664	1.097	2.523
	Autonomy	-.304	.427	.508	1	.476	.738	.320	1.703
	Beneficence	.632	.193	10.764	1	**.001**	1.881	1.290	2.744
	Subj Norms	-.205	.236	.755	1	.385	.814	.512	1.294
	PBC*	-.079	.145	.295	1	.587	.924	.695	1.229

Reference Criterion: *Detached*

Expediter. As Subjective Norms scores increased by 1, the likelihood that the cluster will be Expediter increased by 2.583 times, in comparison to Detached (*p* = .008). Perceived control, attitude, autonomy and Beneficence were not significant predictors for the Expediter cluster (all *p values* > .05).

Objector. As Beneficence scores increased by 1, the likelihood that the cluster will be Objector increased by 7.044 times, in comparison to Detached (*p* < .001). Perceived control, subjective norms, attitude and autonomy were not significant predictors for the Objector cluster (all *p values* > .05).

Complier. As Beneficence scores increased by 1, the likelihood that the cluster will be Complier increased by 3.337 times, in comparison to Detached (*p* < .001). Perceived control, subjective norms, attitude and autonomy were not significant predictors for the Complier cluster (all *values* > .05).

Facilitator. As Subjective Norms scores increased by 1, the likelihood that the cluster will be Facilitator increased by 2.104 times, in comparison to Detached (*p* = .028). As Beneficence scores increased by 1, the likelihood that the cluster will be Facilitator increased by 2.982 times, in comparison to Detached (*p* = .001). Perceived control, autonomy and attitude were not significant predictors for the Facilitator cluster(all *p values* > .05).

Table 2: *Comparison of Clusters with Reference Criterion: Detached*

Reference: **DETACHED**

Cluster								95% CI	
Expediter	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-5.608	3.120	3.231	1	.072			
	Attitude	-.065	.353	.034	1	.854	.937	.469	1.873
	Autonomy	.588	.602	.956	1	.328	1.801	.554	5.858
	Beneficence	.461	.336	1.876	1	.171	1.585	.820	3.066
	Subj Norms	.949	.356	7.095	1	**.008**	2.583	1.285	5.193
	PBC*	.007	.218	.001	1	.973	1.007	.657	1.544

Cluster								95% CI	
Objector	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-7.098	2.924	5.891	1	.015			
	Attitude	.469	.346	1.841	1	.175	1.599	.812	3.150
	Autonomy	-.135	.581	.054	1	.816	.873	.280	2.727
	Beneficence	1.952	.346	31.901	1	**.000**	7.044	3.578	13.869
	Subj Norms	.545	.368	2.191	1	.139	1.725	.838	3.551
	PBC*	-.016	.222	.005	1	.943	.984	.637	1.520

Cluster								95% CI	
Complier	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-4.181	2.866	2.128	1	.145			
	Attitude	.563	.354	2.529	1	.112	1.756	.877	3.516
	Autonomy	-.387	.565	.469	1	.493	.679	.224	2.056
	Beneficence	1.205	.331	13.218	1	**.000**	3.337	1.743	6.389
	Subj Norms	.682	.355	3.684	1	.055	1.978	.986	3.970
	PBC*	-.111	.215	.264	1	.608	.895	.587	1.366

Cluster								95% CI	
Facilitator	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-6.403	2.880	4.945	1	.026			
	Attitude	.444	.342	1.685	1	.194	1.559	.797	3.048
	Autonomy	.284	.561	.257	1	.612	1.329	.443	3.986
	Beneficence	1.093	.321	11.586	1	**.001**	2.982	1.590	5.595
	Subj Norms	.744	.339	4.806	1	**.028**	2.104	1.082	4.090
	PBC*	-.071	.207	.119	1	.730	.931	.621	1.397

Reference Criterion: *Complier*

Expediter. As Attitude scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 46.6%, in comparison to Complier (*p* = .007). As Beneficence scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 52.5%, in comparison to Complier (*p* < .001). As Autonomy scores increased by 1, the likelihood that the cluster will be Expediter increased by 2.653 times, in comparison to Complier (*p* = .027). Perceived control and subjective norms were not significant predictors for the Expediter cluster (all *p values* > .05).

Detached. As Subjective norms scores increased by 1, the likelihood that the cluster will be Detached decreased by 49.4% (p=.055). As Beneficence scores increased by 1, the likelihood that the cluster will be Detached *decreased* by 70.0%, in comparison to Complier (*p* < .001). Perceived control, attitude and autonomy were not significant predictors for the Detached cluster (all *p values* > .05).

Objector. As Beneficence scores increased by 1, the likelihood that the cluster will be Objector increased by 2.111 times, in comparison to Complier (*p* < .001). Perceived control, subjective norms, attitude and autonomy, were not significant predictors for the Objector cluster (all *p values* > .05).

Facilitator. Perceived control, subjective norms, beneficence, attitude and autonomy were not significant predictors for the Facilitator cluster (all *p values* > .05).

Table 3 *Comparison of Clusters with Reference Criterion: Complier*

Reference: **COMPLIER**

Cluster								95% CI	
Expediter	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-1.426	2.182	.427	1	.513			
	Attitude	**-.628**	.234	7.189	1	**.007**	.534	.337	.845
	Autonomy	.976	.441	4.892	1	**.027**	2.653	1.117	6.298
	Beneficence	**-.744**	.210	12.510	1	**.000**	.475	.315	.718
	Subj Norms	.267	.261	1.042	1	.307	1.306	.782	2.180
	PBC*	.118	.158	.559	1	.455	1.125	.826	1.534

Cluster								95% CI	
Detached	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	4.181	2.866	2.128	1	.145			
	Attitude	-.563	.354	2.529	1	.112	.569	.284	1.140
	Autonomy	.387	.565	.469	1	.493	1.473	.486	4.461
	Beneficence	**-1.205**	.331	13.218	1	**.000**	.300	.157	.574
	Subj Norms	**-.682**	.355	3.684	1	**.055**	.506	.252	1.015
	PBC*	.111	.215	.264	1	.608	1.117	.732	1.704

Cluster								95% CI	
Objector	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-2.917	1.708	2.918	1	.088			
	Attitude	-.094	.200	.220	1	.639	.911	.616	1.347
	Autonomy	.252	.370	.465	1	.495	1.287	.623	2.655
	Beneficence	.747	.197	14.404	1	**.000**	2.111	1.435	3.105
	Subj Norms	-.137	.256	.287	1	.592	.872	.528	1.439
	PBC*	.095	.147	.414	1	.520	1.099	.824	1.467

Cluster								95% CI	
Facilitator	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-2.222	1.736	1.638	1	.201			
	Attitude	-.119	.204	.340	1	.560	.888	.595	1.325
	Autonomy	.671	.365	3.383	1	.066	1.957	.957	4.002
	Beneficence	-.112	.169	.439	1	.508	.894	.641	1.246
	Subj Norms	.061	.227	.073	1	.787	1.063	.681	1.659
	PBC*	.039	.135	.085	1	.771	1.040	.799	1.354

Reference Criterion: *Objector*

Expediter. As Attitude scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 41.4%, in comparison to Objector (*p* = .013). As Beneficence scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 77.5%, in comparison to Objector (*p* < .001). Perceived control, subjective norms and autonomy were not significant predictors for the Expediter cluster (all *p values* > .05).

Detached. As Beneficence scores increased by 1, the likelihood that the cluster will be Detached *decreased* by 85.8%, in comparison to Objector (*p* < 0.001). Perceived control, subjective norms, attitude and autonomy were not significant predictors for the Detached cluster (all *p values* > .05).

Complier. As Beneficence scores increased by 1, the likelihood that the cluster will be Complier *decreased* by 52.6%, in comparison to Objector (*p* <0.001). Perceived control, subjective norms, attitude and autonomy were not significant predictors for the Complier cluster (all *p values* > .05).

Facilitator. As Beneficence scores increased by 1, the likelihood that the cluster will be Facilitator *decreased* by 57.7% , in comparison to Objector (*p* <0.001). Perceived control, subjective norms, attitude and autonomy were not significant predictors for the Facilitator cluster (all *p values* > .05).

Table 4: *Comparison of Clusters with Reference Criterion: Objector*

Reference: **Objector**

Cluster								95% CI	
Expediter	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	1.491	2.213	.454	1	.501			
	Attitude	**-.534**	.214	6.224	1	**.013**	.586	.385	.892
	Autonomy	.724	.448	2.608	1	.106	2.062	.857	4.962
	Beneficence	**-1.491**	.229	42.481	1	**.000**	.225	.144	.352
	Subj Norms	.404	.278	2.115	1	.146	1.497	.869	2.580
	PBC*	.023	.163	.021	1	.886	1.024	.744	1.409

Cluster								95% CI	
Detached	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	7.098	2.924	5.891	1	.015			
	Attitude	-.469	.346	1.841	1	.175	.625	.317	1.232
	Autonomy	.135	.581	.054	1	.816	1.145	.367	3.574
	Beneficence	**-1.952**	.346	31.901	1	**.000**	.142	.072	.279
	Subj Norms	-.545	.368	2.191	1	.139	.580	.282	1.193
	PBC*	.016	.222	.005	1	.943	1.016	.658	1.569

Cluster								95% CI	
Complier	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	2.917	1.708	2.918	1	.088			
	Attitude	.094	.200	.220	1	.639	1.098	.743	1.624
	Autonomy	-.252	.370	.465	1	.495	.777	.377	1.604
	Beneficence	**-.747**	.197	14.404	1	**.000**	.474	.322	.697
	Subj Norms	.137	.256	.287	1	.592	1.147	.695	1.893
	PBC*	-.095	.147	.414	1	.520	.910	.682	1.214

Cluster								95% CI	
Facilitator	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	.695	1.732	.161	1	.688			
	Attitude	-.025	.178	.020	1	.887	.975	.688	1.382
	Autonomy	.419	.367	1.307	1	.253	1.521	.741	3.121
	Beneficence	**-.859**	.184	21.799	1	**.000**	.423	.295	.607
	Subj Norms	.198	.238	.695	1	.405	1.219	.765	1.945
	PBC*	-.055	.137	.164	1	.686	.946	.723	1.238

Reference Criterion: *Facilitator*

Expediter. As Attitude scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 39.9%, in comparison to Facilitator (*p* = .017). As Beneficence scores increased by 1, the likelihood that the cluster will be Expediter *decreased* by 46.8%, in comparison to Facilitator (*p* = .001). Perceived control, subjective norms and autonomy were not significant predictors for the Facilitator cluster (all *p values* > .05).

Detached. As Subjective Norms scores increased by 1, the likelihood that the cluster will be Detached *decreased* by 52.5%, in comparison to Facilitator (*p* =.028) As Beneficence scores increased by 1, the likelihood that the cluster will be Detached *decreased* by 66.5%, in comparison to Facilitator (*p* = .001). Perceived control, autonomy and attitude were not significant predictors for the Detached cluster (all *p values* > .05).

Objector. As Beneficence scores increased by 1, the likelihood that the cluster will be Objector increased by 2.362 times, in comparison to Facilitator (*p* < .001). Perceived control, subjective norms, autonomy and attitude were not significant predictors for the Objector cluster (all *p values* > .05).

Complier. Perceived control, subjective norms, autonomy, attitude and beneficence were not significant predictors for the Complier cluster (all *p values*> .05).

Table 5: *Comparison of Clusters with Reference Criterion: Facilitator*

Cluster								95% CI	
Expediter	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	.796	2.154	.137	1	.712			
	Attitude	**-.509**	.213	5.736	1	**.017**	.601	.396	.912
	Autonomy	.304	.427	.508	1	.476	1.356	.587	3.129
	Beneficence	**-.632**	.193	10.764	1	**.001**	.532	.364	.775
	Subj Norms	.205	.236	.755	1	.385	1.228	.773	1.952
	PBC*	.079	.145	.295	1	.587	1.082	.814	1.439

Cluster								95% CI	
Detached	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	6.403	2.880	4.945	1	.026			
	Attitude	-.444	.342	1.685	1	.194	.641	.328	1.254
	Autonomy	-.284	.561	.257	1	.612	.753	.251	2.258
	Beneficence	**-1.093**	.321	11.586	1	**.001**	.335	.179	.629
	Subj Norms	**-.744**	.339	4.806	1	**.028**	.475	.245	.924
	PBC*	.071	.207	.119	1	.730	1.074	.716	1.611

Cluster								95% CI	
Objector	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	-.695	1.732	.161	1	.688			
	Attitude	.025	.178	.020	1	.887	1.026	.724	1.454
	Autonomy	-.419	.367	1.307	1	.253	.657	.320	1.349
	Beneficence	.859	.184	21.799	1	**.000**	2.362	1.647	3.388
	Subj Norms	-.198	.238	.695	1	.405	.820	.514	1.308
	PBC*	.055	.137	.164	1	.686	1.057	.808	1.383

Cluster								95% CI	
Complier	Predictor	B	SE	Wald	df	Sig.	Exp(β)	Lower	Upper
	Intercept	2.222	1.736	1.638	1	.201			
	Attitude	.119	.204	.340	1	.560	1.127	.755	1.681
	Autonomy	-.671	.365	3.383	1	.066	.511	.250	1.045
	Beneficence	.112	.169	.439	1	.508	1.119	.803	1.559
	Subj Norms	-.061	.227	.073	1	.787	.940	.603	1.467
	PBC*	-.039	.135	.085	1	.771	.962	.739	1.252

Summary of Predictors

ATTITUDE was a significant predictor for

- Objector > Expediter
- Complier > Expediter
- Facilitator > Expediter

SUBJECTIVE NORMS was a significant predictor for

- Expediter > Detached
- Facilitator > Detached
- Complier > Detached

Subjective norms was not a significant predictor for Objector

BENEFICENCE was a significant predictor for

- Objector > Expediter, Detached, Complier, Facilitator
- Facilitator > Expediter, Detached
- Complier > Detached, Expediter

AUTONOMY was a significant predictor for

- Expediter > Complier

Autonomy was not a significant predictor for Objector, Facilitator, or Detached

PERCEIVED BEHAVIOURAL CONTROL was not a significant predictor in this model

Bibliography

This list includes references cited in all chapters of this thesis, including the published articles in this thesis, and all other works reviewed but not cited.

Quick Links [Ctrl^click]:

-A-B-C-D-E-F-G-H-I-J-K-L-M-N-O-P-Q-R-S-T-U-V-W-Y-Z

-A-

Acock, A., & DeFleur, M. L. (1972). A configurational approach to contingent consistency in attitude—Behavior relationship. *American Sociological Review*, *37*, 714–726.

Adams, J. A., Bailey, D. E., Anderson, R. A., & Docherty, S. L. (2011). Nursing Roles and Strategies in End-of-Life Decision Making in Acute Care: A Systematic Review of the Literature. *Nursing Research and Practice*, *2011*. https://doi.org/10.1155/2011/527834

Adams, K., Ashe, G., Chisholm, J., Daws, T., & Green, S. (2017). What matters most. *Canadian Medical Association Journal*, *189*(E642). https://doi.org/10.1503/cmaj.732941

Adesina, O., DeBellis, A., & Zannettino, L. (2014). Third-year Australian nursing students' attitudes, experiences, knowledge, and education concerning end-of-life care. *International Journal of Palliative Nursing*, *20*(8), 395–401. https://doi.org/10.12968/ijpn.2014.20.8.395

Aghababaei, N. (2013). The Euthanasia-Religion Nexus: Exploring Religious Orientation and Euthanasia Attitude Measures in a Muslim Context: *OMEGA - Journal of Death and Dying*, *66*(4), 333–341. https://doi.org/10.2190/OM.66.4.d

ACHLR (Australian Centre for Health Law Research). (2021, August 15). 20 years explained in 2 pages. Professors White and Willmott distil all of their #VAD research into a 2-page summary about VAD law, policy and practice: Https://bit.ly/3iHZINL. #assisteddying #qldpol #nswpol #voluntaryassisteddying @QUT @qutlaw https://t.co/XqNiHKiMOC [Tweet]. *@HealthLawQUT*. https://twitter.com/HealthLawQUT/status/1427048786837184513

AIHW. (2020, August 7). *Deaths in Australia, Leading causes of death*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control: From cognition to behavior* (J Kuhl&J Beckmann (Eds.), pp. 11–39). Springer-Verlag.

Ajzen, I. (1988). *Attitudes, personality, and behavior*. Dorsey Press.

Ajzen, I. (2001). Nature and operation of attitudes. *Annual Review of Psychology*, *52*, 27–58. https://doi.org/10.1146/annurev.psych.52.1.27

Ajzen, I. (2015). The theory of planned behaviour is alive and well, and not ready to retire: A commentary on Sniehotta, Presseau, and Araújo-Soares. *Health Psychology Review*, *9*(2), 131–137. https:///dx.doi.org/10.1080/17437199.2014.883474?

Ajzen, I, & Fishbein, M. (2000). Attitudes and the attitude-behavior relation: Reasoned and automatic processes. *European Review of Social Psychology*, *11*(1), 1–33. https://doi.org/10.1080/14792779943000116

Ajzen, I, & Madden, T. J. (1986). Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control. *Journal of Experimental Social Psychology*, *22*(5), 453–474. https://doi.org/10.1016/0022-1031(86)90045-4

Ajzen, Icek. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*, 179–211.

Ajzen, Icek. (2006). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior. *Journal of Applied Social Psychology*, *32*(4), 665–683. https://doi.org/10.1111/j.1559-1816.2002.tb00236.x

Akhtar-Danesh, N., Baumann, A., & Cordingley, L. (2008). Q-Methodology in Nursing Research: A Promising Method for the Study of Subjectivity. *Western Journal of Nursing Research*, *30*(6), 759–773. https://doi.org/10.1177/0193945907312979

Albers, G., Francke, A. L., de Veer, A. J. E., Bilsen, J., & Onwuteaka-Philipsen, B. D. (2014). Attitudes of nursing staff towards involvement in medical end-of-life decisions: A national survey study. *Patient Education and Counseling*, *94*(1), 4–9. https://doi.org/10.1016/j.pec.2013.09.018

Alreck, P. L., & Settle, R. B. (1995). *The Survey Research Handbook* (2nd ed.). Irwin.

American Nurses Association. (2019). *The Nurse's Role When a Patient Requests Medical Aid in Dying*. American Nurses Association. https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf

American Nurses Association archive. (2013). *Euthanasia, assisted suicide, and aid in dying*. http://www.nursingworld.org/positionstatements

ANMJ. (2019, June 19). Voluntary assisted dying: What nurses need to know. *Australian Nursing and Midwifery Journal*. https://anmj.org.au/voluntary-assisted-dying-what-nurses-need-to-know/

Arabie, P., Hubert, L. J., & De Soete, G. (1999). *Clustering And Classification* (2nd ed.). World Scientific. https://books.google.com/books/about/Clustering_And_Classification.html?id=HbfsCgAAQBAJ

Aranda, S., Bence, G., & O'Connor, M. (1999). Euthanasia: A perspective from Australia. *International Journal of Palliative Nursing*, *5*(6), 298–304. https://doi.org/10.12968/ijpn.1999.5.6.8958

Armatas, C. A., Venn, T. J., & Watson, A. E. (2014). Applying Q-methodology to select and define attributes for non-market valuation: A case study from Northwest Wyoming, United States. *Ecological Economics*, *107*, 447–456. https://doi.org/10.1016/j.ecolecon.2014.09.010

Armitage, C. J., & Christian, J. (2003). From attitudes to behaviour: Basic and applied research on the theory of planned behaviour. *Current Psychology*, *22*(3), 187–195. https://doi.org/10.1007/s12144-003-1015-5

Armitage, C. J., & Conner, M. (1999a). Predictive validity of the theory of planned behaviour: The role of questionnaire format and social desirability. *Journal of Community & Applied Social Psychology*, *9*(4), 261–272. https://doi.org/10.1002/(SICI)1099-1298(199907/08)9:4<261::AID-CASP503>3.0.CO;2-5

Armitage, C. J., & Conner, M. (1999b). The theory of planned behaviour: Assessment of predictive validity and ’perceived control. *British Journal of Social Psychology*, *38*(1), 35–54. https://doi.org/10.1348/014466699164022

Armitage, C. J., & Conner, M. (2000). Social cognition models and health behaviour: A structured review. *Psychology & Health*, *15*(2), 173–189. https://doi.org/10.1080/08870440008400299

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *British Journal of Social Psychology*, *40*(4), 471–499.

Armstrong, J. J. (2012). K-Means Cluster Analysis of Rehabilitation Service Users in the Home Health Care System of Ontario: Examining the Heterogeneity of a Complex Geriatric Population. *Archives of Physical Medicine and Rehabilitation*, *93*(12), 2198–2205. https://doi.org/10.1016/j.apmr.2012.05.026

Arnold, D. O. (1970). Dimensional Sampling: An Approach for Studying a Small Number of Cases. *The American Sociologist*, *5*(2), 5.

Asare, M. (2015). Using the theory of planned behavior to determin the condom use behavior among college students. *American Journal of Health Studies*, *30*(1), 43.

Asch, D. A. (1996). The Role of Critical Care Nurses in Euthanasia and Assisted Suicide. *The New England Journal of Medicine*, *3334*, 1374–1379. https://doi.org/DOI: 10.1056/NEJM199605233342106

Australian Broadcasting Corporation. (2017, November 16). *Euthanasia bill fails to pass NSW Parliament by just one vote* [Text]. ABC News. http://www.abc.net.au/news/2017-11-16/nsw-parliament-votes-on-euthanasia-bill/9158384

Australian Bureau of Statistics. (2017a). *2016 Census: Religion* [Census data]. https://www.abs.gov.au/AUSSTATS/abs@.nsf/mediareleasesbyReleaseDate/7E65A144540551D7CA258148000E2B85

Australian Bureau of Statistics. (2017b). *Main Features—Australia’s leading causes of death, 2016*. 33.3.0 - Causes of Death, Australia, 2016. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Australia's%20leading%20causes%20of%20death,%202016~3

Australian Centre for Health Law Research. (2019). *End of life law in Australia*. Queensland University of Technology. https://cms.qut.edu.au/__data/assets/pdf_file/0006/863196/VAD-ELLA-factsheet-19-June-2019.pdf

Australian College of Nursing. (2018a). *Australian College of Nursing (ACN) submission to the ACT Legislative Assembly on the Inquiry into End of Life Choices in the ACT* (p. 7).

Australian College of Nursing. (2018b). *Voluntary-Assisted-Dying-in-Victoria.pdf*. Australian College of Nursing. https://www.acn.edu.au/wp-content/uploads/2018/09/Voluntary-Assisted-Dying-in-Victoria.pdf?_zs=JWAPl&_zl=g6ET1

Australian Doctor Group. (2019, September 5). *Palliative Care Australia clarifies stance on assisted dying* [Medical]. https://www.ausdoc.com.au/news/palliative-care-australia-clarifies-stance-assisted-dying

Australian Government Department of Health. (2018). *Health Workforce Data | Summary Statistics*. https://hwd.health.gov.au/summary.html#part-2

Australian Human Rights Commission. (2016). *Euthanasia, human rights and the law* [Issues Paper]. Australia Human Rights Commission. https://www.humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law

Australian Medical Association. (2016a). *Euthanasia and Physician Assisted Suicide 2016*. Australian Medical Association, Ltd. https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

Australian Medical Association. (2016b). *Position Statement on Euthanasia and Physician Assisted Suicide 2016*. Australian Medical Association, Ltd. https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402

Australian Medical Association. (2017, October 18). *Euthanasia and Physician Assisted Suicide*. Australian Medical Association. https://ama.com.au/media/euthanasia-and-physician-assisted-suicide

Australian Medical Students Association. (2018). *Policy Document—Voluntary Assisted Dying*. AMSA. https://www.amsa.org.au/sites/amsa.org.au/files/Voluntary%20Assisted%20Dying%20%282018%29.pdf

Australian Nursing and Midwifery Federation. (2016). *ANMF Position Statement: Assisted Dying*. ANMF. http://anmf.org.au/documents/policies/PS_Assisted_Dying.pdf

Australian Nursing Federation. (2012). *Nursing federation voluntary euthanasia / assisted suicide*. http://anf.org.au/documents/policies/PS_Voluntary_euthanasia.pdf

-B-

Baddock, K. (2018). *End of Life Choice Bill: Submission to the Justice Select Committee*. http://www.nzma.org.nz/__data/assets/pdf_file/0009/79695/NZMA-Submission-on-End-of-Life-Choice-Bill-FINAL.PDF

Bagozzi, R. P. (1984). Expectancy-value attitude models: An analysis of critical measurement issues. *International Journal of Research in Marketing*, *1*(r), 295–310.

Bagozzi, R. P., Baumgartner, H., & Yi, Y. (1992). State versus Action Orientation and the Theory of Reasoned Action: An Application to Coupon Usage. *Journal of Consumer Research*, *18*(4), 505–518. https://doi.org/10.1086/209277

Bagozzi, R. P., & Yi, Y. (1989). The degree of intention formation as a moderator of the attitude-behavior relationship. *Social Psychology Quarterly*, *52*(4), 266–279. https://doi.org/10.2307/2786991

Bagozzi, R. P., Yi, Y., & Baumgartner, J. (1990). The level of effort required for behaviour as a moderator of the attitude–behaviour relation. *European Journal of Social Psychology*, *20*(1), 45–59. https://doi.org/10.1002/ejsp.2420200105

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelkia, A. P. (2000). SPIKES - a six-step protocol for delivering bad news: Application to the patient with cancer. *Oncologist*, *5*, 302–311. https://doi.org/10.1634/theoncologist.5-4-302

Bakalis, N. A., Filippia, N., Maria, N., & Kiekkas, P. (2013). The attitude of Greek student nurses toward euthanasia. *Journal of Nursing Education and Practice*, *4*(1), 237. https://doi.org/10.5430/jnep.v4n1p237

Ballou, J., & Lavrakas, P. J. (2008). *Encyclopedia of survey research methods* (Vol. 2). SAGE Research Methods.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Bulletin*, *84*, 191–215.

Bandura, A. (2005). The evolution of social cognitive theory. In *Great Minds in Management*. Oxford University Press.

Bandura, A. (2011). The Social and Policy Impact of Social Cognitive Theory. In M. Mark, S. Donaldson, & B. Campbell (Eds.),. (Pp. 33-70). New York, NY:Guilford Press. In *Social Psychology and Evaluation, M. Mark, S. Donaldson & B. Campbell (Eds.).* (pp. 33–70). Guilford Press.

Bandura, A., & National Inst of Mental Health. (1986). *Social foundations of thought and action: A social cognitive theiory*. Prentice-Hall.

Banner, D., Schiller, C. A., & Freeman, S. (2019). Medical assistance in dying: A political issue for nurses and nursing in Canada. *Nursing Philosophy*, *00*(e12281). https://doi.org/10.1111/nup.12281

Bannigan, K., & Watson, R. (2009). Reliability and validity in a nutshell. *Journal of Clinical Nursing*, *18*(23), 3237–3243. https://doi.org/10.1111/j.1365-2702.2009.02939.x

Baranzke, H. (2012). “Sanctity-of-Life“—A Bioethical Principle for a Right to Life? Ethic Theory Moral Prac (2012) 15:295–308. *Ethical Theory and Moral Practice*, *15*, 295–308. https://doi.org/DOI 10.1007/s10677-012-9369-0

Barbour, C. M. (2017). The Flipped Classroom Method: Exploration of Nurse Educators’ Perspectives Using Q-Methodology. *Global Nursing E-Repository*. 44th

Bartels, L., & Otlowski, M. (2010). A right to die? Euthanasia and the law in Australia. *Journal of Law and Medicine*, *17*, 532–555.

Barua, P. (2013). The Moderating Role of Perceived Behavioral Control: The Literature Criticism and Methodological Considerations. *International Journal of Business and Social Science*, *4*(10), 57–59. https://doi.org/10.30845/ijbss

Bascom, P. B., & Tolle, S. W. (2002). Responding to requests for physician-assisted suicide: “These are Uncharterd Waters for Both of Us....” *JAMA*, *288*(1), 91–99.

Bazinger, C., & Kuhlberger, A. (2012). Theory use in social predictions. *New Ideas in Psychology*, *30*(3), 319–321. https://doi.org/10.1016/j.newideapsych.2012.02.003

BBC News. (2012, October 17). *Uruguay legalises abortion*. BBC News. https://www.bbc.com/news/world-latin-america-19986107

Bearden, W. o, Hardesty, D. M., & Rose, R. L. (2001). Consumer Self-Confidence: Refinements in Conceptualization and Measurement. *Journal of Consumer Research*, *28*(1), 121–134. https://doi.org/10.1086/321951

Beauchamp, T, & Childress, J. (2001). *Principles of biomedical ethics* (6th ed.). Oxford University Press.

Beauchamp, Tom. (2019). The Principle of Beneficence in Applied Ethics. In *The Stanford Encyclopedia of Philosophy, Edward N. Zalta (ed.)* (Spring 2019). https://plato.stanford.edu/entries/principle-beneficence/#ProbOverDemaBene

Beck, L., & Ajzen, I. (1991). Predicting dishonest actions using the theory of planned behavior. *Journal of Research in Personality*, *25*(3), 285–301. https://doi.org/10.1016/0092-6566(91)90021-H

Becker, M. H., & Maiman, L. A. (1975). Sociobehavioral determinants of compliance with health and medical care recommendations. *Medical Care*, *134*(1), 10–24.

Beckstead, J. W. (2002). Using hierarchical cluster analysis in nursing research. *Western Journal of Nursing Research*, *24*(3), 307–319.

Begley, A.-M. (1998). Beneficent voluntary active euthanasia: A challenge to professionals caring for terminally ill patients. *Nursing Ethics*, *5*, 294–306.

Behuniak, S. M., & Svenson, G. (2003). *Physician-assisted Suicide*. Rowman & Littlefield Publishers. https://books.google.com/books/about/Physician_assisted_Suicide.html?id=zVOCZjuI8PkC

Benassi, M., Garofalo, S., Ambrosini, F., Sant’Angelo, R. P., Raggini, R., De Paoli, G., Ravani, C., Giovagnoli, S., Orsoni, M., & Piraccini, G. (2020). Using Two-Step Cluster Analysis and Latent Class Cluster Analysis to Classify the Cognitive Heterogeneity of Cross-Diagnostic Psychiatric Inpatients. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.01085

Bender, L. (1992). A feminist analysis of physician-assisted dying and voluntary active euthanasia. *Tennessee Law Review*, *59*, 519–530.

Bendiane, M. K., Galinier, A., Favre, R., Ribiere, C., Lapiana, J.-M., Obadia, Y., & Peretti-Watel, P. (2007). French district nurses’ opinions towards euthanasia, involvement in end-of-life care and nurse–patient relationship: A national phone survey. *Journal of Medical Ethics*, *33*(12), 708–711. https://doi.org/10.1136/jme.2006.018374

Bennet, S., & Bowers, D. (1976). Factor analysis: The centroid method. In *An Introduction to Multivariate Techniques for Social and Behavioural Scioences.* (pp. 8–25). Palgrave.

Berghs, M., Dierckx de Casterle, B., & Gastmans, C. (2005). The complexity of nurses' attitudes toward euthanasia: A review of the literature. *Journal of Medical Ethics*, *31*(8), 441–446. https://doi.org/10.1136/jme.2004.009092

Bergkvist, L. (2009). The role of confidence in attitude–intention and beliefs–attitude relationships. *International Journal of Advertising*, *28*(5), 863–880. https://doi.org/10.2501/ S026504870920093X

Bergkvist, L. (2010). A Call for a Broader Range of Dependent Variables in Advertising Research. In *Terlutter R., Diehl S., Okazaki S. (eds) Advances in Advertising Research* (Vol. 1). Gabler. https://link-springer-com.proxy.library.adelaide.edu.au/chapter/10.1007/978-3-8349-6006-1_4#citeas

Berinsky, A. J., Margolis, M. F., & Sances, M. W. (2016). Can we turn shirkers into workers? *Journal of Experimental Social Psychology*, *66*, 20–28. https://doi.org/10.1016/j.jesp.2015.09.010

Bernaix, L. (2000). Nurses' Attitudes, Subjective Norms, and Behavioral Intentions Toward Support of Breastfeeding Mothers. *Journal of Human Lactation*, *16*(3), 201–209. https://doi.org/10.1177/089033440001600304

Bernheim, J, Deschepper, R., Distelmans, W., Bilsen, J., & Deliens, L. (2008). Development of palliative care and legalisation of euthanasia: Antagonism or synergy? *BMJ : British Medical Journal*, *336*, 864–867.

Bernheim, JL, & Raus, K. (2017). Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care. *Journal of Medical Ethics*, *43*, 489–494. https://doi:10.1136/medethics-2016-103511

Bertani, L., Carone, M., Caricati, L., Demaria, S., Fantuzzi, S., Guarasci, A., & Pirazzoli, L. (2016). Using the Theory of Planned Behavior to explore hospital-based nurses' intention to use peripherally inserted central catheter (PICC): A survey study. *Acta Bio Medica*, *87*(4-S), 23–29.

Bester, J. C. (2020). Beneficence, Interests, and Wellbeing in Medicine: What It Means to Provide Benefit to Patients. *The American Journal of Bioethics*, *20*(5), W4–W11.

Beuthin, R., Bruce, A., & Scaia, M. (2018). Medical assistance in dying (MAiD): Canadian nurses' experiences. *Nursing Forum*, *53*(4), 511–520. https://doi.org/10.1111/nuf.12280

Bieleke, M., Legrande, E., Mignon, A., & Gollwitzer, P. M. (2018). More than planned: Implementation intention effects in non-planned situations. *Acta Psychologica*, *184*, 64–74. https://doi.org/10.1016/j.actpsy.2017.06.003

Bilsen, J., Cohen, J., Chambaere, K., Onwuteaka-Philipsen, B., Mortier, F., & Deliens, L. (2009). Medical end-of-life practices under the euthanasia law in Belgium. *New England Journal of Medicine*, *361*(11), 1119–1121.

Bilsen, J., Robijn, L., Chambaere, K., Cohen, J., & Deliens, L. (2014). Nurses' involvement in physician-assisted dying under the euthanasia law in Belgium. *International Journal of Nursing Studies*, *51*(12), 1696–1697. https://doi.org/10.1016/j.ijnurstu.2014.05.007

Birnbacher, D., & Dahl, E. (2008). *Giving death a helping hand: Physician-assisted suicide and public policy. An international perspective* (Vol. 38). Springer.

Blainey, G. (2001). *The tyranny of distance how distance shaped Australia's history* (21st century ed., revised). Macmillan.

Blaxter, M. (1990). *Health and lifestyles*. Routledge.

Blondeau, D., Roy, L., Dumont, S., Godin, G., & Martineau, I. (2005). Physicians' and Pharmacists' Attitudes Toward the Use of Sedation at the End of Life: Influence of Prognosis and Type of Suffering. *Journal of Palliative Care*, *21*(4), 238–245.

Bloomer, M., Lee, S., & O'Connor, M. (2011). End of life clinician-family communication in ICU: a retrospective observational study - implications for nursing. *Australian Journal of Advanced Nursing*, *28*(2), 17–23.

Bluey, R. (2011). Doctors, Medical Students Abandon AMA in Search of Alternatives. *The Daily Signal*. http://dailysignal.com/2011/06/23/doctors-medical-students-abandon-ama-in-search-of-alternatives/

Boston Women's Health Book Collective. (1998). *History of Abortion* [Boston Women's Health Book Collective]. Our Bodies, Ourselves for the New Centruy. https://www.feminist.com/resources/ourbodies/abortion.html

Botti, M., & Reeve, R. (2003). Role of knowledge and ability in student nurses' clinical decision-making. *Nursing & Health Sciences*, *5*(1), 39–49. https://doi.org/10.1046/j.1442-2018.2003.00133.x

Boudewyns, V. (2013). *A Meta-Analytical Test of Perceived Behavioral Control Interactions in the Theory of Planned Behavior* [PhD dissertation, University of Maryland]. http://hdl.handle.net/1903/13973

Boughey, M. (2021, December). *Responding to the Voluntary Assisted Dying (VAD) Legislation at St. Vincent's Hospital Melbourne*. VAD Implementation. https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Webinars/Dr-Mark-Boughey.pdf

Boutain, D. (2005). Social justice in nursing: A review of the literature. In *Caring for the Vulnerable, M de Chesnay & B Anderson, eds.* (5th ed., pp. 21–29). Jones and Bartlet Learning.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braverman, D. W., Marcus, B. S., Wakim, P. G., Mercurio, M. R., & Kopf, G. S. (2017). Health Care Professionals' Attitudes About Physician-Assisted Death: An Analysis of Their Justifications and the Roles of Terminology and Patient

Competency. *Journal of Pain and Symptom Management*, *54*(4), 538–545. https://doi.org/10.1016/j.jpainsymman.2017.07.024

Bravo, G., Rodrigue, C., Arcand, M., Downie, J., Dubois, M.-F., Kaasalaine, S., Hertogh, C. M., Pautex, S., & Block, L. V. den. (2018). Nurses' perspectives on whether medical aid in dying should be accessible to incompetent patients with dementia: Findings from a survey conducted in Quebec, Canada. *Geriatric Nursing*, *0*(0). https://doi.org/10.1016/j.gerinurse.2017.12.002

Breckenridge, J. N. (2010). Replicating Cluster Analysis: Method, Consistency, and Validity. *Multivariate Behavioral Research*. https://doi.org/10.1207/s15327906mbr2402_1

Brewer, N., DeFrank, J. T., & Gilkey, M. B. (2016). Anticipated regret and health behavior: A meta-analysis. *Health Psychology*, *35*(11), 1264–1275. https://doi.org/10.1037%2Fhea0000294

Brown, R. D., & Pirtle, T. (2008). Beliefs of professional and family caregivers about the sexuality of individuals with intellectual disabilities: Examining beliefs using a Q-methodology approach. *Sex Education*, *8*(1), 59–75. https://doi.org/10.1080/14681810701811829

Brown, S R. (1993). A Primer on Q Methodology. *Operant Subjectivity*, *16*(3/4), 91–138.

Brown, S R. (1996). Q Methodology and Qualitative Research: *Q Methodology and Qualitative Research*, *6*(4), 561–567. https://doi.org/10.1177/104973239600600408

Brown, Steven R. (1980). *Political subjectivity: Applications of Q methodology in political science*. Yale University Press. https://qmethod.org/?s=Brown+%281980%29

Brown, T. (2006). *Confirmatory Factor Analysis for Applied Research*. Guilford Press. https://books.google.com/books/about/Confirmatory_Factor_Analysis_for_Applied.html?id=KZwDkH2G2PMC

Brzostek, T., Dekkers, W., Zalewski, Z., Januszewska, A., & Górkiewicz, M. (2008). Perception of Palliative Care and Euthanasia Among Recently Graduated and Experienced Nurses: *Nursing Ethics*, *15*(6), 761–776. https://doi.org/10.1177/0969733008095386

Buchbinder, M., Brassfield, E. R., & Mishra, M. (2019). Health Care Providers' Experiences with Implementing Medical Aid-in-Dying in Vermont: A Qualitative Study. *Journal of General Internal Medicine*, *34*(4), 636–641. https://doi.org/10.1007/s11606-018-4811-1

Buchheit, S., Marcus, M., Doxey, T. P., & Stinson, S. R. (2018). A Technical Guide to Using Amazon's Mechanical Turk in Behavioral Accounting Research. *Behavioral Research in Accounting*, *30*(1), 111–122. https://doi.org/10.2308/bria-51977

Buiting, H. M., Gevers, J. K., Rietjens, J. A. ., Onwuteaka-Philipsen, B. D., Maas, P. J., Heide, A., & van Delden, J. J. (2008). Dutch Criteria of Due Care for Physician-Assisted DYing in Medical Practice: A Physician Perspective. *Journal of Medical Ethics*, *34*(9).

Bullock, E. (2015). Assisted Dying and the Proper Role of Patient Autonomy. In Jukka Varelius & M. Cholbi (Eds.), *New Directions in the Ethics of Assisted Suicide and Euthanasia*. Springer Verlag.

Burgess, K. (2017, November 29). *Committee to investigate assisted dying scheme for the ACT*. Canberra Times. http://www.canberratimes.com.au/act-news/committee-to-investigate-assisted-dying-in-canberra-di-natale-backs-law-change-20171128-gzu60z.html

Buriak, S. E., Potter, J., & Bleckley, M. K. (2015). Using a Predictive Model of Clinician Intention to Improve Continuing Health Professional Education on Cancer Survivorship. *Journal of Continuing Education in the Health Professions*, *35*(1), 57–64. https://doi.org/10.1002/chp.21266

-C-

Cameron, R. (2009). A sequential mixed model research design: Design, analytical and display issues. *International Journal of Multiple Research Approaches*, *3*(2), 140–152.

Cameron, R., & Miller, P. (2007). Mixed methods research: Phoenix of the paradigm wars. *21st ANZAM Conference*. Australian & New Zealand Academy of Management, Sydney.

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation my the multitrait-multimethod matrix. *Psychological Bulletin*, *56*(2), 81.

Canadian Cancer Society. (2013). *One question may help provide dignity at the end of life: Study* -. Www.Cancer.Ca. http://www.cancer.ca/en/about-us/for-media/media-releases/national/2013/end-of-life-pdq/?region=on

Canadian Medical Association. (2017). *Education on medical assistance in dying*. https://www.cma.ca/en/pages/education-eol-care-medical-assistance-dying.aspx?utm_source=cmaj.ca&utm_campaign=maid-2017&utm_medium=display&utm_content=foundation-advanced-courses-en

Canadian Nurses Association. (2016). *Canadian Nurses Association welcomes report on medical assistance in dying*. https://cna-aiic.ca/news-room/news-releases/2016/canadian-nurses-association-welcomes-report-on-medical-assistance-in-dying

Canadian Nurses Association. (2017a). *National nursing framework on medical assistance in dying in Canada*. https://cna-aiic.ca/~/media/cna/page-content/pdf-en/cna-national-nursing-framework-on-maid.pdf?la=en

Canadian Nurses Association. (2017b). *Respecting choices in end-of-life care: Challenges and opportunities for RNs*. Canadian Nurses Association.

Cane, J., O'Connor, D., & Michie, S. (2012). Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implementation Science*, *7*(1), 37. https://doi.org/10.1186/1748-5908-7-37

Cappelletti, A., Engel, J. K., & Prentice, D. (2014). Systematic Review of Clinical Judgment and Reasoning in Nursing. *Journal of Nursing Education*, *53*(8), 453–458. https://doi-org.proxy.library.adelaide.edu.au/10.3928/01484834-20140724-01

Carecelli, J., & Greene, V. (1997). Crafting Mixed- Method Evaluation designs. In *Advances in Mixed-Method Evaluation: The Challenges and Benefits of Integrating Diverse Paradigms, Greene J and Caracelli V (Eds)*. Jossey-Bass.

Cartwright, C. (2017, February 28). *Northern Territory Euthanasia Collection - "The Northern Territory Rights of the Terminally Ill Act 1995 and the Euthanasia Laws Act 1997: What Really Happened?"* [Keynote presentation]. Academic workshop, Charles Darwin University. https://researcharchive.cdu.edu.au/view/cdu:60824

Case, P., Sparks, P., & Pavey, L. (2016). Identity appropriateness and the structure of the theory of planned behaviour. *British Journal of Social Psychology*, *55*, 109–125. https://doi.org/DOI:10.1111/bjso.12115

Case, P., & Webb, T. L. (2016). The Intention–Behavior Gap. *Social and Personality Psychology Compass*, *10*(9), 503–518. https://doi.org/10.1111/spc3.12265

Casey, D. (2018). Aid in Dying on the Medical-Surgical Unit. *MedSurg Nursing: Pitman*, *27*(6), 392–396.

Churruca, K., Perz, J., & Ussher, J. M. (2014). Uncontrollable behavior or mental illness? Exploring constructions of bulimia using Q methodology. *Journal of Eating Disorders*, *2*(22). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4244064/

Clark, D., Inbadas, H., Colburn, B., Forrest, C., Richards, N., Whitelaw, S., & Zaman, S. (2017). Interventions at the end of life – a taxonomy for 'overlapping consensus.' *Wellcome Open Research*, *2*(7). https://doi.org/10.12688/wellcomeopenres.10722.1

Clark, N. M., Nelson, B. W., Valerio, M. A., Gong, Z. M., & Taylor-Fishwick, J. C. (2009). Consideration of shared decision making in nursing: A review of clinicians' perceptions and interventions. *The Open Nursing Journal*, *3*, 65–75. https://doi.org/10.2174/1874434600903010065

Clarke, D. J., & Holt, J. (2015). Understanding nursing practice in stroke units: A Q-methodological study: *Disability and Rehabilitation*, *37*(20), 1870–1880. https://doi.org/10.3109/09638288.2014.986588

Clinical Ethics Service. (2017). *Medical Assistance in Dying: Values-based self-assessment tool for health care providers*. Alberta Health Service (Canada). https://www.albertahealthservices.ca/assets/info/hp/maid/if-hp-maid-self-assessment-tool.pdf

Clodfelter, R. B., & Adashi, E. Y. (2016). The Liberty to Die—California Enacts Physician Aid-in-Dying Law". *JAMA*, *315*(3), 251–252. https://doi.org/doi:10.1001/jama.2015.16242

Coffey, A., McCarthy, G., Weathers, E., Friedman, M. I., Gallo, K., Ehrenfeld, M., Itzhaki, M., Chan, S., Li, W. H. C., Poletti, P., Zanotti, R., Molloy, D. W., McGlade, C., & Fitzpatrick, J. J. (2013). Nurses' preferred end-of-life treatment choices in five countries. *International Nursing Review*, *60*(3), 313–319. https://doi.org/10.1111/inr.12024

Cohen, J., van Landeghem, P., Carpentier, N., & Deliens, L. (2014). Public acceptance of euthanasia in Europe: A survey study in 47 countries. *International Journal of Public Health*, *59*(1), 143–156. https://doi.org/10.1007/s00038-013-0461-6

Cohen, S. (2019). The logic of the interaction between beneficence and respect for autonomy. *Medicine, Health Care and Philosophy*, *22*(2), 297–304. https://doi.org/10.1007/s11019-018-9876-4

College of Nurses of Ontario. (2017). *Guidance on nurses' roles in medical assistance in dying*. College of Nurses of Ontario. http://www.cno.org/en/news/2016/june-2016/medical-assistance-in-dying--new-guidance-document-for-nurses/

College of Physicians and Surgeons of Ontario. (2015). *Professional Obligations and Human Rights Policy Statement #2-15*. http://www.cpso.on.ca/cpso/media/documents/policies/policy-items/human-rights.pdf

Colliver, J. A. (2000). Effectiveness of Problem-based Learning Curricula: Research. *Academic Medicine*, *75*(3), 259–266.

Conner, M, & Abraham, C. (2001). Conscientiousness and the Theory of Planned Behavior: Toward a more Complete Model of the Antecedents of Intentions and Behavior. *Personality and Social Psychology Bulletin*, *27*(11), 1547–1561. https://doi.org/10.1177/01461672012711014

Conner, M, & Armitage, C. J. (1998). Extending the Theory of Planned Behavior: A Review and Avenues for Further Research. *Journal of Applied Social Psychology*, *28*(15), 1429–1464. https://doi.org/10.1111/j.1559-1816.1998.tb01685.x

Conner, M, McEachan, R., Lawton, R., & Gardner, P. (2016a). Basis of intentions as a moderator of the intention–health behavior relationship. *Health Psychology*, *35*(3), 219–227. https://doi.org/10.1037/hea0000261

Conner, M, McEachan, R. R. C., Lawton, R. J., & Gardner, P. (2016b). Basis of intentions as a moderator of the intention-health behavior relationship. *Health Psychology*, *35*(3), 219–227.

Conner, M, & McMillan, B. (1999). Interaction eåects in the theory of planned behaviour: Studying cannabis use. *British Journal of Social Psychology*, *38*, 195–222. https://doi.org/10.1348/014466699164121

Conner, M, & Sparks, P. (2002). Ambivalence and Attitudes. *European Review of Social Psychology*, *12*(1), 37–70. https://doi.org/10.1080/14792772143000012

Conner, M, & Sparks, P. (2005). Theory of planned behaviour and health behaviour. *Predicting Health Behavior*, *2*(1), 121–162.

Conner, Mark. (2014). Extending not retiring the theory of planned behaviour: A commentary on Sniehotta, Presseau and Araújo-Soares. *Health Psychology Review*, *9*(2), 141–145. https://doi.org/10.1080/17437199.2014.899060

Converse, L., Barrett, K., Rich, E., & Reschovsky, J. (2015). Methods of Observing Variations in Physicians' Decisions: The Opportunities of Clinical Vignettes. *Journal of General Internal Medicine*, *30*(3), 586–594. https://doi.org/10.1007/s11606-015-3365-8

Cook, T. D., Campbell, D. T., & Peracchio, L. (1990). Quasi experimentation. In *Handbook of industrial and organizational psychology M. D. Dunnette & L. M. Hough (Eds.),* (pp. 491–576). Consulting Psychologists Press. (Reprinted in revised form from "Handbook of Industrial and Organizational Psychology," Wiley, 1982).

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/doi: 10.1177/1049732312452938.

Cooke, R., & Sheeran, P. (2004). Moderation of cognition-intention and cognition-behaviour relations: A meta-analysis of properties of variables from the theory of planned behaviour. *British Journal of Social Psychology*, *43*(2), 159–186. https://doi.org/10.1348/0144666041501688

Côte, F., Gagnon, J., Houme, P. K., & Gagnon, M.-P. (2012). Using the Theory of Planned Behaviour to predict nurses' intention to integrate research evidence into clinical decision-making. *Journal of Advanced Nursing*, *68*(10), 2289–2298. https://doi.org/10.1111/j.1365-2648.2011.05922.x

Creswell, J. (2010). Mapping the field of mixed methods research. In *Handbook of mixed methods in social & behavioral research. A. Tashakkori & C. Teddlie (Eds.),* (2nd ed., pp. 45–68). Sage.

Creswell, J., & Plano Clark, V. (2007). *Designing and Conducting Mixed Methods Research*. Sage.

Creswell, J. W. (1994). *Research Design: Qualitative, quantitiative and mixed methods approaches* (1st ed.). SAGE Publications.

Cronbach, L. J. (1951). Coefficient Alpha and the Internal Structure of Tests. *Psychometrika*, *16*, 297–334.

Cureton, A., & Hill, T. E. (2018). Kant on Virtue: Seeking the Ideal in Human Conditions. In *The Oxford Handbook of Virtue, Nancy E Snow (Ed.)*. Oxford University Press Oxford. https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199385195.001.0001/oxfordhb-9780199385195-e-13

-D-

D'Agostino, F., Pancani, L., Romero-Sánchez, J., Lumillo-Gutierrez, I., Paloma-Castro, O., & Vellone, E. (2018). Nurses' beliefs about nursing diagnosis: A study with cluster analysis. *Journal of Advanced Nursing*, *74*, 1359–1370. https://doi-org.proxy.library.adelaide.edu.au/10.1111/jan.13545

Danyliv, A., & O'Neill, C. (2015). Attitudes towards legalising physician provided euthanasia in Britain: The role of religion over time. *Social Science & Medicine*, *128*, 52–56. https://doi.org/10.1016/j.socscimed.2014.12.030

Daws, T., Landry, J., Viens, P., Beuthin, R., Maynard, E., & Regglar, J. (2020). *Bringing up Medical Assistance in Dying (MAiD) as a Clinical Care Option*. Canadian Association of MAID Assessors and Providers (CAMAP). https://camapcanada.ca/wp-content/uploads/2020/02/Bringing-up-MAiD.pdf

De Bal, N., Gastmans, C., & Dierckx de Casterle, B. (2008). Nurses' involvement in the care of patients requesting euthanasia: A review of the literature. *International Journal of Nursing Studies*, *45*(4), 626–644. https://doi.org/10.1016/j.ijnurstu.2007.06.009

De Beer, T., Gastmans, C., & Dierckx de Casterle, B. (2004). Involvement of nurses in euthanasia: A review of the literature. *Journal of Medical Ethics*, *30*(5), 494–498. https://doi.org/10.1136/jme.2003.004028

de Casterlé, B., Denier, Y., De Bal, N., & Gastmans, C. (2010). Nursing care for patients requesting euthanasia in general hospitals in Flanders, Belgium. *Journal of Advanced Nursing*, *66*(11), 2410–2420. https://doi-org.proxy.library.adelaide.edu.au/10.1111/j.1365-2648.2010.05401.x

De Hert, M., van Bos, L., Sweers, K., Wampers, M., De Lepeleire, J., & Correll, C. U. (2015). Attitudes of Psychiatric Nurses about the Request for Euthanasia on the Basis of Unbearable Mental Suffering(UMS). *PLOS ONE*, *10*(12). https://doi.org/10.1371/journal.pone.0144749

DeFrank, J. T. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review*, *108*.

Deliens, L, Mortier, F., Bilsen, J., Cosyns, M., van der Stichele, R., Vanoverloop, J., & Ingels, K. (2000). End-of-life decisions in medical practice in Flanders, Belgium: A nationwide survey. *The Lancet*, *356*(9244), 1806–1811. https://doi.org/10.1016/S0140-6736(00)03233-5

Deliens, Luc, & Wal, G. van der. (2003). The euthanasia law in Belgium and the Netherlands. *The Lancet*, *362*(9391), 1239–1240. https://doi.org/10.1016/S0140-6736(03)14520-5

den Ouden-Smit, C. (2018, February). Relevant—Magazine of Right to Die—NL (NVVE). *Relevant*, *44*(1), 6.

Denier, Y., Dierckx de Casterle, B., De Bal, N., & Gastmans, C. (2009). Involvement of Nurses in the Euthanasia Care Process in Flanders (Belgium): An exploration of two perspectives. *Journal of Palliative Care*, *25*(4), 264–274.

Denier, Y., Gastmans, C., de Bal, N., & de Casterlé, B. (2010). *Communication in nursing care for patients requesting euthanasia: A qualitative study*. Journal of Clinical Nursing. https://doi.org/10.1111/j.1365-2702.2010.03367.x

Dennis, K. E. (1986). Q-methodology: Relevance and application to nursing research. *Advances in Nursing Science.*, *8*(3), 6–17. https://psycnet.apa.org/doi/10.1097/00012272-198604000-00003

Dierckx de Casterlé, B. (2015). Realising skilled companionship in nursing: A utopian idea or difficult challenge? *Journal of Clinical Nursing*, *24*(21–22), 3327–3335. https://doi.org/10.1111/jocn.12920

Dierckx de Casterlé, B., Verpoort, C., De Bal, N., & Gastmans, C. (2006). Nurses' views on their involvement in euthanasia: A qualitative study in Flanders (Belgium). *Journal of Medical Ethics*, *32*(4), 187–192. https://doi.org/10.1136/jme.2005.011783

Dierickx, S., Deliens, L., Cohen, J., & Chambaere, K. (2017). Involvement of palliative care in euthanasia practice in a context of legalized euthanasia: A population-based mortality follow-back study. *Palliative Medicine*, *32*(1), 114–122. https://doi.org/10.1177/0269216317727158

Dillman, D. A., & Smyth, J. D. (2007). Design Effects in the Transition to Web-Based Surveys. *American Journal of Preventive Medicine*, *32*(5), S90–S96. https://doi.org/10.1016/j.amepre.2007.03.008

Dilorio, C. (1997). Neuroscience nurses' intentions to care for persons with HIV/AIDS. *Journal of Neuroscience Nursing*, *29*(1), 50–55.

Doo, H. J., & Lee, Y. J. (2015). Subjectivity of nursing Ssudents' experience of simulaton based learning: An application of Q-methodology. *Advanced Science and Technolgoy Letters*, *120*, 13–19.

Doolan, R., & Bradley, S. L. (2017, August 7). Recognition for broad based nursing role in assisted dying. *End of Life Choice*, *50*. https://docs.wixstatic.com/ugd/1062e1_65eda15fd49b450186db71b642ee8138.pdf

Downie, J. (2018a). View of An Alternative to Medical Assistance in Dying? The Legal Status of Voluntary Stopping Eating and Drinking (VSED). *Canadian Journal of Bioethics*, *1*(2), 48–58.

Downie, J. (2018b, July 3). Can Nurse Practitioners mention MAiD to patients? [Death & Assisted Dying, Health Education, Law & Policy]. *Impact Ethics*. https://impactethics.ca/2018/07/03/can-nurse-practitioners-mention-maid-to-patients/#more-4158

Downie, @jgdownie. (2019, March 7). Thankful that Canadian physicians and nurse practitioners have a duty to inform patients about option of #MAiD. Protection of vulnerable people includes protection from exclusion. #ICEL3. *Twitter Post*. https://twitter.com/jgdownie/status/1103686643159126017

Downs, D. S., & Hausenblas, H. A. (2005). Elicitation studies and the theory of planned behavior: A systematic review of exercise beliefs. *Psychology of Sport and Exercise*, *6*(1), 1–31. https://doi.org/10.1016/j.psychsport.2003.08.001

Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing Distress Protocols for Research on Sensitive Topics. *Archives of Psychiatric Nursing*, *23*(5), 343–350. https://doi.org/10.1016/j.apnu.2008.10.008

Dunn, H., Quinn, L., Corbridge, S. J., Eldeirawi, K., Kapella, M., & Collins, E. G. (2018). Cluster Analysis in Nursing Research: An Introduction, Historical Perspective, and Future Directions: *Western Journal of Nursing Research*, *40*(11), 1658–1676. https://doi.org/10.1177/0193945917707705

Dykema, J., Jones, N. R., Piché, T., & Stevenson, J. (2013). Surveying Clinicians by Web: Current Issues in Design and Administration. *Evaluation & the Health Professions*, *36*(3), 352–381. https://doi.org/10.1177/0163278713496630

Dziopa, F., & Ahern, K. (2011). A Systematic Literature Review of the Applications of Q-Technique and Its Methodology. *Methodology*, *7*(2), 39–55. https://doi.org/10.1027/1614-2241/a000021

-E-

Eagly, A H, & Chaiken, S. (1993). *The psychology of attitudes.* Harcourt Brace Jovanovich College Publishers.

Eagly, A H., & Chaiken, S. (2007). The Advantages of an Inclusive Definition of Attitude. *Social Cognition*, *25*(5), 582–602. https://doi.org/10.1521/soco.2007.25.5.582

Edwards, M. (2016). Changing laws on medical assistance in dying: Implications for critical care nurses. *Canadian Journal of Critical Care Nursing*, *27*(3), 18–23.

Ek, K., Westin, L., Prahl, C., Osterlind, J., Strang, S., & Bergh, I. (2014). Death and caring for dying patients: Exploring first-year nursing students' descriptive experiences. *International Journal of Palliative Nursing*, *20*(10), 509–515. https://doi.org/10.12968/ijpn.2014.20.10.509

Ellemers, N., van der Toorn, J., Paunov, Y., & van Leeuwen, T. (2019). The Psychology of Morality: A Review and Analysis of Empirical Studies Published From 1940 Through 2017. *Personality and Social Psychology Review*, *23*(4), 332–366. https://doi.org/10.1177%2F1088868318811759

Elliott, A. M., Smith, B. H., Penny, K. I., Smith, W. C., & Chambers, W. A. (1999). The epidemiology of chronic pain in the community. *The Lancet*, *354*(9186), 1248–1252. https://doi.org/10.1016/S0140-6736(99)03057-3

Elmore, J., Wright, D. K., & Paradis, M. (2016). Nurses' moral experiences of assisted death: A meta-synthesis of qualitative research. *Nursing Ethics*, *25*(8), 955–972. https://doi.org/10.1177/0969733016679468

ELNEC. (2017). *Accredited Online Classes and Cert Refresher Training | Relias Academy*. ELNEC: End-of-Life Nursing Education Consortium. http://elnec.academy.reliaslearning.com/

Emanuel, E., Onwuteaka-Philipsen, B. D., Urwin, J. W., & Cohen, J. (2016). Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA*, *316*(1), 79–90. https://doi.org/10.1001/jama.2016.8499

Emanuel, L. L. (2005). Facing Requests for Physician-Assisted Suicide: Toward a Practical and Principled Clinical Skill Set. *JAMA*, *280*(7), 643–647. https://doi.org/10.1001/jama.280.7.643

End of Life Directions for Aged Care. (2020, March 12). *Legal Assisted Dying Factsheet*. Fact Sheet: Assisted Dying. https://www.eldac.com.au/tabid/5757/Default.aspx

Essential Research. (2016). *The Essential Report*. http://www.essentialvision.com.au

Esses, V. M., & Maio, G. R. (2002). Expanding the Assessment of Attitude Components and Structure: The Benefits of Open-ended Measures. *European Review of Social Psychology*, *12*(1), 71–101. https://doi.org/10.1080/14792772143000021

Eun, J. Y., Ho, Y. B., Eon, N. R., & Ha, E. H. (2014). Attitudes toward simulation-based learning in nursing students: An application of Q methodology. *Nurse Education Today*, *34*(7), 1062–1068. https://doi.org/10.1016/j.nedt.2014.02.008

European Institute of Bioethics. (2014). *Belgian Euthanasia Increases by 89% in four years.* https://www.ieb-eib.org/en/document/belgian-euthanasia-increases-by-89-in-four-years-382.html

Evans, L. (2015). Nurses' attitudes to assisted suicide: Sociodemographic factors. *British Journal of Nursing*, *24*(12), 623–632.

Evenblij, K., Pasman, H., van der Heide, A., Hoekstra, T., & Onwuteaka-Philipsen, B. D. (2019). Factors associated with requesting and receiving euthanasia: A nationwide mortality follow-back study with a focus on patients with psychiatric disorders, dementia, or an accumulation of health problems related to old age. *BMC Medicine*, *17*(1). https://doi.org/10.1186/s12916-019-1276-y

Everitt, B. S., & Skrondal, A. (2010). *The Cambridge Dictionary of Statistics* (4th ed.). Cambridge University Press.

-F-

Faine, J., & Edwards, J. (2017, October 17). *How the death of his father changed Daniel Andrews' mind about euthanasia* [Text]. ABC News. http://www.abc.net.au/news/2017-10-17/death-father-changed-daniel-andrews-mind-about-euthanasia/9053002

Feinberg, M., & Willer, R. (2012). The Moral Roots of Environmental Attitudes. *Psychological Science*, *XX*(X), 1–7. https://doi.org/10.1177/0956797612449177

Fernández-Sola, C., Granero-Molina, J., Manrique, G. A., Castro-Sánchez, A. N., Hernández-Padilla, J. M., & Márquez-Membrive, J. (2012). New regulation of the right to a dignified dying in Spain: Repercussions for nursing: *Nursing Ethics*, *19*(5), 619–628. https://doi.org/10.1177/0969733011429016

Ferrell, B. R., Virani, R., Grant, M., Rhome, A., Malloy, P., Bednash, G., & Grimm, M. (2005). *Evaluation of the End-of-Life Nursing Education Consortium Undergraduate Faculty Training Program* [Research-article]. Http://Www.Liebertpub.Com/Jpm. https://doi.org/10.1089/jpm.2005.8.107

Festinger, L. (1962). Cognitive Dissonance. *Scientific American*, *207*(4), 93–106. https://doi.org/10.1038/scientificamerican1062-93

Fetz, K., Vogt, H., Ostermann, T., Schmitz, A., & Schulz-Quach, C. (2018). Evaluation of the palliative symptom burden score (PSBS) in a specialised palliative care unit of a university medical centre—A longitudinal study. *BMC Palliative Care*, *17*(1), 1–13. https://doi.org/10.1186/s12904-018-0342-0

Field, A. (2000). *Discovering Statistics Using SPSS for Windows*. SAGE Publications. https://books.google.com/books/about/Discovering_Statistics_Using_SPSS_for_Wi.html?id=LhEPlzgwRdQC

Finch, E. (2001). Issues of Confidentiality in Research into Criminal Activity: The Legal and Ethical Dilemma. *Mountbatten Journal of Legal Studies*, *5*(1 & 2), 34–50.

Fishbein, M. (2000). The role of theory in HIV prevention. *Aids Care*, *12*(3), 273–278. https://doi.org/10.1080/09540120050042918

Fishbein, M., & Ajzen, I. (1975). *Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research*. Addison-Wesly.

Fitzgerald, J. L. (2012). Supervised injecting facilities: A case study of contrasting narratives in a contested health policy arena. *Critical Public Health*, *23*(1), 77–94. https://doi-org.access.library.unisa.edu.au/10.1080/09581596.2012.735360

Fleming, A., & Kydd, A. (2018). What makes a nursing home homely? A Scottish based study, using Q methodology of the perceptions of staff, residents and significant others: *Journal of Research in Nursing*, *23*(2–3), 141–158. https://doi.org/10.1177/1744987118757837

Ford, R. (2010). An analysis of nurses' views of harm reduction measures and other treatments for the problems associated with illicit drug use. *Australian Journal of Advanced Nursing*, *28*(1), 11–24.

Fraiman, R., & Justel, A. (2008). Selection of Variables for Cluster Analysis and Classification Rules. *Journal of American Statistical Association*, *103*(483), 1294–1303. https://doi.org/doi.org:10.2307/27640162

Francis, J., Eccles, M., Johnston, M., Walker, A., & Grimshaw, J. (2004). *Constructing questionnaires based on the theory of planned behaviour: A manual for health services researchers*. Centre for Health Services Research. University of Newcastle (U.K.).

Francis, J. J., O'Connor, D., & Curran, J. (2012). Theories of behaviour change synthesised into a set of theoretical groupings: Introducing a thematic series on the theoretical domains framework. *Implementation Science*, *7*(1), 35. https://doi.org/10.1186/1748-5908-7-35

Francke, A. L., Albers, G., Bilsen, J., de Veer, A. J. E., & Onwuteaka-Philipsen, B. D. (2016). Nursing staff and euthanasia in the Netherlands. A nation-wide survey on attitudes and involvement in decision making and the performance of euthanasia. *Patient Education and Counseling*, *99*(5), 783–789. https://doi.org/10.1016/j.pec.2015.11.008

Fujioka, J. K., Mirza, R. M., McDonald, P. L., & Klinger, C. A. (2018). Implementation of Medical Assistance in Dying: A Scoping Review of Health Care Providers' Perspectives. *Journal of Pain and Symptom Management*, *55*(6), 1564–1576. https://doi.org/10.1016/j.jpainsymman.2018.02.011

Fuscaldo, G., Gwini, S. M., Larsen, R., & Venkataramani, A. (in press) (2021). Do Health Service staff support the implementation of Voluntary Assisted Dying at their workplace? *Internal Medicine Journal* https://doi.org/10.1111/imj.15285

-G-

Gagnon, J., & Duggleby, W. (2014). The provision of end-of-life care by medical-surgical nurses working in acute care: A literature review. *Palliative and Supportive Care*, *12*(05), 393–408. https://doi.org/10.1017/S1478951513000965

Galynker, I. (2017). *The Suicidal Crisis*. Oxford University Press.

Gamondi, C., Borasio, G., Oliver, P., Preston, N., & Payne, S. (2017). Responses to assisted suicide requests: An interview study with Swiss palliative care physicians. *BMJ Supportive and Palliative Care*. https://doi.org/10. 1136/ bmjspcare- 2016-001291

Ganzini, L, Dobscha, S. K., Heintz, R. T., & Press, N. (2003). Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families. *Journal of Palliative Medicine*, *6*(3), 381–390.

Ganzini, L, Roy, E. R., & Dobscha, S. K. (2008). Prevalence of depression and anxiety in patients requesting physicians' aid in dying: Cross sectional survey. *BMJ*, 337: a1682. https://doi-org.proxy.library.adelaide.edu.au/10.1136/bmj.a1682

Ganzini, Linda, & Back, A. L. (2016). The Challenge of New Legislation on Physician-Assisted Death. *JAMA Internal Medicine*, *176*(4), 427. https://doi.org/10.1001/jamainternmed.2016.0047

Ganzini, L, Goy, E. R., & Dobscha, S. K. (2008). Why Oregon Patients Request Assisted Death: Family Members' Views. *Journal of General Internal Medicine*, *23*(2), 154–157. https://doi.org/10.1007/s11606-007-0476-x

Ganzni, L., Nelson, H., Schmidt, T., Kraemer, D., Delorit, M., & Lee, M. (2000). Physicians' experiences with the Oregon Death With Dignity Act. *New England Journal of Medicine*, *342*(8), 557–563. https://doi.org/DOI: 10.1056/NEJM200002243420806

Gardenfors, P. (2004). Conceptual Spaces as a Framework for Knowledge Representation. *Mind and Matter*, *2*(2), 9–27.

Gastmans, C., Lemiengre, J., & Dierckx de Casterlé, B. (2006). Role of nurses in institutional ethics policies on euthanasia. *Journal of Advanced Nursing*, *54*(1), 53–61. https://doi.org/10.1111/j.1365-2648.2006.03790.x

Gastmans, C., Van Neste, F., & Schotsmans, P. (2004). Facing requests for euthanasia: A clinical practice guideline. *Journal of Medical Ethics*, *30*(2), 212–217. https://doi.org/10.1136/jme.2003.005082

Germain, C. P. (1980). Nursing the dying: Implications of Kübler-Ross' staging theory. *Annals of the American Academy of Political and Social Science*, *447*, 46–58.

Gerson, S. (2018). *Hospice professionals' experiences with patients: A qualitative study of suicide and hastened death in Washington State* [University of Lancaster]. http://eprints.lancs.ac.uk/123925/

Gerson, S., Lewis, D., & Gamondi, C. (2016). Euthanasia, Assisted Dying, and Assisted Suicide in Palliative Care Settings: Reports from the Netherlands, Switzerland, and Washington State (TH323). *Journal of Pain and Symptom Management*, *51*(2), 326–327. https://doi.org/10.1016/j.jpainsymman.2015.12.147

Gibbons, F. X. (2006). *Behavioral intentions, expectations, and willingness. Health behavior constructs: Theory, measurement, and research.* (p. 17). National Cancer Institute. https://cancercontrol.cancer.gov/brp/research/constructs/intent-expect-will.pdf

Gielen, J., van den Branden, S., & Broeckaert, B. (2009a). Religion and Nurses' Attitudes To Euthanasia and Physician Assisted Suicide: *Nursing Ethics*, *16*(3), 303–318. https://doi.org/10.1177/0969733009102692

Gielen, J., van den Branden, S., & Broeckaert, B. (2009b). The operationalisation of religion and world view in surveys of nurses' attitudes toward euthanasia and assisted suicide. *Medicine, Health Care and Philosophy*, *12*(4), 423–431. https://doi.org/10.1007/s11019-009-9217-8

Gillan, P. C., van der Riet, P. J., & Jeong, S. (2014). End of life care education, past and present: A review of the literature. *Nurse Education Today*, *34*(3), 331–342. https://doi.org/10.1016/j.nedt.2013.06.009

Glanz, K., & Bishop, D. (2010). The Role of Behavioral Science Theory in Development and Implementation of Public Health Interventions | Annual Review of Public Health. *Annual Review of Public Health*, *31*, 399–418.

Glassman, L. R., & Albarracin, D. (2006). Forming Attitudes That Predict Future Behavior: A Meta-Analysis of the Attitude–Behavior Relation. *Psychological Bulletin*, *132*(5), 778–822. https://doi.org/10.1037/0033-2909.132.5.778

Godin, G., Amireault, S., Vezina-im, L., & Sheeran, P. (2012). Implementation intentions intervention among temporarily deferred novice blood donors. *Transfusion*, *53*(8), 8. https://doi.org/10.1111/j.1537-2995.2012.03939.x

Godin, G., Bélanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008). Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories. *Implementation Science*, *3*(1). https://doi.org/10.1186/1748-5908-3-36

Godin, G., Conner, M., & Sheeran, P. (2005). Bridging the intention-behaviour gap: The role of moral norm. *British Journal of Social Psychology*, *44*(4), 497–512. https://doi.org/10.1348/014466604X17452

Godin, G., & Kok, G. (1996). The theory of planned behavior: A review of its applications to health-related behaviors. *American Journal of Health Promotion*, *11*(2), 87–98.

Godin, G., Naccache, H., Morel, S., & Ebacher, M. F. (2000). Determinants of nurses' adherence to universal precautions for venipunctures. - PubMed—NCBI. *American Journal of Infection Control*, *28*(5), 359–364. https://doi.org/10.1067/mic.2000.107594

Goethals, S., Gastmans, C., & Casterlé, B. (2010). Nurses' ethical reasoning and behaviour: A literature review. *International Journal of Nursing Studies*, *47*(5), 635–650. https://doi.org/10.1016/j.ijnurstu.2009.12.010

Goffman, E. (1974). The frame analysis of talk. *The Goffman Reader*, 167–200.

Gollwitzer, P. M., & Sheeran, P. (2006). Implementation Intentions and Goal Achievement: A Meta-analysis of Effects and Processes. *Advances in Experimental Social Psychology*, *38*, 69–119. https://doi.org/10.1016/S0065-2601(06)38002-1

Gonzalez-Mulé, E., & Aguinis, H. (2018). Advancing Theory by Assessing Boundary Conditions With Metaregression: A Critical Review and Best-Practice Recommendations. *Journal of Management*, *44*(6), 2246–2273. https://doi.org/10.1177/0149206317710723

Goodwin, L. D. (2009). The Role of Factor Analysis in the Estimation of Construct Validity. *Measurement in Physical Education and Exercise Science*, *3*(2), 85–100. https://doi.org/10.1207/s15327841mpee0302_2

Gorsuch, N. M. (2006). *The Future of Assisted Suicide and Euthanasia*. Princeton University Press.

Gorsuch, R. L., & Ortberg, J. (1983). Moral obligation and attitudes: Their relation to behavioral intentions. *Journal of Personality and Social Psychology*, *44*(5), 1025–1028. http://psycnet.apa.org/doi/10.1037/0022-3514.44.5.1025

Gott, M., Moeke-Maxwell, T., Morgan, T., Black, S., Williams, L., Boyd, M., Frey, R., Robinson, J., Slark, J., Trussardi, G., Waterworth, S., Wharemate, R., Hansen, W., Smith, E., Kaka, K., Henare, K., Henare, E., Poto, M., Tipene-Carter, E., & Hall, D. (2017). Working bi-culturally within a palliative care research context: The development of the Te Ārai Palliative Care and End of Life Research Group. *Mortality*, *22*(4), 291–307. https://doi.org/10.1080/13576275.2016.1216955

Government of Canada, D. of J. (2016). *Consultations on Physician-Assisted Dying—Summary of Results and Key Findings*. https://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html

Government of Canada, H. (2016). *Medical assistance in dying*. Medical Assistance in Dying. https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

Government of the Netherlands. (2017). *Euthanasia*. https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request

Government of Victoria. (2017). *Voluntary Assisted Dying Bill 2017 Explanatory Memorandum*. Victorian Bills Explanatory Memoranda. http://classic.austlii.edu.au/au/legis/vic/bill_em/vadb2017312/vadb2017312.html

Government of Victoria (Australia). (n.d.). *A note on language*. Ministerial Advisory Panal on Voluntary Assisted Dying: Final Report. https://www.anmfvic.asn.au/~/media/files/anmf/campaigns/end%20of%20life%20choices/a-note-on-language-from-ministerial-advisory-panel-on-voluntary-assisted-dying-final-report-pdf-1.pdf?la=en

Government of Victoria, D. of H. and H. S. (2019a). *Health practitioner information on voluntary assisted dying*. Information for Nurses and Allied Health Professionals. https://www2.health.vic.gov.au:443/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information

Government of Victoria, D. of H. and H. S. (2019b, December). *Voluntary Assisted Dying Review Board Report of Operations 2019*. Voluntary Assisted Dying Portal. https://www.bettersafercare.vic.gov.au/about-us/about-scv/councils/vad-review-board

Government of Western Australia, D. of H. (2021, May 7). *Voluntary Assisted Dying Implementation Leadership Team—Communique May 2021* [Implementation Update]. Voluntary Assisted Dying Act 2019. https://mailchi.mp/health.wa.gov.au/implementation-leadership-team-communique-february-8830453?e=d1bd2be380

Goy, E. R., Carlson, B., Simopoulos, N., Jackson, A., & Ganzini, L. (2006). Determinants of Oregon Hospice Chaplains' Views on Physician-Assisted Suicide—ProQuest. *Journal of Palliative Care*, *22*(2), 83–90.

Graboyes-Russo, S. (1997). HOT TOPIC: Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill. *University of Miami Law Review*, *51*(3), 907.

Graf, A., Bar-On, H., Henin, T., Piotrowski, R., von Raggamby, A., & Lang, S. (2012). *InContext—Literature review & research survey*. 7th Framework Programme. www.incontext-fp7.eu

Graham, J., Haidt, J., Koleva, S., Motyl, M., Iyer, R., Wojcik, S. P., & Ditto, P. H. (2013). Moral Foundations Theory: The Pragmatic Validity of Moral Pluralism. *Advances in Experimental Social Psychology*, *47*, 55–130.

Greenland, S., Mansournia, M. A., & Altman, D. G. (2016). Sparse data bias: A problem hiding in plain sight. *BMJ*, *352*. https://doi.org/10.1136/bmj.i1981

Griffin, M., & Clark, C. M. (2014). Revisiting Cognitive Rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing*, *45*(12), 535–542. https://doi.org/10.3928/00220124-20141122-02

Grol, R. P., Bosch, M. C., Hulscher, M. E., Eccles, M. P., & Wensing, M. (2007). Planning and Studying Improvement in Patient Care: The Use of Theoretical Perspectives. *The Milbank Quarterly*, *85*(1), 93. https://doi.org/10.1111/j.1468-0009.2007.00478.x

Gudat, H., Rehmann-Sutter, C., & Ohnsorge, K. (2015). Communication of wishes to die. In *The patient's wish to die* (pp. 203–216). Oxford University Press.

Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating Quantitative and Qualitative Results in Health Science Mixed Methods Research Through Joint Displays. *Annals of Family Medicine*, *13*(6), 554. https://doi.org/10.1370/afm.1865

Gushee, D. P. (2006). *The Sanctity of Life*. Trinity International University Center for BioEthics. https://cbhd.org/content/sanctity-life

-H-

Ha, E. H. (2014). Attitudes toward Video-Assisted Debriefing after simulation in undergraduate nursing students: An application of Q methodology. *Nurse Education Today*, *34*(6), 978–984. https://doi.org/10.1016/j.nedt.2014.01.003

Ha, E. H. (2018). Experience of nursing students with standardized patients in simulation-based learning: Q-methodology study. *Nurse Education Today*, *66*, 123–129. https://doi.org/10.1016/j.nedt.2018.04.023

Haddad, L. M., & Geiger, R. A. (2019). *Nursing Ethical Considerations*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK526054/

Hagbaghery, M. A., Salsali, M., & Ahmadi, F. (2004). The factors facilitating and inhibiting effective clinical decision-making in nursing: A qualitative study. *BMC Nursing*, *3*(1), 1–11. https://doi.org/10.1186/1472-6955-3-2

Hagger, M S, & Luszczynska, A. (2014). Implementation Intention and Action Planning Interventions in Health Contexts: State of the Research and Proposals for the Way Forward. *Applied Psychology: Health and Well‐Being*, *6*(1), 1–47. https://doi.org/10.1111/aphw.12017

Hagger, Martin S., & Chatzisarantis, N. L. D. (2009). Integrating the theory of planned behaviour and self-determination theory in health behaviour: A meta-analysis. *British Journal of Health Psychology*, *14*(2), 275–302. https://doi.org/10.1348/135910708X373959

Haidt, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review*, *108*(4), 814–834. https://doi.org/10.1037/0033-295X.108.4.814

Hair, J., Andersen, R., Tatham, R., & Black, W. (1998). *Multivariate data analysis* (Vol. 6). Pearson.

Hall, K. L., Oh, A., Perez, L. G., Rice, E. L., Patel, M., Czajkowski, S., & Klesges, L. (2018). The ecology of multilevel intervention research. *Translational Behavioral Medicine*, *8*(6), 968–978. https://doi.org/10.1093/tbm/iby102

Han, H. (2014). The norm activation model and theory-broadening: Individuals' decision-making on environmentally-responsible convention attendance. *Journal of Environmental Psychology*, *40*, 462–471. https://doi.org/10.1016/j.jenvp.2014.10.006

Hankins, M., French, D., & Horne, R. (2000). Statistical guidelines for studies of the theory of reasoned action and the theory of planned behaviour. *Psychology & Health*, *15*(2), 151–161. https://doi.org/10.1080/08870440008400297

Hanna, D. R. (n.d.). Moral distress: The state of the science. *Research and Theory for Nursing Practice*, *18*(1), 73.

Hanrahan, K. (2019, May). *Voters unite in support for euthanasia, but that's where it stops*. ABC News. https://www.abc.net.au/news/2019-05-08/vote-compass-social-issues-euthanasia-transgender-republic-drugs/11087008

Hanson, J. J. (n.d.). *A momentum shift against assisted suicide*. Washington Examiner. Retrieved September 17, 2017, from http://www.washingtonexaminer.com/a-momentum-shift-against-assisted-suicide/article/2632967

Harty, C., Chaput, A. J., Buna, D., Trouton, K., & Naik, V. N. (2018). *The Oral MAiD Option in Canada Part 1: Medication protocols*. Canadian Association of MAID Assessors and Providers (CAMAP).

Health Vic. (2019). *Health practitioner participation in voluntary assisted dying*. Victoria State Government. https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/preparing-to-take-medications

Heide, Agnes van der, Delden, J. J. van, & Wal, G. van der. (2004). Doctor-assisted dying: What difference does legalisation make? *The Lancet*, *364*, 24–25. https://doi.org/10.1016/S0140-6736(04)17628-9

Hendry, M., Pasterfield, D., Lewis, R., Carter, B., Hodgson, D., & Wilkinson, C. (2012). Why do we want the right to die? A systematic review of the international literature on the views of patients, carers and the public on assisted dying: *Palliative Medicine*, *27*(1), 13–26. https://doi.org/10.1177/0269216312463623

Henoch, I., Melin-Johansson, C., Bergh, I., Strang, S., & Ek, K. (2017). Undergraduate nursing students’ attitudes and preparedness toward caring for dying persons – A longitudinal study. *Nurse Education in Practice*, *26*, 12–20. https://doi.org/10.1016/nepr. 2017.06.007

Hensel, D. (2014). Typologies of Professional Identity Among Graduating Baccalaureate-Prepared Nurses. *Journal of Nursing Scholarship*, *46*(2), 125–133. https://doi.org/10.1111/jnu.12052

Hewitt, J., White, B., Del Villar, K., Willmott, L., Greaves, L., & Meehan, R. (2020). Voluntary assisted dying in Victoria: Why knowing the law matters to nurses: *Nursing Ethics*. https://doi.org/10.1177/0969733020944457

Hold, J. L. (2015). A good death: Narratives of experiential nursing ethics. *Nursing Ethics*. https://doi.org/10.1177/0969733015602051

Holt, J. (2008). Nurses’ attitudes to euthanasia: The influence of empirical studies and methodological concerns on nursing practice. *Nursing Philosophy*, *9*(4), 257–272. https://doi.org/10.1111/j.1466-769X.2008.00373.x

Holt, J. (2019). Nurses’ attitudes to euthanasia eleven years on: Has anything changed? *Nursing Philosophy*, 1–3. https://doi.org/10.1111/nup.12249

Honey, S., Bryant, L. D., Murray, J., Hill, K., & House, A. (2013). Differences in the perceived role of the healthcare provider in delivering vascular health checks: A Q methodology study. *BMC Family Practice*, *14*(1), no pagination. https://doi.org/10.1186/1471-2296-14-172

Honkanen, P., & Verplanken, B. (2004). Understanding Attitudes Towards Genetically Modified Food: The Role of Values and Attitude Strength. *Journal of Consumer Policy*, *27*(4), 401–420. https://doi.org/10.1007/s10603-004-2524-9

Horizon Research Ltd. (2012). *New Zealanders’ Views on End of Life Choices.* https://www.horizonpoll.co.nz/attachments/docs/horizon-research-end-of-life-choices-survey--1.pdf

Our Care, Our Choice Act, no. HB 2739, House of Representatives (2018). https://www.capitol.hawaii.gov/session2018/bills/HB2739_.HTM

Howe, L. C., & Krosnick, J. A. (2017). Attitude Strength. *Http://Dx.Doi.Org/10.1146/Annurev-Psych-122414-033600*, *68*, 327–351. https://doi.org/10.1146/annurev-psych-122414-033600

Huang, C.-M., Hung, W.-S., Lai, J.-N., Kao, Y.-H., Wang, C.-L., & Guo, J.-L. (2016). Maternity staff perspectives regarding resource demands of breastfeeding supportive practices in accordance with the Baby-Friendly Hospital Initiative accreditation: A Q methodology approach. *Journal of Advanced Nursing*, *72*(6), 1301–1312. https://doi.org/10.1111/jan.12928

Hudson, P L, Schofield, P., Kelly, B., Hudson, R., & O’Connor, M. (2006). Responding to desire to die statements from patients with advanced disease: Recommendations for health professionals. *Palliative Medicine*, *20*(7), 703–710. https://doi.org/10.1177/0269216306071814

Hudson, P. L., Kristjanson, L. J., Ashby, M., Kelly, B., Schofield, P., Hudson, R., Aranda, S., O’Connor, M., & Street, A. (2016). Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: A systematic review: *Palliative Medicine*. https://doi.org/10.1177/0269216306071799

Hudson, P. L. (2021, August 12). *25yrs of Nursing Webinar: What are the implications of voluntary assisted dying for nursing practice* [Video webinar]. https://www.youtube.com/watch?v=EEdKTS4h1EI

Hung, C.-C., Chu, T.-P., & Lee, B.-O. (2016). Nurses’ attitude and intention of medication administration error reporting—Hung—2016—Journal of Clinical Nursing—Wiley Online Library. *Journal of Clinical Nursing*, *25*(3–4), 445–453.

Huong, Q. N., Gelman, E. J., & Bush, T. A. (2018). Characterizing Kaiser Permanente Southern California’s Experience With the California End of Life Option Act in the First Year of Implementation. *JAMA Internal Medicine*, *178*(3), 417–421. https://doi.org/doi:10.1001/jamainternmed.2017.7728

Hurst, S. A., & Mauron, A. (2003). Assisted suicide and euthanasia in Switzerland: Allowing a role for non-physicians. *BMJ : British Medical Journal*, *326*(7383), 271.

Hurst, S. A., & Mauron, A. (2006). The ethics of palliative care and euthanasia: Exploring common values. *Palliative Medicine*, *20*(2), 107–112. https://doi.org/10.1191/0269216306pm1109oa

-I-

IBM. (2017). *SPSS for Windows* (Version 25) [Computer software].

IBM Knowledge Center. (2014). *GLM Univariate Analysis*. GLM Univariate Analysis. www.ibm.com/support/knowledgecenter/sslvmb_sub/statistics_mainhelp_ddita/spss/base/idh_glmu.html

IBM SPSS Statistics for Windows (Version 25). (2017). [Computer software]. http://www-01.ibm.com/support/docview.wss?uid=swg21476197

Inghelbrecht, E, Bilsen, J., Mortier, F., & Deliens, L. (2009). Attitudes of nurses towards euthanasia and towards their role in euthanasia: A nationwide study in Flanders, Belgium. *International Journal of Nursing Studies*, *46*(9), 1209–1218. https://doi.org/10.1016/j.ijnurstu.2009.02.009

Inghelbrecht, E, Bilsen, J., Mortier, F., & Deliens, L. (2010). The role of nurses in physician-assisted deaths in Belgium. *Canadian Medical Association Journal*, *182*(9), 905–910. https://doi.org/10.1503/cmaj.091881

Inghelbrecht, Els, Bilsen, J., Mortier, F., & Deliens, L. (2008). Factors related to the involvement of nurses in medical end-of-life decisions in Belgium: A death certificate study. *International Journal of Nursing Studies*, *45*(7), 1022–1031. https://doi.org/Bergh

Itzchakov, G., & van Harreveld, F. (2018). Feeling torn and fearing rue: Attitude ambivalence and anticipated regret as antecedents of biased information seeking. *Journal of Experimental Social Psychology*, *75*, 19–26. https://doi.org/10.1016/j.jesp.2017.11.003

-J-

Jannette, J., DeWolf Bosek, M. S., & Rambur, B. (2013). Advanced Practice Registered Nurse Intended Actions Toward Patient-directed Dying. *JONA's Healthcare Law, Ethics and Rgulation*, *15*(2), 80–88. https://doi.org/doi:10.1097/NHL.0b013e3182919e81

Jansen, L. A., Wall, S., & Miller, F. G. (2019). Drawing the line on physician-assisted death. *Journal of Medical Ethics*, *45*, 190–197. https://dx.doi.org/10.1136/medethics-2018-105003

Janssens, R., Delden, J. J. M. van, & Widdershoven, G. A. M. (2012). Palliative sedation: Not just normal medical practice. Ethical reflections on the Royal Dutch Medical Association's guideline on palliative sedation. *Journal of Medical Ethics*, *38*(11), 664–668. https://doi.org/10.1136/medethics-2011-100353

Jasser, M. Z. (2017). *Draft Resolution 014 to American Medical Association House of Delegates*. https://www.ama-assn.org/sites/default/files/media-browser/public/hod/a17-014.pdf

Jo, K.-H., Kim, Y.-J., & Sohn, K.-C. (2012). Types of Perception toward End-of-Life Medical Decision-making of Clinical Nurses: Q-Methodological Approach. *The Korean Journal of Hospice and Palliative Care*, *15*(1), 18–29.

Johnson, E., Shu, S. B., Dellaert, B., & Weber, E. U. (2012). Beyond Nudges: Tools of a Choice Architecture. *Marketing Letters*, *23*, 487–504. http://dx.doi.org/10.1007/s11002-012-9186-1

Johnson, E. J., & Goldstein, D. G. (2003). Do Defaults Save Lives? *Science*, *302*(5649), 1338–1339. https://doi.org/10.1126/science.1091721.

Johnstone, M.-J. (2012). Organization Position Statements and the Stance of "Studied Neutrality" on Euthanasia in Palliative Care. *Journal of Pain and Symptom Management*, *44*(6), 896–907. https://doi.org/10.1016/j.jpainsymman.2011.12.276

Joinson, A. (1999). Social desirability, anonymity, and internet-based questionnaires. *Behavior Research Methods, Instruments, & Computers*, *31*(3), 433–438. https://doi.org/10.3758/BF03200723

Jonas, K., Diehl, M., & Bromer, P. (1997). Effects of Attitudinal Ambivalence on Information Processing and Attitude-Intention Consistency. *Journal of Experimental Social Psychology*, *33*(2), 190–210. https://doi.org/10.1006/jesp.1996.1317

Joseph-Williams, N., Edwards, A., & Elwyn, G. (n.d.). The importance and complexity of regret in the measurement of good decisions: A systematic review and a content analysis of existing assessment instruments. *Health Expectations*, *14*, 59–83. https://doi.org/10.1111/j.1369-7625.2010.00621.x 2010

Joseph-Williams, N., Edwards, A., & Elwyn, G. (2010). The importance and complexity of regret in the measurement of 'good' decisions: A systematic review and a content analysis of existing assessment instruments. *Health Expectations*, *14*(1), 59–83. https://doi.org/10.1111/j.1369-7625.2010.00621.x

Julesz, M. (2014). {Euthanasia outside Europe} trans. From Hungarian. *Orvosi Hetilap*, *155*(32), 1259–1264. https://doi-org.proxy.library.adelaide.edu.au/10.1556/OH.2014.29978

Julesz Máté. (2014). Euthanasia outside Europe. *Orvosi Hetilap*, *155*(32), 1259–1264. https://doi.org/10.1556/OH.2014.29978

-K-

Kagi, J. (2017, August 9). *WA parliamentary committee to examine legalising euthanasia* [Text]. ABC News. http://www.abc.net.au/news/2017-08-09/wa-parliament-to-vote-on-euthanasia-committee/8791074

Kaiser, F. G., & Schultz, P. W. (2009). The Attitude–Behavior Relationship: A Test of Three Models of the Moderating Role of Behavioral Difficulty1. *Journal of Applied Social Psychology*, *39*(1), 186–207. https://doi.org/10.1111/j.1559-1816.2008.00435.x

Kant, I., & Ellington (trans), J. W. (1993). *Grounding for the Metaphysics of Morals* (3rd ed.). Hackett.

Karadeniz, G., Yanikkerem, E., Pirinçci, E., Erdem, R., Esen, A., & Kitapçioğlu, G. (2008). Turkish Health Professional’s Attitude Toward Euthanasia: *OMEGA - Journal of Death and Dying*, *57*(1), 93–112. https://doi.org/10.2190/OM.57.1.e

Kashima, Y., Gallois, C., & McCamish, M. (1993). The theory of reasoned action and cooperative bheavious: It take two to use a condom. *British Journal of Social Psychology*, *32*, 227–239.

Kaufman, L., & Rouseeuw, P. J. (2008). *Finding groups in data: An introduction to cluster analysis*. John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470316801.fmatter

Keenan, J. F. (1995). Proposing cardinal virtues. *Theological Studies*, *56*(4), 709–729. https://doi.org/10.1177%2F004056399505600405

Keenan, J. F. (1996). The concept of sanctity of life and its use in contemporary bioethical discussion. In *In Sanctity of life and human dignity. K Bayertz (ed)* (pp. 1–18). Dordrecht.

Kennedy, W. (2017). Beneficence and Autonomy in Nursing a Moral Dilemma: *British Journal of Perioperative Nursing*. https://doi.org/10.1177/175045890401401103

Kent, B. (2002). Psychosocial factors influencing nurses’ involvement with organ and tissue donation. *International Journal of Nursing Studies*, *39*(4), 429–440. https://doi.org/10.1016/S0020-7489(01)00045-1

Kerkhof, A. J. F. M. (2000). How to deal with requests for assisted suicide: Some experiences and practical guidelines from the Netherlands. *Psychology, Public Policy, and Law*, *6*(2), 45r2-466. https://doi.org/10.1037/1076-8971.6.2.452

Kerr, T., Tyndall, M., Li, K., Montaner, J., & Wood, E. (2005). *Safer injection facility use and syringe sharing in injection drug users*. Lancet. http://linkinghub.elsevier.com/retrieve/pii/S0140673605664756

Ketchen, D. J., Thomas, J. B., & Snow, C. C. (1993). Organizational Configurations and Performance: A Comparison of Theoretical Approaches. *Academy of Management Journal*, *36*(6), 1278–1313. https://doi.org/10.5465/256812

Voluntary assisted dying bill 2017, New South Wales Parliament (testimony of T Khan). https://www.legislation.nsw.gov.au/bills/97266ac5-2c04-4132-8e4a-ffa431f76992

Kilanowski, J. F. (2017). Breadth of the Socio-Ecological Model. *Journal of Agromedicine*, *22*(4), 295–297.

Kim, M.-S., & Hunter, J. E. (2016). Relationships Among Attitudes, Behavioral Intentions, and Behavior: A Meta-Analysis of Past Research, Part 2. *Communication Research*. https://doi.org/10.1177/009365093020003001

Kitchener, B. A. (1998). Nurse characteristics and attitudes to active voluntary euthanasia: A survey in the Australian Capital Territory. *Journal of Advanced Nursing*, *28*(1), 70–76. https://doi.org/10.1046/j.1365-2648.1998.00775.x

Knowles, S., Lam, lLT, McInnes, E., Elliott, D., Hardy, J., & Middleton, S. (2015). Knowledge, attitudes, beliefs and behaviour intentions for three bowel management practices in intensive care: Effects of a targeted protocol implementation for nursing and medical staff. *BMC Nursing*, *14*(1), not paginated. https://doi.org/10.1186/s12912-015-0056-z

Kompanje, E. J. O., Piers, R. D., & Benoit, D. D. (2013). Causes and consequences of disproportionate care in intensive care medicine(. *Current Opinion in Critical Care*, *19*(6), 630–635.

Kopala, B., & Kennedy, S. L. (2016). Requests for Assisted Suicide: A nursing issue: *Nursing Ethics*. https://doi.org/10.1177/096973309800500103

Kouwenhoven, P. S., van Thiel, G. J. W. M., Raijmakers, N. J. H., Rietjens, J. A. C., van der Heide, A., & van Delden, J. J. M. (2014). Euthanasia or physician-assisted suicide? A survey from the Netherlands. *European Journal of General Practice*, *20*(1), 25–31. https://doi.org/10.3109/13814788.2013.813014

Kuhn, T. (1957). *The Copernican revolution: Planetary astronomy in the development of Western thought*. Random House.

Kuhne, N., Abernot, Y., & Camus, D. (2008). Q-sort, a useful research method in care in cases of psychiatric nursing of the aged. *Recherche en soins infirmiers*, *95*, 46–56.

Kuhse, H. (1987). *The Sanctity-of-Life Doctrine in Medicine: A Critique*. Oxford University Press. https://philpapers.org/rec/KUHTSD

Kuhse, H., & Singer, P. (1989). The quality/quantity-of-life distinction and its moral importance for nurses. *International Journal of Nursing Studies*, *26*(3), 203–212. https://doi.org/10.1016/0020-7489(89)90001-1

Kuhse, H., & Singer, P. (1993). Voluntary euthanasia and the nurse: An Australian survey. *International Journal of Nursing Studies*, *30*(4), 311–322. https://doi.org/10.1016/0020-7489(93)90103-2

-L-

Lackey, N. (1986). Use of the Q methodology in validating defining characteristics of specified nursing diagnoses. *Classification of Nursing Diagnoses: Proceedings of the Sixth Conference*, 191–196.

Lamb, C., Evans, M., Babenko-Mould, Y., Wong, C., & Kirkwood, K. (2018). Nurses' use of conscientious objection and the implications for conscience. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.13869

Landau, S., & Ster, I. C. (2010). Cluster Analysis: Overview. In *International Encyclopedia of Education Eds. Penelope Peterson, Eva Baker and Barry McGaw* (3rd ed., pp. 72–83). Elsevier Science.

Landeen, J., Pierazzo, J., Akhtar-Danesh, N., Baxter, P., van Eijk, S., & Evers, C. (2015). Exploring Student and Faculty Perceptions of Clinical Simulation: A Q-Sort Study. *Journal of Nursing Education*, *54*(9), 485–491. https://doi.org/10.3928/01484834-20150814-02

Langteau, R. A. (2010). *Neurologists' discussion intentions regarding a medical innovation: An examination of psychological determinants and personal normative influences - ProQuest Dissertations & Theses Global - ProQuest* [Doctoral thesis, University of Minnesota]. https://search-proquest-com.access.library.unisa.edu.au/pqdtglobal/docview/824640924/fulltextPDF/59CF31E0D32540F1PQ/30?accountid=14649

Lavine, H., Thomsen, C. J., Zanna, M. P., & Bordiga, E. (1998). On the Primacy of Affect in the Determination of Attitudes and Behavior: The Moderating Role of Affective-Cognitive Ambivalence. *Journal of Experimental Social Psychology*, *34*(4), 398–421. https://doi.org/10.1006/jesp.1998.1357

Lavoie, M., Godin, G., Vezina-im, L., Blondeau, D., Martineau, I., & Roy, L. (2016). Psychosocial determinants of nurses' intention to practise euthanasia in palliative care. *Nursing Ethics*, *23*(1), 48–60. https://doi.org/10.1177/0969733014557117

Lavoie, M., Godin, G., Vezina-im, L.-A., Blondeau, D., Martineau, I., & Roy, L. (2014). Effect of Knowing Patients' Wishes and Health Profession on Euthanasia. *Journal of Palliative Care & Medicine*, *4*(01), 6. https://doi.org/10.4172/2165-7386.1000169

Lavoie, M., Godin, G., Vézina-Im, L.-A., Blondeau, D., Martineau, I., & Roy, L. (2015). Psychosocial determinants of physicians' intention to practice euthanasia in palliative care. *BMC Medical Ethics*, *16*(1), 6. https://doi.org/10.1186/1472-6939-16-6

LeBlanc, G., Gagnon, M. P., & Sanderson, D. (2012). Determinants of Primary Care Nurses' Intention to Adopt an...: CIN: Computers, Informatics, Nursing. *CIN: Computers, Informatics, Nursing*, *30*(9), 496–502. https://doi.org/10.1097/NXN.0b013e318257db17

Lee, C., Duck, I., & Sibley, C. (2017). Demographic and psychological correlates of New Zealanders' support for euthanasia. *The New Zealand Medical Journal*, *130*(1448), 9–16.

Lee, W., Price, A., Rayner, L., & Hotopf, M. (2009). Survey of Doctors' Opinions of the Legalisation of Physician Assisted Suicide. *Psycho-Oncology*, *18*(3), 328–328.

Legal Services Commision of South Australia. (2021). Patients’ Rights (au). Legal Services Commission of South Australia. https://www.lawhandbook.sa.gov.au/ch29s01.php

Légaré, F., Godin, G., Dodin, S., Turcot, L., & Laperrière, L. (2003). Adherence to Hormone Replacement Therapy: A Longitudinal Study Using the Theory of Planned Behaviour. *Psychology and Health*, *18*(3). https://doi.org/10.1080/0887044031000146824

Lehto, R., Olsen, D., & Chan, R. R. (2016). When a Patient Discusses Assisted Dying: Nursing practice Implication. *Journal of Hospice & Palliative Nursing*, *18*(3), 184–191. https://doi.org/10.1097/NJH.0000000000000246

Leopold, S. S., & Porcher, R. (2018). Editorial: Sparse-data Bias—What the Savvy Reader Needs to Know. *Clinical Orthopaedics and Related Research*, *476*(4), 657. https://doi.org/10.1007/s11999.0000000000000228

Levinm, P. F. (1999). Test of the Fishbein and Ajzen models as predictors of health care workers glove use. *Research in Nirsimg and Health*, *22*(4), 295–307.

Lewin, K. (1951). *Field theory in social science: Selected theoretical papers* (Dorwin Cartwright (ed.)). Harpers.

Lewis, E. F., Hardy, M., & Snaith, B. (2013). Estimating the Effect of Nonresponse Bias in a Survey of Hospital Organizations: *Evaluation & the Health Professions*, *36*(3), 330–351. https://doi.org/10.1177/0163278713496565

Lewis, P, & Black, I. (2013). Adherence to the request criterion in jurisdictions where assisted dying is lawful? A review of the criteria and evidence in the Netherlands, Belgium, Oregon, and Switzerland. *Journal of Law and Medical Ethics*, *41*(4), 885–8899. https://doi.org/10.1111/jlme.12098

Lewis, Penney. (2016). The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia. *The Journal of Law, Medicine & Ethics*, *35*(1), 197–210. https://doi.org/10.1111%2Fj.1748-720X.2007.00124.x

Li, M., Watt, S., Escaf, M., Gardam, M., Heesters, A., O’Leary, G., & Rodin, G. (2017). Medical Assistance in Dying—Implementing a Hospital-Based Program in Canada. *New England Journal of Medicine*, *376*(21), 2082–2088. https://doi.org/10.1056/NEJMms1700606

Liberman, A., & Chaiken, S. (1991). Value conflict and thought-induced attitude change. *Experimental Social Psychology*, *27*, 203–216.

Lipp, A. (2008). A review of termination of pregnancy: Prevalent health care professional attitudes and ways of influencing them. *Journal of Clinical Nursing*, *17*(13), 1683–1688. https://doi.org/10.1111/j.1365-2702.2007.02205.x

Lo, B. (2018). Beyond Legalization—Dilemmas Physicians Confront Regarding Aid in Dying. *New England Journal of Medicine*, *378*(22), 2060–2062. https://doi.org/DOI: 10.1056/NEJMp1802218

Long, J., & Cumming, J. (2013). Psychosocial Predictors. In *Encyclopedia of Behavioral Medicine, M.D. Gellman & J.R. Turner (eds)* (pp. 1584–1585). Springer. https://link.springer.com/referenceworkentry/10.1007/978-1-4419-1005-9_485

Lowenstein, G. F., Weber, E. U., Hsee, C. K., & Welch, N. (2001). Risk as feelings. *Psychological Bulletin*, *127*, 267–286.

Lutzen, K., Dahlqvist, V., Eriksson, S., & et al. (2006). Developing the concept of moral sensitivity in health care practice. *Nursing Ethics*, *13*(2), 187–196.

-M-

MacCleod, R. D., Wilson, D. M., & Malpas, P. J. (2012). Assisted or Hastened Death: The Healthcare Practitioner's Dilemma. *Global Journal of Health Science;*, *4*(6). https://doi.org/10.5539/gjhs.v4n6p87

MacFarlan, A. (2014). *Q-methodology*. Better Evaluation. https://www.betterevaluation.org/en/evaluation-options/qmethodology

Maclure, J., & Taylor, C. (2011). *Secularism and the freedom of Conscience (J M Todd, Trans)* (1st ed.). Harvard University Press.

Madden, T. I., Ellen, P. S., & Ajzen, I. (1992). A Comparison of the Theory of Planned Behavior and the Theory of Reasoned Action. *Personality and Social Psychology Bulletin*, *18*(1), 3–9. https://doi.org/10.1177/0146167292181001

Magelssen, M., Le, N. Q., & Supphellen, M. (2019). Secularity, abortion, assisted dying and the future of conscientious objection: Modelling the relationship between attitudes. *BMC Medical Ethics*, *20*(1), (no pagination). https://doi.org/10.1186/s12910-019-0408-4

Maggelssen, M., Le, N. Q., & Supphellen, M. (2019). Secularity, abortion, assisted dying and the future of conscientious objection: Modelling the relationship between attitudes. *BMC Medical Ethics*, *20*(1). https://doi.org/10.1186/s12910-019-0408-4.

Malone, L. D., Anderson, J., & Croxon, L. (2016). Are newly graduated nurses ready to deal with death and dying? - A literature review. *Nursing and Palliative Care*, *1*(14), 89–93.

Malpas, P., Mitchell, K., & Koschwanez, H. (2015). End-of-Life Medical Practices in General Practice in New Zealand—13 years On. *New Zealand Medical Journal*, *128*(1418), 29–36.

Malpas, P., Mitchell, K., & Owens, G. (2004). End of Life Decision-Making by New Zealand General Practitioners: A National Survey. *The New Zealand Medical Journal*, *117*(1196).

Manns, H. (n.d.). *The fear that dare not speak its name: How language plays a role in the assisted dying debate*. The Conversation. Retrieved January 18, 2018, from http://theconversation.com/the-fear-that-dare-not-speak-its-name-how-language-plays-a-role-in-the-assisted-dying-debate-86308

Manstead, A. S. R. (2000). The role of moral norm in the attitude–behavior relation. In *Applied social research. Attitudes, behavior, and social context: The role of norms and group membership D.J. Terry & M.A. Hogg (Eds.)* (pp. 11–30). Lawrence Erlbaum Associates.

Manstead, A. S. R. (2011). The benefits of a critical stance: A reflection on past papers on the theories of reasoned action and planned behaviour. *British Journal of Social Psychology*, *50*(3), 366–373. https://doi.org/10.1111/j.2044-8309.2011.02043.x

Manstead, A. S. R., Proffitt, C., & Smart, J. L. (1983). Predicting and Understanding Mothers' Infant- Feeding Intention and Behavior: Testing the Theory of Reasoned Action. *Journal of Personality and Social Psychology*, *44*, 657–671. https://doi.org/10.1037//0022-3514.44.4.657

Marcatto, F., & Ferrante, D. (2008). The Regret and Disappointment Scale: An instrument for assessing regret and disappointment in decision making. *Judgment and Decision Making*, *3*(1), 13.

Marshall, S. L., Gould, D., & Roberts, J. (1994). Nurses' attitudes towards termination of pregnancy. *Journal of Advanced Nursing*, *20*(3), 567–576.

Martin Fishbein. (1967). A behavior theory approach to the relations between beliefs about an object and the attitude toward the object. In *Attitude Theory and Measurement*. Wiley.

Martin, R., Martin, P. Y., Smith, J. R., & Hewstone, M. (2007). Majority versus minority influence and prediction of behavioral intentions and behavior. *Journal of Experimental Social Psychology*, *43*(5), 763–771. https://doi.org/10.1016/j.jesp.2006.06.006

Martineau, I., Blondau, D., Godin, G., & Gagnea, C. (2007). Do Ethical Principles Explain Moral Norm? A Test for Consent to Organ Donation. *ResearchGateournal of Applied Biobehavioral Research*, *9*(4), 230–243.

Matzo, M. L., & Emanuel, E. J. (1997). Oncology nurses' practices of assisted suicide and patient-requested euthanasia. *Oncology Nurses Forum*, *24*(10), 1725–1732.

Maxwell, J. A. (2016). Expanding the History and Range of Mixed Methods Research: *Journal of Mixed Methods Research*, *10*(1), 12–27. https://doi.org/10.1177/1558689815571132

McCabe, H. (2007). Nursing involvement in euthanasia: A 'nursing-as-healing-praxis' approach. *Nursing Philosophy*, *8*(3), 176–186. https://doi.org/10.1111/j.1466-769X.2007.00313.x

McCarthy, J., & Monteverde, S. (2018). The Standard Account of Moral Distress and Why We Should Keep It. *HEC Forum*, *30*(4), 319–328. https://doi.org/10.1007/s10730-018-9349-4

McDougall, R., & Pratt, B. (2020). Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation. *BMC Medical Ethics*, *21*(1), 1–10. https://doi.org/10.1186/s12910-020-00483-5

McDougall, R., White, B., Ko, D., Keogh, L., & Willmot, L. (2021). Junior doctors and conscientious objection to voluntary assisted dying: Ethical complexity in practice. *Journal of Medical Ethics*, *0*, 1–5. https://doi.org/doi:10.1136/medethics-2020-107125

McEachan, R. R. C., Conner, M., Taylor, N. J., & Lawton, R. J. (2011). Prospective prediction of health-related behaviours with the Theory of Planned Behaviour: A meta-analysis. *Health Psychology Review*, *5*(2), 97–144. https://doi.org/10.1080/17437199.2010.521684

McInerney, F., & Seibold, C. (1995). Nurses'definitions of and attitudes towards euthanasia. *Journal of Advanced Nursing*, *22*(1), 171–182. https://doi.org/10.1046/j.1365-2648.1995.22010171.x

McLemore, M., & Levi, A. (2011). Nurses and Care of Women Seeking Abortions, 1971 to 2011. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *40*(6), 672–677. https://doi.org/10.1111/j.1552-6909.2011.01302.x

Medew, J. (2016, November 24). Four in 10 Doctors want voluntary euthanasia, Australian Medical Association survey shows. *Sydney Morning Herald*. http://www.smh. com.au/national/health/ doctors-should-be-involvedin- euthanasia-if-lawschange- australian-medicalassociation- survey-shows- 20161123-gsw8s2.html

Medical Council of New Zealand. (2012a). *The New Zealand Medical Workforce in 2012.* Medical Council of New Zealand, Wellington. https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2012.pdf

Medical Council of New Zealand. (2012b). *The New Zealand Medical Workforce in 2012.* https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2012.pdf

Mertens, D. (2005). *Research and Evaluation in Education and Psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Sage.

Metherell, L. (2019, June). *Victoria first jurisdiction to allow euthanasia in over two decades* [Sound]. ABC Radio. https://www.abc.net.au/radio/programs/am/victoria-first-jurisdiction-to-allow-euthanasia-in-two-decades/11215256

Miguel, S., Caldeira, S., & Vieira, M. (2018). The Adequacy of the Q Methodology for Clinical Validation of Nursing Diagnoses Related to Subjective Foci. *International Journal of Nursing Knowledge*, *29*(2), 97–103. https://doi.org/10.1111/2047-3095.12163

Mill, J. S. (1900). *Principles of political economy.* P F Collier & Sons.

Miller, D. G., & Kim, S. V. H. (2017). Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: A qualitative review of review committee judgements. *BMJ Open*, *7*(10), e017628. https://doi.org/10.1136/bmjopen-2017-017628

Miller, F. G., & Gelinas, L. (2013). Nudging, Autonomy and Valid Consent: Context Matters. *The American Journal of Bioethics*, *13*(6), 12–37. https://dx.doi.org/10.1080/15265161.2013.781866

Miller, L. L., Harvath, T. A., Ganzini, L., Goy, E. R., Delorit, M. A., & Jackson, A. (2016). Attitudes and experiences of Oregon hospice nurses and social workers regarding assisted suicide: *Palliative Medicine*. https://doi.org/10.1191/0269216304pm961oa

Miller, N. E., & Dollard, J. (1941). *Institute of Human, Social learning and imitation*. Oxford University Press.

Criminal Code of Canada, R.S.C, 1985, c. C-46 § 241.2 (2016). http://laws-lois.justice.gc.ca/eng/acts/C-46/page-54.html#h-79

Mischel, W., Shoda, Y., & Mendoza-Denton, R. (2002). Situation-Behavior Profiles as a Locus of Consistency in Personality: *Current Directions in Psychological Science*, *11*(2), 50–54. https://doi.org/doi-org./10.1111%2F1467-8721.00166

Mohamad, I. B., & Usman, D. (2013). Standardization and Its Effects on K-Means Clustering Algorithm. *Research Journal of Applied Sciences, Engineering and Technology*, *6*(17), 3299–3303. https://doi.org/10.19026/rjaset.6.3638

Molina-Mula, J., Gallo-Estrada, J., & Perelló-Campaner, C. (2018). Impact of Interprofessional Relationships from Nurses' Perspective on the Decision-Making Capacity of Patients in a Clinical Setting. *International Journal of Environmental Research and Public Health*, *15*(1). https://doi.org/10.3390/ijerph15010049

Montanaro, E. A., Kershaw, T. S., & Bryan, A. D. (2018). Dismantling the theory of planned behavior: Evaluating the relative effectiveness of attempts to uniquely change attitudes, norms, and perceived behavioral control. *Journal of Behavioral Medicine*, *41*(6), 757–770. https://doi.org/10.1007/s10865-018-9923-x

Monteverde, S. (2017). Editorial: Nursing and assisted dying: Understanding the sounds of silence. *Nursing Ethics*. https://doi.org/10.1177/0969733016684967

Monteverde, Settimio. (2016). Caring for tomorrow's workforce: Moral resilience and healthcare ethics education. *Nursing Ethics*, *23*(1), 104–116. https://doi.org/10.1177/0969733014557140

Mossey, S., Montgomery, P., Raymond, J., & Killam, L. (2102). Typology of Undergraduate Nursing Students' Unsafe Clinical Practices: Q-Methodology. *Journal of Nursing Education*, *51*(5), 245–253. https://doi.org/10.3928/01484834-20120309-01

Motter, A. E., & Campbell, D. K. (2013). *Chaos at fifty*. Physics Today. https://physicstoday.scitation.org/doi/abs/10.1063/PT.3.1977

Muller, M. T., Pijnenborg, L., Onwuteaka-Philipsen, B. D., van der Wal, G., & van Eijk, J. T. M. (1997). The role of the nurse in active euthanasia and physician-assisted suicide. *Journal of Advanced Nursing*, *26*(2), 424–430. https://doi.org/10.1046/j.1365-2648.1997.1997026424.x

Musgrave, C. F., Margalith, I., & Goldsmidt, L. (2001). Israeli Oncology and Nononcology Nurses' Attitudes Toward Physician-Assisted Dying: A Comparison Study. *Oncology Nursing Forum*, *28*(1), 50–57.

Musgrave, C. F., & Soudry, I. (2000). An exploratory pilot study of nurse-midwives' attitudes toward active euthanasia and abortion. *International Journal of Nursing Studies*, *37*(6), 505–512. https://doi.org/10.1016/S0020-7489(00)00033-X

Muskin, P. R. (1998). The Request to Die: Role for a Psychodynamic Perspective on Physician-Assisted Suicide. *JAMA*, *279*(4), 323–328. https://doi.org/10.1001/jama.279.4.323

Myers, R. H., & Montgomery, D. C. (1997). A Tutorial on Generalized Linear Models. *Journal of Quality Technology*, *29*(3), 274–291. https://doi.org/10.1080/00224065.1997.11979769

-N-

Naseh, L., Rafiei, H., & Heidari, M. (2015). Nurses' attitudes towards euthanasia: A cross-sectional study in Iran. *International Journal of Palliative Nursing*, *21*(1). https://doi.org/10.12968/ijpn.2015.21.1.43

Natan, M. B., Beyll, V., & Neta, O. (2009). Nurses' perception of the quality of care they provide to hospitalized drug addicts: Testing the Theory of Reasoned Action. *International Journal of Nursing Practice*, *15*(6), 566–573.

Natan, M., Hanukayev, A., & Fares, S. (2011). Factors affecting Israeli nurses' reports of violence perpetrated against them in the workplace: A test of the theory of planned behaviour—Natan—2011—International Journal of Nursing Practice—Wiley Online Library. *International Journal of Nursing Practice*, *17*(2), 141–150. https://doi.org/10.1111/j.1440-172X.2011.01919.x

National Collaborating Centre for Methods and Tools,. (2015). *Mixed-Method Appraisal Tool (MMAT)*. McMaster University (ON). https://www.webcitation.org/5tTRTc9yJ

Nayak, S., Wilson, D., & Yoshino, J. (2016). How is death hastening done? A review of existing sactioned death hastening decision-making processes and practices. *International Journal of Nursing Student Scholarship*, *3*, 18.

Nelson, J. M., Cook, P. F., & Ingram, J. C. (2014). Utility of the theory of planned behavior to predict nursing staff blood pressure monitoring behaviours. *Journal of Clinical Nursing*, *23*(3–4), 461–470. https://doi.org/10.1111/jocn.12183

New Zealand House of Representatives. (2017). *Petition 2014/18 of Hon Maryan Street and 8,974 others* (p. 52). https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24

New Zealand Medical Association. (2005a). *Position Statement: Euthanasia 2005*. New Zealand Medical Association. https://www.nzma.org.nz/__data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

New Zealand Medical Association. (2005b). *Position Statement: Euthanasia 2005*. https://www.nzma.org.nz/__data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

New Zealand Nurses Organisation. (2016a). *Professional Challenges—Assisted Dying Position Statement (Draft)*. http://www.nzno.org.nz/Portals/0/Files/Documents/Consultation/2016%2011%2008%20%20Guidelines%20-%20Assisted%20Dying%20Position%20Statement.pdf:

New Zealand Nurses Organisation. (2016b). The Maryan Street petition to investigate fully public attitudes towards the introduction of legislation which would permit medically-assisted dying in the event of a terminal illness or an irreversible condition which makes life unbearable. http://www.nzno.org.nz/Portals/0/Files/Documents/Consultation/2016%2011%2008%20%20Guidelines%20-%20Assisted%20Dying%20Position%20Statement.pdf

New Zealand Parliament. (2017). *End of Life Choice Bill*. New Zealand Parliament. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_74307/end-of-life-choice-bill

Newman, I., & Ramlo, S. (2010). Using Q-methodology and Q factor analysis in mixed methods research. In *Handbook of Mixed Methods in Social and Behavioral Research , Teddlie,E. and Tashakkori,A. (Eds)* (2nd ed., pp. 505–530). Sage.

Newman, T. (2005). *Links between ethics and public policy: a q methodological study of physician assisted suicide and euthanasia* [PhD dissertation]. Kent State University.

Newton, J. D., Newton, F. J., Ewing, M. T., Burney, S., & Hay, M. (2013). Conceptual overlap between moral norms and anticipated regret in the prediction of intention: Implications for theory of planned behaviour research. *Psychology & Health*, *28*(5), 495–513. https://doi.org/10.1080/08870446.2012.745936

Nibbelink, C. W., & Brewer, B. B. (2018). Decision-Making in Nursing Practice: An Integrative Literature Review. *Journal of Clinical Nursing*, *27*(5–6), 917. https://doi.org/10.1111/jocn.14151

Nilstun, T., Melltorp, G., & Hermerén, G. (2016). Surveys on attitudes to active euthanasia and the difficulty of drawing normative conclusions: *Scandinavian Journal of Public Health*, *28*, 111–116. https://doi.org/10.1177/140349480002800206

Norman, G. R., & Schmidt, H. G. (1992). The psychological basis of problem-based learning: A review of the evidence. *Academic Medicine*, *67*(9), 557–562.

Norman, G. R., & Steiner, D. L. (2008). *Biostatistics: The Bare Essentials* (3rd ed.). People’s Medical Publishing House. https://books.google.com/books/about/Biostatistics.html?id=8rkqWafdpuoC

Norris, J. M., Plonsky, L., Ross, S., & Schoonend, R. (2015). Guidelines for Reporting Quantitative Methods and Results in Primary Research. *Language Learning*, *65*(2), 470–476. https://doi.org/DOI: 10.1111/lang.12104

Norten, A. (2012). Predicting Nurses’ Acceptance of Radiofrequency Identification Technology. *CIN: Computers, Informatics, Nursing*, *30*(10), 531–537.

Notani, A. S. (1998). Moderators of Perceived Behavioral Control’s Predictiveness in the Theory of Planned Behavior: A Meta-Analysis. *Journal of Consumer Psychology (Lawrence Erlbaum Associates)*, *7*(3), 247.

Notani, A. S. (2008). Moderators of Perceived Behavioral Control’s Predictiveness in the Theory of Planned Behavior: A Meta-Analysis. *Journal of Consumer Psychology*, *7*(3), 247–271. https://doi.org/10.1207/s15327663jcp0703_02

NSW Department of Health. (2005). *Guidelines for end-of-life care and decision-making*. NSW Dept. of Health.

Nuffield Council on Bioethics. (2021). What’s on the horizon for bioethics? [Ethical issues in biology and medicine]. *What’s on the Horizon for Bioethics?* https://www.nuffieldbioethics.org/news/whats-on-the-horizon-for-bioethics-2021-infographic-published-today

Australian Broadcasting Corporation (2019, June). Nurses, GPs at odds with doctors after issuing support for WA voluntary euthanasia laws. https://www.abc.net.au/news/2019-06-26/nurses-gps-back-voluntary-euthanasia-laws-in-wa/11249828

Nursing and Midwifery Board of Australia. (n.d.). *Registrant data* (p. 19) [Quarterly]. Retrieved January 2, 2020, from https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

Nursing and Midwifery Board of Australia. (2018). *Nursing and Midwifery Board of Australia: Registrant data 1 January 2018—31 March 2018*. Nursing and Midwifery Board of Australia. http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

Nursing Council of New Zealand. (2015). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2014-2015*. Wellington. http://www.nursingcouncil.org.nz/Publications/Reports-and-workforce-statistics

Nyborg, K., Howarth, R. B., & Brekke, K. A. (2003). Green Consumers and Public Policy: On Socially Contingent Moral Motivation. *SSRN Electronic Journal*, *28*(4), 351–366. https://doi.org/10.2139/ssrn.471661

-O-

Oates, J. R., & Maani-Fogelman, P. A. (2019). *Nursing Grief and Loss*. StatPearls Publishing [Internet]. http://www.ncbi.nlm.nih.gov/books/NBK518989/

O’Boyle, C. A., Henly, S. J., & Larson, E. (2001). Understanding adherence to hand hygiene recommendations: The theory of planned behavior. - PubMed - NCBI. *American Journal of Infection Control*, *29*(6), 352–360. https://doi-org.proxy.library.adelaide.edu.au/10.1067/mic.2001.18405

Ohnsorge, K., Keller, H. R. G., Widdershoven, G. A., & Rehmann-Sutter, C. (2012). ‘Ambivalence’ at the end of life: How to understand patients’ wishes ethically. *Nursing Ethics*, *19*(5), 629–641. https://doi.org/10.1177/0969733011436206

Oliver, P. (2016). *Another week? Another week! I can’t take another week’ Addressing barriers to effective access to legal assisted dying through legislative, regulatory and other means* [Doctoral thesis]. University of Auckland.

Oliver, P. (2017). *Report on research into Swiss palliative care professionals’ attitudes, experiences and practices in relation to assisted suicide in Switzerland*.

Oliver, P., Wilson, M., & Malpas, P. J. (2017). New Zealand doctors’ and nurses’ views on legalising assisted dying in New Zealand. *The New Zealand Medical Journal*, *130*(1456), 6–15.

Olson, J., & Zanna, M. (1993). Attitudes and attitude change. *Annual Review of Psychology*, *44*, 117–132.

Onwezen, M. C., Antonides, G., & Bartels, J. (2013). The Norm Activation Model: An exploration of the functions of anticipated pride and guilt in pro-environmental behaviour. *Journal of Economic Psychology*, *39*, 141–153. https://doi.org/10.1016/j.joep.2013.07.005

Onwuegbuzie, A. J., Collins, K. M. T., & Frels, R. K. (2013). Using Bronfenbrenner’s ecological systems theory to frame quantitative, qualitative, and mixed research. *International Journal of Multiple Research Approaches*, *7*(1), 2–8. https://doi.org/10.5172/mra.2013.7.1.2

Onwuteaka-Philipsen, B., Brinkman-Stoppelenburg, A., Delden, H. van, & Heide, A. van der. (2013). There is more to end-of-life practices than euthanasia – Authors' reply. *The Lancet*, *381*(9862), 202–203. https://doi.org/10.1016/S0140-6736(13)60087-2

Onwuteaka-Philipsen, B D, Muller, M. T., & van der Walab, G. (1997). Euthanatics: Implementation of a protocol to standardise euthanatics among pharmacists and GPs. *Patient Education and Counseling*, *31*(2), 131–137. https://doi.org/10.1016/S0738-3991(97)00998-1

Onwuteaka-Philipsen, B., Willmott, L., & White, B. P. (2019). Regulating voluntary assisted dying in Australia: Some insights from the Netherlands. *Medical Journal of Australia*, *211*(10), 438-439.e1. https://doi.org/10.5694/mja2.50310

Onwuteaka-Philipsen, Bregje D., Brinkman-Stoppelenburg, A., Penning, C., Jong-Krul, G. J. de, Delden, J. J. van, & Heide, A. van der. (2012). Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: A repeated cross-sectional survey. *The Lancet*, *380*(9845), 908–915. https://doi.org/10.1016/S0140-6736(12)61034-4

Oregon Nurses Association. (1997). Assisted Suicide: The Debate Continues. *The Oregon Nurse*, *62*(3). https://hawaiinursescontinuingeducation.com/wp-content/uploads/2018/03/ONA_AssistedSuicide_2015-06-.pdf

Oregon Nurses Association. (2015). *Oregon Nurses Association Position Statement: Assisted Suicide*. https://cdn.ymaws.com/www.oregonrn.org/resource/resmgr/Docs/ONA-PosState_AsstSuicide.pdf

Ost, S. (2010). The de-medicalisation of assisted dying: is a less medicalised model the way forward? *Medical Law Review*, *18*(4), 497–540. https://doi.org/10.1093/medlaw/fwq025

Ostroff, C., & Schulte, M. (2007). Multiple perspectives of fit in organizations across levels of analysis. In *The organizational frontiers series. Perspectives on organizational fit, C. Ostroff & T.A. Judge (Eds)* (pp. 3–69). Lawrence Erlbaum Associates Publishers.

Otter, C. (2017, May). *Parliament of Victoria—Voluntary Assisted Dying Bill 2017*. Voluntary Assisted Dying Bill 2017. https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13834-voluntary-assisted-dying-bill-2017#_ftn4

Ouellette, J. A., & Wood, W. (1998). Habit and intention in everyday life: The multiple processes by which past behavior predicts future behavior. *Psychological Bulletin*, *124*(1), 54–74. https://doi.org/10.1037/0033-2909.124.1.54

-P-

Paice, J. A., Ferrell, B. R., Virani, R., Grant, M., Malloy, P., & Rhome, A. (2006). Appraisal of the Graduate End-of-Life Nursing Education Consortium Training Program. *Journal of Palliative Medicine*, *9*(2), 353–360. https://doi.org/10.1089/jpm.2006.9.353

Paige, J. B., & Morin, K. H. (2014). Q-Sample Construction: A Critical Step for a Q-Methodological Study. *Western Journal of Nursing Research*, *38*(1), 96–110. https://doi.org/10.1177/0193945914545177

Paige, J. B., & Morin, K. H. (2015). Using Q-Methodology to Reveal Nurse Educators' Perspectives about Simulation Design. *Clinical Simulation in Nursing*, *11*(1), 11–19. https://doi.org/10.1016/j.ecns.2014.09.010

Pakes, F. (2005). Under Siege: The Global Fate of Euthanasia and Assisted-Suicide Legislation. *European Journal of Crime, Criminal Law and Criminal Justice*, *13*(2), 119–135. https://doi.org/10.1163/1571817054300594

Palliative Care Australia. (2016). *Euthanasia and Physician Assiosted Suicide*. Palliative care Australia. http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/08/20160823-Euthanasia-and-Physician-Assisted-Suicide-Final.pdf

Palliative Care Nurses Australia. (2017). *Position Statement: Euthanasia and Physician Assisted Suicide*. Palliative Care Nurses Australia. http://www.pcna.org.au/images/documents/Euthanasia%20Position%20Statement%20Final%20170717.pdf

Papavasiliou, E., Payne, S., Brearley, S., Brown, J., & Seymour, J. (2013). Continuous Sedation (CS) Until Death: Mapping the Literature by Bibliometric Analysis. *Journal of Pain and Symptom Management*, *45*(6), 1073-1082.e10. https://doi.org/10.1016/j.jpainsymman.2012.05.012

Park, J., & Ha, S. (2014). Understanding Consumer Recycling Behavior: Combining the Theory of Planned Behavior and the Norm Activation Model. *Family and Consumer Sciences Research Journal*, *42*(3), 278–291. https://doi.org/10.1111/fcsr.12061

Parker, D., Manstead, A. S. R., & Stradling, S. G. (1995). Extending the theory of planned behaviour: The role of personal norm. *British Journal of Social Psychology*, *34*(2), 127–138. https://doi.org/10.1111/j.2044-8309.1995.tb01053.x

Parliament of Tasmania. (2020, September 7). *End Of Life Choices (Voluntary Assisted Dying) Bill 2020 30 of 2020*. Annual List of Bills. https://www.parliament.tas.gov.au/bills/Bills2020/30_of_2020.htm

Pattinson, S. D. (2018). *Revisiting Landmark Cases in Medical Law* (1st ed.). Routledge. https://doi.org/10.4324/9781315750651

Patton, M. Q. (2014). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. SAGE Publications.

Patton, M. Q. (2015). Chapter 8. Qualitative analysis and interpretation. In *Qualitative Research and Evaluation Methods: Integrating Theory and Practice*. Sage.

Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economics*, *25*(4), 217–221.

Perry, L., Xu, X., Duffield, C., Gallagher, R., Nicholls, R., & Sibbritt, D. (2017). Health, workforce characteristics, quality of life and intention to leave: The 'Fit for the Future' survey of Australian nurses and midwives. *Journal of Advanced Nursing*, *73*(11), 2745–2756. https://doi.org/10.1111/jan.13347

Perugini, M., & Bagozzi, R. P. (2001). The role of desires and anticipated emotions in goal-directed behaviours: Broadening and deepening the theory of planned behaviour. *British Journal of Social Psychology*, *40*(1), 79–98. https://doi.org/10.1348/014466601164704

Pesut, B. (2019). Shades of gray: Conscientious objection in medical assistance in dying. *Nursing Inquiry*, *00*(e:12308), 8. https://doi.org/10.1111/nin.12308

Pesut, B, Greig, M., Thorne, S., Storch, J., Burgess, M., Tishelman, C., Chambaere, K., & Janke, R. (2019). Nursing and euthanasia: A narrative review of the nursing ethics literature: *Nursing Ethics*, *27*(1), 152–167. https://doi.org/10.1177/0969733019845127

Pesut, B, Thorne, S., Grieg, M., Fulton, A., Janke, R., & Vis-Dunbar, M. (2019b). Ethical, policy, and practice implications of nurses'experiences with assisted death: A Synthesis. *Advances in Nursing Science*, *42*(3), 216–230. https://dx-doi-org.proxy.library.adelaide.edu.au/10.1097%2FANS.0000000000000276

Pesut, B, Thorne, S., Stager, M. L., Schiller, C. J., Penney, C., Hoffman, C., Greig, M., & Roussel, J. (2019). Medical Assistance in Dying: A Review of Canadian Nursing Regulatory Documents: *Policy, Politics, & Nursing Practice*. https://doi.org/10.1177/1527154419845407

Pesut, Barbara, & Thorne, S. (2019, September 27). *Why people choose medically assisted death revealed through conversations with nurses* [Academic]. The Conversation. http://theconversation.com/why-people-choose-medically-assisted-death-revealed-through-conversations-with-nurses-122000

Pesut, B., Thorne, S., Wright, D. K., Schiller, C., Huggins, M., Puurveen, G., & Chambaere, K. (2021). Navigating medical assistance in dying from Bill C-14 to Bill C-7: A qualitative study. BMC Health Services Research, 21(1), 1–16. https://doi.org/10.1186/s12913-021-07222-5

Pew Research Center. (2013). *Religious Groups' Views on End-of-Life Issues*. Pew Research Center's Religion & Public Life Project. http://www.pewforum.org/2013/11/21/religious-groups-views-on-end-of-life-issues/

Piras, S. E., Minnick, A., Lauderdale, J., Dietrich, M. A., & Vogus, T. J. (2018). The Effects of Social Influence on Nurses' Hand Hygiene...: Journal of Nursing Administration. *Journal of Nursing Administration*, *48*(4), 216–221. https://doi.org/doi:10.1097/NNA.0000000000000602

Pomery, E. A., Gibbons, F. X., Reis-Bergan, M., & Gerrard, M. (2009). From Willingness to Intention: Experience Moderates the Shift From Reactive to Reasoned Behavior: *Personality and Social Psychology Bulletin*, *35*(7), 894–908. https://doi.org/10.1177/0146167209335166

Portenoy, R. K., Coyle, N., Kash, K. M., Brescia, F., Scanlon, C., O'Hare, D., Misbin, R. I., Holland, J., & Foley, K. M. (1977). Determinants of the Willingness to Endorse Assisted Suicide. *Psychosomatics*, *38*(3), 277–287. https://doi.org/10.1016/S0033-3182(97)71465-8

Potier, C., Laprevote, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependency*, *145*(1), 48–68. https://10.1016/j.drugalcdep.2014.10.012

Priester, J. R., Nayakankuppam, D., Fleming, M. A., & Godek, J. (2004). The A2SC2 Model: TheInfluence of Attitudes and Attitude Strength on Consideration and Choice. *Journal of Consumer Research*, *30*(4), 574–587. https://doi.org/10.1086/380290

Prochaska, J. O., & Di Clemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, *19*(3), 276–288.

-Q-

Quaghebeur, T., Dierckx de Casterle, B., & Gastmans, C. (2009). Nursing and Euthanasia: A review of argument-based ethics literature. *Nursing Ethics*, *16*(4), 466–486. https://doi.org/10.1177/0969733009104610

Qualtrics. (2020a). *Qualtrics software version XM* (XM) [Computer software].

Qualtrics. (2020b). *Sample Size Calculator*. Qualtrics. https://wordpressstaging.qualtrics.com/blog/calculating-sample-size/

Quill, T. E. (2012). Physicians Should “Assist in Suicide” When it is Appropriate. *The Journal of Law, Medicine & Ethics*, *40*(1), 57–65. https://doi.org/10.1111/j.1748-720X.2012.00646.x

Quill, T. E., Back, A. L., & Block, S. D. (2016). Responding to Patients Requesting Physician-Assisted Death: Physician Involvement at the Very End of Life. *JAMA*, *315*(3), 245–246. https://doi.org/10.1001/jama.2015.16210

Quill, T. E., & Brody, R. V. (1995). “You Promised Me I Wouldn’t Die Like This!”: A Bad Death as a Medical Emergency. *Archives of Internal Medicine*, *155*(12), 1250–1254. https://doi.org/10.1001/archinte.1995.00430120015002

Quill, T. E., & Cassel, C. K. (1995). Nonabandonment: A Central Obligation for Physicians. *Medicine and Public Issues*, *122*(5), 368–374.

Quill, T. E., & Cassel, C. K. (2003). Professional organizations’ position statements on physician-assisted suicide: A case for studied neutrality. *Annals of Internal Medicine*, *138*(3), 208–211.

Quill, T. E., Ganzini, L., Truog, R. D., & Pope, T. M. (2018). Voluntarily Stopping Eating and Drinking Among Patients With Serious Advanced Illness—Clinical, Ethical, and Legal Aspects. *JAMA Internal Medicine*, *178*(1), 123–127. https://doi.org/10.1001/jamainternmed.2017.6307

-R-

Rachels, J. (1975). Active and passive euthanasia. *New England Journal of Medicine*, *292*, 78–80. https://doi.org/10.1056/NEJM197501092920206

Rae, N., Johnson, M., & Malpas, P. (2015). New Zealanders' Attitudes toward Physician-Assisted Dying. *Journal of Palliative Medicine*, *18*(3), 259–265. https://doi.org/10.1089/jpm.2014.0299

Ramlo, S, & Newman, I. (2011). Q Methodology and Its Position in the Mixed-Methods Continuum. *Operant Subjectivity: The International Journal of Q Methodology*, *34*(3), 172–191.

Ramlo, Sue. (2016). Centroid and Theoretical Rotation: Justification for Their Use in Q Methodology Research. *Mid-Western Educational Researcher*, *28*(1), 73–92.

Raosoft, Inc. (2004). *Sample size calculator*. Raosoft Inc. www.raosoft.com/samplesize

Raz, J. (2017). *Intention and Motivation* [Oxford Legal Studies Research Paper]. https://scholarship.law.columbia.edu/faculty_scholarship/2044

Reber, B. H., Kaufman, S. E., & Cropp, F. (2000). Assessing Q-Assessor: A Validation Study of Computer-Based Q Sorts versus Paper Sorts. *Operant Subjectivity*, *23*(4), 192–209.

Reese, S. (2016). *Medscape Ethics Report 2016: Life, Death, and Pain* (Life, Death and Pain) [Medscape]. https://www.medscape.com/features/slideshow/ethics2016-part2#page=1

Rehmann-Sutter, C., Gudat, H., & Ohnsorge, K. (2015). *The Patient's Wish to Die*. Oxford University Press. https://books.google.com/books/about/The_Patient_s_Wish_to_Die.html?id=kJPxCQAAQBAJ

Rise, J., Sheeran, P., & Hukkelberg, S. (2010). The Role of Self-identity in the Theory of Planned Behavior: A Meta-Analysis. *Journal of Applied Social Psychology*, *40*(5), 1085–1105. https://doi.org/10.1111/j.1559-1816.2010.00611.x

Rivis, A., Sheeran, P., & Armitage, C. J. (2009). Expanding the Affective and Normative Components of the Theory of Planned Behavior: A Meta-Analysis of Anticipated Affect and Moral Norms. *Journal of Applied Social Psychology*, *39*(12), 2985–3019. https://doi.org/10.1111/j.1559-1816.2009.00558.x

Robertson, J. (2017, June). *Euthanasia survey hints at support from doctors, nurses and division*. The Sydney Morning Herald. http://www.smh.com.au/nsw/euthanasia-survey-draws-out-ethical-debate-among-doctors-and-nurses-20170624-gwxspn.html

Roche, B. (2018, May 2). *Abortion: INMO calls for conscientious objection safeguards*. The Irish Times. https://www.irishtimes.com/news/ireland/irish-news/abortion-inmo-calls-for-conscientious-objection-safeguards-1.3481966

Rogers, E. M. (1962). *Diffusion of innovations* (1st ed.). Fee Press of Glencoe.

Rogers, K. B. (2014). *Mapping the Social Ecology of Culture: Social Position, Connectedness, and Influence as Predictors of Systematic Variation in Affective Meaning* [PhD dissertation]. Duke University.

Rosenfeld, B. (2000). Methodological issues in assisted suicide and euthanasia research. *Pschology, Public Policy, and Law*, *6*(2), 559–574. https://doi.org/10.1037//1076-8971.6.2.559

Rothman, A. (2004). ‘Is there nothing more practical than a good theory?’: Why innovations and advances in health behavior change will arise if interventions are used to test and refine theory. *International Journal of Behavioral Nutrition and Physical Activity*, *1*(11). https://doi.org/10.1186/1479-5868-1-11

Royal Australasian College of Physicians. (2018). *RACP Position Statement on Medical Assistance in Dying*. RACP (Sydney). https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/medical-assistance-in-dying

Royal College of Nursing. (2016). *When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death (2nd ed)*. Royal College of Nursing. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/december/005822.pdf

Royal Dutch Medical Board (KNMG). (2012a). *Guidelines for the practice of euthanasia and physician-assisted suicide*. KNMG. https://www.knmg.nl/contact/about-knmg.htm

Royal Dutch Medical Board (KNMG). (2012b). *Guidelines for the practice of euthanasia and physician-assisted suicide*. https://www.knmg.nl/contact/about-knmg.htm

Ryan, H., Schofield, P., Cockburn, J., Butow, P., Tattersall, M., Turner, J., Girgis, A., Bandaranayake, D., & Bowman, D. (2005). How to recognize and manage psychological distress in cancer patients. *European Journal of Cancer Care*, *14*(1), 7–15. https://doi.org/10.1111/j.1365-2354.2005.00482.x

Ryan, R. M., & Deci, E. L. (2000). Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions. *Contemporary Educational Psychology*, *25*(1), 54–67. https://doi.org/10.1006/ceps.1999.1020

Rycroft-Malone, J., Fontenla, M., Seers, K., & Bick, D. (2009). Protocol-based care: The standardisation of decision-making? *Journal of Clinical Nursing*, *18*(10), 1490–1500. https://doi.org/10.1111/j.1365-2702.2008.02605.x

-S-

Sainani, K. L. (2014). Explanatory versus predictive modeling. *PM&R*, *6*(9), 841–844. https://doi.org/10.1016/j.pmrj.2014.08.941

Sandberg, T., & Conner, M. (2008). Anticipated regret as an additional predictor in the theory of planned behaviour: A meta-analysis. *British Journal of Social Psychology*, *47*(4), 589–606. https://doi.org/10.1348/014466607X258704

Savulescu, J. (2015). Autonomy, Interests, Justice and Active Medical Euthanasia. In *N: New Directions in the Ethics of Assisted Suicide and Euthanasia Cholbi M., Varelius J. (eds)* (Vol. 64, pp. 41–58). International Library of Ethics, Law, and the New Medicine, Springer, Cham. http://link.springer.com/chapter/10.1007/978-3-319-22050-5_4

Savulescu, J., & Schuklenk, U. (2017). Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception. *Bioethics*, *31*(3), 162–170. https://doi.org/10.1111/bioe.12288

Scherrens, A.-L., Beernaert, K., Robijn, L., Deliens, L., Pauwels, N. S., Cohen, J., & Deforche, B. (2018). The use of behavioural theories in end-of-life care research: A systematic review. *Palliative Medicine*, *32*(6), 1055–1077. https://doi.org/doi/10.1177/0269216318758212

Schneider, K. H. (2017). Psychometric Evaluation of a New Instrument to Evaluate School Nurses' Perceptions on Concussion Care Management. *Journal of School Nursing (Sage Publications Inc.)*, *33*(5), 364–373. c8h. https://doi.org/10.1177/1059840516686842

Schulte, M., Ostroff, C., Schmulyian, S., & Kinicki, A. (2009). Organizational Climate Configurations: Relationships to Collective Attitudes, Customer Satisfaction, and Financial Performance. *Journal of Applied Psychology*, *94*(3), 618–634. https://doi.org/10.1037/a0014365

Schwartz, S. H. (1977). Normative Influences on Altruism. *Advances in Experimental Social Psychology*, *10*, 221–279. https://doi.org/10.1016/S0065-2601(08)60358-5

Schwarz, J. K. (2003). Understanding and Responding to Patients' Requests for Assistance in Dying. *Journal of Nursing Scholarship*, *35*(4), 377–384. https://doi.org/10.1111/j.1547-5069.2003.00377.x

Seale, C. (2009). Legalisation of euthanasia or physician-assisted suicide: Survey of doctors' attitudes. *Palliative Medicine*, *23*, 205.

Shaghaghi, A., Bhopal, R. S., & Sheikh, A. (2011). Approaches to Recruiting 'Hard-To-Reach' Populations into Research: A Review of the Literature. *Health Promotion Perspectives*, *1*(2), 86. https://doi.org/10.5681/hpp.2011.009

Sharp, S. (2019). Belief in Life After Death and Attitudes Toward Voluntary Euthanasia. *Omega (United States)*, *79*(1), 72–89. https://doi.org/10.1177/0030222817715755

Sheahan, L. (2016). Exploring the interface between 'physician-assisted death' and palliative care: Cross-sectional data from Australasian palliative care specialists. *Internal Medicine Journal*, *46*(4), 443–451. https://doi.org/10.1111/imj.13009

Sheeran, P. (2002). Intention—Behavior Relations: A Conceptual and Empirical Review. *European Review of Social Psychology*, *12*(1), 1–36. https://doi.org/10.1080/14792772143000003

Sheeran, P., & Abraham, C. (2003). Mediator of Moderators: Temporal Stability of Intention and the Intention-Behavior Relation. *Personality and Social Psychology Bulletin*, *29*(2), 205–215. https://doi.org/10.1177/0146167202239046

Sheeran, P., Godin, G., Conner, M., & Germain, M. (2017). Paradoxical Effects of Experience: Past Behavior Both Strengthens and Weakens the Intention- Behavior Relationship. *Journal of the Association for Consumer Research*, *2*(3). https://doi.org/10.1086/691216

Sheeran, P., Norman, P., & Orbell, S. (1999). Evidence that intentions based on attitudes better predict behaviour than intentions based on subjective norms. *European Journal of Social Psychology*, *29*(2–3), 403–406.

Sheeran, P., Trafimow, D., & Armitage, C. J. (2009). Predicting behaviour from perceived behavioural control: Tests of the accuracy assumption of the theory of planned behaviour. *British Journal of Social Psychology*, *42*(3), 393–410. https://doi.org/10.1348/014466603322438224

Sheppard, B. H., Hartwick, J., & Warshaw, P. R. (1988). The Theory of Reasoned Action: A Meta-Analysis of Past Research with Recommendations for Modifications and Future Research. *Journal of Consumer Research*, *15*(3), 325. https://doi.org/10.1086/209170

Sheridan, L. (2017). *When Patients Ask to Die: The Role of Nurses in Medical Assistance in Dying* [Masters Thesis, University of Western Ontario]. https://ir.lib.uwo.ca/etd/5041

Shoham, S., & Gonen, A. (2008). Intentions of hospital nurses to work with computers: Based on the theory of planned behavior. *CIN: Computers, Informatics, Nursing*, *26*(2), 106–116. https://doi.org/10.1097/01.NCN.0000304777.48155.e3

Shotorbani, S., Zimmerman, F. J., Frederick, J., Bell, J. F., & Ward, D. (2004). Attitudes and Intentions of Future Health Care Providers Toward Abortion Provision—ProQuest. *Perspectives on Sexual and Reproductive Health*, *36*(2), 58–63.

Shunk, D. H., & DiBenedetto, D. K. (2020). Motivation and social cognitive theory. *Contemporary Educational Psychology*, *60*, 101832. https://doi.org/10.1016/j.cedpsych.2019.101832

Silbergeld Jecker, N. A., Jonsen, A. R., & Pearlman, R. A. (2007). *Bioethics: An Introduction to the History, Methods, and Practice*. Jones and Bartlet Learning.

Simons, J., & Carey, K. B. (1998). A Structural Analysis of Attitudes toward Alcohol and Marijuana Use: *Personality and Social Psychology Bulletin*, *24*(7), 727–735. https://doi.org/10.1177/0146167298247005

Singer, P. (2009). Speciesism and moral status. *Metaphilosophy*, *40*(3-4), 567–581. https://doi.org/10.1111/j.1467-9973.2009.01608.x

Singh, A., Yadav, A., & Rana, A. (2013). K-means with Three different Distance Metrics. *International Journal of Computer Applications*, *67*(10), (0975-8887.

Sjostrand, M., Helgesson, G., Eriksson, S., & Juth, N. (2013). Autonomy-based arguments against physician-assisted suicide and euthanasia: A critique. *Mkedical and Health Care Philosophy*, *16*(2), 225–230. https://doi.org/10.1007/s11019-011-9365-5

Skitka, L., Baumann, C. W., & Sargis, E. G. (2005). Moral conviction: Another contributor to attitude strength or something more? *Journal of Personality and Social Psychology*, *88*, 895–917.

Smith, C. M. (2011). Scripts: A Tool for Cognitive Rehearsal. *Journal of Continuing Education in Nursing*, *42*, 535–536. https://doi.org/10.3928/00220124-20111118-03

Snelling, P. C. (2004). Consequences count: Against absolutism at the end of life. *Journal of Advanced Nursing*, *46*(4), 350–357. https://doi.org/10.1111/j.1365-2648.2004.03001.x

Somerville, M. (1997). Euthanasia by confusion. *University New South Wales Law Journal*, *20*(3), 550–559.

Sparks, p, & Guthrie, C. A. (1998). Self-Identity and the Theory of Planned Behavior: A Useful Addition or an Unhelpful Artifice?1. *Journal of Applied Social Psychology*, *28*(15), 1393–1410. https://doi.org/10.1111/j.1559-1816.1998.tb01683.x

Sparks, P., Hedderley, D., & Shepherd, R. (1992). An investigation into the relationship between perceived control, attitude variability and the consumption of two common foods. *European Journal of Social Psychology*, *22*(1), 55–71.

Spence, R. A., Blanke, C. D., Keating, T. J., & Taylor, L. P. (2017). Responding to Patient Requests for Hastened Death: Physician Aid in Dying and the Clinical Oncologist. *Journal of Oncology Practice*, *13*(10), 693. https://doi.org/10.1200/JOP.2016.019299

Stacey, F. G., James, E. L., Chapman, K., Courneya, K. S., & Lubans, D. R. (2015). A systematic review and meta-analysis of social cognitive theory-based physical activity and/or nutrition behavior change interventions for cancer survivors. *Journal of Cancer Survivorship*, *9*(2), 305–338. https://doi.org/10.1007/s11764-014-0413-z

Stainton Rogers, R. (1995). Q Methodology. In *Q Methodology. Rethinking Methods in Psychology. Smith, J.A., Harre, R., Van Langenhove, L. (Eds.),* (pp. 178–192). Sage. http://dx.doi.org/10.4135/9781446221792.n12

Starks, H., Pearlman, R., Hsu, C., Back, A., Gordon, J., & Bharucha, A. (2005). Why now? Timing and circumstances of hastened deaths. *Journal of Pain and Symptom Management*, *30*(3), 215–226. https://doi.org/doi:10.1016/j.jpainsymman.2005.03.012

Statistics, Australia Commonwealth Bureau of Statistics, (2017, June 27). *Media Release - 2016 Census: Religion*. https://www.abs.gov.au/AUSSTATS/abs@.nsf/mediareleasesbyReleaseDate/7E65A144540551D7CA258148000E2B85

Steg, Linda., & Groot, Judith. (2010). Explaining prosocial intentions: Testing causal relationships in the norm activation model. *British Journal of Social Psychology*, *49*(4), 725–743. https://doi.org/10.1348/014466609X477745

Steinley, D, & Brusco, M. J. (2008). Selection of Variables in Cluster Analysis: An Empirical Comparison of Eight Procedures. *Psychometrika*, *73*(1), 125–144. https://doi.org/10.1007/s11336-007-9019-y

Steinley, Douglas. (2006). K-means clustering: A half-century synthesis. *British Journal of Mathematical and Statistical Psychology*, *59*(1), 1–34. https://doi.org/10.1348/000711005X48266

Stephenson, W. (1935). Technique of factor analysis. *Nature*, *136*(297).

Stern, M. J., Bilgen, I., & Dillman, D. A. (2014). The State of Survey Methodology: Challenges, Dilemmas, and New Frontiers in the Era of the Tailored Design. *Field Methods*, *26*(3), 284–301. https://doi.org/10.1177/1525822X13519561

Stevens, C. A., & Hassan, R. (1994a). Management of death, dying and euthanasia: Attitudes and practices of medical practitioners in South Australia. *Journal of Medical Ethics*, *20*(1), 41.

Stevens, C. A., & Hassan, R. (1994b). Nurses and the management of death, dying and euthanasia. *Medicine and Law*, *13*, 541–554.

Stewart, C., Kerridge, I., La Brooy, C., & Komessarof, P. (2020). Suicide related materials and voluntary assisted dying. *Health Law Reporter*, *27*, 839–845.

Stokes, F. (2017). The Emerging Role of Nurse Practitioners in Physician-assisted Death. *The Journal for Nurse Practitioners*, *13*(2), 150–155. https://doi.org/10.1016/j.nurpra.2016.08.029

Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist*, *47*(1), 6–22.

Sutton, S, French, D. P., Hennings, S. J., Mitchell, J., Warham, N. J., & Griffin, S. (2003). Eliciting Salient Beliefs in Research on the Theory of Planned Behaviour: The Effect of Question Wording. *Current Psychology: Developmental, Learining, Personality, Social*, *22*(3), 234–251.

Sutton, Stephen. (1998). Predicting and Explaining Intentions and Behavior: How Well Are We Doing? *Journal of Applied Social Psychology*, *28*(15), 1317–1338. https://doi.org/10.1111/j.1559-1816.1998.tb01679.x

Suva, G., Penney, T., & McPherson, C. J. (2019). Medical Assistance in Dying: A Scoping Review to Inform Nurses' Practice. *Journal of Hospice & Palliative Nursing*, *21*(1), 46–53. https://doi.org/10.1097/NJH.0000000000000486

Swildens-Rozendaal, W. (2012). *Regional euthanasia review committees* (p. 36) [Annual Report]. http://www.worldrtd.net/sites/default/files/newsfiles/RTE.JV2011.ENGELS.DEF_.pdf

Swiss Academy of Medical Science. (2012). *Problems with physician assisted suicide. Position paper of the Central Ethical Committee.* http://www. samw. ch/ en/ News/ News. html

Symonds, J. E., & Gorard, S. (2008). The Death of Mixed Methods: Research Labels and their Casualties. *The British Educational Research Association*, 1–19.

-T-

Taber, K. S. (2018). The Use of Cronbach's Alpha When Developing and Reporting Research Instruments in Science Education. *Research Science Education*, *48*, 1273–1296. https://doi.org/10.1007/s11165-016-9602-2

Tallis, R. (2007). The assisted suicide debate (Neil M. Gorsuch's The Future of Assisted Suicide and Euthanasia'). *The Times Literary Supplement*, *5434*, 15.

Tamayo-Velazquez, M.-I., Simon-Lorda, P., & Cruz-Piqueras, M. (2012). Euthanasia and physician-assisted suicide: Knowledge, attitudes and experiences of nurses in Andalusia (Spain). *Nursing Ethics*, *19*(5), 677–691. https://doi.org/10.1177/0969733011436203

Tanida, N., Asai, A., Ohnishi, M., Nagata, S. K., Fukui, T., Yamazaki, Y., & Kuhse, H. (2002). Voluntary Active Euthanasia and the Nurse: A comparison of Japanese and Australian nurses: *Nursing Ethics*, *9*(3), 313–322. https://doi.org/10.1191/0969733002ne513oa

Tashakkori, A., & Teddlie, C. (2010). The nature and general characteristics of mixed methods research. In *Handbook of Mixed Methods in Social & Behavioral Research* (2nd ed.). Sage.

Teddlie, C., & Tashakkori, A. (2003). The nature and general characteristics of mixed methods research. In *Handbook of Mixed Methods in Social & Behavioral Research Teddlie,C and Tashakkori A (Eds.)* (1st ed.). Sage.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of Mixed Methods Research: Integrating quantitative and qualitative approaches in social and behavioral sciences*. Sage.

Terkamo-Moisio, A., Kvist, T., Kangasniemi, M., Laitila, T., Ryynänen, O.-P., & Pietilä, A.-M. (2017). Nurses' attitudes towards euthanasia in conflict with professional ethical guidelines. *Nursing Ethics*, *24*(1), 70–86. https://doi.org/10.1177/0969733016643861

Terkamo-Moisio, A., Kvist, T., & Pietila, A.-M. (2015). Multifaceted Nature of Euthanasia: Perceptions of Finnish Re... : Journal of Hospice & Palliative Nursing. *Journal of Hospice & Palliative Nursing*, *17*(2), 105–112. https://doi.org/doi: 10.1097/NJH.0000000000000131

Terry, D. J., Hogg, M. A., & White, K. M. (1999). The theory of planned behaviour: Self-identity, social identity and group norms. *British Journal of Social Psychology*, *38*(3), 225–244. https://doi.org/10.1348/014466699164149

Brannon, L., Tagler, M., Eagly, AH. The moderating role of attitude strength in selective exposure to information. (2007). *Journal of Experimental Social Psychology*, *43*(4), 611–617. https://doi.org/10.1016/j.jesp.2006.05.001

Thompson, C., & Baker, R. (2008). Q Methodology in Nursing Research. In *Nursing Research: Designs and Methods, Roger Watson, ed.* (p. 412). Elsevier.

Thompson-Leduc, P., Clayman, M. L., Turcotte, S., & Légaré, F. (2015). Shared decision-making behaviours in health professionals: A systematic review of studies based on the Theory of Planned Behaviour. *Health Expectations*, *18*(5), 754–774. https://doi.org/10.1111/hex.12176

Thurn, T., Borasio, G., Chio, A., Galvin, M., McDermott, C., Mora, G., Sermeus, W., Winkler, A., & Anneser, J. (2019). Physicians' attitudes toward end-of-life decisions in amyotrophic lateral sclerosis. *Amyotroph Lateral Scler Frontotemporal Degener.*, *21*, 1–8. https://doi.org/doi: 10.1080/21678421.2018.1536154

Ting, L., Petrini, M. A., & Stone, T. E. (2018). Baccalaureate nursing students' perspectives of peer tutoring in simulation laboratory, a Q methodology study. *Nurse Education Today*, *61*, 235–241. https://doi.org/10.1016/j.nedt.2017.12.001

Todd, J., Kothe, E., Mullan, B., & Monds, L. (2014). Reasoned versus reactive prediction of behaviour: A meta-analysis of the prototype willingness model. *Health Psychology Review*. https://www-tandfonline-com.access.library.unisa.edu.au/doi/abs/10.1080/17437199.2014.922895

Tomlinson, E., & Stott, J. (2014). Assisted dying in dementia: A systematic review of the international literature on the attitudes of health professionals, patients, carers and the public, and the factors associated with these. *International Journal of Geriatric Psychiatry*, *30*(1), 10–20. https://doi.org/10.1002/gps.4169

Tormala, Z. L., & Rucker, D. D. (2018). Attitude certainty: Antecedents, consequences, and new directions. *Consumer Psychology Review*, *1*(1), 72–89. https://doi.org/10.1002/arcp.1004

Torres-Harding, S. R., Siers, B., & Olson, B. D. (2012). Development and Psychometric Evaluation of the Social Justice Scale (SJS). *American Journal of Community Psychology*, *50*(1–2), 77–88. https://doi.org/10.1007/s10464-011-9478-2

Tracy, S. J. (2010). Qualitative quality: Eight '"big-tent"' criteria for excellent qualitative research. *Qualitative Inquiry*, *16*, 837–851.

Triandis, H. C. (1980). Values, attitudes, and interpersonal behavior. *Nebraska Symposium on Motivation*, *27*, 195–259.

Trowell, F. (2009). Exploring the Nursing Implications of Physician-Assisted Suicide in the UK. *Nursing Times*, *105*(30), 31–33.

Tsai, T., & Gill, J. (2013). Interactions in Generalized Linear Models: Theoretical issues and an application to personal vote-earning attributes. *Social Sciences*, *2*, 91–113. https://doi.org/10.3390/socsci2020091

Tsang, S., Royse, C. F., & Terkawi, A. S. (2017). Guidelines for developing, translating, and validating a questionnaire in perioperative and pain medicine. *Saudi Journal of Anaesthesia*, *11*(Suppl 1), S80. https://doi.org/10.4103/sja.SJA_203_17

Tucker, K. L., & Steele, F. B. (2007). Patient choice at the end of life: Getting the language right. *Journal of Legal Medicine*, *28*(3), 305–325. http://dx.doi.org/10.1080/01947640701554427

Tulsky, A. J., Ciampa, R., & Rosen, J. E. (2000). Responding to Legal Requests for Physician-Assisted Suicide. *Annals of Internal Medicine*, *132*(6), 494–499.

Turner, J., Zapart, S., Pedersen, K., Rankin, N., Luxford, K., & Fletcher, J. (2005). Clinical practice guidelines for the psychosocial care of adults with cancer. *Psycho-Oncology*, *14*(3), 159–173. https://doi.org/10.1002/pon.897

-U-

United Nations. (1948). Universal Declaration of Human Rights. United Nations. https://www.un.org/en/about-us/universal-declaration-of-human-rights

U.S. Dept of Health and Human Services, N. I. of H. (2017, May 17). *Providing Care and Comfort at the End of Life*. National Institute on Aging. http://www.nia.nih.gov/health/providing-comfort-end-life

USA Today. (2013). Vermont Governor signs end-of-life bill. *USA Today*. http://www.usatoday.com/story/news/politics/2013/05/20/vermont-physician-assisted-death-bill/2343481/

-V-

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

Valenta, A. L., & Wigger, U. (1997). Q-methodology: Definition and Application in Health Care Informatics. *Journal of the American Medical Informatics Association*, *4*(6), 501–510. https://doi.org/10.1136/jamia.1997.0040501

Vallerand, R. J., Deshaies, P., Cuerrier, J.-P., Pelletier, L. G., & Mongeau, C. (1992). Ajzen and Fishbein's theory of reasoned action as applied to moral behavior: A confirmatory analysis. *Journal of Personality and Social Psychology*, *62*(1), 98–109. https://doi.org/10.1037/0022-3514.62.1.98

Valois, P., Desharnais, R., & Godin, G. (1988). A comparison of the Fishbein and Ajzen and the Triandis attitudinal models for the prediction of exercise intention and behavior. *Journal of Behavioral Medicine*, *11*(5), 459–472. https://doi.org/10.1007/BF00844839

van Bruchem-van de Scheur, G. G., van der Arend, A. J. G., Spreeuwenberg, C., Abu-Saad, H. H., & Ter Meulen, R. H. J. (2007). Euthanasia and physician-assisted suicide in the Dutch homecare sector: The role of the district nurse. *Journal of Advanced Nursing*, *58*(1), 44–52. https://doi.org/10.1111/j.1365-2648.2007.04224.x

van Bruchem-van de Scheur, G. G., Van Der Arend, A. J. G. van der, H Huijer, A.-S., Spreeuwenberg, C., van Wijmen, F. C. B., & ter Meulen, R. H. J. (2008). The role of nurses in euthanasia and physician-assisted suicide in The Netherlands. *Journal of Medical Ethics*, *34*(4), 254. https://doi.org/10.1136/jme.2006.018507

Van Brunchem-van de Scheur, G., Van Der Arend, A. J. G., Huijer Abu-Saad, H., Van Wijmen, F. C. B., Spreeuwenberg, C., & Ter Meulen, R. H. J. (2008). Euthanasia and assisted suicide in Dutch hospitals: The role of nurses. *Journal of Clinical Nursing*, *17*(12), 1618–1626. https://doi.org/10.1111/j.1365-2702.2007.02145.x

van der Heide, A, Deliens, L., Faisst, K., Nilstun, T., Norup, M., Paci, E., van der Wal, G., & van der Maas, P. J. (2003). End-of-life decision-making in six European countries: Descriptive study. *The Lancet*, *362*(9381), 345–350. https://doi.org/10.1016/S0140-6736(03)14019-6

Van deScheur, A., van der Arend, A., van Wijmen, F. C. B., Huda Huijer, A.-S., & Ter Meulen, R. H. J. (2008). Dutch Nurses' Attitudes Towards Euthanasia and Physician-Assisted Suicide: *Nursing Ethics*, *15*(2), 186–198. https://doi.org/10.1177/0969733007086016

van Hooft, S. M., Dwarswaard, J., Jedeloo, S., Bal, R., & van Staa, A. (2015). Four perspectives on self-management support by nurses for people with chronic conditions: A Q-methodological study. *International Journal of Nursing Studies*, *52*(1), 157–166. https://doi.org/10.1016/j.ijnurstu.2014.07.004

van Os, A., de Gilder, D., van Dyck, C., & Groenewegen, P. (2015). Responses to professional identity threat. *Journal of Health Organization and Management*, *29*(7), 1011–1028.

van Wersch, P. J. M. (2016). *Annual Report: Regional Euthanasia Review Committees* (p. 46) [Annual Report]. Government of the Netherlands. https://www.euthanasiecommissie.nl/uitspraken/jaarverslagen/2015/april/26/jaarverslag-2015

Van Wesemael, Y., Cohen, J., Onwuteaka-Philipsen, B. D., Bilsen, J., & Deliens, L. (2009). Establishing specialized health services for professional consultation in euthanasia: Experiences in the Netherlands and Belgium. *BMC Health Services Research*, *9*(1). https://doi.org/10.1186/1472-6963-9-220

Vanden Berghe, P., Mullie, A., Desmet, M., & Huysmans, G. (2016). Assisted dying – the current situation in Flanders: Euthanasia embedded in palliative care. *European Journal of Palliative Care*, *20*(6), 266–272.

VanGeest, J., & Johnson, T. P. (2011). Surveying Nurses: Identifying Strategies to Improve Participation. *Evaluation & the Health Professions*. https://doi.org/10.1177/0163278711399572

Varelius, J. (2006). The value of autonomy in medical ethics. *Medical Health Care Philosophy*, *9*(3), 377–388. https://dx.doi.org/10.1007%2Fs11019-006-9000-z

Vermette, L., & Godin, G. (1996). Nurses’ iontentions to provide home care: The impact of AIDS and homosexuality. *AIDS Care-Psychological and Socio-Medical Aspects of AIDS/HIV*, *8*(4), 479–488.

Vermont. An act relating to patient choice and control at end of life, Pub. L. No. Act 39, S.77 (2013). http://legislature.vermont.gov/bill/status/2014/S.77

Verplanken, B., Aarts, H., van Knippenberg, A., & Moonen, A. (1998). Habits versus planned behaviour: A field experiment. *British Journal of Social Psychology*, *37*, 111–128.

Verpoort, C., Gastmans, C., De Bal, N., & Dierckx de Casterle, B. (2004). Nurses’ attitudes to euthanasia: A review of the literature. *Nursing Ethics*, *11*(4), 349–365.

Verpoort, C., Gastmans, C., & de Casterlé, B. (2004). Palliative care nurses’ views on euthanasia. *Journal of Advanced Nursing*, *47*, 592–600.

Vézina-Im, L.-A., Lavoie, M., Krol, P., & Olivier-D’Avignon, M. (2014). Motivations of physicians and nurses to practice voluntary euthanasia: A systematic review. *BMC Palliative Care*, *13*(1), 20. https://doi.org/10.1186/1472-684X-13-20

Victoria Minister for Health. (2017, March). $5 Million Palliative Care Boost To Support More Victorians To Die At Home. *Premier of Victoria*. https://www.premier.vic.gov.au/5-million-palliative-care-boost-to-support-more-victorians-to-die-at-home/

Victorian Law Reform Commission. (1999). *Law of Abortion: Final report: Appendix A - History of Abortion Law Policy*. http://www.lawreform.vic.gov.au/content/appendix-history-abortion-law-policy#footnote-77508-3

Vogelstein, E. (2017). Evaluating the American Nurses Association’s arguments against nurse participation in assisted suicide: *Nursing Ethics*, *10*(1), 1–10. https://doi.org/10.1177/0969733017694619

Volker, D. L. (2004). Methodological issues associated with studying an illegal act. *Advances in Nursing Science*, *27*(2), 117–128.

Volker, D. L. (2016). Palliative care and requests for assistance in dying. In *Legal and Ethical Aspects of Care* (p. 17). Oxford University Press. https://books.google.com/books/about/Legal_and_Ethical_Aspects_of_Care.html?id=5wsHCwAAQBAJ

-W-

Wallston, B. S., & Wallston, K. A. (1978). Locus of control and health: A Review of the literature. *Health Education Monographs*, *6*, 107–117.

Wallston, K. A. (1989). Assessment of control in health care settings. In A. Stepetoe & A. Appels (Eds). In *Stress, personal control and health* (pp. 85–105). Wiley.

Wallston, K. A. (1991). The importance of placing measures of health locus of control beliefs in a theoretical context. *Health Education Research*, *6*(2), 251–252. https://doi.org/10.1093/her/6.2.251

Wang, D. (2001). Unsupervised Learning: Foundations of Neural Computation. *AI Magazine*, *22*(2), 101–101.

Warshaw, P. R., & Davis, F. D. (1985). Disentangling behavioral intention and behavioral expectation. *Journal of Experimental Social Psychology*, *21*(3), 213–228. https://doi.org/10.1016/0022-1031(85)90017-4

Wasserman, J., Clair, J. M., & Ritchey, F. J. (2005). A Scale to Assess Attitudes toward Euthanasia. *OMEGA - Journal of Death and Dying*, *51*(3), 229–237.

Watts, S., & Stenner, P. (2012). *Doing Q Methodological Research. Theory, Method and. Interpretation.* Thousand Oaks.

Webb, T. L., & Sheeran, P. (2006). Does changing behavioral intentions engender behavior change? A meta-analysis of the experimental evidence. *Psychological Bulletin*, *132*(2), 249–268. https://doi.org/10.1037/0033-2909.132.2.249

Weingarten, M. A. (2007). On the sanctity of life. *The British Journal of General Practice*, *57*(537), 332.

Western Australia Health Department. (2020). *Voluntary Assisted Dying Act 2019 Implementation Project: Fact Sheet*. Government of Western Australia. https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Fact-Sheet-Health-and-related-service-providers.pdf?mc_cid=745a3c8f8b&mc_eid=6e056d44cd

Western Australia Parliament. (2017, August 23). *Inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices*. Inquiry Details. http://www.parliament.wa.gov.au/parliament/commit.nsf/($all)/702507C2CB8742824825818700247E53?opendocument

Wexler, D. (1995). Reflections on the scope of therapeutic jurisprudence. *Psychology, Public Policy, and Law*, *1*(1), 220–236. https://doi.org/10.1037/1076-8971.1.1.220

White, B., & Willmott, L. (2018). Future of assisted dying reform in Australia. *Australian Health Review*, *42*(6), 616–620. https://doi.org/10.1071/AH18199

White, B., Willmott, L., Sellars, M., & Yates, P. (2021). Prospective oversight and approval of assisted dying cases in Victoria, Australia: A qualitative study of doctors’ perspectives. *BMJ Supportive & Palliative Care*, *0*, 1–10. https://doi.org/10.1136/bmjspcare-2021-002972

White, K. M., Starfelt, L. C., Jimmieson, N. L., Campbell, Graves, N. (2015). Understanding the determinants of Australian hospital nurses' hand hygiene decisions following the implementation of a national hand hygiene initiative. *Health Education Research*, *30*(6), 959–970. https://doi.org/10.1093/her/cyv057

White, K. R., & Coyne, P. J. (2011). Nurses' perceptions of educational gaps in delivering end-of-life care. *Oncology Nursing Forum*, *38*(6), 711–717.

Wicker, A. W. (1969). Attitudes versus actions: The relationship of verbal and overt behavioral responses to attitude objects. *Journal of Social Issues*, *25*, 41–78.

Wiebe, E., Shaw, J., Green, S., Trouton, K., & Kelly, M. (2018). Reasons for requesting medical assistance in dying. *Canadian Family Physician*, *64*(9), 674.

Wilbourn, M., Salamonson, Y., Ramjan, L., & Chang, S. (2018). Development and psychometric testing of the Attitudes, Subjective Norms, Perceived Behavioural Control, and Intention to Pursue a Career in Mental Health Nursing scale. *International Journal of Mental Health Nursing*, *27*(1), 72–81. https://doi.org/10.1111/inm.12295

Williams, G. (2007). *Intention and causation in medical non-killing: The impact of criminal law concepts on euthanasia and assisted suicide.* Routledge (New York).

Willmott, L., White, B., & Downie, J. (2013). Withholding and Withdrawal of 'Futile' Life-Sustaining Treatment: Unilateral Medical Decision-Making in Australia and New Zealand. *Journal of Law and Medicine*, *20*(4), 907–924.

Wilson, M. (2020). *The University of Adelaide—My data* [Data repository]. Figshare. https://doi.org/10.25909/5ef147c894344

Wilson, M, Oliver, P., & Malpas, P. J. (2019). Nurses' views on legalising assisted dying in New Zealand: A cross-sectional study. *International Journal of Nursing Studies*, *89*, 116–124. https://doi.org/10.1016/j.ijnurstu.2018.03.012.

Wilson, M. R. (2020). *Cluster Dataset* [Figshare]. University of Adelaide. https://doi.org/10.25909/12980420

Wilson, M, Wiechula, R., Cusack, L., & Wilson, M. (2020). Nurses' intentions to respond to requests for legal assisted dying: A Q-methodological study. *Journal of Advanced Nursing*, *76*, 642–653. https://doi.org/10.1111/jan.14257

Wilson, M, Wilson, M., Edwards, S., Cusack, L., & Wiechula, R. (2020). The role of attitude in nurses' intentions to respond to requests for legal assisted dying. *Nursing Ethics*, 1–17. https://doi.org/10.1177/0969733020966777

Wong, W., Eiser, A. E., Mrtek, R. G., & Heckerling, P. S. (2004). By-Person Factor Analysis in Clinical Ethical Decision Making: Q Methodology in End-of-Life Care Decisions. *The American Journal of Bioethics*, *4*(3), W8–W22. https://doi.org/10.1080/15265160490505506

Woods, M., & Bickley Asher, J. (2015). Nurses and the euthanasia debate: Reflections from New Zealand. *International Nursing Review*, *62*(1), 13–20. https://doi.org/10.1111/inr.12145

World Medical Association. (2017). *WMA - The World Medical Association-Modern physicians' pledge approved by World Medical Association*. https://www.wma.net/news-post/modern-physicians-pledge-approved-by-world-medical-association/

World Medical Association. (2018). *Declaration of Geneva*. Declaration of Geneva. https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/

Wright, A. L., Zammuto, R. F., & Leitch, P. W. (2017). Maintining the values of a profession: Institutional work and moral emotions in the emergency department. *Academy of Management Journal*, *60*(1), 200–237. bth.

Wright, D. K., Chirchikova, M., Daniel, V., Blitzas, V., Elmore, J., & Fortin, M.-L. (2017). Engaging with patients who desire death: Interpretation, presence, and constraint. *Canadian Oncology Nursing Journal*, *276*(1), 56–64. https://doi.org/DOI: 10.5737/236880762715664

-Y-

Yaseen, Z., Kopeykina, I., Gutkovich, Z., Bassirnia, A., Cohen, L. J., & Galynker, I. (2014). Predictive Validity of the Suicide Trigger Scale (STS-3) for Post-Discharge Suicide Attempt in High-Risk Psychiatric Inpatients. *PLOS ONE*, *9*(1), e86768. https://doi.org/10.1371/journal.pone.0086768

Yong, A. G., & Pearce, S. (2013). A Beginner's Guide to Factor Analysis: Focusing on Exploratory Factor Analysis. *Tutorials in Quantitative Methods for Psychology*, *92*(2), 79–94. https://doi.org/10.20982/tqmp.09.2.p079

Young, A., Volker, D., Riger, P., & Thorpe, D. (1993). Oncology nurses' attitudes regarding voluntary, physician-assisted dying for competent, terminally ill patients. *Oncology Nursing Forum*, *20*(3), 445–451.

Young, J. E., Winters, J., Jaye, C., & Egan, R. (2021). Patients' views on end-of-life practices that hasten death: A qualitative study exploring ethical distinctions. *Annals of Palliative Medicine*, *10*(3), 3563574–3563574. https://doi.org/10.21037/apm-20-621

Youngcharoen, P., Vincent, C., Chang, G. P., Corte, C., Eisenstein, A. R., & Wilkie, D. J. (2016). Nurses' pain management for hospitalized elderly patients with postoperative pain. *Western Journal of Nursing Research*, *38*(11), 1409–1432.

Yousefy, A., Rezaei, H., & Beigzadeh, A. (2015). The perspective of nurses towards euthanasia and assisted suicide: A review article. *Report of Health Care*, *1*(2), 7.

Yzer, M. (2012). Perceived Behavioral Control in Reasoned Action Theory: A Dual-Aspect Interpretation. *The ANNALS of the American Academy of Political and Social Science*, *640*(1), 101–117. https://doi.org/10.1177/0002716211423500

-Z-

Zenz, J., Tryba, M., & Zenz, M. (2015). Palliative care professionals’ willingness to perform euthanasia or physician assisted suicide. *BMC Palliative Care*, *14*(60). https://doi.org/DOI 10.1186/s12904-015-0058-3

Zhang, Z., & Castelló, A. (2017). Principal components analysis in clinical studies. *Annals of Translational Medicine*, *5*(17). https://doi.org/10.21037/atm.2017.07.12

Zolait, A. H. S. (2014). The nature and components of perceived behavioural control as an element of theory of planned behaviour. *Behaviour & Information Technology*, *33*(1), 65–84. http://dx.doi.org/10.1080/0144929X.2011.630419