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School of Social Work

The University of British Columbia
Vancouver, Canada

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DE-6 (2/88)
MEDICAL SOCIAL WORKERS’ VALUES, VIEWS AND PRACTICE REGARDING EUTHANASIA

ABSTRACT

Medical social workers from health care institutions in the urban lower-mainland of British Columbia were asked about their views, values and practice regarding passive and active euthanasia. This qualitative, exploratory study focused on the attitudes, values and structures that influence professional social work practice with clients requesting euthanasia. During the months of August to November, 1994, seventeen medical social workers, who were experienced in this area, were interviewed. An interview guide format was used that was previously tested in a pilot study of this project. Within the pre-selected categories; views, values and practice, responses were described and emerging themes were identified through content analysis. The study results confirm medical social workers are playing an active professional role with terminally-ill patients, families and staff when requests are made for euthanasia in the health care system. In this study population, in most cases, the social worker’s views, whether for or against euthanasia, did not determine his/her practice with patients. Instead, it was the social worker’s willingness to give up his/her control in the
patient/professional relationship in an effort to support the patient's decision to die with dignity. This practice was based on the value of patient self-determination being paramount against all other interests. Self-determination was ranked as the most influential factor in determining practice by most of the participants. Responses revealed there was a lack of understanding by health care professionals at all levels regarding the process of separating personal values from the professional obligation to respect patient self-determination. Feminist medical ethics suggests that all health care professionals need to engage in self-evaluation to address any need they may have for power and control in the professional/patient relationship. Furthermore, medical social workers should recognize their own such needs, particularly when their personal views and values come into conflict with a patient's decision regarding euthanasia. This study not only presents the issues of power and control that social workers and other health care professionals experience in the medical system, it also explores and describes the contributions social workers have made in their practice with patients who request the right to die with dignity.
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CHAPTER 1: INTRODUCTION

Preface

Over the past two years, I have focused on studying, discovering, and writing about euthanasia and social work practice. The idea of covering this topic in a thesis brought many reactions from the social workers I discussed these plans with. What I remember most about these reactions are two things. First, many people commented that euthanasia was such an interesting topic to write about. These comments were interesting to me because I have wondered why other social workers did not say it was interesting to study social work practice. Their comments suggest that many social workers, at least initially, found the topic of euthanasia more interesting than what social workers think or are doing about requests for euthanasia. I have always felt that both were interesting and important.

Secondly, almost everyone I spoke with mentioned that euthanasia was a really ‘trendy’ topic to study. For this reason, it was supposed to be a good choice for a thesis topic. Although I thought the same way at first, after completing a literature review, I found that euthanasia is neither ‘trendy’ or new. Likewise, the concept of people debating the pros and cons of euthanasia is also hundreds of years old. It now appears to me that, even though the euthanasia debate may have
taken on additional arguments, and old ones have a new twist, that not much has changed about these debates since the beginning.

I remember studying Socrates in English class at the University of Regina. We read about how Socrates gathered his friends together to tell them of his plan to drink the hemlock. Of course his friends were upset and concerned. They discussed what would happen to Socrates after his death, why he had made this decision to take his own life, and how much they would miss him. As a practicing social worker, who has had some professional experience with requests for euthanasia in the health care setting, I have heard these same arguments and discussions when a patient considers euthanasia for his/herself.

I assumed that underlying such arguments were basic views, values and perspectives that help direct our beliefs in this area. Because of their perspectives, people would chose to believe arguments either for, or against, euthanasia. With this in mind, I wanted to see where social workers stood in this debate. I wanted to find out which perspectives they used to shape their views about euthanasia. Furthermore, I was interested in how these views translated into the service we give terminally-ill patients in social work practice. These experiences and questions were the impetus for this study.

Chapter one of this thesis covers the laws around euthanasia, the euthanasia debate, and the relationship euthanasia has to social work practice. Chapter two describes my feminist perspective in detail,
which underlies my perceptions and analysis in this research study. The methodological considerations are described in chapter three, and the results of the study are presented in chapter four. To enhance the usefulness of this study, chapter five suggests the implications these findings may have on social workers and their practice. This chapter also addresses considerations for further research in this area.

Because of my feminist perspective, I have emphasized the importance of the language used in this thesis. This focus on language underlies my concern about using the term 'patient' throughout this thesis. From my feminist perspective, this term denotes the superior position of the professional over a vulnerable client in the health care system. This is not a term used in many social work facilities, but is the term used to describe clients in many medical facilities, including many of those involved in this study. I am conscious of this contradiction with my perspective. However, I have chosen to use the term 'patient' because it is the most familiar language of the respondents, and of most other health care professionals who are most likely to read this work.
Background

The 1990's have given rise to a public and professional awareness of the need for change in the Canadian health care system. The expanded role of technology in medicine and the social changes in attitudes and values have led to a questioning of several aspects of health care. More and more we hear of dissatisfied individuals and communities demanding profound changes in the way health care is perceived and provided. Nowhere is this more evident than with death and dying.

When death occurs in the medical context, there are aspects of it that pass beyond the control of the dying individual to professionals and institutions. The loss of that control, and the right to exercise control over one's death, are issues that have led to an increasing demand by individuals for legalized euthanasia. (Gomez, 1991) There are individuals who want the fully-sanctioned ability to choose the right to die before death would naturally occur, and the right to have a physician assist in that death. There have been few more emotional

1. Euthanasia includes the following elements in this study: the competency of the patient is assumed, and the informed patient with a terminal or life-threatening illness has asked for his or her life to be ended. Euthanasia also includes both passive and active euthanasia. Active euthanasia is a positive act of commission, such as death by lethal injection. Passive euthanasia implies an act of omission, such as the withholding or withdrawal of treatment. In either instance, the intent is to end the patient's life at their request.
and divided ethical health issues than the one of euthanasia.

**History**

There is nothing new about the concept of euthanasia. Socrates first drank the hemlock drink after a long discussion with his friends about the dignity of a good death (Mappes, 1991). In the history of Western civilization, requests for euthanasia and debates about the ethics of this practice date back to Greece and Rome. From Socrates to the first recorded bill to legalize euthanasia in Ohio in 1906, the euthanasia debate has raged on. Throughout the United States and Britain, the debate over euthanasia and physician-assisted suicide has paralleled the era of scientific Western medicine, as it still does today (Ezekiel, 1994).

The Voluntary Euthanasia Society in Britain was the first organization devoted to helping individuals die with dignity. Since its inception in the 1930’s, there were continual efforts made to broaden these societies throughout the Western world, and to challenge laws that limit an individual’s right to die. One of the first legal challenges followed a confession by an elderly physician in London. He revealed he had assisted with five different deaths during his career. Later, in 1936, a bill to legalize euthanasia throughout Britain was put forth, but was rejected by the House of Lords. Still, reports of euthanasia continued, and individuals and interest groups kept fighting for the right to die with dignity (Ezekiel, 1994).
The demand for, and attention given to euthanasia, continues to grow among the public today. Individuals such as Nancy B. in Quebec, took her request to be disconnected from a respirator to the Quebec Supreme court before being allowed to legally refuse the medical treatment that was keeping her alive (Williams, 1993). Derek Humphry's best-selling book, Final Exit, describes the practicalities of self-deliverance and assisted suicide for the dying (Humphry, 1992).

The public and the media have consistently followed the views and actions of Dr. Jack Kevorkian, a U.S. doctor who has designed a special machine to help provide euthanasia. It has been efforts such as these that have forced the issue of euthanasia out of medicine, and into the courts.

**Euthanasia and the Law**

The world watches the country of Holland, as it has been an example of legalized euthanasia for the past fifteen years (Alexander, 1989). This situation evolved not out of the passing of a law legalizing euthanasia, but rather out of a series of judgments since 1973 that have allowed the practice of euthanasia not to be criminalized (Gomez, 1991). Because of this precedent, the law in the Netherlands allows that euthanasia is justifiable if three conditions are met:

First, the patient must initiate the request, which must be persistent and consistent over several weeks, and made without pressure from the family or others. Second, there must be utter or unbearable distress, that cannot be relieved. And third, a second doctor must be satisfied that all the conditions have been met.  

Jennett, 1991, pg. 177
This system also requires that each case of euthanasia is reported to the police, who then investigate to ensure physicians have complied with all three conditions of the law (Jennett, 1991).

In states such as California and Washington, public ballots have been held to find out whether the public supports the legalization of euthanasia. Initiative 119, the “Death with Dignity” bill in Washington state, was rejected in 1991 (Annas, 1994). California still does not have legal euthanasia after two attempted bills in 1988 and 1992 (Annas, 1994). The limitations on euthanasia in these bills were more stringent than those in the Netherlands including a six month life expectancy clause. However, they also included proposals that would allow euthanasia for mentally incompetent, as well as competent, terminally-ill patients. This is unique to the California initiative, but has never been passed (Jennett, 1991).

But on November 8, 1994, Oregon voters passed “The Death With Dignity Act”, a measure to initiate physician-assisted suicide in their state (Fiscus, 1995). This bill contained a “prescription only” clause. “Physicians could provide patients with the means to end their lives, but would not be in the position of actually administering the lethal medication.” (Gianelli, 1994, pg. 1) This legislation means that physicians can prescribe the lethal dose, but cannot participate in giving it to the patient. The patient would need to give the lethal dose to him/herself or find someone other than his/her physician to administer it. However, this initiative has since been blocked by a law
suit filed by the national right-to-life advocates (Fiscus, 1995). Until the court rules on the law suit, The Death With Dignity Act would not be upheld in court.

The Canadian Situation

The laws governing active euthanasia and assisted suicide are contained in the Criminal Code of Canada. In September, 1993, the Supreme Court of Canada upheld the intent of Section 241(b) of the Criminal Code which prohibits giving assistance to someone to commit suicide. This law is based on the state's interest in protecting and preserving life (pg. 270). There is, however, prosecutorial discretion in some provinces, including British Columbia, which allows the Crown Counsel to decide whether it seems appropriate to prosecute in each given case of euthanasia (Criminal Justice Branch, 1994).

In British Columbia, Sue Rodriguez challenged the laws denying physician-assisted suicide through her public and profound challenge of the present laws via the Canadian Charter of Rights and Freedoms in 1992 (Rafuse, 1993). The Supreme Court of Canada rendered a decision in 1993 that denied Ms. Rodriguez's appeal to die with dignity (Criminal Justice Branch, 1994). Since her death by physician-assisted suicide on February 12, 1994, Member of Parliament, Svend Robinson has introduced a bill in the federal legislature to legalize physician-assisted suicide, one form of active euthanasia. These individuals, and many others have forced the right-to-die issue into our lives.
The Euthanasia Debate

Context

Euthanasia ("the good death") has been practiced intermittently and on an isolated basis in various cultures and civilizations for almost one-hundred years (Chesney, 1963). But the respect for human life and the autonomy of the individual have made euthanasia unacceptable in most Western civilizations (Alexander, 1989. p. 480). Physicians have long been facing conflicts between extending life and relieving suffering. At the same time, terminally-ill individuals are requesting that physicians help them die at a time of their own choosing. Within this context, the euthanasia debate was born.

Physician-assisted suicide, like active euthanasia, is illegal in Canada. The definitive difference between these two concepts is often semantics. The Canadian Medical Association treats both these terms as the same at this point, identifying respect for their possible differences (Sawyer, 1993). This study also does the same.

The Canadian Medical Association states that the language of euthanasia is "daunting in both its context and the subtlety of its nuances" (Sawyer, 1993. p. 1463). In post-modernist, socialist feminism, the language of a concept is very important in presenting its intended or underlying meaning (Wetzel, 1991). While reviewing the literature and throughout the research process, it became evident that euthanasia is a concept which evokes different emotions and meanings for each person.
Using the definition of euthanasia cited in chapter one, this concept not only presents 'gray areas' in its wide practical definition, but also in its practical application. "Definitions are not morally neutral. Rather, they shape our perception of reality—they select, they emphasize, they embody biases" (De Wachter, 1992. p.23). Differences in how individuals perceive euthanasia, or can apply it in their society, can lead to numerous ethical dilemmas when considering this concept (Mappes, 1991). Margaret Rhodes suggests that social workers are not immune to these dilemmas in their personal or professional decision-making (Rhodes, 1992). She concludes "that social workers, as do other professionals, sometimes restrict their ethical vision by drawing ethical boundaries around their understanding of clients, our relationships with colleagues, our cultures, and political issues" (Rhodes, 1992. p. 40). For the purposes of this study, it is important to be aware of the arguments and the ethical dilemmas regarding euthanasia and social work, and then to consider how these ethical boundaries are shaped.

**Arguments**

One of the most common arguments against euthanasia stems from the medical and legal perspectives that the deliberate termination of life is always wrong (Williams, 1993 and Mappes, 1991). The traditional goal of medicine is to promote life, therefore euthanasia is unacceptable. This argument is a precursor for the 'sanctity of life' principle, which is the belief that human life is fundamentally good and
always worthy of preservation. This argument is derived from both religious and traditional secular medical ethics (Williams, 1993).

The second argument against euthanasia is based on the likelihood or possibility of harmful consequences should euthanasia be legalized. Such harmful consequences might include the diminution of societal values, the loss of trust in physicians, or the trend toward ‘killing’ people being increased. This is most commonly known as the ‘slippery slope’ argument, which suggests that the progression of the devaluation of human life would be inevitable (Elliot, 1993). From another perspective, the philosophical argument that parallels these beliefs is one which suggests that the advantages of euthanasia do not outweigh the possible disadvantages (Mappes, 1991).

The third common argument against euthanasia is rooted in the legal and medical systems. This argument supports the idea that implementation of laws and practice guidelines around euthanasia would simply be too problematic. Who will direct the action and what is the intent behind it? There is great concern that the design of laws and the practice of euthanasia would be open to abuse and that sensitivity might not be given to individual situations (Williams, 1993).

To present the possible dilemmas that social workers could face when considering euthanasia, we need to understand the opposing sides of the above debates. With respect to the sanctity of life principle, those in favor of euthanasia oppose this view based on the quality of life principle. This principle suggests that not only is life
important, but also the quality of that life. Thus, each individual will decide if the life they have, or the suffering they are enduring, is worth the extension of their life under such suffering (Cassel, 1991).

The argument against euthanasia because of the possible consequences, is philosophically opposed by those who require proof that these, or like consequences, have occurred (Browne, 1993). In philosophy, this is not a viable argument unless you can prove that these or like consequences exist. In the case of the Netherlands, the only country in the world to have legalized euthanasia, statistics indicate there is no proof as yet that the slippery slope of euthanasia exists (Latimer, 1992 and Gomez, 1991).

One of the most recent arguments in favor of euthanasia is based on the "belief that it is beneficent, kind, and compassionate to 'put the patient to sleep', and the concomitant recognition that the patient and family are suffering" (Reichel, 1989, p. 1321). This definition of suffering recognizes both the physical and the emotional part of the person. Certain religious principles stand in opposition to this argument based on the value some religions place on suffering. It is believed that important spiritual work may be done during suffering, and that patients will not finish their spiritual work if they take their life before God intends (Cragg, 1983).

There is also much opposition from the palliative care movement in Canada to the 'compassionate' argument in favor of euthanasia. Palliative care is "an active and compassionate care primarily directed
toward improving the quality of life for those who are dying” (Ogden, 1994. pg. 1). Its goal is to provide pain management together with the coordinated support of a multi-disciplinary team of health care providers. The palliative care field has opposed euthanasia on the basis that the need for euthanasia would be obsolete if suffering and pain could be controlled through the efforts of palliative care. The palliative care movement suggests that the solution to the “euthanasia problem” is to direct financial support and research into palliative care resources (Cherny, 1994, Dickens, 1994, Moulin, 1994, Roy, 1993).

As social work ethics enters the debate, one of the key values that would favor euthanasia is a person's right to self-determination. Clearly the Social Work Code of Ethics (CASW, 1994) states that every individual has the right to self-determination and that social workers should advocate this right for their clients (Woodsworth, 1984). Social work philosophy states that "social workers believe and are committed to the values of acceptance, self-determination and the respect of individuality" (CASW, 1983. p. 2). Consequently, the Canadian social work statement on euthanasia and assisted-suicide says that “it is the fundamental right of all persons to determine their own best interests” (CASW, 1994. pg. 1). This philosophical commitment toward helping clients attain self-determination suggests a favorable position on euthanasia.

The opposing side of this argument comes from both medical and religious institutions. There is a strong religious ethic that a higher
power dictates our paths in life and in death. Therefore, choosing the
time and kind of death for oneself is not thought to be a matter of self-
determination, but rather a matter determined by God (Cragg, 1983).
There is also a wide range of literature indicating that self-
determination is conditional and has limits unique to each situation
(Fried, 1993). While there are other issues in the euthanasia debate,
the above viewpoints represent some of the most common arguments
for and against euthanasia.

Attitudes Regarding Euthanasia

Studying the attitudes regarding euthanasia can give us much
insight into what society’s values and views are about death and dying.
It was last year, at the university library in San Francisco, when I first
discovered that California had recently voted against a proposed law to
legalize physician-assisted suicide and voluntary euthanasia.
California is also a state that has had legalized capital punishment
since the closing of Alcatraz prison in 1963 (Quillen, 1991). Herein lies
the contradiction. It is acceptable to give a lethal injection to a criminal,
but not to allow a physician to give it to a terminally-ill patient at the
patient’s own request. It seems that California, like many other states
in the United States and provinces, in Canada, ultimately chooses the
ways in which it is appropriate for citizens to die. It made sense to me
that these social attitudes would be influenced by such factors as
cultural and spiritual beliefs, professional values, medical practices,
and the present political and economic situation.
In 1993, the Ministry of Health in British Columbia struck the Special Advisory Committee on Ethical Issues in Health Care (SACEIHC) to deal with the euthanasia issue. After much study, the committee failed to reach a consensus or recommendation on the actual issue of euthanasia (SACEIHC, 1994). This was the same 'non-position' taken by the British Columbia Royal Commission on Health Care and Costs (1991). It reported, "the committee's lack of consensus also reflects the lack of unanimity that Canadians in general appear to display on this issue" (pg. 1). However, the 'Closer to Home' summary did recommend changes in Section 241(b) of the Criminal Code to allow for patients to have passive and active euthanasia in the health care system (1991, pg. 34).

In Canada the field of palliative care has launched a huge movement against the practice of euthanasia. The palliative care industry states that it is the appropriate response of the health care professions, government, and society to make available, and practice the principles of palliative care medicine to all patients with terminal illness. Euthanasia, even at the request of the patient, should not be available, according to the ‘Palliative Care Statement on Euthanasia and Physician-Assisted Suicide in Canada’ (Mounlin, 1994. pg. 80).

William's studies of the Canadian Medical Association members suggests that many Canadian physicians now hold conflicting views on this emotionally charged subject (Williams, 1993). The literature suggests that "physicians value the concept of patient autonomy but
place it in the context of other ethical and legal concerns" (Fried, 1993. pg. 722). A study of the attitudes of physicians at different levels of practice suggested physicians did not consider the 'right-to-die' as a 'licence to kill' (Caralis, 1992). However, at the Canadian Medical Association's 1993 annual meeting, physicians voted against the practice of euthanasia or physician-assisted suicide (Quinn, 1994).

Further research about the attitudes of medical students, house staff, and faculty physicians toward euthanasia were investigated at the Miami school of Medicine. The results showed that although there was much more acceptance by the respondents toward passive than active euthanasia, there were generally uncertainties surrounding all decisions and practices. These uncertainties in euthanasia were mostly related to the confidence of the medical diagnosis and the physician's moral justification of assisting patients to die (Caralis, 1992).

The largest professional nurses' organization in the United States has opposed involvement with euthanasia in professional practice, but recognizes that each nurse may not be in agreement with this stance (Haddad, 1991). A Japanese study of physicians' and nurses' attitudes towards euthanasia indicated that more doctors than nurses favor euthanasia (Takeo, 1991). Interestingly enough, in Takeo's study, the results revealed that both professions wanted to have the right-to-die themselves, but were much more indefinite as to whether this should be 'allowed' for patients.
Social Work and Euthanasia

Physicians, other health care professionals, theologians, philosophers, social scientists and legal scholars are now challenged to consider the ethical dilemmas around euthanasia from a new perspective. To this list, we must add professional social workers.

Social workers are part of the health care team that directly provides services to people who request euthanasia and their families. In the United States, the National Association of Social Workers published their policy statement concerning end-of-life decisions in 1994. It states that “social workers should be free to participate or not participate in assisted-suicide matters. NASW’s position is based on the principle of client self-determination, and his/her choice should be intrinsic to aspects of life and death” (pg. 60). The Canadian Association of Social Workers approved its own policy statement in October, 1994. It too, is based on the patient’s fundamental right to determine his/her own best interests. Furthermore, this document states “there is a necessity to view the issue of euthanasia in the broader context of care for persons who are dying” (CASW, 1994. pg.1).

Social workers have a role in advocacy and social action on behalf of client groups (CASW, 1983). It is my hope that as social workers continue to read about and consider the issue of euthanasia, they will respond to the public and to the individuals who are asking for this alternative health care practice. This response may need to come in
the form of social action on behalf of a vulnerable group in society. "Commitment to one's values and social action in their behalf, means that everyone has a responsibility to take an active role in the growth and freedom of others as well as their own" (Wetzel, 1986. pg. 166). Issues regarding euthanasia will challenge social workers to engage in self-evaluation and social action initiatives that are so much part of the roots of social work.

In this study, socialist feminist theory and feminist medical ethics provide a conceptual framework for understanding both the broader context of our health care system and its response to those who request euthanasia. This theory provides principles, consistent with those in social work, which can be used as an alternative method of analysis for considering euthanasia. These principles, and a feminist ethical framework for considering euthanasia, will be discussed in chapter two. This paper deals with euthanasia from the point of view of social workers who have experience in this area. Hopefully, it will provide us with some insight into their efforts on behalf of individuals who require support in order to die with dignity.

Purpose

The purpose of this paper, is to explore the value and practice issues that medical social workers perceive as important when dealing with issues around euthanasia. Knowledge in this area will help the social work profession gain insight into the views of social workers
about euthanasia. The study results will help the reader to understand the factors that influence medical social work practice in this area.

It is also important for social workers, like other health care professionals, to review and examine their values and practices. It is hoped that the results of this study will draw attention to areas of practice where social workers may need to make changes. This information serves to enhance our awareness of the issues faced by social workers regarding practice with euthanasia. Understanding these issues enhances the professional's ability to deal with his/her patient's demands for self-determination through choosing his/her own death.

Gaining insight into the views and social work practice of medical social workers who have dealt with some of the dilemmas surrounding euthanasia may help other social workers who are just beginning to wrestle with this topic. This aids in professional growth, and offers suggestions for alternatives in social work practice. It also encourages social work practice that is sensitive to the broader perspective and the development of better understanding of the possible oppressions, discriminations, and influences involved in the present health care system. As the policy statement from the CASW states, “potentially, we are all stakeholders in a society that values death with dignity. Understanding what this means to both individuals and members of our society is our task” (pg. 2).
CHAPTER 2: THEORETICAL PERSPECTIVES

The vast amount of literature, including media reports regarding euthanasia gives credence to the complexity of this issue and the resurgence of public interest in the topic. Euthanasia has legal, philosophical, sociological, cultural, religious, and medical implications. Each field offers theory and views that add to the euthanasia debate. This chapter discusses the theoretical framework behind the author's feminist perspective regarding euthanasia. This perspective, and my purpose for investigating euthanasia and social work practice, are grounded in socialist feminist theory and feminist medical ethics.

In this chapter, the feminist goals common to all feminist perspectives are first presented. Secondly, this chapter addresses the feminist movements in health care within each of the four most common feminist perspectives. And thirdly, my own perspective drawn from feminist philosophy and feminist medical ethics is presented. This perspective is discussed in the context of how it relates to euthanasia and how medical social workers deal with requests for euthanasia from their patients.

Feminist Theories

Eastman (1973, pp.164 -165) and Sturdivant (1991, pp. 44-45) summarize the goals of the feminist movement since the 1970's:
These goals represent both political/social and personal goals for women. In my perspective, each goal represents not only the agenda for women, but for men, children and all vulnerable and discriminated or oppressed groups in society. The goals Eastman and Sturdivant cite that are relevant to the ever-present problems social workers and patients face in the health care system are as follows:

1. to gain individual and collective control over women's lives in creating support for one another in alternative ways of living;
2. to gain increasing understanding of the ways in which women have been programmed and oppressed and of the social institutions that create the context of this oppression;
3. changing the external reality of women's situations through an economic revolution that will end a system that exploits most people for the good of a few;
4. creation of a cultural revolution that will undermine the centuries of social programming that women have undergone; that is, realization that the quality of lives is not determined by accident or biology, but by our social system;
5. full self-determination, including economic independence;
6. to use consciousness raising as a vehicle for personal liberation.

The above objectives provide a reason for understanding and challenging the present health care system. These common goals of feminism also support the purpose and relevance of this research topic. They draw attention to the need for full self-determination, the need to gain individual and collective control, and the need to increase understanding and insight into the oppressive realities of our world today. These goals parallel what individuals who want to die with dignity are fighting for. This study explores this situation from the
social workers’ point of view, and reveals the need for consciousness-raising within the social work community regarding its own acts of oppression against those who request euthanasia.

Social workers also need to increase their understanding of the structures that influence aspects of health care. It is important, as the feminist goals suggest, to move beyond understanding, into political or social action to bring about meaningful changes. In order to achieve this, the sharing of economic, political and medical knowledge must be broadened to include the consumer.

Finally, my motivation is based on the feminist emphasis on the person’s right to self-determination. It has been my experience that a patient’s right to self-determination does not alone result in the achievement of that self-determination. In order to achieve self-determination, there is a necessary reciprocal relationship between the patient and the professional. The patient has the right to make his/her own decision, but the professional who has the power to give or impede that decision must allow the patient to put that right into action. Because of the present power imbalances inherent in the health care system, the patient is still vulnerable to having his/her rights met by those more powerful. Consequently, there is an obligation by health care workers to respect a patient’s right to autonomy in an active way. In the present hierarchical system, this may very well include fighting for it.
A feminist perspective emphasizes the existence of power in medicine and the values held in the medical structure as having dramatic implications for the practice of euthanasia. The power of science and hierarchy in the delivery of health care can leave patients in a vulnerable position. The authority afforded medicine in our society often comes into direct conflict with a patient's right to self-determination.

Acknowledgment and understanding of these influential factors is extremely important for social workers who are concerned about the oppression their patients may experience when requesting euthanasia. Feminist principles and social work practice have many theoretical similarities. In fact, Mullaly states that, "feminist theory and analysis are enormous sources of information and inspiration for structural social work theory and practice" (1993. pg. 148). Therefore, I am drawing on the principles of feminist ideology to provide a framework for understanding the power relationships that effect social work views, values and practice with patients requesting euthanasia.

**Feminism and Health Care**

Within the feminist movement, the women's health movement has been drawing attention to health care issues for decades. Since the 1930's, middle-class feminists and working class people have joined together in their fight for control over health and health care responsibilities. Each of the four most common feminist perspectives: liberal, radical, Marxist, and socialist had their own feminist ideology
regarding women's health issues (Jaggar, 1977 and 1983). The women's health movement of today involves all types of feminists and their differing theoretical and philosophical perspectives.

**Liberal Feminism and Health Care**

The first theoretical perspective is the liberal feminist position, crystallized by Betty Friedan's classic text, *The Feminine Mystique*. Liberal feminism recognizes that the structure of medicine reflects the power position of the males over females (Fee, 1978 and Sandelowski, 1991). It demands that women have equal opportunities in the medical system, and gain the power men have enjoyed in this system. Liberal feminists have also raised issues around the hierarchical doctor-patient relationship. The existence of power dynamics and the control of knowledge in the 'specialist' relationship is opposed by this group of feminists (Fee, 1978).

The liberal feminist agenda for change is to balance out the sexes in the existing medical structure. They believed that more women in decision-making positions of power, research, and education would naturally change the overwhelmingly male-biased health care system (Fee, 1978). Liberal feminism does not condemn the power imbalance outright, it simply believes that women should share that power.

Most critics of this agenda believe this solution is simplistic. The idea of copying men as models or competing for male power positions does not really address the ramifications of power in a system or change the hierarchical structure. This type of philosophy
presupposes that a hierarchical system with females in power would somehow be better than when males have the power. Although some changes would undoubtedly take place, a transformation of power dynamics has not been the result, in my experience in health care institutions.

Ultimately, I do not believe that female physicians, or females in powerful positions, would be the sole answer to structural or philosophical issues of oppression. For patients this will still create a hierarchical relationship with their health care professional. Thus far, my review of the literature, my experience in the health care system, and the data from my research, support the fact that gender has not proven to be a factor in determining the conscience of health care workers, or social workers, toward patients requesting euthanasia. Paternalistic females in professional positions of power will not change the lack of control experienced by vulnerable patients.

The liberal feminist solution for changes in health care also falls short of addressing the plight of laborers within the health care system. It is likely that only women of privilege will be able to work their way into powerful positions. Thus, the liberal solution does not address the problem of hierarchy for working class people employed in health care, hierarchical relationships at all levels of the health system, or the control a female professional could have over vulnerable patients. These issues are all relevant to terminally-ill patients who request euthanasia.
Radical Feminism and Health Care

The second type of feminism is radical feminism, or as it is recently referred to, cultural feminism (Sturdivant, 1991). "Radical feminist goals are not to achieve equality with men under the existing social and economic structures, but to entirely transform the social institutions" (Fee, 1978. pg. 282). The biological division of the sexes has been a fundamental concept for radical feminists. Philosophically, these views of the original radical feminists became known as cultural feminism. "Cultural feminists sought to create a new culture based on what they considered to be the female mode of consciousness, female characteristics, and female values" (Sturdivant, 1991. pg. 42).

When considering health issues, radical feminists moved beyond the liberal concern for doctor-patient relationships. They saw no possibility of equalizing this relationship, and looked only to alternatives methods of health care outside the present system. They sought solutions in self-help health groups, lay female health workers, and alternative women's health centers. The simple message was that only women can understand a women's health (Sandelowski, 1989., Fee, 1978 and Sturdivant, 1991).

The radical feminist recognition of the power imbalance in the doctor/patient relationship helps us to watch for control issues between the two. Building alternatives for individualized health care is also an important recognition, and one of the motivations for this analysis. However, the radical feminist agenda toward gender separate health
care is not necessarily relevant to euthanasia or social work practice. This does not address issues for other victims in the health care system, other than women. Many oppressed groups, the elderly, males and male children would not be able to realistically access alternative women's health care. Health care and the social workers within the health care system have obligations to all their clients.

The health care structures that influence practice with euthanasia need to be addressed for both male and female patients. Changing the culture of society to that which is primarily 'female' may not bring about a change in views on death and dying, the right to choose death, or the rights of consumers over professional interests. A separatist view would also suggest that there is now a respect for a man's right to choose his own death. The recent publishing of Dr. Raphael Boutin's struggle to receive euthanasia confirms that men may not have privilege in this arena (Cardwell, 1995. pg. 18).

In social work practice, humans are valued as relational, interdependent, social beings (Sheafor, 1991). The Social Work Code of Ethics states the primary focus of social work is on relationship patterns between all people and their socioeconomic resources, services and opportunities in their respective communities (BCASW, 1994. pg. 4). Social work has long viewed human beings as inevitably in contact with one another. This claim contradicts the radical feminist view that the lives of males and females would be improved by the separation of the sexes. It is my perspective that social workers need
to be open and respectful of their male and female patients in the framework of understanding their experience as a lifetime of interrelationships that may be all a part of their decision to request death.

**Marxist Feminism and Health Care**

The third feminist perspective involved in the women's health movement was drawn from the principles of Marxism. In the Marxist orientation to health care, the defects of the health care system as a whole are the problem. Marxist feminists are concerned with the power and profit motive of corporate and professional interests in the health care business. "They are also opposed to the classism, racism and sexism that divides consumers and health care works" (Sandelowski, 1989. pg. 22).

Marxist feminists have brought forward the issue of cultural and personal differences in the definitions of health and illness. This insight is particularly relevant to the issue of euthanasia. As previously addressed in this paper, euthanasia has been caught in a conflict of definitions between legal, moral, religious and medical structures (Sandelowski, 1981). The definitions of euthanasia are closely linked to each person's definition of acceptable death and dying. With the power of medicine and science (male oriented), it is not surprising that death is not seen as a natural or evolutionary experience under the control of the patient. With respect to euthanasia, a mercy killing could be viewed as compassionate, yet the early death is often viewed as a
scientific failure (Fee, 1878). It is my belief that these definitions have been greatly influenced by the medicalization of health care and the morality of the powerful in society.

Another valuable contribution Marxist feminists have made to the health movement is their call for action toward positive changes in health care that would benefit all consumers. They advocate for changes that would not only be good for women, but would also be good for men and children (Sandelowski, 1989 and Fee, 1978).

Marxist feminism addresses other key issues in health care that are also my issues of concern regarding euthanasia. It is less separatist than radical feminism. It addresses the need for quality health care for all people. It recognizes the problem of hierarchy, and it addresses the need for systems to be responsive to the individual needs of its consumers. Consumer rights are exactly what the public have been asking for in health care since the beginning of the women’s health movement. For patients who want the ability to determine their health care or their own kind of death, this may be the real issue.

Much of the purpose for doing this study was drawn from the principles of liberal, radical, and Marxist feminist theory, as well as the core principles of feminism. It is, however, the fourth type of feminist philosophy, socialist feminism, that provides the most support for my feminist perspective. It addresses the issues in health care that are most relevant to patients and social workers dealing with the issues surrounding euthanasia.
Socialist Feminism and Health Care

Socialist feminism draws on the Marxist structural analysis, but adds the cultural considerations of the radical feminists. It is a blending of the two perspectives, without being separatist. It is concerned with both class and labour, both production and reproduction. The vision of socialist feminism is to “transform the entire fabric of social relationships” (Jaggar, 1977. pg. 279). Socialist feminists want to change power relationships in human interactions, even before the occurrence of a revolution in the capitalist means of production” (Ibid. pg. 280). They recognize the importance of this subjective factor in bringing about meaningful, sustainable change in our political, social and economic structures. One of the most notable contributions made to the feminist movement by socialist feminism was the claim that “the personal is political”, a concept that is part of the theoretical perspective of this work.

Feminist theory as a body of theories is still evolving. The emergence of alternative feminist theories and criticism of each perspective, even from within the women’s movement, is evidence of that evolution and growth. Recently, feminist authors have used feminist principles to enter the field of ethics. Feminist principles are particularly useful when analyzing broad issues in health care, as well as issues presented in the euthanasia debate. Feminist medical ethics use feminist principles to analyze and challenge traditional male-oriented ethics. This paper suggests feminist medical ethics is an
excellent tool to look at the present medical ethics regarding euthanasia.

**Feminist Medical Ethics**

Feminist medical ethics is a relatively new concept. Author Carol Gilligan was one of the earlier writers on ethics from the feminist perspective (1982). She first presented the idea that girls and women approach ethical dilemmas in different ways than do men and boys. In her alternative approach to ethics, Gilligan suggested we need to be aware that when solving ethical issues, men base their judgments on comprehensive, generalizeable, abstract ethical systems which are based on rights. In contrast, women are concerned with understanding the specific human dynamics of a situation. According to Gilligan, women try to avoid hurting people and are concerned with providing a more holistic care for others (1982). These differences explain why our culture has the ethics it does. Since society is controlled by men, it is not surprising there is a male-oriented approach towards ethical issues.

Since Gilligan, one of the foremost authors in feminist ethics, and particularly medical ethics, is Susan Sherwin. Susan Sherwin subscribes to the socialist feminist perspective, which supports her basic theoretical concepts for understanding medical ethics and the health care system (1992). She uses the following feminist ethical principles as guidelines for dealing with medical ethics.

Firstly, Sherwin claims that in feminist medical ethics, “the personal is political”. She believes that “for medical ethics to be
feminist, there must also be a political dimension” (pg. 22). The personal is political is relevant to medical ethical issues such as euthanasia. Even though these issues are highly personal, they are also inseparable from such things as societal issues, oppression, class and capitalism. In other words, the right to choose one’s own death may be a personal decision, but it has implications for everyone. If one person is not allowed the right to die, then the challenge on behalf of that one person will benefit all people to have the right to die with dignity. “It is not a question of which comes first, the personal or the political. Neither is one a prerequisite for the other, both must occur conjointly” (Mullaly, 1993, pg. 148). It is assumed in feminist ethics, as it is in this study, that what affects each person individually is worth fighting for collectively and politically.

Secondly, Susan Sherwin suggests we need to take steps to understand the subjective views of patients, and the relationships between patients and their health care workers before we can deal with the ethical situation. She recognizes that equally as important as societal views, “each situation involves complex relationships of various sorts of interdependencies among persons of widely different degrees of power. Feminist medical ethics is not only concerned with the actions and relationships, but also should focus on questions of character and the development of a person’s individual attitude” (pg. 21). Each person is an individual with a complex history that is interrelated
with the oppressions they have experienced in their lives and in the medical system.

According to feminist medical ethics, it is equally as important to understand the situation the way the patient sees it as it is the way society might see it. This "person in environment" perspective is also referred to in social work philosophy (CASW, 1994). This concept suggests that each person is an individual with his/her own beliefs about what is best for them. Each person is also an individual in the context of the environment, and all the influences and culture of the society in which he/she lives. Thus, it is equally as important for social workers to understand the subjective view of their patients as it is to understand the environment in which they live. A feminist ethical perspective would suggest that social workers need to investigate and consider the power dynamics within society that may underscore each person’s viewpoint.

Thirdly, it is extremely important, according to Sherwin, to understand the medical system as a power for production and profit. The political and economic role of medicine is revealed through analysis with the socialist feminist perspective. Sherwin suggests that medicine in Western society is a business. There are services and production to be tackled and cost/benefits to be considered. The power of medicalization created a hierarchy of professionals (producers) and patients (consumers). In this system, the power rests with the producers. Understanding Western medical structures as a
resource for profit and production gives us insight into the reasons for oppression in the medical system.

Conceiving of health care as a business also gives us insight into possible reasons why patients who request euthanasia come up against such resistance. In a health system where ‘fixing’ people and saving lives is the service offered, the request for an ‘early death’ comes into direct conflict with the services offered. Professionals are judged, and the system as a whole is judged, on the ability to provide life-saving treatment. The benefits are financial, advancement and the satisfaction that may come with success. Although death is an inevitable future for every living being, death is not considered a product of good, scientific medicine in our present health culture. Thus, the request for euthanasia contradicts the values and life-saving goals of medicine today, and is not viewed as producing health consumers or generating financial gain in the system.

Much of the socialist feminist ideology supports the principles of feminist medical ethics. Sherwin refers to feminist medical ethics as the promotion of the sharing of knowledge between professional and consumer, the absolute right of patients to be empowered and control their own health care experience, and the opposition to gender, race or class discrimination in the health care system. Further, feminist medical ethics recognize patients as members of oppressed groups by virtue of their inferior relationship with their doctor/the medical system, because of their vulnerable health state, and because they are not in
control of the knowledge or the treatment in many instances (1992).

These concepts are all relevant to the individuals who come into the health care system, as terminal patients, and request care that is not always considered appropriate by those in power. Using feminist ethical principles, these patients can be further understood in light of their oppressions and vulnerability in the medical system. Recognizing this situation creates further reasons for social workers to take an advocacy role in their practice with vulnerable patients.

Since euthanasia is presented as an ethical issue in a patriarchal, capitalist society, we must not view it outside of the context of the larger picture. The society, and the powerful structures in that society, will have defined the issue and, by virtue of socially-constructed norms, will have made it an issue. In another societal structure, euthanasia may not be presented as an issue at all. But, in the Western medical model, we need to consider euthanasia in the context of who will profit from it, who has control over the delivery of euthanasia and why, and finally, what factors are oppressing those who request it? This understanding should concurrently reveal a subjective understanding of one's own position, oppressions, and views about euthanasia.

Finally, the emphasis Sherwin's feminist medical ethics places on society's ascriptions of illness is also relevant to euthanasia. Sherwin suggests that our present ascriptions of illness reflect our patriarchal, capitalist society. Our society defines and values according to its own morality. Since morality is socially generated, and our Western
society is male-oriented, ascriptions of illness reflect male morality and values. Thus, illness is regarded as pathological, and it requires fixing. As it stands in the present health care system, all that can be done to fix the illness or save the life, should be attempted.

A feminist perspective suggests we need to ascribe different meanings to illness than those described above. It is suggested by Sherwin that events such as sickness, childbirth, death and dying would be viewed as natural life processes, and not in need of aggressive treatment. Using feminist ethics for analysis, it is important to be aware that a concept such as euthanasia is viewed in the context it is because the morality around it is socially constructed. It would be also important then, to keep this in mind when addressing the issue of euthanasia. Feminist medical ethics asks us to consider what are the ascriptions of an acceptable death in our society and where did they come from.

The above is not an exhaustive discussion of every concept of feminism, feminist medical ethics, or all the possible relevance they may have to any issue important to patients and medical social workers. But, it is my belief that feminists and non-feminists can use many of the above principles of feminism to analyze and help understand ethics in the context of a patriarchal, hierarchical society. As an alternative to traditional ethics, or to broaden a present perspective, feminist principles could shed new light on one’s perspective in the euthanasia debate. Introducing feminist ethics into
the existing medical system would be a 'patient-friendly' alternative to
the traditional, patriarchal analysis. This research explores whether
medical social workers use their 'feminist glasses' to analyze the issues
that arise when patients request a dignified death.

Medical social workers are part of the professional health care
team. They can have a direct impact on the direction of patient care,
often as patient advocates in a highly-medicalized and paternalistic
health-care system. Social workers in health-care institutions may be
the only professionals with a perspective and in a position to support a
patient through the process of fighting for self-determination. Feminist
theory and the Social Work Code of Ethics suggest that we must
advocate on behalf of the vulnerable, both individually and collectively
(Jevne, 1993 and CASW, 1994). On behalf of those patients requesting
euthanasia and demanding their right to self-determination, medical
social workers who have confronted euthanasia professionally, can
inform those with less experience in this area, about their views, values
and practice. This study is a vehicle in which experienced medical
social workers can share their knowledge and their ethics on
professional practice with patients who request euthanasia.
CHAPTER 3: METHODOLOGICAL CONSIDERATIONS

Description of Design

There is limited literature available about the views or practice of social workers regarding euthanasia. An extensive search of Canadian, U.S. and European literature revealed that no qualitative studies are available on the subject. Consequently, this study fulfills a need for exploratory and descriptive work in this area. According to Patton, it is particularly appropriate to use qualitative methods where specific outcomes are not sought, valid, or where reliable quantitative measures are not available. "Where outcome measurements have not been developed and tested, it is more appropriate to gather descriptive information than to use some scale that has the merit of being quantitative but whose validity and reliability are suspect" (Patton, pg. 130).

In this early stage of research in this area, the goal was to explore and understand the topic of euthanasia and social work practice. Before gathering quantitative, statistical information, an attempt was made in this study to describe what the issues were for social workers. These findings might then be used to direct further study in the area. The qualitative design enhanced the opportunity for achieving greater depth, meaning, and understanding of the research results.
The Certificate of Approval for the above research study was given by the UBC Research Ethics Committee on February 10, 1994 (Appendix E).

Pilot Study

Sample Selection and Criteria

A pilot study was carried out with three medical social workers from the lower-mainland of British Columbia. Each was known to the researcher and were selected for their knowledge of the subject area and of social work research. The purpose of the pilot study was explained to each participant to ensure the each knew his/her responses would be reflected in the research study results. Pilot participants also had the task of giving feedback to the researcher about the interview guide and process. Medical social workers in the pilot study were not recruited from the proposed research study population. Because the number of possible participants was unknown at the time of the recruitment, the study population was not limited by including participants in the pilot study.

Methods

The purpose of this pilot was to test the research interview guide in a data-gathering, personal interview. The pilot informs the researcher about the relevance of the interview guide prior to interviewing the study population. This pilot study process added credibility and validity to the interview guide and to the research project. The participants' interpretations and comments regarding the
interview questions provided information to the researcher which allowed changes to be made in the interview guide and process.

Data collection was done through a data-gathering interview. The interview guide, containing open-ended questions, gave each participant a better opportunity to express his/her views than would a questionnaire (Patton, 1990. pg.23&24). Changes and clarification were made by the researcher and by the pilot participants throughout the interview. This flexibility enhanced the flow of information and allowed for depth and richness in participant responses.

Pilot Study Analysis

All pilot study interviews were audio-taped and transcribed. To ensure confidentiality, all identifying, individual information was deleted from the transcripts. 2Grounded theory was used to pull out themes in the text. Lastly, the scale of directiveness was used to assess the level of probing in each question in the pilot interviews. This scale helped the researcher to self-evaluate the amount of leading done in the interviews, and to make adjustments accordingly during subsequent interviews.

The pilot study process adequately fulfilled its purpose in this study. Grounded theory was used successfully to draw out themes for the researcher to pursue in the research study. Where questions were

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2. Grounded theory - is a theory that is discovered, developed, and verified through systematic data collection and analysis of the study data. Using grounded theory, one begins with an area of study, and what is relevant to that area is allowed to emerge.
confusing to participants, or when the researcher needed to probe and lead more than was comfortable, the responses ultimately lacked depth and clarity. Grounded theory and the participant feedback drew attention to these problem areas. The necessary revisions were made to the interview guide and the research process. They are reflected in the pilot study results.

Pilot Study Results

The information from the pilot was drawn from two different sources, the feedback from participants and analysis of the content. Rather than providing information on the topic, the analysis helps to answer the question of whether the interview guide is effective in gathering the information sought by the researcher. The following discussion considers both the information learned from the pilot participants as well as the implications of that information. Both have influenced the research study design.

Definition of euthanasia

The definition of active and passive euthanasia in this study was provided to each participant at the beginning of the interview. All three participants indicated the importance of this frame of reference. Two of the participants wanted to discuss distinctions between the definitions
of passive euthanasia, active euthanasia, and palliative care used in this study. There may be little difference between the practical applications of both, but the moral implications are often quite different. Consistent with the literature review, the participants believed the language around euthanasia was sometimes daunting, and the terms of reference were necessary for clarity in discussing the topic.

Regarding the study definition of euthanasia cited in chapter one, responses were, "I think that given competency is assumed and the patient is informed about options and possible treatment, it's fine", "As defined by you, I don't have any problem with passive euthanasia", and "I'm really glad you told me about the definition of euthanasia in your study because I wouldn't answer this in the same way". Each participant indicated in his/her feedback that he/she would have likely responded differently if the definition of euthanasia was different than the one used in this study. The word 'euthanasia' was complex and carried its own meaning for each participant, so the details given in the definition provided the common frame of reference necessary to discuss 'euthanasia' in this study.
Therefore, to maximize the opportunity for a clear understanding of the terms between researcher and participant, the study terms were given to each participant in the research study before the interview took place. The questions were revised to make distinctions between passive and active euthanasia. The participants were asked at the beginning of the interview if they had any difficulties with these definitions, and if so, they had the opportunity to elaborate on their own definition or meaning of euthanasia.

**Interview guide revision**

The participants viewed question number one (regarding views) and question number four (regarding future practice) as the easiest to answer. (see appendix D - Interview guide) These questions generated the clearest and richest responses in the study results. All participants thought questions two and three (regarding values and factors) were the most difficult to answer. In each interview, clarification of these questions was sought by the participants. Each expressed that values were sometimes hard to articulate unless one had time to think about them beforehand. The question about factors that influence practice yielded much the same response.
The pilot study participants thought it would be more effective to consider the questions ahead of time, rather than to be probed more at the interview. Because of the complexity of issues around euthanasia, the participants stated they could have given clearer, more detailed, better thought out responses if they had time to consider the questions prior to the interview. They believed this would have decreased the number of "superficial" responses, the number of lengthy responses given while attempting to consider their position, and would have increased the opportunity for thoughtful, detailed information in the content. Since this study's goal was to acquire in-depth information from the participants, a spontaneous response was not as important as was a complete one. Therefore, steps were taken to let each participant know the content of the revised interview guide questions at the time interviews were arranged.

Question three was designed to elicit responses from the participants about their practice through the use of a case scenario or example. The pilot study participants appeared to have difficulties working through the dilemmas and answering the question. However, it was also true that these participants have not had much experience with clients requesting euthanasia, thus they had less opportunity to
consider the issues of euthanasia as they relate to their practice. Because it was reasoned that the research study population would likely be more familiar with the client group, a decision was made to leave the example in question three, and to divide the question into cases of both active and passive euthanasia for clarity in practice.

Each participant in the pilot study thought the interview was unintrusive, non-judgmental, and comfortable. They appreciated the opportunity to pick the time and place for the interview. They indicated there was no pressure to respond a certain way. Each participant in the pilot said he/she enjoyed the opportunity to address the topic and to examine his/her "thinking" on the issue more closely. In light of the purpose of this pilot and the information it provided, every effort was made to accommodate all suggestions given by the pilot participants.

**Research Study**

**Sample Selection and Criteria**

Study participants in this research study were medical social workers from the urban lower-mainland of British Columbia. The 1993 *Survey of Social Workers in British Columbia* states there were 354 medical social workers employed in this capacity (UBC, 1993). The
sample for this study was purposive, however, and recruited from a smaller group of social workers within the medical system. The participants were recruited from both acute and extended care medical facilities. This purposive sample was used to direct the research questions towards the participants most able to answer questions about euthanasia on a professional level, thus adding relevance and richness to the results. Only participants who had dealt with patients' requests for euthanasia were included. This criterion excluded social workers with only a theoretical knowledge of dealing with such requests.

The criteria for inclusion in this study was to be a practicing medical social worker in an urban health-care institution in the lower-mainland of British Columbia. Each participant held BSW or MSW degrees. This allowed for a baseline knowledge of social work values and practice amongst all participants. This minimum education requirement also confirmed participant's eligibility for BCASW registration. This was done so that the results of this study would be relevant to the professional association for social workers in British Columbia.
Recruitment Procedures

In July, 1994, 'Notification Requesting Participation' letters (Appendix B) were mailed to forty-seven medical social workers in urban health-care institutions in the lower mainland of British Columbia. This number represents all social workers identified from staff listings who were currently working in areas that were most likely to have patients with life-threatening or terminal illnesses. This selection was purposefully made to reach social workers who have dealt with requests for euthanasia from their patients, a criterion for inclusion in this study. There was a 36% response rate to the 'Notification Requesting Participation' letters.

The 'Notification Requesting Participation' letter was forwarded to each possible participant. As stated in the notification letter, the researcher phoned individuals who had not already responded to see if they were interested in participating. The interviews were conducted at the time and place selected by each participant.

During the recruitment period, the researcher was contacted by two medical social workers from different health care institutions who were in opposition to this research study. They did not wish to
participate, but were upset that the topic of euthanasia was going to be studied in the social work arena. Another social worker was also concerned with the definition of euthanasia being divided into passive and active forms. This person thought that 'killing was killing', and there was no need for distinctions between passive and active euthanasia.

To address these concerns, I explained that the definition of euthanasia in this study was included to respond to the concerns of pilot study participants regarding the need to separate 'passive' and 'active' euthanasia, for discussion purposes. In addition, this definition reflects an amalgamation of the current definition used by the Canadian Medical Association and the one found in The Social Work Dictionary (Barker, 1991. pg. 78).

In response to the social workers' opposition to studying euthanasia and social work practice, I encouraged these social workers to participate, so that their views would be represented in this study. Both social workers declined to participate. The range of views between these social workers who opposed the study, the views of social workers who called to support this research effort, and the views of those who participated, confirms that there is often controversy
attached to any discussion of euthanasia, even at the level of exploratory research.

Demographics of Participants

Seventeen medical social workers from urban health-care institutions in the lower-mainland of British Columbia were interviewed for this study. Nine medical institutions were represented. They included both acute and extended care units at Vancouver hospitals (Laurel Street and UBC sites), St. Paul's hospital, B.C. Rehabilitation Society centers, Surrey Memorial hospital, Holy Family hospital, St. Vincent's and Normandy hospitals. Nine of the participants identified themselves as employed in extended care health units, and eight were from acute care. Extended care included geriatrics, hospice, AIDS, Alzheimer's Disease, rehabilitation, extended care units and palliative care. Acute care included ICU, CCU, organ transplants, psychiatry, rehabilitation, palliative care and oncology.

Only respondents who had dealt with patient's requests for euthanasia were included in the research study. This criterion excluded social workers with only a theoretical knowledge of dealing with such requests. All participants had dealt with passive euthanasia. One participant stated she had been involved with passive euthanasia
one to five times, two stated they were involved six to ten times, and
the remaining fourteen had been involved over ten times.

Regarding active euthanasia, five participants had not been
directly involved. Ten participants had been involved from one to five
times, one had been involved six to ten times, and one participant has
had over ten requests for active euthanasia in his career. This number
of requests, coming from varied areas of medical social work,
confirmed there is a role for social workers, and that euthanasia is an
issue that needs attention.

Five of the participants had a BSW and the remaining twelve held
an MSW degree. Four were male and thirteen were female. The age
ranges included seven participants from 30-39, 7 participants from 40-
49, and 3 participants from 50-59. The years of related social work
experience ranged from five to thirty, with the average years of medical
social work being fifteen.

The participants' health cultural background was explored to
account for possible differences in the way individuals and groups in
the study viewed health and illness. For example, if spiritual healing is
the social worker's health culture, health issues may be viewed very
differently from that of the Western medical model of health. In the
study demographics, only two participants cited their health cultural background as 'European', the remaining fifteen subscribed to the western medical model or a combination of western and holistic or spiritual healing. The demographical information collected is found in Appendix A.

**Data Collection Procedures**

The research study interviews were carried out from August to November, 1994. The researcher conducted all interviews. The 'Interview Consent Form' (Appendix C) was completed with each participant prior to the interview taking place. At the beginning of each interview, the definition of terms used in this study was covered. A mutual understanding of the study terms was important for clarity in dialog on this complex topic.

The researcher also shared that there were no right, wrong, or expected answers to the research questions. Only the participant's response was being sought in this study. This was done to encourage the participant to speak as freely as possible about his/her views and professional practice. The study purpose is found in Appendix D.

The research measure was a person-to-person, data-gathering interview. As opposed to the questionnaire, the interview was the
preferred research measure by both the pilot participants and the researcher. It was reasoned that more detail and clarity about social workers' views of euthanasia would be achieved through the interview format than any other research measure. It was assumed that the key informants, also being social workers, would be most comfortable expressing their ideas verbally. Being a social worker myself, it is my experience that most other social workers prefer expressing their ideas verbally rather than in writing. Each interview lasted between one to two hours.

The interview guide used in the research study was revised from the one used in the pilot study. The four original pre-selected categories: views about euthanasia, values behind those views of euthanasia, medical social workers' practice with clients requesting euthanasia, and the future role of social workers in this area, were still the focus. However, the study participants would now be asked to rate the level of importance he/she placed on each stated value or factor in questions two and three. This will provide knowledge about the relevance of these factors in social work practice. The revised interview guide, developed as a result of the pilot study interviews, is Appendix D.
Data Analysis Strategy

All research study interviews were audio-taped and transcribed. To ensure confidentiality, all identifying, individual information was deleted from the transcripts. After transcription, where there were confusing pieces of text, or where there was a possibility of misinterpretation of the content, clarification was made with participants by phone. After completion of all interviews and analysis, four of the participants were contacted for the purpose of peer review. This gave me the opportunity to discuss the study results with participants, and to get their feedback on the relevance of these results to experience and practice in this area. This peer review also provided a check on any researcher bias or assumptions in the analysis.

Content analysis was used to identify categories within the pre-selected themes, to bring meaning and build understanding of the content, and to identify any emerging themes from the data. The four preselected themes were social workers' views, social workers' values, social workers' role/practice, and future practice regarding euthanasia. Categories that emerged within the theme of 'views' were; definitions of euthanasia, views in favor of euthanasia, views against euthanasia, professional vs personal views, and the evolution of views. Under the
theme of social workers' values emerged four main categories/values; self-determination, quality of life, compassion, and religious or spiritual values.

The results of this study confirm a role for medical social workers regarding patient requests for euthanasia. Categories presented most often by the participants were counselling, social work with patients, social work with families, social work with staff, uniqueness of practice, and barriers to social work practice in this area. Within the theme of practice and the social work role, the issue of power and control over the patient's right to self-determination was paramount in the participant responses. Through further analysis, it was found that the social worker's 'willingness to take the journey' by eliminating the power each social worker has in his/her professional role with patients, was considered a necessary part of non-judgmental practice.

Finally, the responses about future social work practice with patients requesting euthanasia are presented. Categories emerged from the theme of 'future practice' addressing social work practice in society, social work practice in the medical system, and social work practice within the profession.
All transcripts were coded through a line-by-line analysis of the content. Open codes were penciled on the right-hand-side of the transcript. Clusters and pre-selected themes on the left. Categories and their frequency of appearance in the transcripts were identified. Where subgroups appeared, they were also identified and compared if possible. Colored highlighters were used on the transcripts to identify important quotes or thoughts in each of the four categories. The results of this analysis and discussion of the findings are presented in chapter four.

Limitations of Research

The results of this study apply to the study population and are not generalizable. The views of social workers not wishing to participate, or who did not fit the selected criterion, were not reflected in this study.

Although every effort was made to recruit individuals who opposed social work practice with euthanasia, the majority of respondents were in favor of this practice on some level. The recruitment was from a purposive sample of medical social workers practicing in areas most likely to have terminal patients. Concerning all forty-seven participants contacted by letter, it was unknown to the researcher what any of their
views might be regarding euthanasia. Each was encouraged to take part in the study regardless of their views for or against euthanasia.

Out of forty-seven, seventeen social workers agreed to take part in the study. Twelve out of the forty-seven possible participants were unable to be reached, so their views were unknown. Another five social workers voiced their views against euthanasia and the idea of researching the topic. None of these five social workers agreed to participate. The remaining thirteen possible participants indicated they were positive about the research topic, but could not participate in the study. Reasons included difficulties with time commitments, lack of knowledge in the area, changes in job duties, retirement, or the discovery that the criterion for inclusion would not be met. This data may reflect attitudes in the social work population as a whole, or may be a flaw in the recruitment procedures.

Credibility

In quantitative research, credibility is typically measured in the form of validity and reliability. Patton states the credibility issue for qualitative inquiry depends on three distinct but related elements. The first element required to enhance the quality and credibility is "rigorous techniques and methods for gathering high-quality data that is carefully
Secondly, the credibility of the researcher, which is dependent on training, experience, and presentation of self, is an important element. And thirdly, the researcher requires a “fundamental appreciation for naturalistic inquiry, qualitative methods, inductive analysis, and holistic thinking”. The emphasis on holistic understanding in qualitative methods is a sharp contrast to the logic and procedures of traditional quantitative evaluation (Patton, pg. 49). This holistic thinking, necessary to credible qualitative inquiry, is also fundamental to social work and to my feminist perspective. The utmost effort was made to enhance the quality and credibility of this research through employment of the above criterion.

The pilot study was carried out to enhance the credibility of the research design and the results. This process involved others in the creation of the research design and increased the effectiveness of the interview guide. Efforts were also made to review the text with participants for the purposes of clarification and peer review. This increased the likelihood of text and findings that reflect the intentions of the participants.

The above research design and methodology were used to elicit the most accurate responses from the study participants. The findings
in this study reflect the responses of seventeen social workers in the
BC lower mainland medical institutions. These results and a
discussion of the findings are presented in Chapter Four.
CHAPTER 4: PRESENTATION AND DISCUSSION OF THE FINDINGS

Introduction

Direct quotes from the seventeen participants, four males and thirteen females, were the basic fabric of the following exploratory results. They allow the researcher and the reader to access the thoughts, values and concerns of the participants. The results presented here invite the reader to make his/her own interpretation of the findings and raise his/her own questions for future study (Patton, 1990).

The respondents' views of the four preselected themes of views of euthanasia, values and factors behind those views, practice with patients, and goals for future practice are presented and discussed in this chapter. Through the process of qualitative analysis, categories, linkages, and connections emerged from within the four preselected themes.

Medical social workers responses reflect the way they conceive of and deal with the medical ethics of euthanasia in their practice.
Feminist theory suggests that behaviors, actions and viewpoints are to be considered in light of concepts such as power, control, oppression, self-evaluation and patriarchy. (Jaggar, 1977 and Sherwin, 1992) The fabric of social relationships is considered a function of the societal structure under patriarchal and capitalist agendas. (Jaggar, 1977) All relationships should be considered with this in mind. The presentation of participants responses were analyzed according to key concepts addressed in the socialist feminism and feminist medical ethics. This study investigates whether the medical social workers interviewed considered their own practice regarding euthanasia in the framework of feminist medical ethics.

Presentation of Findings

Social Workers' Views

Definition of Euthanasia

Each participant (n=17) responded to the study questions in the context of his/her understanding of the forms of euthanasia, as defined in the study terms (Appendix F). The pilot study participants expressed concerns that the definitions and language surrounding euthanasia could be complex and personal. A single term could carry a different emotional and practical meaning for many different people. This
appeared to be the case for some research participants as well. However, as best they could, the participants answered the interview questions as per the study definition they were given at the beginning of each interview.

Out of the seventeen participants interviewed, twelve participants saw no difference between passive and active euthanasia, except to define the specific acts involved. They did not separate the two definitions when discussing their views regarding euthanasia. One person said that "passive is really active too, because passive cannot have results without the doctor obliging the patient". Another stated, "there are as many differing views on whether morphine accelerates death as there are clinicians, its really all semantics anyway". Most others stated passive and active were the same for the purpose of discussion, whether they expressed negative or positive views towards the concept.

The remaining five social workers viewed passive and active euthanasia as two separate concepts with different meanings and implications. They were related to the acceptability of the practice, the role others play in it, and the gray areas between different forms of euthanasia. One participant appreciated the opportunity to separate
passive and active because he/she "have had many requests for both, but dealt with each differently in practice". One person described the difference as follows, "I am against all euthanasia and I disagree with most passive euthanasia, but some of it has become more acceptable over time". Another participant disagreed with the study definition,

I agree with passive euthanasia as your definition describes because I don't believe that it is euthanasia. Passive euthanasia, by your definition, is a natural process of death and is not a death greatly accelerated. So, it is really not euthanasia. In other words, if the death is naturally occurring, that is much different than killing the person. And euthanasia is killing the person.

Sixteen out of seventeen participants felt more comfortable with the study definition, but expressed their concern over the differences in meaning and acceptability of the term euthanasia in the medical setting. Four individuals drew special attention to the practice of passive euthanasia never being referred to as such, yet being acceptable common practice. They responded in this way:

They wouldn't use the term passive here, even though the practice is common place. What we would do is say it is a level of intervention or a restriction of treatment. The term 'health care directive' gets thrown in instead of the term 'passive euthanasia'.

In terms of the passive euthanasia, although it's not called that, nobody here has a problem with it. But for active, for staff, it doesn't happen, it isn't discussed, it doesn't occur. That has been made very clear.

Euthanasia is gray. When there is not much you can do medically, it may all become passive. Then technology pushes us to keep
people alive that clearly dying slowly the whole time. Sedation is constantly increased, and that in itself hastens the death. This is done all the time and is acceptable, but nobody calls it euthanasia.

So, basically when someone is deemed as competent and requests death, this is described as euthanasia. When someone deemed as incompetent requests death, it is seen as suicide. In practice, we might agree to send someone competent home to die without treatment, as a form of passive euthanasia. We, of course don't call it passive euthanasia, we call it a discharge plan.

One other concern expressed by several participants about the definition and about health care in general, is the issue of competence. Some shared their view that health care professionals may hassle their patients with competency tests for their own lack of comfort with the situation. Some also suggested that the assessment of 'competence' is often used to oppress patients rather than empower them. The social workers' experiences lead them to comment this way:

I have seen it where the staff go nuts. Oh, the patient must be depressed, let's do blood, let's do thirteen tests, call in the psychiatrist. They will find an excuse to not deal with this request. At least it will get them past the weekend.

The issue of competence has been an ongoing fight. For example, if someone has been diagnosed with even a slight dementia, they are immediately, suddenly not competent to make decisions about their health care. I have found that even people with some dementia may not be competent by a test, but certainly are able to make their own decisions over time.

If a person has a terminal illness, of course they will be feeling down. This doesn't mean that they are clinically depressed. Also, if people come into the hospital competent, it is strange that they
will be tested and deemed incompetent as soon as they mention they don't want the care we want to give them.

Most people have the ability to reason things out and have the right to do that. It is interesting that we are always taught that every suicidal thought is a cry for help, and yet I see that euthanasia is not a sign of pathology. Competence comes on many levels.

Sherwin's medical ethics emphasizes that we need to think about society's ascriptions to illness when we consider medical issues. She suggests that these ascriptions are defined according to a morality that is socially generated. (Sherwin, 1992) The participant responses suggest that medical social workers are aware of the importance of the meaning ascribed to the word 'euthanasia'. Each participant gave meaning and definition to the word 'euthanasia' based on his/her own experience and values around the practice, as well as morality of scientific medicine. The statements suggest that social workers have been influenced by the morality of our present medical system as is true of most people.

**Views in Favor of Euthanasia**

All participants, but one, indicated they were in favor of passive euthanasia. All participants indicated they were sharing their personal views. "Technology doesn't bring quality of life. Euthanasia is
compassionate and heals by comforting suffering." Another participant stated, "Every individual has the right to choose for themselves, it is not for everyone, but we have the right to request euthanasia and to have assistance." One social worker supported euthanasia because, "it is an issue of personal choice. We define our own quality of life and I don’t believe that suffering through a terminal illness is necessary for everyone".

Eleven participants stated they could think of no limitations they would put on their support for euthanasia, given the definition used in this study. Two of the social workers, however, were concerned with the element of depression that may exist in terminal patients. They wanted to ensure that clinical depression would be ruled out before they would feel comfortable supporting the patient’s decision. Likewise, another social worker wanted to be certain the patient’s illness would be terminal, although no minimum time until death was mentioned.

Views Against Euthanasia

Seven social workers interviewed were against some type of euthanasia. Only one participant was against all forms of euthanasia, as defined in the study, because "killing someone is always wrong and
our culture places supreme value on the preservation of life. It should also not be assumed life is over because of suffering. The remaining six participants were either against active euthanasia or were concerned about the 'slippery slope' possibility, and therefore were unable to support active euthanasia. These were all stated as personal views. One person expressed concern that "people are vulnerable as patients. I recognize they can be influenced and taken advantage of by the more powerful". For another, active euthanasia is a concern because "when people die, it is a process, and they ask for it in a low place of despair. They will change their minds when they get support".

The following quotes from four of the respondents present other concerns each had about euthanasia.

I am not in favor of active euthanasia because I feel society has failed a patient by taking part in the easy way out instead of supporting this person through to the end. We should not be asking our doctors to kill people. Involving someone else in that act is what's wrong.

This is going to mean we may devalue the lives of older people, of people with cancer, or people with AIDS. Are we going to start to deny people treatment once we start thinking about active euthanasia. Where do we draw the line, particularly when our resources are so tight?

I am concerned that the energy spent in discussing this with patients in health care should be better spent providing support for them to live. I think that if we could put our efforts into supporting people until they die naturally, there would be a lot less requests.
It is sad. Euthanasia is so negative, I wish we were more positive about a person’s death.

I am a little concerned about the slippery slope. I think another concern I have is that patients are just not making that decision for themselves, they are involving other people.

**Professional vs Personal Views**

A personal view is a statement about thoughts and opinions held on a certain topic. A professional view is about thoughts or opinions held that relate or impact on professional practice. Out of the seven social workers who were against active euthanasia on a personal level, only two held consistent views on a professional level. These two social workers explained why they could not be involved with euthanasia on a professional level. One said, “It is too much to ask of people, to get involved. Ultimately we should let people choose their own journey, but you can’t ask someone else to take that journey with you”. And the other responded that; “they (patients) have their right to self-determination, but I can’t necessarily help them if my views are in conflict”.

The remaining fifteen participants stated that they believed it was necessary to support the patient regardless of whether the social worker’s personal views were in conflict with those of their patients. They expressed the need for social workers to separate their personal
views from their practice. They felt that a social worker, whether for or against a patient's decision to request euthanasia, was obligated to support his/her decision as a matter of professional practice. In other words, their professional views became those expressed by the competent patient in regard to their own perceived best interests, as illustrated by the following three responses.

I don't agree with active euthanasia on a personal level, but I would support a patient who wanted it because my personal views are not his/her concern regarding their own death.

Sometimes I think about the slippery slope and the way we can make people feel a burden, and I have seen miracles happen through illness, so I am still debating about my personal views. However, this does not interfere with my social work practice with patients. And I know this because I have been in this professional position many times.

So, I have some concerns about euthanasia, but I am a person who is committed to personal choice. If the person is really making that choice for themselves, and there are people around who can assist the person to die or provide the means, then that's okay.

A participant in agreement with euthanasia said; "I happen to be in favor of euthanasia for some, but that doesn't matter. If I agree or don't agree, for or against, it's their (patient's) choice". And one social worker represented the views of this group well by saying,

My personal and professional views are alike in many ways, but I don't impose my personal beliefs on my patients even when they aren't the same. I have had occasion to work through that conflict
and it is necessary. I don’t impose or preach or encourage one way or the other. I guess this is more my professional views.

Evolution of Views

Six social workers described their views regarding euthanasia as “always having been there”, or “I’ve always thought this way, but more so over the years.” However, most of the participants in this study related their views about euthanasia as an evolution of thought. Over time and with experience they gained understanding of their views. They talked about “continually having to think about these kinds of ethics and debate them. One person said; “this doesn’t serve to change my mind, it just keeps me growing”. Another described the evolution process as being “lots of personal and professional experience in dealing with these issues, not ignoring them. This makes me grow”. And several participants suggested that it has been a function of age and wisdom that allows them to practice non-judgmentally. “With age our views change” and, “I’m learning more about myself all the time as I confront these issues with others”. One participant expressed relief that “with age, views change, thank-God. Struggling with these issues in a direct manner helps to gain compassion and insight into others circumstances”. Others stated:

Early on in my life and my career, I had strong views of right and wrong. Now that I am getting older, I am less judgmental. It is
quite wrong to feel you know what’s best for people. We often find out later in life that what we were so right about earlier on, is completely inappropriate later. We don’t have to worry about that control tactic if we let people decide for themselves. It is their life. It boils down to respecting others. It’s much kinder.

I think I may have always believed in euthanasia, or the principle under a different name, but I think my feeling around this has been refined a great deal over the years. I’ve had many experiences and contacts with this. My feelings at first were more of a coffee-table-type opinion. Now it is something I believe that has justification and a reason that is thought out.

I think it’s an evolution not of just working with people, but an evolution of myself over the years. Just the things that I have encountered in my own personal life, my professional life, and feeling confident enough to get close to people without losing yourself, this takes time and growth. These are my “growing up views.”

The evolution of views was also described as a factor for the participants who opposed euthanasia. Some participants talked about the necessity to review and assess one’s views on ethical questions as a professional and personal growing process. “Each time we go through this on our ward, as a unit, we struggle with some of the issues. It is hard because these are value-based decisions.”

For the two social workers who did not feel they could support a client requesting euthanasia, they too described an evolution of their views. They viewed their evolution in spiritual growth as an ongoing process for themselves.
My years of spiritual growth and training and experience have taught me to expect miracles. I have that same respect for someone else's journey. I should not interfere with any possibility of a spiritual journey or growth experience yet to be learned by someone else.

As I continue learning and see the technology change, I have become more accepting of some forms of passive euthanasia. I don't believe in it, but it does have to do with culture. I think we reflect what we believe in our culture, and as culture changes, and spiritual growth happens, views could change.

Feminist medical ethics suggests that we need to recognize and value the experiences of all individuals, and to view their decisions in the context of their experiences, their relationships, and in society. As social workers should do this for their patients, the same could be done to understand the views of social workers. The above illustrates how social workers' experiences, values, age, relationships, and being part of the culture in which they live, are all part of the views they expressed. The study perspective encourages us to respect this experience and our patient's right to make his/her own decisions, as we would our own. (Sherwin, 1992)

Social Workers' Values

For question number two in the interview guide, participants were asked to identify the values or factors that influence practice and to rank those values in order of their importance in determining practice in
this area. The valuing of a patient's right to self-determination was stated most frequently as the most influential factor in determining social work practice. The importance of quality of life was second, and the belief in compassion was the third factor determining most participant's practice with patients who request euthanasia.

**Self-determination**

The patient's right to self-determination was cited as the most important factor influencing the practice of ten of the social workers interviewed. Three others identified it as very important, and ranked it second or third. The term 'self-determination' included values such as the right to choose, the right to autonomy, and the freedom to make one's own decisions. Each of these terms refers to the participant's belief in the patient's right and ability to choose his/her own health care, and ultimately his/her own death. Four participants expressed the meaning and importance of self-determination in these ways.

An individual's right to choose and an individual's freedom to choose, to make their own decisions in life, to move whatever direction they want to move, whether or not I agree with that direction, whether or not I feel they are using their best choice or best judgment, that is the judgment on my part that I don't have any right to make.

The right to self-determination is paramount. This is the basic value that people have the right to direct their own lives and deaths. Tradition suggests that power, perhaps gender issues are
at play, where women or vulnerable people are told what they can and cannot do with either lives and bodies.

Obviously the most important factor for me is self-determination. Within this is the person's right to choose and the essence of assigning value to your experience. And if your experience of life has no value for you, then, I don't think anyone else has any power that morally can supersede that view.

Self-determination is one thing, but I must make a distinction. There is a big difference between having rights and having someone facilitate those rights. So, I don't know that the right to choose and self-determination are two different things, but having those rights and having someone support or respect them are certainly two different things.

Quality of Life

Quality of life for a terminal patient was the second most frequent value stated as an influencing factor in medical social work practice. Each of these participants stressed the importance of a person's quality of life being defined by the patient. This could only be done, according to the participants, through understanding the patient's life-time of experience and relationships. Since this is highly subjective, the person who has lived the life is the best one to evaluate it's quality at any given time. One social worker described the value of quality of life as "adding life to your years, not years to your life". Three other participants addressed the subjectiveness of each person's quality of life in these responses:
We can try to make patients comfortable, but we can't give them quality of life. We can bring them to a safe environment, we can give them support and counselling, we can help them attend to unfinished business, and we can help their families, but we can't give them quality of life. And what is quality of life anyway, each culture defines it differently, and each individual within that culture will define it according to their own life.

Quality of life is a continuum. We may value the length of our lives at one point in life, but later want quality of life. I think it is equated to the degree of suffering, both mentally and physically. When the degree of suffering is such that the person experiences a sense of purgatory, that would be no quality of life for them. The definition is subjective and can only be made by one person—the patient. The medical, clinical, and ethical teams can be involved in helping clarify their thoughts, but the patient needs to incorporate this information into their own sense of quality of life.

It is a seesaw between autonomy and quality of life for the most important factor. Mostly because they can be so dependent. How can you have quality of life if nobody allows you to make your decisions. And how can you define your quality of life if your definition has no meaning for those who have power over you.

**Compassion**

The third most frequent response given by participants regarding the values and factors that influence practice was the element of compassion. Compassion included the right to be free of pain, to have dignity in life and death, and to have respect for the suffering experienced by terminal patients. One person said that "compassion should always be a contributing factor". Two other participants
revealed that their religious beliefs were compatible with the giving of compassion. "In my religious view, people aren't required to suffer to be with God" and "I do believe we need to attend to a spiritual self and a spiritual world, and I think that this is the power of individuals and people collectively. This is compassion". Another participant described his/her views on compassion in the response below.

I don't believe that suffering is a necessary part of life or something that each individual should go through. I don't think it necessarily makes us better people. There is a whole religious school of thought around suffering and the importance of it, but it is my spiritual belief that compassion is what's necessary at a time of suffering.

Although there was considerable agreement that compassion is very important, some participants also raised the concern that compassion is not inherent in passive euthanasia. They expressed that we also need to be more effective with passive euthanasia, or else offer active euthanasia in our hospitals, in order to be compassionate. One participant gives an example of uncompassionate euthanasia.

On the issue of euthanasia, the present health care system does not move fast enough to have compassion. I have seen patients starve themselves slowly or live in dreadful pain because the staff and administration are still deciding how they feel about the death. In these cases, the system works so slowly that the suffering for patients is inhumane.
One social worker thought, "the family, the patient, and the medical community should be able to choose active euthanasia when passive euthanasia is uncompassionate." For several participants, it was important that active euthanasia be legalized and practiced in such a way that death is compassionate after all.

**Religious/Spiritual Values**

In the responses above, religious and spiritual values were also identified as having an influence over participants' practice. Five participants stated religion or spiritual views were factors. However, there were considerable differences in what those beliefs were. For example, as presented above, the spiritual views of some social workers are consistent with supporting those who request euthanasia for compassionate reasons. In contrast, the religious beliefs of other participants lead them to value the preservation of life above all else.

**Factors/Values that Guide Practice**

Other values and factors identified by the participants, with less frequency than those above, were culture, personal and professional values, and medical technology. Many feminist values such as the right to self-determination and the assignment of value to our experiences were identified as factors, but only one participant
specifically identified them as feminist values. Likewise, values such as the preservation of life were identified as religious values, yet from the feminist perspective, could be characterized as medicalized values as well. What is noticeably absent is any mention, by even one of the participants, of a concern for the legalities surrounding euthanasia.

**Social Workers' Role/Practice**

Throughout my medical social work practice, and while researching this topic, euthanasia has often been referred to as illegal and rare, if not non-existent, in our health care institutions. In the pilot study, none of the social workers indicated they were ever involved with patients requesting euthanasia. This was revealing since one of the social workers worked with terminally ill patients, and the other two had access to patients who faced other severe illnesses, and may have considered euthanasia. However, the demographic data collected in this study confirms there are requests for euthanasia in the health care setting. Since the medical social workers in this study have indeed been involved in these cases, there also appears to be a role for medical social workers in this area.

The above section of this chapter presented some of the issues faced by medical social whose patients request euthanasia. The
following section organizes the specific practice techniques shared by the participants into overall categories of informed consent, counselling, social work with patients, social work with families, and social work with staff. But first, there are two issues that clearly stand out in this entire piece of research. From analyzing the text in its entirety, the two important concepts of 'power and control', and the social worker's 'willingness to take the journey' have played a critical role in determining social work practice. These two concepts are discussed in the next section.

**Power and Control**

Throughout the analysis of the views, values and practice for all seventeen participants, there emerged an overarching theme regarding the issue of euthanasia. This theme was power and control. In many of the quotes sighted above, participants have shared the importance of separating their own views and values from those of their patients. Furthermore, they have described the evolution of professional and personal growth one might go through in order to master this necessary skill.

With respect to practice, the element of power and control is nowhere more important. Espousing the values of self-determination, and
putting those values into practice are often two different things. Stating that one values self-determination above all did not necessarily translate into practice for each study participant. The determining factor, as analyzed by the researcher, was the additional capability of being able to let go of the power and control held by virtue of being a health care professional. This included the acknowledgment of that power, taking steps to ensure the professional/patient relationship is an egalitarian one, and undertaking a sincere self-analysis of the personal need for control in situations of conflict. One participant stated that; “Imposing your own values on someone else is an issue of control, not euthanasia”. The following are the concerns that six participants shared about the harmful power that is inherent in the professional/patient relationship.

We need to always remember that talking to people about really important personal things is an incredible way to connect with someone. The power of that relationship can be honored or abused by either party, but we are the party with the professional position and they are the vulnerable.

I know I have always believed in self-determination, and then it was identified again in social work education. But what you aren’t taught is that you will be working in a very rigid medical model. I see patients all the time who have been forced to give up their power, passively wondering what they should do, vulnerable. Since I get close to them, whatever I say, they may do. I don’t like that. I think that time and time again, people lose their control through illness. So, through my work, the importance of self-
determination and giving back the control has become important for me to advocate for people.

Social workers on both sides of the issue run the risk of practicing within their own value system, not necessarily following the principles of their profession. Each social worker needs to become self-aware. In the efforts we make to protect the client's rights, we sometimes forget our responsibility as the professional to help them see all sides and not to proceed comfortably because this request also fits with the social worker's agenda. We should try to be helpful, not just supportive. There is a very difficult balance with the right to self-determination and using our skills toward effecting change. This can be a very controlling and powerful position.

When talking about euthanasia, what happens is they start to talk about the bigger questions. And out of that comes the ideas like you should take control so the patient doesn't want to die. And that is where euthanasia I think in a way is a presenting problem. The issues behind it are control, out of fear mostly.

Even the act of euthanasia is one which naturally has one ill person needing another in order to carry out the act. Either to prescribe or help or whatever. It could be a very empowering process in another non-medicalized system, but here I always wonder why patients have to give up their power to someone else. Being ill is a process in giving up control over your life, your body, your death. Talk about a slippery slope!

It has been my experience that other professionals are much more concerned about their own views or legal or moral consequences than I am. In some cases this is logical because the doctor will have to order the drug or the nurse may have to administer it. I am in the position of not having to give the dose or stop life-saving treatment. But this is not to say that I don't take my position to assist and support someone's request for euthanasia seriously. As I said before, my support and my counselling could be as influential as pulling the plug, so I don't feel that far away from an active participant. I am very much aware that even the process I use could be powerful, maybe even liableless.
The element of power and control over vulnerable patients runs throughout the research data. All participants said they were opposed to the loss of control patients experience in the health care system. However, participants admitted they often could do very little to prevent the systemic abuse of power. Power imbalances are supported by the structure, culture, and even the disciplines within the system.

In meetings we have about euthanasia, it amazes me how reasonable staff always sound. And they can present their own opinion in a clearly rational argument. Any patient that is even slightly vulnerable would feel very unreasonable if he/she were to go against such a care plan. A good social worker should be able to recognize those kinds of subtle coercions that go on all the time in this system. Make no mistake, we are still operating day to day under the medical, hierarchical medical model, yet are trying to compromise with consumerism when it is demanded.

Others focused on the obligation every social worker has to practice in the best interest of his/her clients. Fulfilling this obligation can be greatly influenced by the social worker's willingness to let go of the professional power he/she has. And one of the most important reasons patients should have the all the power is that "when patients have the control, they are also more able to change their mind".

This study's perspective addresses the need for each person to engage in self-evaluation regarding his/her participation in the oppression of others. In the social workers' responses above, most
indicate their ability to do this self-evaluation on behalf of other professionals and for society in general, but it may not be that social workers are engaging in this evaluation of themselves first. It seems reasonable to assume that most of us have participated in the 'subtle coercions' referred to above, even as social workers. Therefore, self-evaluation is as important as recognizing this control in others. These are all considerations that would be a necessary part of equalitarian social work practice.

Willingness to Take the Journey

Given the above concerns regarding power and control, it follows that the right to client self-determination might be difficult to ensure. Yet, in social work, it is considered one of the most important values to uphold in non-judgmental practice. But does the commitment to this value always generate the same behavior in practice? Some social workers admitted that regardless of their commitment to the right to self-determination, they were not able to support their patients in some instances. Analysis of the content regarding practice showed this to be the case. Consequently, a theoretical commitment to a specific set of values does not necessarily result in social work practice based on the same values. From the data collected in this study, it appeared that a
further element was required in order to act on the value of self-determination -- the willingness to take the journey.

This concept is closely related to issues of power and control, and refers to the social worker's ability to support the patient regardless of differences in values. It is the choice by the social worker to support someone else's values in a professional capacity. It involves taking the journey someone else has designed. This requires a willingness to deal with each situation in a non-judgmental fashion. And perhaps the most difficult part, is the willingness to have your values challenged, and still choose to support the patient in the decision he/she believes is best.

For those who are willing to take the journey, they must invite this challenge as a growth experience, both personally and professionally. Furthermore, unless their values have been challenged, social workers won't necessarily know if or how they can separate the values of their clients from their own. Because all participants in this study have been involved with patient requests for euthanasia, their comments on the realities of transforming the value of self-determination into practice are extremely valuable. They have experience in the area, and had the
opportunity to confront incongruencies that may exist between theory and practice.

Most of the social work practice described in this study showed participants have become willing to take the journey regardless of their personal views or the choices of patients. However, two participants expressed the difficulties they have experienced when trying to allow a patient his/her right to self-determination, when these choices seem terribly wrong to the social worker. Ethical dilemmas surfaced for these participants when dealing with euthanasia because it is an act that most often requires the support of others. Through this involvement, the lives of those who choose to support the patient are also affected. For these participants, providing this professional service had too great an effect on the social worker personally. These two social workers were not willing to take the journey at the expense of their own value system, and responded in this way.

If a patient insists on euthanasia, they will be transferred out of hospital. This doesn’t mean that everyone has to agree with us, or follow our wishes, but we don’t have to support it either. My role as a counsellor for patients is one in which I must be supportive. But that doesn’t mean I can’t share my own view, and who knows, maybe even influence that patient. I just couldn’t support this, it goes against everything I believe in.

We are all on a soul journey, I believe that we have no idea what kind of work we need to do yet even at the end of their life. So none of us can judge for another to end their lives. And I don’t
think it is fair for someone to ask me to take the journey that I don't want to take by supporting them in an act I don't agree with. They are involving someone else's soul journey.

One of the social workers interviewed said that; "one can avoid the task of dealing with ethical dilemmas by only working where there would be no challenges to your value system". Therefore, only those who supported euthanasia would be in a position of choosing whether or not to take the journey guided by someone else's self-determination. This could be true, for example, in palliative care. Here, patients and staff agree to the principles of palliative care before treatment begins. The palliative care movement does not support euthanasia, and out of the palliative care social workers represented in this study, some stated they were against euthanasia, and some stated they were not.

**Counselling**

Concern for the emotional pain and suffering of the person requesting euthanasia appeared in every interview. Beyond this, concern for the patient's family, the doctor or person who would assist with the death, and concern for the impact on social workers who work with euthanasia were all expressed. All participants identified that euthanasia is an act that is not done in isolation. Euthanasia impacts emotionally on many individuals around the patient. This emotional impact is generally accepted in the medical setting. As a result, one of the roles of medical social workers regarding euthanasia has been counselling with patients, families and other health care staff.
Social work with the patient

Regarding counselling with patients who request euthanasia, many practice ideas were presented in the interviews. First and foremost, most participants stated it was "of utmost importance to be open to hearing the request and discussing it". Participants said they couldn't overstate how important it is for social workers to become comfortable discussing death. This is an extremely difficult task, but a very important one. One participant reminds social workers they need to; "be open and available to be asked if you can help someone die. If you aren't, chances are you won't be asked, patients won't feel safe with you from the beginning." The task of being open to hearing patients discuss their plans for death is a continued role throughout the counselling process because it should be expected that patients may change their minds.

Next, participants addressed the idea of ensuring informed consent. When a request is brought to the attention of the social worker, part of the social work role presented was to clarify the diagnosis, ensure the patient was aware of the medical options available to him/her, and ensure adequate information has been shared with the patient for him/her to make an informed decision. Before proceeding with any plans, participants stressed the need for patients to have two things; all the information about their situation and all the options available to them. It is important to respect the patient's right to request euthanasia, but as one social worker identified, "we
should always continue to encourage and review options for dealing
with life as well”. The importance of informed consent was echoed by
two participants in these statements:

"There are control issues, dignity issues, pain issues, quality of life
issues, and stress issues. So social workers need to address
these with the patient to be sure euthanasia is their choice and
there is no coercion.

I don’t think we inform families very well. When we are 99% sure
someone is going to die, we tell the patient that the prognosis is
not good. We don’t say they are going to die. Also, we don’t think
patients can handle all the medical details, and perhaps its us that
can’t handle their reaction, so they don’t get all the information.
This information is absolutely necessary for people to make
decisions about their death.

Including all the information necessary to make an informed
decision, “one of the most valuable skills social workers can offer is our
training in communication and problem-solving skills” according to one
participant. "Discuss the feelings, go over the pros and cons of
euthanasia, for patients and for those who love them, and address the
likelihood of them receiving the help they may need in the facility or
ward they are in.” Participants commented on the “need to discuss
with the patient the effects of euthanasia on his/her family members
and others close to them”.

It is the social work role to ask the question that nobody else in the
hospital will ask. Sometimes I even apologize before I ask, but it is
very important and social workers often end up in this role. For
example, "are you saying you would like to die or ... Do you want to die right now? How? Are you really trying to say you are tired of life?" Sometimes this is not the message, check it out. In my experience patients sometimes want to know that euthanasia is an option even though they don't want to do it now, or maybe ever.

Our role is to make it safe for the individual to discuss their request. Put the facilities words into plain non-medical language, and help them clarify their wishes. Social workers need to really keep check on the jargon that goes on in hospitals. This is a great way for staff to have power over patients.

In the quotes above, participants are addressing the importance of language and the sharing of knowledge in the medical system. These are important principles, but it is also important to consider the power that language or information holds in any forum. (Jaggar, 1977, Sherwin, 1992, and Sawyer, 1993) Using the situation described above, there is a withholding of information by the knowledgeable, from those who are vulnerable. This can be a direct expression of power. Also, even if the information was shared with the patient, if the language is not understandable to the patient, then it really has not been shared. From the study perspective, the use of language to control knowledge is considered an act of power.

Many social workers emphasized "the importance of therapy to deal with the loss and the suffering through illness. These concerns include the wishes for and/or the fears about death". For this reason,
“social workers need to understand the dynamics of death and dying and be able to talk about them directly”. Many patients may want to keep their plans for euthanasia between themselves and the physician. Even though it may ultimately be the patient’s decision, one participant tried to encourage patients to discuss their wishes with their loved ones and let them in on the plan. “There will be more anger if it is done without their knowledge. Families need to be able to say they understand and to say good-bye.”

Support and advocacy were the most frequent cited roles of social work with euthanasia. These concepts include many things. Support can come in the form of “helping the patient get his/her house in order, arranging for pastoral care, helping with family issues, and most of all, listen with compassion”. Advocacy also comes in many colors. The most frequent example of practicing advocacy was the role of the social worker as mediator. “A social worker’s uniqueness comes from our skills as mediators. We put things on the table in meaningful terms. We do this not only to share information, but as a therapeutic role”. One social worker summed up the role of advocacy by saying “social workers should be the part of the health care team that represents the interests of the patient. Many patients are afraid of dealing with
medical staff on personal issues, or signing contracts (such as health care directives), or worry what will happen to their care if they are perceived wrongly". Within the medical facilities represented in this study, most participants described their role as being the closest person in the health care system to a “formal patient advocate”.

It is worth acknowledging that many participants expressed their belief that if a social worker finds he/she is unable to support the patient once a decision in favor of euthanasia has been made, a referral to another social worker should be made, in the best interests of the client. It would be appropriate to explore the request initially, and to ensure the patient has been given all the options, but not to continue counselling as the social worker’s bias may be troubling to the patient. "Another social worker, the local ‘Right to Die Society’ or the ‘Hemlock Society’ may be more appropriate once a decision in favor of euthanasia has been made.” A referral could be made to one the persons or organizations noted that are more comfortable and familiar with dealing with euthanasia.

Social work with families

For every patient who considers euthanasia there will be implications for family members and loved ones who are involved.
Euthanasia can be a devastating possibility for family who have already been through difficult times dealing with the terminal illness of a loved one. "With euthanasia, there is a lot of family work. This is where the social work role is crucial, because we are the only ones with contact with the family". Many participants who have done a lot of family work and described what they believe was the social work role with the family. Four participant responses regarding practice techniques are presented below:

With euthanasia, what I have done generally speaking, is try to gather the entire family and any other significant persons. In the cases where I have done this, the patient has either wanted euthanasia or has said so earlier in their illness. This is very much a process and is not like a meeting where a decision is made right there. I have always given them as much time as they need. Just use this as a vehicle to discuss feelings, and options, preparing them in advance for what could be ahead. Telling them factual information about what would happen if the patient decides to go ahead with euthanasia. Pain relief and the process of death and so on are discussed. This is also a chance to get collaborative information on what the family or friends know about the wishes of the patient. Has there been discussion about death wishes or how the patient wanted his/her life or death to be? How specific was that? How serious was the discussion? How clear and how strongly have wishes been expressed to the family in the past? And discuss how this will effect everyone. Sometimes, in fact most times, there are quite a few talks like this. You may need to bring in others from the health care team as well. You need to be prepared to give a lot of time to everyone involved.

Families are also concerned about what each member of the patient’s family will feel about the death. There are often conflicts, some old and some new, that will arise at a time like this. Often
family want to be supported by others in the family because they may feel guilty for even considering their loved one’s wishes for fear it will be seen by others as an act of selfishness or whatever. Social workers should try to discuss everyone’s differing levels of comfort with euthanasia. This helps everyone have the chance to express their feelings, to avoid unheard concerns, everyone feels they have been part of the process, and less guilt feelings as a result. Families need to know it is quite normal for family members to have different opinions on this than their siblings or perhaps the patient themselves. This process can also empower the patient to make an informed decision for themselves with the knowledge of how others will be affected.

I don’t think that families disagree with patients as much as they differ on their degree of commitment to the patient’s plan. It will be very difficult for some family members to carry through to the death without panicking. They need to be prepared for varying degrees of commitment at different times. I have found that many members would agree that euthanasia is a possibility given the wishes of their loved one. But they often look to each other to see if it would be O.K. to support this. Consequently, most sit on the fence a lot throughout the dying process. Often, families who have discussed their wishes before the request for death comes, can support their family member without feeling guilty. I really try to bring people to make a decision one way or the other, as this seems to have been very helpful for family in the end. Those who were undecided still at the time of death, panic and find it more difficult to grieve later. Their ambivalence should at least be acknowledged. In my experience, those who decided or committed to some degree to support or not to support, are clearer on their feelings and are able to grieve the death more easily. Even if they do not want their loved one to die, they seem to feel they said their piece and they were heard and considered. So, it is helpful for them to be encouraged to work through their views to a decision point if possible. Encourage everything to be said as much as possible between patient, family and friends before the death.

I try to help families by stopping the anxiety. What I mean by that is that near any death or in serious illness, family and often staff start getting anxious, naturally, and start demanding of each other.
Family are questioning everything. Why isn't he eating? He looks like he's thirsty, and is he in pain a thousand times? Nurses often get defensive of their care giving about here. So, I try to get people to focus on practical help for the patient. I encourage things like having the nurses teach the family to give backrubs and stroking, so that they feel they are comforting and doing what they can. Dabbing the lips with water or whatever. It helps families to have a part in comforting the one they love. It is our role to recognize this panic and this out-of-control sense that people feel at that point and try to help them with it, help them through it.

It was the intention in this study to let the participant responses above explain their social work practice with patients and families. At times, however, there are elements of the responses regarding social work practice that could appear as oppressive, or powerful. For example, it could be good, organized social work practice to gather families and staff together to have meetings about the patient's request for euthanasia. Or, it can also be an extension of the scientific, rigid way of dealing with this issue. Having people meet may not be the most comfortable or helpful way to approach all patients or staff.

In another example, the differing views of families are normalized. This may be a very helpful tool, or may be a perpetuation of the social worker's views onto the family. In many cases, the above responses indicate a form of practice that assumes the professional may know what is best for the families of patients who are dying in this way. This may be its own form of power. This study suggests that each social
worker needs to investigate that possibility his/herself. One thing seems obvious, there is an overarching reality that social work practice has its challenges being delivered in the context of the professional, scientific, organized medical system.

Social work with staff

All seventeen participants said they were not only a social worker for the patients and their families, but also for the other staff on the health care team or on the ward. Participants stated they spent a great deal of time, both formally and informally, with staff to deal with issues of loss, controlling behavior toward patients, value conflicts, and in staff debriefing sessions after a death. It often happened that "staff just come into the office to get your ear when things upset them with the rest of the medical team". Social workers do not have the role of staff counsellor in their job descriptions, but it appeared that for many of the social workers in this study, it was a professional expectation just the same. These five responses illustrate their concerns.

Anyone who is helping or is close to a person wanting to end their life, and I mean personally or professionally, is not going to come away untouched. No matter how professional you are, you could never keep an experience like this from being personal as well.

Considering the social work position, I am perhaps just removed enough, yet involved enough, to support other professionals throughout the process. I have been involved in debriefing and supporting other staff after certain deaths. I have even helped to
have certain nurses scheduled with certain patients if others are unprepared to support the patient’s wishes. This is both helpful for the staff and the patient. This can be a respectful process for everyone given the right attention.

I have spent a lot of both formal and informal time with staff. I am careful to be seen on the ward and be around. And to be available to hear any viewpoint. From my experience, the nurses get very anxious. Towards the end, there is often family, nurses, and pastoral care in the patient’s room constantly. So, I try to ask the patient beforehand who they would like around during the dying process. This way we can try to be flexible to accommodate both the needs of the patient with his/her dignity.

The rest of the team is so medicalized. They are often over-invested and cannot allow the thought to enter their mind that it is reasonable for them to be at work and working hard, and doing a good job and at the same time, their patient is dying. I think they feel completely responsible for the health and happiness, and feelings of that person, and they aren’t able to make any separations. It really leaves stuff to deal with because the staff ‘own’ too much of the patients.

I have found myself in the role of modeling communication skills for other staff to use. You notice that nursing and some physicians will use your good lines with patients after they watch you talk to people, and I use there is too. But just kind of educating other staff as you go along about how to work with patients in a non-medical way, without doing it formally, has not only helped the patients in my view, but I think the staff has learned some things about what value social workers really are.

Many participants also mentioned their valuable role as team members on their ward or in their facility. "The team approach to dealing with difficult ethical issues such as euthanasia is so important."

Social workers’ specific roles on each health care team, and the stated
team effectiveness varied in this study. But, the benefit gained by having a well-functioning health care team was identified by all participants. "It’s not a matter of getting along on a team, but it is being able to respect each other’s professional contribution for the benefit of the patient." This kind of team work “allows for the power dynamics to be minimized, and the ability to problem-solve and listen to each other maximized”.

**Uniqueness of Social Work Practice**

Although not asked as a specific question, all social workers interviewed felt they contributed a unique kind of practice that was extremely beneficial to the patients and was much different than the practice of others on the health care team. Answers were given with regard to practice with euthanasia, but could refer to medical social work practice with other client groups. Many participants described the ability of social workers “to assess a situation from a more holistic or non-medicalized perspective” than others on the health care team usually do. Other participants described differences in the way social workers use communication skills, and the therapeutic reasons for employing these techniques. One social worker believed that “the social worker provides a safe environment for the request to be
discussed. This is not possible from the medical professionals who are also concerned about their own responsibilities of providing medical care”.

The most frequent comment about the uniqueness of social work practice regarding euthanasia was that most social workers learn to separate their own needs from those of their patients. This ability in other health care professionals, particularly the nursing staff, was felt to be lacking. Many participants stated they were often less likely than other staff to engage in controlling behaviors with patients. Moreover, the ability to recognize these oppressions was seen as a unique contribution of the social workers on the ward. Efforts need to be made to eliminate the power imbalance in the professional/patient relationship, thus enhancing the opportunity for patient self-determination. According to most of the participants, social workers are the most likely of all the health care team to make these efforts. The following five responses explain their views.

You know, with respect to giving a patient self-determination, doctors are far more likely to do this than nurses are. And this is very important because doctors may have the power to write orders. But nurses are powerful in their role as the caregiver for each patient. Their lack of respect for client self-determination can be a constant twenty-four hour degrading thing for patients. And doctors may not value self-determination, but they do what the patient wants, as long as they aren't going to get sued, because
they are much more medical about things. In their (doctor’s) eyes, patients are patients. I (the doctor) doesn’t care who you are, everybody has the right to medical treatment. Leave the rest for the social worker. But the nurses think that if they look after you and care about you, you are obligated to listen to their opinions about your life.

Physicians tend to be open to what social workers have to say much more than the nursing staff. When challenged, they stick with what they know, medicine. But nurses think they know what the patient needs because they spend a lot of time with them. In this case, spending time is important, but how that time is spent and for what reason, is more important. Chatting with patients is not necessarily gathering data and integrating it with professional knowledge of the whole picture. There is quite a difference between what we accomplish in our visits with families than what the nursing staff does. But they would disagree.

I think in the their minds (nurses) they feel completely responsible for the health and happiness, and feelings of that person. They don’t make a good clean separation, and they own too much of it (vested interest in patients), that’s what I think.

To me euthanasia brings up all the other horror stories we hear about the overfunctioning nurses. Or about other health care staff in hospitals or on wards that do abortions. You know, where they start to talk to the family and stir up troubles because they can’t deal with the choice the patient has made. So often a nurse gets control by muddying the waters, when they really don’t think about the hell the patient may be going through otherwise. They (nurses) are often talking to people when they don’t understand the other family dynamics. This is how they (nurses) subtly get their own needs met instead of the patient’s needs.

I have a great deal of respect for the hours and time nurses put in with patients. And in a lot of cases, front line staff know patients and their families better than we do. But, what right does that give any staff to be able to dictate whether the patient can choose euthanasia or not. Professionally, I think social workers are far more clear on their role at work.
In some medical institutions represented in this study, a referral will be made to pastoral care and to psychology when a patient requests euthanasia. Social workers interviewed expressed their appreciation for collaborative work with these team members, but also saw their roles as much different than the practice of social work. Several participants expressed the idea that no matter what pastoral care does to expand its role, “patients view their services as religious support”. “Unfortunately, patients who don’t want a religious component to their death, will not want a referral to the chaplain.” In situations where the patient and family do want pastoral care involved, “the role of social work is more with the staff”.

With respect to the role of psychology and patients who request euthanasia, participants who worked with psychologists said “they were called in regarding testing for competency”. All participants commenting on this area suggested that “psychologists were not very involved in family work” and that since “they are not part of the health care team, knowledge and trust between the team members is not utilized” when social work is not involved. Based on the number of times the participants had been involved with patient requests for euthanasia, and the knowledge they presented about social work
practice with euthanasia, it appeared the participants (as a group) had
a great deal of experience and expertise in this area. In addition,
participants seemed very proud of the contributions they have made
through their professional practice with terminally-ill patients, the family
members and with other health care staff.

I see us as very different from the psychologist or the chaplain. I
see social work as offering the conscience. A conscience coming
from a strong, theoretical background. The psychologist will
bring in a lot of test results, much of what I consider de-
personalized material. The chaplain will bring in spiritual insights.
But I think that we bring in family and systems, we bring in the
conscience of the team. Social work takes away the labels and
forces the recognition of a patient as a person.

It seems common, and perhaps very practical, in the present day
climate of health care, to express the unique value and worth of any
service being offered. With health care services being restructured
the way they are, and dollars being tight, defining a professional
service is important. In many ways it constitutes the pride inherent in
the contribution a person believes he/she has made to his/her clients or
organization.

Socialist feminism claims that, by the very nature of hierarchical
professional relationships, an inherent situation for oppression exists.
Identifying a practice as unique may be considered a part of the stand-
off between professions in the medical system today. Each professional group appears to be standing its ground and claiming its territory. Theory suggests these professional issues are present in health care today. Perhaps they are, given they manner in which some participants view their importance to patients and staff. This study perspective further suggests that 'uniqueness' is itself a form of professional power. This control over a service, information, or ability could be considered as 'elitist' or 'superior'. Again, every effort needs to be taken to examine the roots of our practice to identify the motivation behind it.

Barriers to Social Work Practice

The responses above present the contributions the participants have made by their practice with patients who request euthanasia, and the family and staff around them. However, participants explained that these contributions have not been made without dealing with some roadblocks along the way. Only a few participants have not experienced barriers while providing social work practice in this area. As presented in the quotes above, most participants met barriers in what they perceived as overly-invested and overly-medicalized behaviors of the health care team. Most participants also expressed
concerns over structural limitations in the medical system, strong religious views that determine health care services for others, the medicalization of death, and paternalistic practice by the powerful in our health care system. The views of five different social workers are presented below:

I almost always come up against somebody's concern over the legal implications, hospital policies, their personal views, or whatever. If the team can't agree, the whole thing will be sent off to the ethics committee, and that's another bunch of philosophers dictating someone else's life, or death I guess in this case. It's heart-breaking to have to tell a terminal patient that the ethics committee has decided they have to suffer some more.

In my experience, people in the medical system are really uncomfortable talking about death. It happens everyday and we refer to it all the time, but we can't really talk about it. And that's what euthanasia is about, death and dying. What the patient wants their death to be like. Death is not seen an a natural part of life here.

If the family threatens to sue the facility or the doctor, then the patient gets no self-determination. If some doctors benefit financially by keeping the patient alive, no self-determination. And if the health facility is Catholic, forget it.

Hospital policies are made to keep the facility from being sued. And doctors are always supposed to save people, so naturally euthanasia is not going to be sanctioned by the administration. It is the kind of stuff law suits are made of.

Because of the mission statement and the structure of the hospital, I am obligated to inform all the disciplines if someone requests euthanasia. Control is a factor here. This hospital gets funded through religious and cultural heavyweights, and they believe in the prolongation of life at all costs. In cases of euthanasia that are found out to be so, the patient will be discharged out of here fast.
A warning was levied by another participant who stated that “they couldn’t really help their clients achieve self-determination if they got fired”. One participant also addressed the conflicts that could arise when a social worker engages in a practice that is not sanctioned by the facility he/she works in. By relating a story about a practice experience, this social worker conveyed the conviction needed and the "big shoulders" one might require to do practice in this area.

I remember the time someone asked for some information on euthanasia. He was terminal and close to the end. I gave him a list of books, phone numbers and lent him my copy of Final Exit. I know this sounds kind of blunt, but it follows a number of years of us going through the fears, the issues, the feelings, the tears, and this was another option he wanted to explore. Well, when this person entered the ward and chose passive euthanasia, there was an uproar. And I was in a lot of trouble for talking to him about this previously because talking is encouraging, apparently. Throughout this whole process, myself and the doctor who agreed with this plan, had been hauled to the administrator’s office a number of times. After the death finally occurred by passive euthanasia, we were firmly told not to tell anybody, and whatever you do, don’t chart it.

Hospital policies dictate practice for many professionals in healthcare institutions. Although there are no policies relating specifically to euthanasia, these medical social workers were aware that their practice is required to meet with the approval of the institution. This supports the existence of a powerful hierarchy in the medical system. The
structure of health-care institutions is such that policies do influence practice for those who work there, and more importantly, those who require service there.

**Future Practice**

From all the responses shared above, it is clear that medical social workers have a role and are making a contribution in the field of social work practice with euthanasia. It is also true, according to the participants, that barriers exist for staff when a terminal patient considers or requests a death of their own choosing. In the final question in the interview guide, participants were asked about the role social workers ideally should have to be most effective with their clients who are considering euthanasia. Participants described their role in the context of their place in society, within the medical system, and as a part of the social work profession.

**Future Practice in Society**

The most frequent comment regarding social work practice in the future was the role that social workers have in society as "change agents", "challengers of the system", and as "being part of social actions initiatives". Ten of the participants expressed the need for "social workers to take part in social justice on behalf of the"
vulnerable”, in this case terminal patients requesting euthanasia. One participant said, “I think social workers have a mandate to be involved at a political and societal level to advocate for changes that ensure client self-determination.” Most participants said the laws needed to be changed to allow the right of a person to choose his/her own death and to have someone assist in that process without penalty. And several participants were concerned with the advances in medical science, a product of our male-oriented, technological society. Here are four of these concerns.

In the future, we need to back up. Examine why we are doing some of the technology we are doing. Sort through the spiritual and legal issues. Rules fit less and less people, we are becoming a society of individualized needs.

My ideal would be to have places to go, paid for by the government, that would help terminal patients have the death they choose. We need to advocate for moneys and laws that would allow this choice for patients. Or at least have it available without barriers in the hospital.

I think as a society we need to rethink our technology and its purpose. Just because we can do something, should we be doing it? Maybe we need to think a little more about prolonging life for terminal patients, and decide what purpose it would serve, who’s purpose it serves, if the patient doesn’t want it. Since patients are commonly treated aggressively, social workers need to bring up these issues to families and to staff.

Social work values around affecting change should direct our future practice. Social workers who believe in euthanasia should be lobbying to have the laws changed and social workers who
don't should also take a stand. But until society decides, we have our principles of practice to fall back on, not our opinions.

Two participants felt the "laws should continue to make euthanasia illegal" and "social workers should not be part of advocating to have people killed legally".

What we do need to think about is suffering and how we are going to deal with it. How can society respond to people's suffering, at all times in their life, not just death. I'd like to see the attention given to dealing with soul pain. That would be my dream. Then they wouldn't need to ask for euthanasia.

These concepts are directly related to the social work role within the health care system. Society's view of euthanasia is very difficult to separate from the way we have come to approach it in the medical system. Mixed in with the responses on the need for changes in society's view of euthanasia, were important insights into the medical system as a product of that society.

**Future Practice in the Medical System**

As stated above, two social workers wanted a minimal role in the future for social workers with respect to euthanasia in the medical system. Most of the participants saw the role as an expanding one. They visualized the social work role to include the clinical practice described in the previous section. In addition, participants thought future practice should include more recognition on the part of the
medical team as to the valuable contributions social workers can make in the medical setting. These contributions include counselling and debriefing for all involved, education regarding teamwork and consumerism, and "being part of helping the team to assess levels of depression or competence for patients who request euthanasia".

Three other participants stated their views on the future practice of social work in the medical system.

Medicine needs to recognize that patients need to have social workers available for counselling and staff development instead of just discharge planning. Social work programs, like ones for terminal patients, should have community follow-up and/or services.

Professionally, social workers should never be the ones to administer drugs in active euthanasia, because there are medical staff who are better suited to understand what should be given, etc. In the same way, social workers need to put themselves in more active participation in other ways, through emotional support and clarification, which is more our expertise.

I would like to see social workers involved in assessing people's capabilities in making this decision and working towards eliminating coercion in these instances. Social work needs to add the social work perspective, the whole picture, to the evaluation of competence.

The debate between palliative care and/or euthanasia being the practice of the future was present in the responses of the participants. All social workers who commented on palliative care believed it was an
extremely important option for those who are terminally ill and should be expanded into the community in the future. However, most of the participants, including two social workers who worked in the palliative care field, concluded palliative care does not meet the needs of all terminal patients, and would not in the future. Some participants felt that palliative care was “elitist” and “anti-choice” because “it is only available to those who can afford it” or “want to spend your last days in the hospital”, and “you have to buy into their palliative care principles or you can’t get the care”. The statement that, “palliative care is not an option for everyone, physically or emotionally”, is consistent with the emphasis participants put on the need for individualized health care in the future.

Future Practice in the Profession

With respect to social work practice with euthanasia as a service of the profession, there was a recognition by the participants that this may be a relatively new or unknown concept for many social workers. Because of this, many participants suggested that social workers “begin educating themselves about practice with euthanasia, and working through the ethics of it”. Most saw it as responsible social work practice to start “discussing the subject and talking about it with
those who are most familiar or who have something to offer in this area. Above all, the participants agreed “we need to be more available in the future to not only discuss this topic but to hear the request for euthanasia from others”, as illustrated in these quotes.

Social workers should ensure they have a strong sense of who they are and where their theory comes from. This helps you to allow others their own perspectives. In the present hierarchical, oppressive medical system, I do not agree with a lot of the policies and services I am supposed to provide. Just because I work in a hospital, which is like a jail itself for many, doesn’t mean we have to act like prison guards. We need to be prepared to use our self-awareness and our security in our beliefs toward patient self-determination.

As a profession we need to have more clinical experience and theory in this area. I think we lack self-esteem amongst social workers, in all fields, but I wonder how we can challenge the system the way we will need to with euthanasia, given we don’t feel confident about ourselves. There is personal work that needs to be done in order to do justice to the needs of our vulnerable clients. We are working in a medical system, but we carry and support many of the values of the patients, not the system. Herein lies the ability to challenge on behalf of patients. But first, let’s look after our own issues at home. That’s what keeps us going.

Social workers should involve themselves in research and studies so that the social work perspective is written and heard. It is unique and we need to prove that with our academics. Social workers in the medical fields who deal with requests for death should join organizations, get information, and talk to other social workers who can help them with their knowledge and practice in this area.

Participants emphasized the need to take extra time to listen and understand their patients. “Even in these times of over-worked staff,
we still need to give this the attention it deserves.” For the two social workers who were against social work practice involving euthanasia, they expressed “the need for a referral (to another social worker) to be made after such a request” or “some investigation into other options for the patient”. One participant summarized not only the elements of social work practice that need to be addressed, but also put them in the context of the social work role in society. This response summarizes much of the responses of most participants.

Well, from a therapeutic point of view, they need to explore the issues and stages of death and dying with their patients, their feelings and the roots of their request. From a larger perspective, social workers can help patients understand the policies of healthcare and legal institutions because these ultimately impede and effect both the patient and their family or helper. Social workers may be helpful in putting together a place and coordination of where euthanasia is carried out, and oversee the procedure to ensure this is the want of the client all the way. They could be monitors of policies in the practical sense because they help the patient to understand what they want and advocate for them in the institutions. This leads me to think that social workers should be active in advocating for procedures and policies that would allow patients to have their needs met in this area. It could go politically or to the professional association, letting their views be known regarding what stand our organization should take on these issues.

Given the large detail in the responses to questions three and four of the interview guide, it was clear the study participants have given a considerable amount of attention to their practice with patients
requesting euthanasia. At times though, some participants felt their contributions were misunderstood in the medical system. It also appears that medical social workers have had the job of 'staff counsellor' fall on them. In view of this role, it is noteworthy to highlight a specific participant response regarding views on future practice.

One participant suggested that there is a real need, now and in the future, to consider providing social workers and/or consultants for social workers. This would be an agency-funded service provided for every social worker employed in the health care setting. Because there is often only one social worker for each multi-disciplinary ward, the social worker may have very little support for him/herself.

There should be social workers for social workers in some formal way. Each hospital should provide the time and funds for the social worker to attend counselling or debriefing sessions for their own support. Since social workers play therapist and supporter for the staff on the ward, and since we carry the stress on our shoulders, we need to recognize and request support for ourselves. In most cases in hospitals, it is understood that the ward social worker does the caregiving, and plays mediator between staff and between patient and staff. It is never in the job description, but this needs to be addressed and vocalized within the profession. I am aware of other countries who have this available to medical social workers, and that is a valuable way of maintaining the emotional and physical health of our profession.
Discussion

The presentation of findings drawn from participant responses serve to help us understand the views, values, practice and problems of medical social workers in this study. As is true in the public realm, participant responses showed they also share a variety of views and values regarding passive and active euthanasia. The responses also describe practice in light of both the social work role and the difficulties one may have in practicing that role. Practice is described in two ways; in the context of providing service in a hierarchical medical system, and through sharing clinical techniques which could be integrated into a social worker's model of practice regarding patients' requests for euthanasia.

Relationships in the Findings

Participant responses and the demographic information validate that requests for euthanasia occur in our health care system today and that social workers have a role in dealing with these requests. Sixteen (n=17) participants were in favor of passive euthanasia and ten were in favor of active euthanasia. However, only two participants stated they were unwilling to support a patient in his/her request for euthanasia.
because of their views against it. In this study population, their views and values in support of patient self-determination did not necessarily determine whether social workers were able or willing to support their patients who chose euthanasia.

To consider this further, the reasoning behind supporting patients becomes clearer when looking at the values that influence practice. If views do not necessarily direct practice, then perhaps values do. There were closer relationships between the values and practice than between views and practice. Ten participants stated the client's self-determination to choose their own death was the number one factor behind their practice. Three others considered it very important, and ranked it second or third, in guiding their practice. These numbers include five participants who stated they were against active euthanasia.

Some social workers who were in favor of euthanasia and some who were not, identified their patient's self-determination as paramount. Still, not all of these social workers were able to support terminal patients who requested euthanasia. This was often the case when there were conflicts between the views of the patient and those of the social worker about whether or not euthanasia was an appropriate
decision in each case. Thus, it follows that the valuing of a client's right to make this decision was not necessarily the determining factor for whether or not the social worker could support the patient in carrying out euthanasia. There needed to be one more factor present—the social worker's 'willingness to take the journey'. This practice involves the social worker's ability to recognize and eliminate power imbalances in the patient/professional relationship. This action precedes the social worker being able to support the patient throughout the request and process of euthanasia, regardless of possible value conflicts between the social worker and patient about the patient's decision. This concept is the 'willingness to take the journey' as the patient has decided their journey will be.

Although views and values may influence the social work practice with euthanasia, some participants stated they were only able to put their client's request before their own ethical conflicts if they were willing to separate their 'need to make the decision', with the client's 'right to make the decision'. This is what taking the journey is about. It involves the willingness to give up the professional power to direct someone else's destiny, even though you may have the power to do so. And this is an important element, since it is unlikely that any human
being would not have conflicts with the decisions of others at least some of the time.

The ability to 'let go of professional power' was an overarching determinant of social work practice with patients who request euthanasia. In this study, it appears that it is not as important whether or not you agree with euthanasia or subscribe to professional values regarding self-determination, as much as it matters that a social worker is willing to give up his/her professional power to influence a decision that is ultimately the patient’s choice of life or death.

Findings Within the Context of Feminism

The overarching issue of power and control in society, in the medical system and within ourselves is presented in this paper. (Jagger, 1977, Sturdivant, 1991 and Sherwin, 1992) Many of the issues, assumptions, and views expressed by the participants can be understood in the context of power and control. Recognizing our own need for power, taking steps to eliminate our participation in oppression, and opposing the existence of any power imbalances are concepts presented in the feminist opposition to hierarchy and oppression. All participants in this study made reference to these
issues in their responses. Some social workers are addressing issues of power in their practice, and some may require further self-evaluation.

Along with the recognition that power exists, comes the realization that there are vulnerable individuals and groups who can be oppressed by the powerful. This realization was presented many times by the participants as they described the ways in which patients who request euthanasia are vulnerable, and their relationships with health care professionals are often oppressive. These hierarchical relationships can also include medical social workers. Regarding practice with euthanasia, in the willingness to take the journey, social workers are challenged to let go of their need for personal power. Social workers may need to consider whether the power imbalances in the professional/patient relationship allow them an opportunity to meet their needs for control. This important self-evaluation increases the opportunity for equalitarian social work practice and lessens the chance for oppression of patients who request euthanasia.

The problems addressed with respect to vulnerable patients and power professionals highlight the reality of this hierarchical relationship in the medical system. It was also apparent in the responses, that it is difficult for professionals to consider any of their own practice to be
oppressive. Given the inherent problems in this relationship, and the difficulty in recognizing it in oneself, it may follow that the concept of professionalism is oppressive by definition. It may also happen, that as the health care system continues to move toward consumerism and patient-driven health care, the concept of professionalism may need to move along with it.

From the beginning of the study, participants confirmed the issue of language as a problem with euthanasia. The definition of forms of euthanasia clearly mean different things and have varied emotional attachments for different people. Even the use of the word "competence" has been used in an oppressive manner according to some participants. Concerns regarding the meanings and emotions behind the language of euthanasia have been identified as a feminist concern in the literature review. These concerns were also raised by participants in this study. Further evidence of the participants using their "feminist lens" appeared in their concerns regarding the consequences of advancing technology beyond ethics, and the recognition of cost/benefit for the powerful in making decisions about the lives of others. (Sherwin, 1992)
Most participants expressed views consistent with the claim that "the personal is political" (Jaggar, 1977). The right to self-determination was very important to most participants. They engaged in educating others, opposing injustices they perceived in the system, and some social workers involved themselves in social action initiatives that would ensure rights for all patients. It is assumed in social feminist ethics that what effects each person individually is worth fighting for collectively and politically. (Sherwin, 1992)

This study has suggested alternative ways to look at an ethical situation. Rather than the traditional philosophical approach, Sherwin's feminist ethics (1992) encourages us to understand the subjective views of patients, the complex relationships in which they coexist, and the differing degrees of power within these interactions. All participants in this study made statements about these concepts. The responses confirm that social workers in this study were concerned about many other feminist principles and issues on behalf of their terminal patients who request euthanasia. However, not all of participants used feminist ethical principles to help them solve their ethical dilemmas in practice. The participants' responses were positive, since Sherwin states that we need to take steps to understand the subjective views of patients, and
the relationships between patients and their health care workers before we can deal with ethical situations (Sherwin, 1992).
CHAPTER 5: IMPLICATIONS AND CONCLUSION

Euthanasia has traditionally been opposed legally and dealt with medically. The traditional medical system does not value the early ending of a life. Thus, there are many barriers for people who do not want to prolong their life, including those with a terminal illness. This conflict continues to draw attention as patients are demanding their rights, as competent people, to be able to make decisions about their lives. Moreover, as with euthanasia, some patients want the right to make decisions about their own death as well.

Socialist feminism and feminist medical ethics offer alternative ways of considering issues, such as euthanasia, that adds a much needed humanization of the present scientific medical system. This perspective suggests we need to consider our values and our professional practice in the context of the hierarchical relationships in the medical system. It suggests that it is important for health care professionals to examine their own views, as well as to consider the subjective views of the patient, within the context of the patriarchal society in which he/she lives. This will help us to recognize and to eliminate the oppression experienced by those who request euthanasia in the present health care system. As a result of these findings, the following conclusions and implications are presented.
Implications for Future Research

There are studies regarding euthanasia in almost every relevant field in the literature, with the exception of social work. This study is only a beginning. Consequently, any comparative or exploratory projects, that would bring new information and understanding to the field, would be beneficial. Further exploration of this topic, or the collection of quantitative or detailed qualitative data relating to any of the issues presented in this research, would be useful inquiry for social workers, health care administrators, and professional social work associations.

In consideration of this project's limitations, further study needs to be done regarding the views of social workers who are opposed to all forms of euthanasia. In this study, differences in views, values or practice were not evident between social workers in different areas of practice, between genders, health cultural backgrounds or age groups. In another study, a larger population may allow for comparisons to be found, if they exist.

This study is limited to the responses of social workers in the lower-mainland of British Columbia. Perhaps studies of the same population from other locations, with different health care climates and practices, would render different or comparable findings. Issues emerging from the text around practice guidelines, the involvement of the social work professional associations, job expectations, or the
impact of values on practice, would be just some of the possible areas for further study.

Implications for Social Work

This study's implications for social work are many because of the direct exploration of social work practice and social work issues. The overarching conclusion is that there is a need for social workers to examine their own issues of power and control, and to take steps to eliminate oppression in their professional practice.

Furthermore, the value of self-determination was cited by participants as the most important influential factor regarding social work practice. Self-determination is valued in socialist feminism and feminist medical ethics, as well as in social work philosophy. The new guidelines from the Canadian Association of Social Workers regarding social work practice and euthanasia are based on the value of self-determination. These guidelines state that "social workers are committed to the values of acceptance, self-determination and respect of individuality" (pg. 1). The challenge of these professional commitments may become very tenuous when life and death are the issues.

To help social workers meet this challenge, social work schools need to recognize it is not enough to have students memorize that the social work profession values self-determination. Social work education needs to go further in light of the challenge faced by social workers to support patient self-determination in all situations. The
Canadian Association of Schools of Social Work, in which the University of British Columbia and the University of Victoria's schools of social work belong, needs to provide appropriate education for social workers in this regard. Further training may be required in alternative medical ethics, women's studies, non-judgmental clinical practice, and in dealing with social work dilemmas, such as the practice of separating personal values from professional obligations in the clinical role. It appears that this can be very difficult in controversial situations such as euthanasia, and our social work education needs to address this reality.

On a personal/practice level, social workers are challenged to find their own workable model of practice to guide them when patients request death by euthanasia, as the participants in this study have been. Medical social workers, who are experienced with euthanasia and social work practice, could have much to offer their profession in terms of theoretical and clinical knowledge, knowledge of practice barriers and specific practice techniques. The responses in this study are evidence of this knowledge.

It could enhance any professional social worker's practice to seek information from his/her peers who are experienced in this area. This information would broaden, what is for many, a theoretical knowledge of euthanasia and social work practice. Furthermore, the study participants described their clinical practice with patients considering euthanasia, families and even other health care staff. These practice
skills and reference to resources, could be used by social workers who are inexperienced in this area, or who want to enhance their present model of practice.

Since the Canadian Association of Social Workers has now released its guidelines for practice regarding euthanasia, The British Columbia Association of Social Workers should see that all medical social workers receive a copy. The BCASW struck a committee to look at social work practice with euthanasia two years ago, but has abandoned this effort. Following the new guidelines from the CASW, the Association should become more involved in helping its members deal with this issue in professional practice. Not only could the BCASW provide information, professional seminars, and forums, but it should also advocate for appropriate training for social workers at the universities and in our places of employment.

Last, but certainly not least, is the personal and professional responsibility of social workers to advocate for social change on behalf of the vulnerable client groups in society they represent. Terminally-ill patients who request euthanasia often fall into this group. Social workers can do something as simple as to initiate discussions at work with their peers, or advocate for a change or clarification of hospital policy around euthanasia practices. On a broader scale, social workers can be part of the political action needed to change social policy and laws regarding euthanasia. Whether social workers are in
favor of, or against, euthanasia they should make their views known
and be involved in the ongoing debate.

In Susan Sherwin's feminist medical ethics, she states that
"research is a social and political activity, which has repercussions in
our collective lives" (1992, pg. 173). This research serves as one of
my efforts in this regard. I encourage other social workers to involve
themselves in whatever changes are necessary to enhance the
opportunity for all terminally-ill patients to have a death with dignity.
BIBLIOGRAPHY


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APPENDIX A

Demographic Data
DEMOGRAPHICS

Please fill out the demographical information below. This information is optional, and will be destroyed upon completion of this research project.

1. Male or Female:


3. Highest degree held:

3. Type of Medical institution you are employed with: eg. long-term care facility, acute care hospital, etc.

4. Area of medical social work practice (eg. expertise or client group).

5. Number of years in related social work practice.

6. Number of times involved with euthanasia -- Passive: 1-5  
6-10  
above 10  
Active: 1-5  
6-10  
above 10

European (herbal or holistic healing):  
First Nations (spiritual healing):  
Combination or Other (specify):
APPENDIX B

Notification Requesting Participation
APPENDIX C

Interview Consent Form
All information that I choose to provide will be held in confidence by the researcher. All identifying individual information will not appear in the final document.

My signature is acknowledgment of receipt of a copy of this form.

Participant Signature: Date:

Interviewer Signature: Date:
APPENDIX D

Interview Guide
MEDICAL SOCIAL WORKERS' VALUES, VIEWS AND PRACTICE REGARDING EUTHANASIA

Please remember there are no right or wrong answers to the research questions. The purpose here is to better understand your views and thoughts about euthanasia and social work practice, so your own response is what is important in this study.

Questions:

1. What are your views on euthanasia?

2. a. What values have you come to hold that influence your social work practice regarding euthanasia?

   b. Please rank the values or factors you have stated in the order of most important to least important in practice.

3. a. Can you think about when you have worked with clients considering passive euthanasia, and tell me what role and responsibilities you have as a social worker? (what is your practice?)

   b. As above using active euthanasia (if applicable).

4. What role should social workers have to be effective with clients who consider euthanasia?
APPENDIX E

Certificate of Approval
UBC Research Ethics Committee