

Is Every Life Worth Saving: Does Religion and Religious Beliefs Influence Paramedic's End-of-Life Decision-making? A Prospective Questionnaire-based Investigation

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Abstract

Background: Paramedics, arriving on emergency cases first, have to make end-of-life decisions almost on a daily basis. Faith shapes attitudes toward the meaning and worth of life itself and therefore influences decision-making. **Objective:** The objective of this study was to detect whether or not religious and spiritual beliefs influence paramedics in their workday life concerning end-of-life decisions, and whether it is legally possible for them to act according to their conscience. **Methods and Design:** This is a literature review of prior surveys on the topic using five key words and questionnaire-based investigation using a self-administered online survey instrument. **Settings/Participants:** Paramedics all over Germany were given the opportunity to participate in this online questionnaire-based study. **Measurements:** Two databases were searched for prior studies for literature review. Participants were asked about their religiosity, how it affects their work, especially in end-of-life situations, how experienced they are, and whether or not they have any legal latitude to withhold resuscitation. **Results:** A total of 429 paramedics answered the questionnaire. Religious paramedics would rather hospitalize a patient holding an advance directive than leave him/her at home ($P = 0.036$) and think death is less a part of life than the nonreligious ($P = 0.001$). Otherwise, the Spearman's rho correlation was statistically insignificant for all tests regarding resuscitation. **Conclusions:** The paramedic's religiosity is not the prime factor in his/her decision-making regarding resuscitation.

Keywords: Emergency care, palliative care, palliative emergency

INTRODUCTION

Religious belief is a very personal matter, which affects our private and our workday life on a daily basis. Human life is sacred to most of all the world's religions, but nonetheless bears the inevitability of death. The manner of how and when one dies was believed to lie in the hands of God, at least concerning the Abrahamic traditions. In the realm of modern medicine, however, our power over life and death has increased. Opinions on how far one should go, concerning medical treatment, to preserve or to save a life may differ.^[1] The strength of one's religious belief varies from one person to another and thus may affect one's views and opinions toward life and death itself, this including medical topics such as abortion, preimplantation diagnostics, palliative medicine, emergency medicine, and more. Our investigation focuses on the prehospital treatment of terminally ill patients

by German paramedics, highlighting the influence of the paramedics' religious beliefs and the judicial framework they have to work in.

There is no consent in Judaism, Islam, and Christianity nor Eastern traditions (e.g., Hinduism and Buddhism) nor indigenous faith systems on opposing suicide, physician-assisted suicide, and euthanasia, but abstaining from life-prolonging procedures is usually allowed by religious authorities.^[1-5] Some religious people, for example, evangelical Christians in the US, seem to ask for

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life-prolonging procedures more often than nonreligious people.^[1,6,7] In addition, Protestants were found to agree to euthanasia more than Catholics.^[4,5] Apparently to some devout people, “Four commonly invoked reasons are (1) hope for a miracle, (2) refusal to give up on the God of faith, (3) a conviction that every moment of life is a gift from God and is worth preserving at any cost, and (4) a belief that suffering can have redemptive value.”^[8]

Paramedics making an end-of-life decision may be influenced by their religious beliefs. Since 3%–5% of all prehospital emergencies concern outpatient palliative emergencies, every paramedic may find himself/herself in the situation having to make an end-of-life decision.^[9] Prior surveys showed that religious belief does influence physicians in their decision-making, concerning withdrawal of life-sustaining treatment and prescribing life-shortening pain medication and euthanasia.^[6,10-19]

What also must be considered is the fact that paramedics are prohibited from withholding resuscitation by German jurisdiction, and therefore are obligated to initiate full resuscitation of patients with no vital signs, although they can of course express their opinions toward the physician’s decision-making, if a physician is present.^[9] If there is no physician present but there is an advance directive or do not attempt resuscitation (DNAR) order on scene, paramedics enter a jurisdictional gray area because they may either put aside such mentioned orders, being under time pressure, not being able to fully verify the order’s authenticity, or they may adhere to its content in good belief of its genuineness. Only the presence of severe injuries, which are not compatible with life and/or definite signs of death (e.g., livor mortis), legally absolve paramedics from withholding resuscitation. This problem has been solved in England and Wales where the so-called Mental Capacity Act (2005) allows people to draw up an “Advanced Decisions to Refuse Treatment,” such as resuscitation. Paramedics there are required by statutory law to respect this:^[20] their guidelines permit them to withhold resuscitation when a formal DNAR order is in place, the patient is terminally ill, death is imminent and unavoidable, and resuscitation would not be successful.^[21]

Our research hypothesis was that paramedics are influenced by their religious belief. To determine whether or not a paramedic’s decision-making in end-of-life situations is influenced by his/her religious beliefs, how they decide given the current judicial framework, and how they would decide were there legal certainty are the main objectives of this study.

METHODS

Two databases, PubMed® and Google Scholar®, were searched for relevant prior investigations exploring the influence of religious and spiritual (R/S) beliefs on end-of-life decision-making using five keywords: End-of-life decision, spirituality, religious belief, palliative care, and resuscitation.

After duplicates were removed and the findings were screened according to abstract and title for their design and relevance to our study, 31 articles were included in the investigation [Table 1]. Two researchers, who took into account the number and type of participants, study design, and results, analyzed the papers found. The search was completed in May 2015.

A prospective questionnaire-based trial was used as the study design using the online tool “www.q-set.de.” In a pilot phase, the questionnaire was answered by 29 paramedics in written form, making sure the readability and appropriateness of the content. No modifications had to be made after the pilot testing. Afterward, the online questionnaire was accessible to paramedics all over Germany via links offered on the Malteser Hilfsdienst homepage (www.malteser.de), which is one of the big companies offering emergency services and on the Deutscher Berufsverband and Rettungsdienst. V. homepage (www.dbrd.de), which is the professional association of German paramedics, for 6 weeks (May 4, 2014). In this period of time, 400 paramedics answered the survey, the round number being sheer coincidence, ~7/day. The 29 written copies were included in the investigation for no changes had been made in the questionnaire. Participants who answered the written form were excluded from the online questionnaire to avoid double answers. Comments or a presentation were not given in advance to avoid bias mistakes. The information gathered in the questionnaire is summarized in Table 2.

Yes and no questions, free answers, and 11-point Likert scales were used for answers and tasks in the mixed methods questionnaire design. The Likert scales were interpreted as follows:

The median number of points plus/minus the standard deviation was interpreted as the average answers, the rest as extreme answers.

For example, with a median of 5 and standard deviation of 2, 7 people who answered 9–11 points on the question “Are you a religious person?” were rated as very religious and people who answered 1–2 points as not at all religious. The same interpretations were used for tasks, for example, 1–3 points as very insecure, 4–8 points as relatively confident, and 9–11 points as very confident.

Palliative care patients were defined as terminally ill patients with no hope of recovery, but who’s symptoms and suffering can and must be alleviated and controlled (WHO Definition of Palliative Care).

Participants in the survey had to meet the following criteria: be an active member in an emergency ambulance service in Germany and participate in the investigation voluntarily. In accordance with the Declaration of Helsinki, all information was given anonymously.

IBM SPSS Statistics 22® (IBM Inc., Armonk, USA) and Microsoft® Excel® 2013 (Microsoft Inc. Redmond, USA) were

Table 1: Relevant articles for literature review; results: Religious and spiritual beliefs influence on end-of-life decisions

Article	Year	Journal	Number of P	Participants	Study design	Results
The association between religiosity and resuscitation status preference among patients with advanced cancer ^[22]	2015	Palliative and Supportive Care	78	Patients	Interviews	No influence
Spiritual background and its association with the medical decision of, DNR at terminal life stages ^[23]	2014	Archives of gerontology and geriatrics	46	Family members	Questionnaire	Influence
EOL Care Beliefs Among Muslim Physicians ^[24]	2014	American Journal of Hospice and Palliative Medicine®	461	Physicians	Online questionnaire	No influence
Are religion and religiosity important to EOL decisions and patient autonomy in the ICU? The Ethicatt study ^[6]	2012	Intensive Care Medicine	304 386 248 330	Physicians Nurses Patients Family members	Questionnaire	Influence
Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer ^[25]	2009	JAMA	345	Patients	Interviews	Influence
To die, to sleep: US physicians' religious and other objections to physician-assisted suicide, terminal sedation, and withdrawal of life support ^[11]	2008	American Journal of Hospice and Palliative Medicine®	1144	Physicians	Online questionnaire	Influence
Religiousness and spiritual support among advanced cancer patients and associations with EOL treatment preferences and quality of life ^[26]	2007	Journal of Clinical Oncology	230	Patients	Interviews	Influence
French district nurses' opinions towards euthanasia, involvement in EOL care and nurse patient relationship ^[27]	2007	Journal of Medical Ethics	602	Nurses	Interviews	Influence
Israeli critical care nurses' attitudes toward physician-assisted dying ^[28]	2006	Heart and Lung	73	Nurses	Questionnaire	Influence
Palliative care nurses' views on euthanasia ^[29]	2004	Journal of Advanced Nursing	12	Nurses	Interviews	Influence
Physicians' religiosity and EOL care attitudes and behaviors ^[10]	2004	The Mount Sinai Journal of Medicine, New York	443	Physicians	Questionnaire	Influence
Should euthanasia be legal? An international survey of neonatal intensive care units staff ^[30]	2004	Arch Dis Child Fetal Neonatal Ed	1391 3410	Physicians Nurses	Questionnaire	Influence
Israeli oncology and nononcology nurses' attitudes toward physician-assisted dying: A comparison study ^[31]	2001	Oncology Nursing Forum	123	Nurses	Questionnaire	Influence
In their own words: Oncology nurses respond to patient requests for assisted suicide and euthanasia ^[32]	2001	Applied Nursing Research	441	Nurses	Questionnaire	Influence
Doctors' and nurses' attitudes towards and experiences of voluntary euthanasia ^[12]	2001	Journal of medical ethics	366	Physicians	Questionnaire	No influence
An exploratory pilot study of nurse-midwives' attitudes towards active euthanasia and abortion ^[33]	2000	International Journal of Nursing Studies	139	Midwives	Questionnaire	Influence
Are medical ethicists out of touch? Practitioner attitudes in the US and UK towards decisions at the end of life ^[7]	2000	Journal of medical ethics	469 759 687	UK nurses US nurses US physicians	Questionnaire	Influence
Attitudes towards euthanasia among physicians, nurses and the general public in Finland ^[16]	1998	Public Health	506/582/587	Physicians Nurses General public	Questionnaire	Influence
EOL decisions in HIV-positive patients: The role of spiritual beliefs ^[34]	1998	AIDS	90	Patients	Interviews	Influence
Nurse characteristics and attitudes to active voluntary euthanasia: A survey in the Australian Capital Territory ^[5]	1998	Journal of Advanced Nursing	1218	Nurses	Questionnaire	Influence
Determinants of the willingness to endorse assisted suicide: A survey of physicians, nurses, and social workers ^[13]	1997	Psychosomatics	1137	Physicians Nurses Social workers	Interviews	Influence
Euthanasia Among US Critical Care Nurses: Practices, Attitudes, and Social and Professional Correlates ^[35]	1997	Medical Care	1139	Nurses	Questionnaire	Influence

Contd...

Table 1: Contd...

Article	Year	Journal	Number of P	Participants	Study design	Results
Issues of death and dying: The perspective of critical care nurses ^[36]	1997	Australian Critical Care	231	Nurses	Questionnaire	No influence
Nursing students' attitudes towards assisted suicide and euthanasia: A study from four different schools of nursing ^[37]	1995	Scandinavian Journal of Caring Science	289	Nursing students	Questionnaire	Influence
Oncology nurses' attitudes towards the legalization of voluntary active euthanasia ^[14]	1994	Cancer nurse	200	Nurses	Questionnaire	Influence
Management of death, dying and euthanasia: Attitudes and practices of medical practitioners in South Australia ^[38]	1994	Journal of Medical Ethics	289	Medical practitioners	Questionnaire	No influence
The current panorama of euthanasia in Spain ^[18]	1993	Revista Clinica Espanola	346 346	Physicians Nurses	Questionnaire	Influence
An international perspective of active euthanasia: Attitudes of nurses in seven countries ^[39]	1993	International Journal of Nursing Studies	319	Nurses	Interviews	No Influence
Attitudes of registered nurses toward euthanasia ^[40]	1992	Death studies	137	Nurses	Questionnaire	Influence
Attitudes towards active euthanasia and its legislation in Spain ^[17]	1992	Medicinaclinica (Barcelona)	346 346	Physicians Nurses	Questionnaire	Influence
Oncology nurses' attitudes regarding voluntary, physician-assisted dying for competent, terminally ill patients ^[41]	1979	Critical Care Medicine	34	Nurses	Questionnaire	No influence

EOL: End-of-life, DNR: Do-not-resuscitate, ICU: Intensive Care Unit

Table 2: Content of the questionnaire

Demographical information	Specific questions about religiosity and spirituality	Specific questions about palliative care patients, EOL situations
Age ^a	Religious denomination ^a	Defining a palliative care patient ^a
Federal state ^a	Strength of belief ^b	Personal experience ^a
Years of experience and current work assignment ^a	Strength of religiosity ^b	Professional training (including palliative care medicine) ^c
	Influence of religious values on private and workday life ^b	Professional experience ^a (including number of emergencies per year, resuscitations per year)
	Whether or not every life is worth living no matter the circumstances ^b	Personal abilities in treating the patients medically and psychologically ^b
	Whether or not death is a part of life ^b	Personal opinion concerning resuscitation ^a
Specific questions about advance directives	Specific questions about palliative care infrastructure	Specific questions about preparations concerning palliative care
Legal frame conditions ^c	Knowledge of regional structures and if they are sufficient ^b	Definite recognizability of palliative care situations ^b
Security in legal handling DNAR orders/advance directives ^b	Whether or not professionally/physician assisted suicide is ethical ^b	Defining therapy goals in written form ^b
Whether or not they would hospitalize a patient holding a DNAR order/advance directive ^b	Whether or not institutions offering professionally/physician assisted suicide are ethical ^b	Constant availability of the patient's palliative care physician ^b
		Defining a clear-cut advance directive in written form ^b

Question type: ^aOpen answer, ^bLikert scale, ^cYes/no question. DNAR: Do not attempt resuscitation order, EOL: End-of-life

Table 3: Occurrence of denominations

Denomination	Participants (%)
Roman Catholic	40.1
Evangelical	32.8
Orthodox	0.3
Nondenominational	20.3
Other	2.6

used as software to analyze the gathered data. The Spearman's rho test was used to determine the association between two variables. $P < 0.05$ was considered statistically relevant for

all tests. No Institutional Review Board approval was sought and obtained.

RESULTS

Twenty-seven studies investigated the influence of medical staff's R/S beliefs on their end-of-life decision-making concerning their patients. Five articles referred to patients,^[6,22,25,26,34] two to family members,^[6,23] one to social worker,^[13] and one to the general public.^[16] In none of them, or indeed in any other papers, did we find that paramedics had been questioned so that this is, to the best of our knowledge,

the first investigative study of paramedics' R/S beliefs and their influence on their work.

Eight articles used interviews, and 23 used questionnaires (two of them online) as the study design. The number of participants ranged from 12 to 4801, most of the investigations (20) had fewer than 500 participants. Seven studies showed no relevant influence of R/S beliefs on end-of-life decision-making^[5,12,22, 24,36,39,41] while the other 24 did indeed show some.^[5,7,6,10,11,13,14,16-18,23,25-29,31-37,40]

A total of 429 paramedics completed our survey. The median age was 31, the median work experience was 8 years, the median number of emergencies per years was 500 (5% of them being dying patients and 3% of them being palliative care emergencies), and the median number of resuscitations was ten per year. About 24.2% were not at all religious, 3.1% were very religious, and 72.7% were moderately religious [Table 3]. Nearly 25.3% of the participants rated themselves as nonbelievers, 10.1% as having strong religious beliefs, and 64.6% as moderately believing. Around 30.4% were not at all influenced, 20.1% were strongly influenced, and 49.5% were moderately influenced by religious values in their workday life.

Nearly 72.2% of the participants stated that palliative care had not been part of their training and 59.2% had not attended further education in palliative care medicine. Almost 42.4% had personal experience with a palliative care situation.

Altogether 59.9% doubted the sense of resuscitating a dying patient and 89% shared this view about resuscitating a dying palliative care patient. Nearly 77.7% considered it ethical not to resuscitate a dying patient and 91.8% not to resuscitate a dying palliative care patient.

A comparison between R/S beliefs (all categories included) and questions about the ethics of withholding resuscitation and the rationality of resuscitation and the hospitalization of palliative care patients produced two statistically relevant *P* values. Paramedics considering themselves to be religious (1) would rather hospitalize a patient holding an advanced directive than leaving him/her at home (*P* = 0.036) than nonreligious and (2) think that death is not a natural part of life itself (*P* < 0.001). Religiosity and strength of belief correlate with attitudes toward euthanasia. Religious and believing paramedics find (3) professionally- and (4) physician-assisted suicide unethical (*P* < 0.0001), as well as (5) institutions that offer it, for example, "Dignitas" from Switzerland (*P* < 0.0001), and (6) are against their introduction in Germany (*P* < 0.0001). There was no significant association between religiosity and the following questions: (7) "Is death a part of life?" (*P* = 0.072), (8) "Is every human life worth living, no matter the circumstances?" (*P* = 0.057), (9) "Would you resuscitate a patient who holds an advanced directive that clearly states he/she does not want to be resuscitated?" (*P* = 0.642), and (10) furthermore, there were no differences between the religious denominations and accordingly the nondenominational [Table 3].

There was a strong correlation between work experience and the following questions: (11) "Is death a part of life?" (*P* = 0.032), (12) "Is withholding resuscitation ethical?" (*P* = 0.048), (13) "Are you confident about treating palliative care patients medically?" (*P* = 0.026), (14) "Would you hospitalize a patient who holds an advanced directive?" (*P* = 0.001), (15) "Would you resuscitate a patient who holds a DNAR order?" (*P* = 0.002), (16) "Are you cognizant of how to handle advanced directives legally?" (*P* = 0.009), and (17) "Do you always act according to the law?" (*P* < 0.0001). More experienced paramedics think that death is more a part of life than the less experienced, furthermore they would not hospitalize a patient who holds an advanced directive, would not resuscitate a patient who holds a DNAR order, and think that they know the legalities of handling an advanced directive legally but at the same time do not always act according to the law.

Paramedics whose training included palliative care medicine or who attended further education in palliative care medicine were (18) more confident in handling advanced directives legally (*P* < 0.0001) and (19) were more competent in treating palliative care patients medically (*P* < 0.0001) and (20) psychologically (*P* < 0.0001) and (21) their relatives psychosocially (*P* = 0.008). Surprisingly, they found it more reasonable to resuscitate (22) dying patients and (23) palliative care patients (*P* = 0.003; *P* = 0.008) and (24) to withhold resuscitation less ethical. They also knew the local facilities for treating palliative care patients better than their colleagues (25), a fact that seems to be important because, the better the facilities are known to the paramedics, (26) the more confident they are in treating the patients medically (*P* = 0.021), (27) psychologically (*P* = 0.018), and (28) their relatives psychosocially (*P* < 0.001).

Paramedics who have personal experience with a palliative care patient in their private surroundings were (29) better equipped to treat patients' relatives psychosocially (*P* = 0.027), but on the other hand (30) knew less of the local facilities (*P* = 0.002) and (31) had attended less further education on the topic (*P* = 0.001).

DISCUSSION

R/S beliefs can affect paramedics in judgment making, in our case concerning hospitalization, and can influence paramedics' opinion on whether or not death is a part of life.

However, other factors impact the matter even more. The current law in Germany prohibits paramedics from withholding resuscitation (*P* < 0.001) even if there is a DNAR order on scene.^[9] Similar results were discovered in a survey among Muslim physicians, where the country of origin and practice rather than R/S beliefs played the major role in end-of-life decision-making. The Sharia law in Saudi Arabia, for example, states that decision of DNR is left up to the treating physicians, whereas the law in the USA states that patient autonomy is the highest priority regardless of religion.^[24] In our study,

76.6% of the paramedics stated that they had no legal latitude in withholding resuscitation in a dying and terminally ill patient. “Failure to render assistance,” “legal uncertainty,” “only a physician may declare someone dead, so I have to start,” “fear of jurisdictional consequences,” and similar reasons were given by the paramedics as to why they would start resuscitation. These answers were repeated throughout the survey. About 74.5% would not resuscitate a dying patient who has an advance directive or DNR order, were there given legal certainty.

Only 9.8% of the participants in our study think that they are competent to handle advanced directives in accordance with the law, a fact that correlates with their training in palliative care medicine ($P < 0.0001$), and 72.2% stated that they had not received any. Over half of the respondents in the survey on Muslim physicians did not receive training in palliative care medicine either.^[24]

More experienced paramedics would not always act according to the law, for example, they would not hospitalize a patient holding an advanced directive, would not resuscitate a patient holding a DNAR order, and consider themselves competent in handling an advanced directive legally. Work experience must, therefore, also be seen as an influencing factor. These results differ from the survey on Muslim physicians, where no correlations between work experience and end-of-life decisions were found, but agree with the study of Younger’s *et al.* conducted in the US, where a stronger correlation between professional background and attitudes toward euthanasia was found, and also Davis’ *et al.* study conducted in seven countries, where a negative correlation between work experience and holding to religious doctrines was found.^[24,39,41]

The paramedics’ abilities in treating palliative care patients medically and the patients’ relatives psychosocially depend on whether or not palliative care was part of the paramedics’ training and whether the paramedics attended further education and knew about the regional infrastructure for treating palliative care patients ($P < 0.001$; $P = 0.021$; 0.018 ; $P < 0.001$). The results of our research were absolutely comparable with those of the literature review. Study design, number and type of participants, and limitations were much the same as in the other investigations. Other studies, which showed influence of R/S beliefs, have in common that participants asked for more intensive treatment and more resuscitation and fewer life-shortening procedures for themselves or their patients.^[6,10,11,23,25,26,34]

CONCLUSIONS

In summary, R/S beliefs can influence paramedics in their decision-making, but other factors, such as professional experience, professional background, special training, and legal frame work conditions, seem to have much greater significance.^[24,39,41] In Germany, the current law and the lack of training and knowledge in the ever-more important field of palliative care medicine are limiting factors. England

and Wales could be examples for German jurisdiction, giving paramedics a legal frame work they can rely on, as a substitute to the current gray area.^[20] In the training program for paramedics in Germany, which is currently being adapted, palliative care medicine, including the required knowledge of the law and local infrastructure, deserves, in our opinion, much greater consideration.

Availability of data and materials

All data and materials are available upon reasonable request. Please direct your request to Mr. Alexander Leibold via email: alexander.leibold@stud.uni-regensburg.de.

Limitations of the study

Reliability or validity testing was not applied to our survey study. Due to the unknown number of paramedics with access to the websites mentioned above, an accurate response rate could not be determined. As the survey completion was voluntary, bias may have affected the responses.

To increase the response rate, a game of chance was offered to participants with the opportunity of winning one out of three Amazon® vouchers. Participants could write their email address anonymously at the end of the questionnaire. www.random.org was used to determine the winners.

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Conflicts of interest

There are no conflicts of interest.

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