Edward Odoom[1], Frederick Acheampong Nimo[1], Mildred Awinpiini Asore[1], Christiana Asiedu[1], Godswill Sedinam Lanyo[1], Esther Naana Gyan[1], Abigail Gyamfi-Samakome[1], Abigail Opokua Tutu[2], Hilda Kessewah Koranteng[1], Kenneth Sekyi Obempong[1], Mustapha Amoadu[3], Nancy Innocentia Ebu Enyan[2]

[1]University of Cape Coast, Department of Adult Health Nursing, Cape Coast, Ghana
[2]Department of Public Health, School of Nursing and Midwifery, College of Health and Allied Sciences, University of Cape Coast, Ghana
[3]Biomedical and Clinical Research Centre, College of Health and Allied Sciences, University of Cape Coast, Ghana

Health workers' attitudes and perceptions towards medically assisted dying: a systematic review

Abstract

Background: Medically assisted dying (MAD), including euthanasia and physician-assisted suicide (PAS), is a highly controversial topic in healthcare, posing significant ethical dilemmas for health workers. This systematic review mapped evidence on health workers' attitudes and perceptions toward MAD.

Methods: Guided by the Aromataris and Pearson (2014) framework and PRISMA-ScR checklist, a comprehensive search was conducted across seven databases (PubMed Central, PsycINFO, Scopus, JSTOR, Google Scholar, Web of Science, institutional repositories) for English, peer-reviewed studies published within the specified timeframe. Data were extracted using a standardized form and analyzed thematically.

Results: The initial search yielded 1,814 records, with 43 studies finally included after rigorous screening. All included studies were from outside Africa and nurses were the most frequently studied professional group (17 studies). Four major themes emerged for perceptions: (1) need for training, education and clear policies; (2) ethical and moral dilemmas; (3) lived experiences and professional meaning and (4) MAD as a way of facilitating good death and reducing suffering. Attitudes were categorized into: (1) supportive, (2) unfavorable, (3) supportive roles beyond direct provision, and (4) emotional and professional ambivalence.

Conclusions: Health workers globally hold complex and diverse attitudes and perceptions toward MAD, influenced by ethical, moral, religious and professional considerations. While many support MAD, aligning with patient autonomy and suffering reduction, this is often tempered by profound ethical and moral dilemmas and emotional challenges. Findings highlight a critical need for enhanced training, clear policies and robust support systems to address professional uncertainties and emotional burdens, ensuring patient-centered care while upholding health worker well-being.

Palliat Med Pract 2026; 20: e01326044

Keywords: medically assisted dying, euthanasia, physician assisted suicide, health workers, attitudes, perceptions, systematic review

Address for correspondence:
Frederick Acheampong Nimo, University of Cape Coast, Department of Adult Health Nursing, +233, Cape Coast, Ghana
e-mail: nimofreddy20@gmail.com

Palliative Medicine in Practice 2026; 20: e01326044

DOI: 10.5603/pmp.111237

Received: 18.02.2026 Accepted: 7.04.2026 Published: 18.05.2026

Introduction

Medically assisted dying (MAD) encompasses euthanasia and physician-assisted suicide (PAS). Although often used interchangeably in the literature and in health practice, there is a clear difference between them. Euthanasia involves a healthcare provider, usually a physician, intentionally administering a lethal substance to a consenting patient in order to end their life and relieve suffering [1, 2]. In contrast, PAS involves a physician providing the patient with the means, usually in the form of a prescription for a lethal drug, which the patient then self-administers [3, 4]. Despite these differences, both actions are classified under MAD due to their shared goal of facilitating death to alleviate intolerable suffering. Medically assisted dying has emerged as one of the most ethically, morally and professionally controversial topics in healthcare. It continues to generate intense debate among policymakers, healthcare providers, religious organizations and the general public. The issue of MAD is complex due to the interplay of legal, clinical, psychological, and personal beliefs involved in end-of-life care decisions [1, 3]. Across the globe, varying legislative frameworks and cultural attitudes have led to a lack of consensus regarding whether such practices are morally or professionally acceptable [5, 6].

As of 2026, about 18 countries worldwide have enacted legal frameworks regulating MAD. These countries include Canada, the Netherlands, Belgium, Luxembourg, Spain, Switzerland, Austria, Germany, Slovenia, Colombia, Ecuador, Uruguay, New Zealand, and Australia. In the United States, MAD is permitted in several states, including Oregon, Washington, California, Colorado, Vermont, Hawaii, Maine, New Jersey, New Mexico, Montana, and Delaware. Also, countries such as India, France, and Taiwan permit passive euthanasia or the withdrawal of life-sustaining treatment, where patients may legally refuse life-prolonging medical interventions under specific conditions [7, 8]. Legal provisions in these countries generally require that the patient is competent, experiencing unbearable suffering, voluntarily and repeatedly requested assistance in dying [8]. While physicians are generally the central figures in these processes due to their capacity to prescribe and administer drugs, a broad spectrum of health workers, including nurse practitioners, pharmacists, palliative care specialists and social workers are frequently involved in MAD-related care. Nurses, for instance, are often at the bedside and may experience a greater emotional burden, yet they are underrepresented in legal and procedural frameworks. Pharmacists may also face moral objections in dispensing lethal medications, while palliative care professionals may find it difficult to accept medical assistance in dying because it conflicts with their role of providing comfort without facilitating death.

The role of health workers in MAD goes beyond clinical duties. They are often the first point of contact for patients expressing the desire to die and may be expected to provide emotional, psychological and spiritual support. This exposure puts them at the center of ethical dilemmas, challenging their professional integrity, moral values, and emotional resilience [9]. Health workers may struggle with competing responsibilities to relieve suffering, preserve life, and to respect patient autonomy [10, 11]. These competing duties often evoke complex attitudes and perceptions among health professionals regarding the morality, legality, and clinical appropriateness of MAD [12].

Despite increasing global discussion on MAD, the available literature remains fragmented and uneven, offering limited clarity for health workers navigating end-of-life care [13–23]. Evidence is largely drawn from jurisdictions where MAD is legal; however, even in these settings, health professionals report uncertainty regarding ethical boundaries, professional roles, and institutional support. Moreover, perspectives of non-physician health workers are inconsistently captured, and empirical evidence from low- and middle-income regions, particularly Africa, is notably absent. This fragmented evidence base constrains informed policy development, training, and workforce preparedness, underscoring the need for a comprehensive synthesis of health workers' attitudes and perceptions toward MAD.

This systematic review synthesized existing evidence on health workers' attitudes and perceptions toward medically assisted dying, examined the ethical, cultural, legal, and professional factors shaping these views. This review aligns with Sustainable Development Goal (SDG) 3.c, which emphasizes the development and strengthening of the health workforce. The review provides insights that can inform training, ethical preparedness, and workforce support in end-of-life care.

Methods

This systematic review was guided by the Joanna Briggs Institute (JBI) framework proposed by Aromataris and Pearson [24]. In addition, reporting of this review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist [25]. The protocol for this review is registered in Open Science Framework with the DOI: https://doi.org/10.17605/OSF.IO/SF7YZ.

Table 1. Search strategies used in selected databases

PubMed Central	("attitude"[MeSH Terms] OR "attitude"[All Fields] OR "attitudes"[All Fields]) AND ("perception"[MeSH Terms] OR "perception"[All Fields]) OR "perspective"[All Fields] OR "view"[All Fields] AND (MEDICAL[All Fields] AND ("suicide, assisted"[MeSH Terms] OR ("suicide"[All Fields] AND "assisted"[All Fields]) OR "assisted suicide"[All Fields] OR ("assisted"[All Fields] AND "suicide"[All Fields]))) OR ("suicide, assisted"[MeSH Terms] OR ("suicide"[All Fields] AND "assisted"[All Fields]) OR "assisted suicide"[All Fields] OR ("physician"[All Fields] AND "assisted"[All Fields] AND "suicide"[All Fields]) OR "physician assisted suicide"[All Fields]) OR (MEDICAL[All Fields] AND ("suicide, assisted"[MeSH Terms] OR ("suicide"[All Fields] AND "assisted"[All Fields]) OR "assisted suicide"[All Fields] OR ("assisted"[All Fields] AND "death"[All Fields]) OR "assisted death"[All Fields])) OR EUTHANASIA[All Fields] AND (("health"[MeSH Terms] OR "health"[All Fields]) AND ("occupational groups"[MeSH Terms] OR ("occupational"[All Fields] AND "groups"[All Fields]) OR "occupational groups"[All Fields] OR "workers"[All Fields])) OR ("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "professionals"[All Fields]) OR "health professionals"[All Fields]) OR ("physicians"[MeSH Terms] OR "physicians"[All Fields] OR "doctors"[All Fields]) OR ("nurses"[MeSH Terms] OR "nurses"[All Fields]) AND ("J Undergrad Neurosci Educ"[Journal] OR "june"[All Fields]) AND 2026[Publication Date])
Scopus	(TITLE-ABS-KEY (attitude OR attitudes OR perception OR perceptions OR perspective OR view OR views)) AND (TITLE-ABS-KEY ("medical assisted suicide" OR "physician assisted suicide" OR "assisted suicide" OR "assisted death" OR euthanasia)) AND (TITLE-ABS-KEY ("health personnel" OR "health professionals" OR "health workers" OR doctors OR nurses OR physicians)) AND (PUBYEAR > 2000 AND PUBYEAR < 2027)
PsycINFO	((attitude* OR perception* OR view* OR perspective*) AND ("medical assisted suicide" OR "assisted suicide" OR "physician assisted suicide" OR "assisted death" OR euthanasia)) AND ("health personnel" OR "health professionals" OR "nurses" OR "physicians" OR "doctors" OR "occupational groups" OR "health workers") AND (PY $\geq$ 2015 AND PY $\leq$ 2025)
JSTOR	(attitude OR attitudes OR perception OR perceptions OR perspective OR view OR views) AND("medical assisted suicide" OR "physician assisted suicide" OR "assisted suicide" OR "assisted death" OR euthanasia) AND ("health personnel" OR "health professionals" OR "health workers" OR doctors OR nurses OR physicians)

JSTOR — Journal Storage

Identifying the research question

The research questions guiding this review are:

1) what is the general attitude of health workers toward medically assisted dying?
2) what are the perceptions of health workers on medically assisted dying?

Identifying relevant literature

A comprehensive search was conducted in four main databases: PubMed Central, PsycINFO, Scopus and JSTOR. To maximize coverage, additional hand searches were carried out in Google Scholar, ProQuest, and relevant institutional repositories. Reference lists of included studies were manually screened for additional eligible studies. The search began with PubMed Central and the search strategy was then modified to suit the search on the remaining databases. Controlled vocabularies and free-text keywords including Medical Subject Headings (MeSH) were used. The development of this search was supported by a Chartered Librarian at the Sam Jonah Library, University of Cape Coast. The search covered publications from inception to June 2025 and included only studies published in English. The last search of this review was done on January 12, 2026 (Table 1).

Selecting relevant studies

All identified articles were imported into Mendeley software for reference management and duplicate removal. Then, titles and abstracts were screened by a team of 13 trained graduate students who were supervised by MA and NIEE, to identify full-text eligible records. This stage was guided by the eligibility criteria. Subsequently, two groups of authors (EO, FAN, LF, PW, ENG, VH) and (AE, BN, GKG, FN, KOS, VD, ATKO, AG) independently screened the full-text records guided by predetermined inclusion and exclusion criteria. At this phase, any disagreements between the reviewers were resolved through open dialogue and consensus. In instances where consensus was not reached, an additional reviewer was tasked to make the final decision.

Eligibility criteria

Studies published from inception to May 2025 that examine health workers' attitudes and perceptions of medically assisted dying, written in English and available as peer-reviewed articles or grey literature (theses/dissertations), will be included, while opinion pieces, editorials without empirical data, and conference abstracts without full texts will be excluded (Table 2).

Table 2. Eligibility criteria

Inclusion criteria	Exclusion criteria
• Studies focusing on health workers' attitudes and perceptions of medically assisted dying • Studies conducted between inceptions and May 2025 • Published in English • Peer-reviewed journal articles, grey literature (thesis, dissertations)	• Opinion pieces, editorials without empirical data • Conference, abstracts without full texts

Study assessment

The methodological quality of included studies was appraised to assess the rigor and potential risk of bias within the evidence base. Cross-sectional and qualitative studies were assessed using the JBI critical appraisal checklists appropriate to each study design, while the single mixed-methods study was appraised using the Mixed Methods Appraisal Tool (MMAT). Each appraisal tool comprises a series of structured criteria addressing key domains such as sampling, measurement validity, confounding, data analysis, and methodological transparency. Studies were independently appraised by trained reviewers, and any discrepancies were resolved through discussion and consensus. Cross-sectional surveys were rated as low (1–4), moderate (5–6), or high (7–8) quality. Qualitative studies were scored as low (1–5), moderate (6–7), or high (8–10). MMAT had low (1–2), moderate (3), or high (4–5) categories. All appraised studies were included in this review regardless of their score. Excluding studies based on methodological quality would have risked omitting relevant perspectives, particularly in an area where evidence is limited, context-dependent, and ethically sensitive.

Data extraction

A standardized data extraction form was developed in Microsoft Excel to collect key information from each included study. The form was pretested on five randomly selected studies. Data extracted included: author(s), year of publication, country, study design, sample size, professional category of health workers, key findings on attitudes and perceptions. Two independent groups of authors (BN, AP, LF, FN, KOS) and (AE, EO, GKG, PW, ENG and VH) extracted data. This helped address any biases that might arise in the process and also ensured that only relevant items are extracted from the relevant studies. Disagreements were resolved through dialogue.

Synthesis

All extracted data were synthesized to directly address the review questions using a descriptive and convergent approach. Study findings were organized and summarized across predefined domains of attitudes and perceptions, allowing comparison of commonalities and differences across studies rather than inductive theory generation. Results were presented narratively and in tabular form. Descriptive statistics were used to summarize study characteristics, including country, year of publication, study design, and health worker category. Patterns and trends in the evidence were visualized using charts and maps created in Microsoft Excel.

Consultation

The authors consulted a Chartered Librarian to refine the search strategy and ensure a comprehensive literature search. Additionally, experts in medical ethics, palliative care and end-of-life decision-making were consulted to provide input to enrich the interpretation of the findings, discussion, and analysis.

Results

Search results

Search conducted in the main databases produced 1,780 records. Additional 34 records were retrieved from a hand-search in other databases making a total of 1,814 records. Mendeley Software was used to remove 190 duplicates summing up unique records to 1,624. Titles and abstracts of the 1,624 records were screened and 13 full-text eligible records were retrieved after the removal of 1,570 records. The authors also searched the reference lists of the included studies and this produced 10 additional full-text record, bringing the total number of eligible full-text records to 64. Finally, 43 records were included in this systematic review after 21 records were rejected with reasons (Fig. 1).

Characteristics of included studies

All 43 included studies were drawn predominantly in high- and middle-income countries. Europe accounted for the largest share (24 studies), followed by Asia (5), North America (8) and Oceania (6) (Fig. 2). Most studies used a cross-sectional design (34), with eight qualitative studies and one mixed-methods study (Fig. 3). Publications spanned from 1995 to 2025, with a marked increase from 2015 onward, indicating growing scholarly interest. Sample sizes

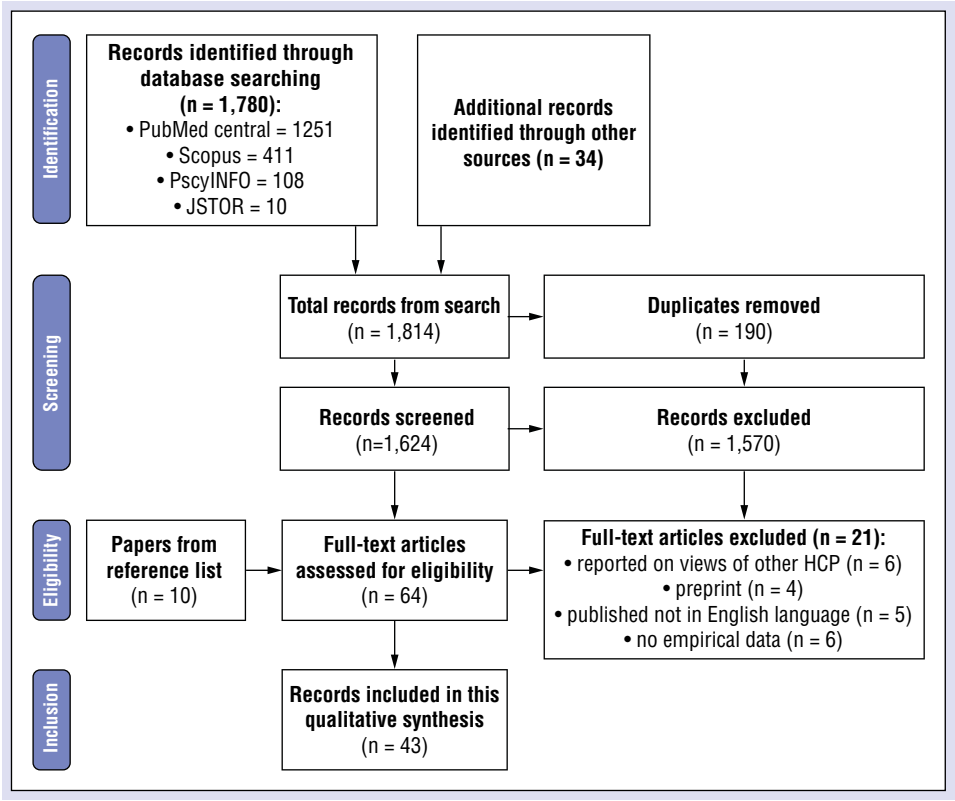

Figure 1. PRISMA flow chart diagram

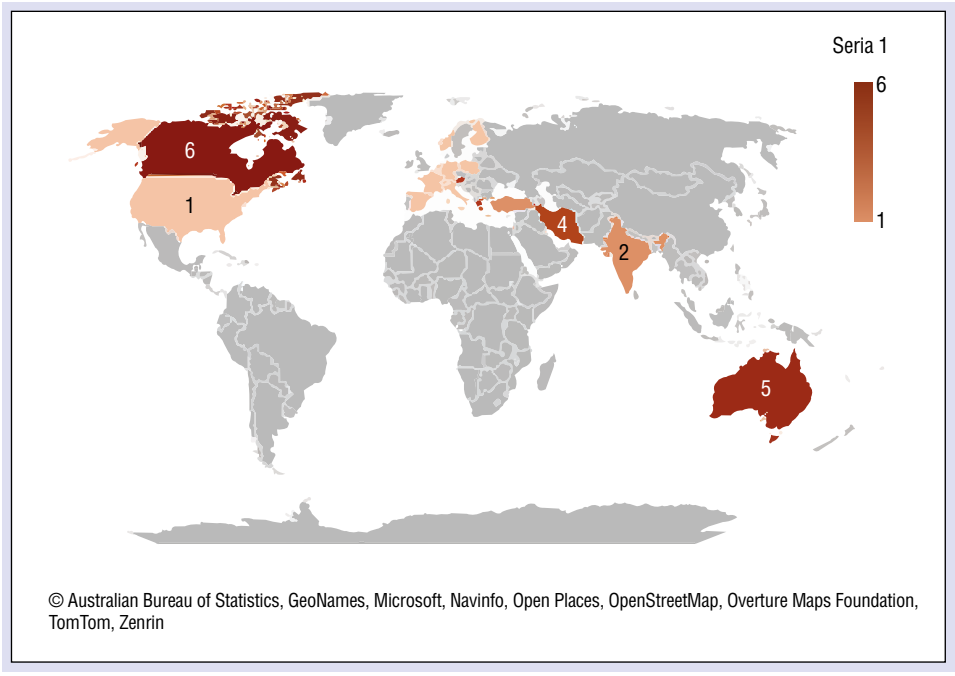

Figure 2. Map showing countries where included studies were conducted

in cross-sectional studies ranged from 94 to 3,683 participants, while the mixed-methods study included 106 participants. Nurses were the most frequently studied group (17 studies), followed by physicians (5), combined physician–nurse samples (7), mixed healthcare professionals (7), pharmacists (3), and nurses with nursing students (2). See details of study characteristics in (Suppl. File 1).

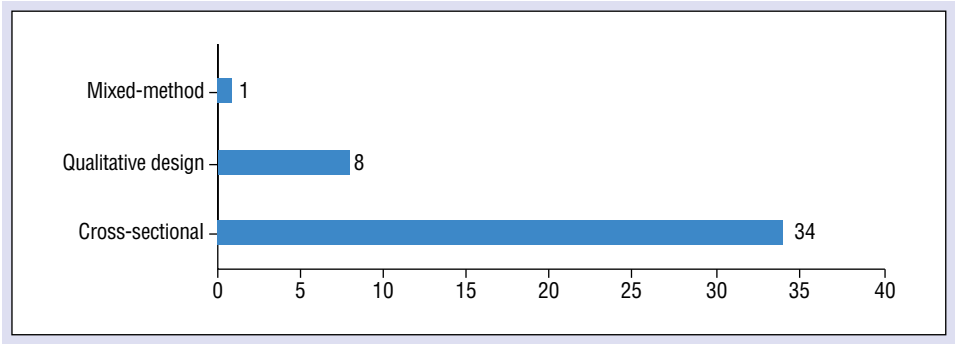

Figure 3. Study design of included studies

Quality assessment

Among the cross-sectional studies, 25 failed to account for confounding variables. Ten of the cross-sectional studies were appraised as low risk with no high-risk studies. All eight qualitative studies were appraised as low risk, indicating high methodological rigor. However, most studies did not provide a statement regarding the influence of the researcher on the research and vice versa. See details of study appraisal in (Suppl. File 2).

Perceptions of health workers on medically assisted dying

Four themes were identified in the literature concerning health workers' perceptions of MAD. These were the perceived need for training, education and clear policies, ethical and moral dilemmas around MAD, professional meaning in MAD practice.

Ethical and moral dilemmas around medically assisted dying

Health workers expressed divergent moral and ethical views concerning MAD. Some regarded euthanasia as wrong in practice for patients and believed patients should instead be counseled on the matter [26]. Others held that physicians should preserve life even when patients wished to die [15, 27]. Medically assisted dying was viewed as incongruent with the principles of medicine and palliative care [28], conflicting with moral commitments to preserve life [28]. At the same time, some health workers emphasized autonomy, stating that professionals should have the choice whether or not to assist in suicide.

Professional reflection on medically assisted dying practice

Some health workers described MAD as a practice that should be desensitized and routinized within healthcare systems [29]. Positive experiences, such as peace, gratitude, and fulfillment, were also reported [27, 29]. For some, participation in MAD was considered a privilege, transforming their own suffering and aligning with their professional goals of holistic care [27, 29]. Another recurring perception was the role of MAD in facilitating a dignified death and alleviating suffering. Some health workers perceived MAD as a way to provide patients and families with a "good death" [29]. Others described euthanasia as a commitment to reducing suffering [3, 28]. It was also emphasized that patients should have the right to expedite their own death [3, 15, 30]. Facilitating good dying experiences [28] and ensuring that euthanasia is accessible and dignified for both patients and families were highlighted [31].

Perceived need for training, education and clear policies on medically assisted dying

Nine studies reflected health workers' perceptions that effective engagement with MAD depends on the availability of adequate training, education, and clearly defined policies [32]. Participants perceived gaps in MAD-related knowledge and program quality [31], as well as insufficient clarity regarding professional roles and responsibilities [21–33]. Some health workers perceived the administration of lethal medications as falling outside nurses' professional responsibilities [34], while others viewed euthanasia as a responsibility of professional or regulatory bodies rather than individual clinicians [21, 22]. Additionally, several studies highlighted perceptions that nurses' perspectives are insufficiently integrated into decision-making processes related to MAD [3, 34, 35] (Table 3).

Attitudes of health workers toward medically assisted dying

Four themes were identified in the literature concerning the attitudes of health workers toward MAD. These themes were supportive attitudes toward MAD, unfavorable attitudes toward MAD, supportive roles beyond direct provision, and emotional and professional ambivalence.

Table 3. Health workers perceptions towards medically assisted dying

Themes	Specific perceptions	Authors
Perceived need for training, education and clear policies on MAD	Additional training on MAD	[32]
	Quality of MAD program should be improved	[31]
	Administering lethal drugs is not a task nurses are allowed to perform	[34]
	Staff education and clearer policies to support ethical engagement with MAD are recommended	[21, 33, 55]
	Uncertain about professional roles and responsibilities	[31, 37]
	Euthanasia is the responsibility of their professional bodies	[21, 22]
	Nurses' perspective should be considered in decision making related to MAD	[3, 34, 35]
Ethical and moral dilemmas around MAD	Euthanasia is wrong in practice for a patient	[26]
	Patients should be counseled on matters of euthanasia	[26]
	Believed physicians should preserve life even when patients wished to die	[15, 27]
	Euthanasia is incongruent with the fundamental principles of medicine and palliative care and conflicts with participants' moral commitment	[28]
	Each professional should have the choice whether or not to assist suicide (70.7%)	[17]
Professional reflection on MAD practice	MAD should be desensitized and routinized	[29]
	MAD as experiences of peace, gratitude, and fulfillment	[27, 29]
	Participation was viewed as a privilege, transforming their own suffering and aligning with their professional goals of holistic care	[27, 29]
	Affording patients and families a good death	[29]
	Euthanasia is a common dedication to reducing suffering	[3, 28]
	Patients have the right to expedite their own death	[3, 15, 30]
	Facilitating good dying experiences	[28]
	Euthanasia should be accessible	[31]
	Dignified to suit patient and family	[31]

MAD — medically assisted dying

Supportive attitudes toward medically assisted dying

Health professionals endorsed the provision of MAD in clinical practice [13, 18–20, 28, 32, 36–40]. Included studies reported that healthcare professionals showed support for patient autonomy in end-of--life decisions [30, 41]. Support for legalization of MAD was also evident in several studies [13–23, 42]. Some health workers reported a willingness to personally perform MAD [13–15, 17, 21, 23, 34, 35, 41, 43–48].

Unfavorable attitudes toward medically assisted dying

Religious beliefs emerged as a prominent factor underpinning opposition to MAD [13]. Discomfort and difficulty in engaging in conversations about MAD were also reported [32]. Overall negative attitudes toward MAD and euthanasia were widely documented among nurses and other healthcare professionals [30, 43, 49, 50]. Palliative care professionals rejected both practices even if the patient is in great suffering [51]. The majority of participants felt unprepared or unsupported to engage with MAD [33, 42, 52]. Explicit refusal to administer lethal medication with the intention of ending a patient's life was also clearly expressed [34].

Supportive roles beyond direct provision of medically assisted dying

Beyond direct involvement in MAD, health workers emphasized the importance of supportive roles. These included providing psychological support when MAD requests were made [26, 33]. Nurses, in particular, advocated for ethical vigilance and individualized approaches to end-of-life care in the context of MAD [29].

Emotional and professional ambivalence

Ambivalent attitudes were also evident among health workers. Some reported being unable to determine how to react when confronted with a MAD request [26]. Others described difficulty in discussing

Table 4. Health workers attitudes towards medically assisted dying

Themes	Specific attitude	Authors
Supportive attitudes toward MAD	Supported provision of MAD	[13, 18–20, 28, 32, 36–38]
	Supported patient autonomy in end-of-life decisions	[30, 41]
	Support legalization of MAD	[13–20, 22, 42, 54]
	Willing to perform MAD	[13–15, 17, 21, 34, 35, 41, 43–48, 55]
Unfavorable attitudes toward MAD	Opposition to MAD due to religion	[13]
	Found conversation about MAD challenging	[32]
	Negative attitudes toward MAD	[30, 43, 50, 56]
	Palliative care professionals rejected both practices even if the patient is in great suffering	[51]
	The majority of participants felt unprepared or unsupported to engage with MAD	[33]
	I would in no case be prepared to administer the drugs in lethal doses with the explicit intention of ending the patient's life	[34]
	Nurses hold a negative attitude towards euthanasia	[49]
Supportive roles beyond direct provision of MAD	Considered providing psychological support as the when there is MAD request	[26, 33]
	Nurses advocated for ethical vigilance and personalized approaches to death	[29]
Emotional and professional ambivalence	Could not figure out how to react when confronted with such a request	[26]
	Found talking about MAD challenging	[32]
	Uncertain to participate	[16, 22, 34, 37, 44]

MAD — medically assisted dying

MAD [32], while some expressed uncertainty about their participation [16, 22, 34, 37, 44, 53] (Table 4).

Discussion

Summary of findings

Health workers reported gaps in training, policy guidance, and clarity of professional roles related to MAD. Ethical and moral views differed, with some opposing MAD on moral or professional grounds and others supporting it based on patient autonomy and the reduction of suffering. Involvement in MAD was associated with emotional distress for some and professional fulfillment for others. Attitudes toward MAD included support, opposition, and ambivalence, and many health workers expressed uncertainty about how to respond to requests for MAD.

Perceptions of medically assisted dying among healthcare professionals

The evidence suggests a significant perceived need for enhanced structured support concerning MAD within the healthcare community. Professionals articulate a desire for additional training on MAD [32] and emphasize that the quality of MAD programs should be improved [31]. This finding points to a recognized gap within the professional community, where current educational and programmatic frameworks are often deemed insufficient to address the complexities inherent in MAD provision. Furthermore, the explicit recommendation for staff education and clearer policies to support ethical engagement with MAD [23, 33] underscores a systemic deficit in institutional guidance. The specific perception that administering lethal drugs is not a task that nurses are allowed to perform highlights a critical area of role ambiguity and calls for urgent legal and ethical clarification within interdisciplinary teams. This call for improved training and clear policies indicates that, for many, the practical and ethically sound implementation of MAD necessitates a more robust and explicitly defined professional context.

Reviewed studies reported uncertainty about professional roles and responsibilities regarding MAD. This ambiguity extends to the belief that euthanasia is the responsibility of their professional bodies [21, 22], suggesting a desire for overarching institutional guidance rather than individual clinicians bearing

the full ethical and practical burden. Importantly, the recurring sentiment that nurses' perspectives should be considered in decision-making related to MAD highlights their critical frontline role and expertise, implying that existing frameworks may not adequately integrate multidisciplinary input in these sensitive discussions. Such uncertainty can significantly impede the consistent and ethically sound application of MAD. This systematic review consistently reveals deep-seated ethical and moral dilemmas around MAD among healthcare professionals.

Healthcare providers perceive that euthanasia practice on a patient is morally wrong [26] and believe that physicians should preserve life even when patients wish to die [15, 27]. This often stems from a perception that euthanasia is incongruent with the fundamental principles of medicine and palliative care and conflicts with participants' moral commitments. Some healthcare providers hold the view that each professional should have the choice whether or not to assist suicide [17], indicating a strong assertion of individual conscience and autonomy within the professional sphere. Additionally, the belief that patients should be counseled on matters of euthanasia suggests an acknowledgment of patient rights and the necessity for comprehensive, empathetic dialogue in end-of-life decisions, even amidst professional moral conflicts. This contrast reflects a profound tension between traditional medical tenets and evolving patient-centered care models. For some healthcare professionals, engaging with MAD translates into profound lived experiences and professional meaning. These experiences are described as instances of peace, gratitude and fulfillment [27], with participation often viewed as a privilege, transforming their own suffering and aligning with their professional goals of holistic care. This suggests that MAD can be integrated into a professional identity focused on alleviating suffering.

The observation that MAD should be desensitized and routinized indicates a pragmatic approach by some to normalize the practice, potentially as a coping mechanism to manage emotional intensity and integrate it into standard care pathways [29]. A significant perception among healthcare professionals is that MAD can serve as a legitimate way of affording patients and families a good death. This perspective aligns with the belief that euthanasia is a common dedication to reducing suffering, positioning MAD as a compassionate intervention in extreme circumstances. The affirmation that patients have the right to expedite their own death further underscores the importance of patient autonomy in end-of-life decisions. The findings consistently emphasize the role of MAD in facilitating good dying experiences and the desire for euthanasia to be accessible and dignified for patients and families, highlighting a patient-centered approach that prioritizes comfort, control and respect in the dying process.

Health workers' attitudes toward medically assisted dying

Medically assisted dying is characterized by a continuum from strong support to firm opposition and considerable professional ambivalence. Many healthcare professionals supported the provision of MAD and expressed strong support for the legalization of MAD. A notable proportion also reported being willing to perform MAD. Conversely, a substantial segment of the healthcare professionals opposed MAD. When confronted with MAD requests, some professionals considered providing psychological support as their primary response [33], indicating a preference for supportive care over direct participation. Beyond direct provision, nurses, for example, were observed to take on supportive roles beyond direct provision, advocating for ethical vigilance and personalized approaches to death [29]. This suggests a different role where professionals uphold ethical standards and patient dignity without necessarily engaging in direct administration.

Finally, a significant aspect of professionals' attitudes is emotional and professional ambivalence. Many reported that they could not figure out how to react when confronted with such a request and found talking about MAD challenging. This uncertainty extended to being uncertain about participating in MAD, revealing a deep-seated emotional and professional struggle that transcends simple support or opposition. This ambivalence highlights the profound psychological and ethical complexities that MAD presents to individual practitioners.

Differences in attitudes towards euthanasia and medically assisted dying

Health workers' attitudes toward euthanasia and PAS often differ due to variations in ethical responsibility, perceived professional roles, and legal implications. Euthanasia, which involves the direct administration of life-ending interventions by a clinician, is frequently viewed as more ethically contentious, as it places the health worker in an active role in ending life [14, 54]. In contrast, PAS, where the clinician provides the means for the patient to self-administer, is sometimes perceived as preserving patient autonomy while maintaining a degree of professional distance [43]. Studies indicate that health workers may express greater acceptance of PAS compared to euthanasia, particularly in contexts emphasizing

individual autonomy and informed consent. However, concerns about potential misuse, moral distress, and conflicts with professional oaths persist for both practices. Religious beliefs, cultural norms, and legal frameworks further shape these attitudes. Overall, distinctions between euthanasia and PAS significantly influence health workers' ethical reasoning and willingness to participate in end-of-life practices.

Cultural and regional contexts significantly influence health workers' attitudes toward euthanasia and PAS. Studies conducted in Western countries, particularly in parts of Europe and North America, often report more permissive attitudes, largely attributed to a strong emphasis on individual autonomy, secularism, and supportive legal frameworks. In contrast, findings from Asian contexts tend to reflect more restrictive views, shaped by religious beliefs, communal value systems, and sociocultural norms that prioritize the sanctity of life. Additionally, variations in healthcare infrastructure and palliative care availability may further affect perspectives, with limited resources sometimes influencing ethical considerations. These differences underscore the importance of contextualizing findings within specific cultural and regional settings.

Implications for policy, practice, and research

The findings underscore the urgent need for coherent, context-sensitive policies that clearly define the legal and professional roles of health workers in relation to MAD, particularly in settings where ethical and legal ambiguity persists. Policy frameworks should be accompanied by enforceable institutional guidelines and regulatory oversight to ensure ethical consistency, professional protection, and patient safety. In practice, structured and mandatory education on MAD is essential to address knowledge gaps, clarify responsibilities across professional groups, and reduce uncertainty in clinical decision-making, alongside accessible psychological and ethical support mechanisms to mitigate moral distress among health workers. Patient- and family-centered care must remain central, with emphasis on dignity, autonomy, and compassionate communication at the end of life. From a research perspective, the dominance of cross-sectional evidence highlights the need for longitudinal and qualitative studies that examine how attitudes evolve over time, identify key socio-cultural and professional determinants, and assess the long-term psychological impact of MAD involvement. Expanding research to underrepresented regions, particularly low- and middle-income countries, is critical to developing globally relevant, ethically robust, and workforce-responsive MAD policies and practices.

Limitations of the review

This review has several important limitations that should be considered when interpreting the findings. First, the evidence base was dominated by cross-sectional survey designs, which, as confirmed by the quality appraisal, limited the ability to examine causal relationships or changes in attitudes and perceptions over time. A substantial proportion of the cross-sectional studies did not adequately account for potential confounding variables, increasing the risk of residual bias and restricting interpretive depth. Although the qualitative studies were generally appraised as methodologically robust, most did not sufficiently address researcher reflexivity, which may have influenced data interpretation. In addition, the exclusive inclusion of English-language, peer-reviewed publications may have introduced publication and language bias, potentially excluding relevant evidence from non-English-speaking or low-resource settings. Finally, synthesizing findings from summary tables rather than full contextual narratives may have resulted in some loss of nuance regarding cultural, legal, and ethical specificities across settings. These limitations highlight the need for more methodologically diverse, contextually grounded, and longitudinal research to strengthen the evidence base on health workers' attitudes and perceptions toward MAD.

Conclusions

Healthcare professionals globally exhibit a wide range of complex perceptions and attitudes toward MAD, shaped by ethical, moral, religious, and professional factors. A significant number support the legalization and provision of MAD, often aligning with principles such as patient autonomy, dignity, and the alleviation of suffering. For many, participating in MAD is perceived as an extension of their commitment to holistic patient care, leading to feelings of peace, gratitude, and fulfillment. However, this support is frequently balanced by significant ethical and moral dilemmas, which can result in unfavorable attitudes or uncertainty, especially concerning active life-ending practices or the imperative to preserve life even when patients desire death. These consistent findings highlight a critical need for enhanced training, clear policies, and robust support systems for healthcare providers to address persistent uncertainties regarding professional roles and responsibilities.

Article information and declarations

Acknowledgments

None.

Author contributions

Conceptualization: EO, CA, and MA; study conceptualization and design: FAN, AGS, and EO; independent data extraction: AOT; study appraisal: ENG, MAA, FAN, and CA; data analysis, data collection, and drafting of the initial manuscript: EO, GSL, and MA; data synthesis and interpretation: EO and CA; overall supervision of the review process: MA and NIEE. Approval of the final version of the manuscript: all authors.

Conflict of interest

The authors declare no conflict of interest.

Funding

This review did not receive any funding.

Supplementary material

The Supplementary Files for this article can be found online at: https://journals.viamedica.pl/palliative_medicine_in_practice/article/view/111237.

References

1. Tadros G, Rakhawy M, Khoweiled A, et al. Perception of physician-assisted suicide among Egyptian psychiatrists: cultural perspective. Psychiatrist. 2018; 35(1): 15–18, doi: 10.1192/pb.bp.110.030411.
2. Heidinger B, Webber C, Chambaere K, et al. International comparison of underlying disease among recipients of medical assistance in dying. JAMA Intern Med. 2025; 185(2): 235–237, doi: 10.1001/jamainternmed.2024.6643, indexed in Pubmed: 39652339.
3. Velasco Sanz TR, Cabrejas Casero AM, Rodríguez González Y, et al. Opinions of nurses regarding euthanasia and medically assisted suicide. Nurs Ethics. 2022; 29(7–8): 1721–1738, doi: 10.1177/09697330221109940, indexed in Pubmed: 35786045.
4. Chen DR, Kuo CT, Wu KCC. Cross-sectional survey on public attitudes and factors related to physician--assisted dying in Taiwan. BMJ Open. 2025; 15(1): e089388, doi: 10.1136/bmjopen-2024-089388, indexed in Pubmed: 39819930.
5. Inglehart RC, Nash R, Hassan QN, et al. Attitudes toward euthanasia: a longitudinal analysis of the role of economic, cultural, and health-related factors. J Pain Symptom Manage. 2021; 62(3): 559–569, doi: 10.1016/j.jpainsymman.2021.01.009, indexed in Pubmed: 33493587.
6. Goldsmith JL, Posner EA. Journal of legal studies: introduction. J Legal Stud. 2002; 31: 707–744.
7. Bouabida K, Chaves B, Anane E, et al. Recent global perspectives and implications of medical-assisted death and euthanasia. Hospic Palliati Med Internat J. 2024; 7(3): 73–76, doi: 10.15406/hpmij.2024.07.00242.
8. Nicol J, Tiedemann M. Medical assistance in dying: the law in selected jurisdictions outside Canada. HillStudies. 2021.
9. Nacak UA, Erden Y. End-of-Life care and nurse's roles. Eurasian J Med. 2022; 54(Suppl1): 141–144, doi: 10.5152/eurasianjmed.2022.22324, indexed in Pubmed: 36655458.
10. Fontalis A, Prousali E, Kulkarni K. Euthanasia and assisted dying: what is the current position and what are the key arguments informing the debate? J R Soc Med. 2018; 111(11): 407–413, doi: 10.1177/0141076818803452, indexed in Pubmed: 30427291.
11. Shariff MJ. Assisted death and the slippery slope-finding clarity amid advocacy, convergence, and complexity. Curr Oncol. 2012; 19(3): 143–154, doi: 10.3747/co.19.1095, indexed in Pubmed: 22670093.
12. Wittrock J. A human right to assisted dying? Autonomy, dignity, and exceptions to the right to life. Nurs Ethics. 2025; 32(7): 2033–2043, doi: 10.1177/09697330251328655, indexed in Pubmed: 40199512.
13. Abohaimed S, Matar B, Al-Shimali H, et al. Attitudes of physicians towards different types of euthanasia in Kuwait. Med Princ Pract. 2019; 28(3): 199–207, doi: 10.1159/000497377, indexed in Pubmed: 30703772.
14. Acquier M, Boyer A, Guidet B, et al. ICU health care workers opinion on physician-assisted-suicide and euthanasia: a French survey. Ann Intensive Care. 2023; 13(1): 19, doi: 10.1186/s13613-023-01114-z, indexed in Pubmed: 36933060.
15. Dopelt K, Cohen D, Amar-Krispel E, et al. Facing death: attitudes toward physician-assisted end of life among physicians working at a tertiary-care-hospital in Israel. Int J Environ Res Public Health. 2021; 18(12), doi: 10.3390/ijerph18126396, indexed in Pubmed: 34199168.
16. Doukas DJ, Waterhouse D, Gorenflo DW, et al. Attitudes and behaviors on physician-assisted death: a study of Michigan oncologists. J Clin Oncol. 1995; 13(5): 1055–1061, doi: 10.1200/JCO.1995.13.5.1055, indexed in Pubmed: 7738611.
17. Gamondi C, Gayet-Ageron A, Borasio GD, et al. Attitudes of university hospital staff towards in-house assisted suicide. PLoS One. 2022; 17(10): e0274597, doi: 10.1371/journal.pone.0274597, indexed in Pubmed: 36301971.
18. Green G, Reicher S, Herman M, et al. Attitudes toward euthanasia-dual view: nursing students and nurses. Death Stud. 2022; 46(1): 124–131, doi: 10.1080/07481187.2020.1716887, indexed in Pubmed: 31983300.
19. Hol H, Vatne S, Ørøy A, et al. Norwegian nurses' attitudes toward assisted dying: a cross-sectional study. Nurs Res Rev. 2022; 12: 101–109, doi: 10.2147/nrr.s363670.
20. Kranidiotis G, Ropa J, Mprianas J, et al. Attitudes towards euthanasia among Greek intensive care unit physicians and nurses. Heart Lung. 2015; 44(3): 260–263, doi: 10.1016/j.hrtlng.2015.03.001, indexed in Pubmed: 25840865.
21. Wilson M, Oliver P, Malpas P. Nurses' views on legalising assisted dying in new zealand: a cross-sectional study. Int J Nurs Stud. 2019; 89: 116–124, doi: 10.1016/j.ijnurstu.2018.03.012, indexed in Pubmed: 29669685.
22. Wong LS, Scahill SL, Barton E, et al. Pharmacists' attitudes towards medically assisted dying. Pharmacy (Basel). 2024; 12(2): 40, doi: 10.3390/pharmacy12020040, indexed in Pubmed: 38391008.
23. Zeilinger EL, Vielgrader TL, Petersen A, et al. Nurses' perspectives on assisted suicide: challenges and support needs. Soc Sci Med. 2025; 366: 117663, doi: 10.1016/j.socscimed.2024.117663, indexed in Pubmed: 39740633.
24. Aromataris E, Pearson A. The systematic review: an overview. Am J Nurs. 2014; 114(3): 53–58, doi: 10.1097/01.NAJ.0000444496.24228.2c, indexed in Pubmed: 24572533.
25. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021; 372: n71, doi: 10.1136/bmj.n71, indexed in Pubmed: 33782057.
26. Ay MA, Öz F. Nurses attitudes towards death, dying patients and euthanasia: a descriptive study. Nurs Ethics. 2019; 26(5): 1442–1457, doi: 10.1177/0969733017748481, indexed in Pubmed: 29495932.
27. Mills A, Bright K, Wortzman R, et al. Medical assistance in dying and the meaning of care: perspectives of nurses,

pharmacists, and social workers.p. Health (London). 2023; 27(1): 60–77, doi: 10.1177/1363459321996774, indexed in Pubmed: 33685263.
28. Blaschke SM, Schofield P, Taylor K, et al. Common dedication to facilitating good dying experiences: qualitative study of end-of-life care professionals' attitudes towards voluntary assisted dying. Palliat Med. 2019; 33(6): 562–569, doi: 10.1177/0269216318824276, indexed in Pubmed: 30688145.
29. Bruce A, Beuthin R. Medically assisted dying in Canada: "beautiful death" is transforming nurses' experiences of suffering. Can J Nurs Res. 2020; 52(4): 268–277, doi: 10.1177/0844562119856234, indexed in Pubmed: 31188639.
30. Testoni I, Bortolotti C, Pompele S, et al. A challenge for palliative psychology: freedom of choice at the end of life among the attitudes of physicians and nurses. Behav Sci (Basel). 2020; 10(10): 1–13, doi: 10.3390/bs10100160, indexed in Pubmed: 33096819.
31. Brown J, Goodridge D, Harrison A, et al. Medical assistance in dying: patients', families', and health care providers' perspectives on access and care delivery. J Palliat Med. 2020; 23(11): 1468–1477, doi: 10.1089/jpm.2019.0509, indexed in Pubmed: 32302505.
32. Hogg S, Nippak P, Spalding K. Implementation of medical assistance in dying: an evaluation of clinician knowledge and perceptions at a large urban multi-site rehabilitation centre in Toronto. J Hosp Adm. 2018; 7(5): 41, doi: 10.5430/jha.v7n5p41.
33. Ward V, Freeman S, Banner D. Hospice care provider perspectives of medical assistance in dying in a Canadian hospice that does not provide medical assistance in dying. Can J Nurs Res. 2022; 54(1): 3–14, doi: 10.1177/0844562120985995, indexed in Pubmed: 33435718.
34. Francke AL, Albers G, Bilsen J, et al. Nursing staff and euthanasia in the Netherlands. A nation-wide survey on attitudes and involvement in decision making and the performance of euthanasia. Patient Educ Couns. 2016; 99(5): 783–789, doi: 10.1016/j.pec.2015.11.008, indexed in Pubmed: 26613667.
35. Terkamo-Moisio A, Gastmans C, Ryynänen OP, et al. Finnish nurses' attitudes towards their role in the euthanasia process. Nurs Ethics. 2019; 26(3): 700–714, doi: 10.1177/0969733017720850, indexed in Pubmed: 28814138.
36. Gawor A, Głębocka A. Palliative care experience and attitudes towards euthanasia among healthcare professionals. Polish Psychological Bulletin. 2019; 50: 101–107, doi: 10.24425/ppb.2019.126024.
37. Isaac S, McLachlan A, Chaar B. Australian pharmacists' perspectives on physician-assisted suicide (PAS): thematic analysis of semistructured interviews. BMJ Open. 2019; 9(10): e028868, doi: 10.1136/bmjopen-2018-028868, indexed in Pubmed: 31666261.
38. Shekhawat RS, Kanchan T, Saraf A, et al. Knowledge, attitude and practices (KAP) of medical professionals on euthanasia: a study from a tertiary care centre in india. Cureus. 2023; 15(2): e34788, doi: 10.7759/cureus.34788, indexed in Pubmed: 36915850.
39. Başar Kara B, Günay O. Euthanasia-related knowledge and attitudes of intensive care nurses working in five provinces in central Anatolian region. J Med Surg Intensive Care Med. 2017; 8(3): 77–81, doi: 10.5152/dcbybd.2018.1558.
40. Głębocka A. Psychological determinants of attitude toward euthanasia: a comparative study of female nurses and female nonmedical professionals. Adv Exp Med Biol. 2018; 1096: 93–103, doi: 10.1007/5584_2018_191, indexed in Pubmed: 29594741.
41. Parpa E, Mystakidou K, Tsilika E, et al. Attitudes of health care professionals, relatives of advanced cancer patients and public towards euthanasia and physician assisted suicide. Health Policy. 2010; 97(2–3): 160–165, doi: 10.1016/j.healthpol.2010.04.008, indexed in Pubmed: 20488575.
42. Wilson M, Wilson M, Edwards S, et al. Role of attitude in nurses' responses to requests for assisted dying. Nurs Ethics. 2021; 28(5): 670–686, doi: 10.1177/0969733020966777, indexed in Pubmed: 33267736.
43. Alborzi J, Sabeti F, Baraz S, et al. Investigating of moral distress and attitude to euthanasia in the intensive care unit nurses. Internat J Pediatr. 2018; 6: 8475–8482, doi: 10.22038/ijp.2018.28177.2439.
44. Freeman LA, Pfaff KA, Kopchek L, et al. Investigating palliative care nurse attitudes towards medical assistance in dying: an exploratory cross-sectional study. J Adv Nurs. 2020; 76(2): 535–545, doi: 10.1111/jan.14252, indexed in Pubmed: 31650568.
45. Khatony A, Fallahi M, Rezaei M, et al. Comparison of attitude of nurses and nursing students toward euthanasia. Nurs Ethics. 2022; 29(1): 208–216, doi: 10.1177/0969733021999751, indexed in Pubmed: 34254542.
46. Stergiannis P, Fanouraki-Stavrakaki E, Manthou P, et al. Investigation on the attitudes and perspectives of medical and nursing staff about euthanasia: data from four regional greek hospitals. Cureus. 2024; 16(2): e53990, doi: 10.7759/cureus.53990, indexed in Pubmed: 38476777.
47. Van Humbeeck L, Piers R, De Bock R, et al. Flemish healthcare providers' attitude towards tiredness of life and euthanasia: a survey study. Aging Ment Health. 2022; 26(1): 205–211, doi: 10.1080/13607863.2020.1870205, indexed in Pubmed: 33432838.
48. Vijayalakshmi P, Nagarajaiah I, Reddy PD, et al. Indian nurses' attitudes toward euthanasia: gender differences. Omega (Westport). 2018; 78(2): 143–160, doi: 10.1177/0030222816688576, indexed in Pubmed: 28114874.
49. Naseh L, Rafiei H, Heidari M. Nurses' attitudes towards euthanasia: a cross-sectional study in Iran. Int J Palliat Nurs. 2015; 21(1): 43–48, doi: 10.12968/ijpn.2015.21.1.43, indexed in Pubmed: 25615834.
50. Safarpour H, Keykha R, Varasteh S, et al. Attitude of nurses towards euthanasia: a cross-sectional study in Iran. Int J Palliat Nurs. 2019; 25(6): 274–282, doi: 10.12968/ijpn.2019.25.6.274, indexed in Pubmed: 31242094.
51. Zenz J, Tryba M, Zenz M. Palliative care professionals' willingness to perform euthanasia or physician assisted suicide. BMC Palliat Care. 2015; 14: 60, doi: 10.1186/s12904-015-0058-3, indexed in Pubmed: 26572742.
52. Malliarou M, Tzenetidis V, Papathanasiou I, et al. Physicians' attitudes towards euthanasia and correlation with their spirituality. Psychiatriki. 2022; 33(4): 323–327, doi: 10.22365/jpsych.2022.078, indexed in Pubmed: 35477087.
53. Schindel TJ, Woods P, Mey A, et al. Hospital pharmacists' experiences with medical assistance in dying: a qualitative study. Can J Hosp Pharm. 2022; 75(4): 294–301, doi: 10.4212/cjhp.3213, indexed in Pubmed: 36246437.
54. Zeilinger EL, Petersen A, Brunevskaya N, et al. Experiences and attitudes of nurses with the legislation on assisted suicide in Austria. Palliat Support Care. 2024 [Epub ahead of print]: 1–7, doi: 10.1017/S147895152400107X, indexed in Pubmed: 39390951.
55. Unseld M, Meyer AL, Vielgrader TL, et al. Assisted suicide in Austria: nurses' understanding of patients' requests and the role of patient symptoms. Int J Environ Res Public Health. 2025; 22(2), doi: 10.3390/ijerph22020218, indexed in Pubmed: 40003444.
56. O'Connor M, Martin C, Willmott L, et al. Australian health professionals' attitudes toward voluntary assisted dying: a cross-sectional survey. Soc Sci. 2021; 10(11): 429, doi: 10.3390/socsci10110429.