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Suffering, Care, and the Boundaries of Life: Opinions of Care Home Employees on Euthanasia

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Abstract: The article presents the results of a qualitative study concerning opinions on euthanasia among women employed in care homes, where elderly residents predominate. The analysis aims to show how professional and personal experiences, as well as exposure to suffering, influence the formation of opinions about euthanasia. The article discusses the results of empirical research based on the theoretical frameworks of the ethics of care (Tronto) as well as emotional labour (Hochschild), also considering the issue of moral injury (Shay). The findings indicate that most respondents support the legalisation of euthanasia, justifying their stance through their knowledge of the dying process and their experience of accompanying others in suffering.

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Introduction

Euthanasia evokes strong emotions in Poland and remains illegal under Article 150 § 1 of the Penal Code and Article 151, which prohibits assistance in suicide. Although the issue of death on request has been present in Western European debates for decades, it has not become the subject of broad and in-depth public discussion in Poland. Attempts to initiate such a debate have been sporadic and have not led to real change, either in law or in public opinion. Unlike the issue of abortion, euthanasia has never attracted wide public attention in Poland, nor has it inspired legislative initiatives by politicians.

In line with contemporary bioethics and the European Association for Palliative Care (EAPC), this article uses the term "euthanasia" to talk about a doctor intentionally ending a life of a person by administering drugs at that person's voluntary and competent request. Following recent recommendations, the article refrains from the active/passive distinction. Practices previously labelled as "passive euthanasia" are discussed as withholding or withdrawing life-sustaining treatment (WD/WH), including the prevention of futile or disproportionate interventions. This distinction is analytically important, because WD/WH does not involve an intention to cause death; death results from the underlying illness (Materstvedt et al., 2003; Radbruch et al., 2016; Cholbi, 2017).

When the media address the topic, they usually do so in an alarmist tone, presenting euthanasia as a culturally 'foreign' phenomenon that threatens traditional values. In recent years, an attempt to break this silence has been made by Mateusz Pakuła (2021) in his book *Jak nie zabiłem swojego ojca i jak bardzo tego żałuję* (En. *How I Did Not Kill My Father and How Much I Regret It*), which describes the author's experience of accompanying his father through death from pancreatic cancer. Despite the numerous awards that the publication received, it did not lead to a broader public debate on the legalisation of assisted suicide.

Despite the importance of the issue in an ageing society, academic research on euthanasia in Poland remains limited and focuses mainly on legal aspects. Only in recent years have sociological and health science studies begun to analyse attitudes towards euthanasia. In 2023, the results of a study examining nurses' views on euthanasia were published. The analysis showed that 46.58% ($N = 68$) of nurses who completed the survey (Stępkowska, Reniec, 2023) supported the legalisation of euthanasia. In 2021, the Public Opinion Research Centre (CBOS) published a report entitled *The Attitudes of Poles Towards Selected Morally Controversial Phenomena and Behaviours* (CBOS, 2021), which also addressed the issue of euthanasia. The respondents were also asked about shortening the lives of terminally ill patients at their request and the study indicated that tolerance towards euthanasia had increased compared with 2013. In the 2013 survey, the respondents had been additionally asked to define euthanasia in their own words, and as the authors noted, "the most common definition given was 'death at the patient's request'" (CBOS, 2013).

This article aims to deepen the understanding of attitudes towards euthanasia through an analysis of the statements of women employed in care homes accommodating mainly elderly people. The voices of these employees are particularly significant, as they accompany their residents in suffering on a daily basis, observe the dying process, and confront its emotional consequences. This experience remains largely invisible to the broader society, yet it constitutes an important source of knowledge about how the boundaries between life, suffering, and dignity are understood (Tronto, 1993; 2013; Hochschild, 2009).

Against this background, the article addresses a certain gap in the literature. The existing research on attitudes towards euthanasia in Poland has focused mainly on nurses and the general public, while the perspectives of long-term care workers remain almost absent from academic debate (Lachowski, Lachowska, Florek-Łuszczki, 2024).

The aim of the article is not only to describe the respondents' opinions, but to reconstruct the moral logic that underlies their support for, ambivalence about, or opposition to euthanasia, and to situate this logic within broader debates on the ethics of care, moral distress, and end-of-life decision-making.

The ethics of care, the concepts of emotional labour, moral distress, and moral injury, as well as the literature on end-of-life decision-making both provide an analytical lens through which to examine how care home employees formulate their views on euthanasia. These frameworks make it possible to see their accounts not merely as individual opinions, but as situated moral reflections emerging from the relational, institutional, and emotional conditions of feminised care work.

Theoretical framework

The analysis of attitudes towards euthanasia among employees of care homes was situated within the theoretical framework of the ethics of care and the theory of emotional labour. The discussion primarily draws on the concept developed by Joan Tronto (1993; 2013), who highlights the relational dimension of care as a moral and social practice. In the author's approach, care is not limited to the performance of nursing activities but also encompasses attentiveness, empathy, and responsibility for another person in their vulnerability.

Care work, performed predominantly by women, involves constant exposure to suffering, dying, and death. As Arlie Hochschild (2009) observes, it represents a form of 'emotional labour' that requires the regulation and management of emotions in order to maintain caring relationships. In this context, discussions about euthanasia are not only moral reflections but also expressions of the emotional costs borne by care home employees.

The concept of moral distress (Jameton, 1984) is also significant for this analysis. It describes the tension experienced by individuals who know which actions would be ethically appropriate, but are unable to take them due to institutional constraints. Employees of care homes, who witness the suffering of their residents yet lack influence over decisions concerning the termination of futile therapy, frequently experience this kind of moral conflict (Pauly, Varcoe, Storch, 2012).

Another relevant point of reference is Jonathan Shay's concept of moral injury, originally developed to describe soldiers' experiences but increasingly applied to professions characterised by high emotional demands (Shay, 1994; 2014). The experience of helplessness in the face of suffering, the inability to alleviate pain, and the awareness of its inevitability may lead to long-term psychological strain (Pereira, Linzer, Berry, 2023). These analytical categories make it possible to understand more fully how care institution employees formulate their opinions on euthanasia – not only as a legal issue but also as an everyday ethical dilemma.

International research on attitudes towards euthanasia has grown substantially over the last two decades. Studies among nurses and other health professionals show that support for assisted dying is strongly shaped by exposure to patients' suffering, professional role, religious beliefs, and national legal frameworks (Dierckx de Casterlé et al., 2006; Holt, 2008; Bellon et al., 2022; Hol et al., 2022). In qualitative studies of palliative and hospice nurses, the respondents often describe euthanasia or assisted dying as one of several possible responses to extreme suffering and as closely intertwined with their understanding of a "good death" (Dierckx de Casterle´ et al., 2006; Kellehear, 2007). At the same time, professional organisations and bioethics debates emphasise the need to distinguish between high-quality palliative care, withholding or withdrawing futile treatment, deep sedation, and active euthanasia (Oberle, Hughes, 2001; Pauly, Varcoe, Storch, 2012).

In Europe and beyond, debates on euthanasia and assisted dying have intensified, with several countries revising their legislation or considering legalisation (Cohen et al., 2006; 2013; Bartolomé-Peral, Coromina, 2020). Comparative studies based on large-scale surveys show clear cross-national differences in the acceptance of euthanasia and assisted dying, but also a general trend towards greater acceptance, particularly among younger and less religious respondents and those with higher levels of education (Cohen et al., 2006; 2013; Stolz et al., 2015; Bartolomé-Peral, Coromina, 2020). These analyses underline the importance of the broader cultural, religious, and institutional context in shaping attitudes towards euthanasia.

Thus, the analytical categories outlined above provide a framework for understanding how employees of care institutions articulate their views on euthanasia.

Methodology

The qualitative research presented in this article is based on twenty in-depth interviews conducted with women employed in care homes, where the majority of residents are elderly people. The women who took part in the study work in institutions located in various regions of Poland. The inclusion criterion was employment in a care facility in a position requiring interaction with its residents. The participants work as medical carers, orderlies, social employees, or psychologists. Each respondent knows the residents personally and interacts with them directly as part of her professional duties.

How do women employed in care homes for the elderly in Poland formulate their views on euthanasia?

How do women working in care homes shape their stance on euthanasia in relation to their professional experiences?

How do their experiences define the limits of when euthanasia is permissible?

The study was based on purposive sampling. Most of the respondents volunteered to participate after reading an announcement published on social media platforms owned by Meta. Additional recruitment methods included the snowball technique and direct contact with care institutions, which were asked to share information about the project with their staff. In total, twenty women agreed to participate in the in-depth interviews.

Only women were invited to take part in the study, which is to reflect their significant numerical dominance within care home staff. Employment in such institutions remains highly feminised both in Poland and across Europe, which is a phenomenon linked to the social attribution of caregiving and nurturing roles to women (Tronto, 1993; 2013; Simonazzi, 2009; Kubisa, 2014).

Employees of care homes encounter individuals at the end of life on a daily basis, often accompanying them during their final moments. Some also perform post-mortem care as part of their duties as medical carers. Given these professional experiences, the opinions of care home employees on euthanasia represent an important and underrepresented voice that deserves to be heard more widely.

Table 1 presents the sociodemographic characteristics of the respondents and their opinions on euthanasia.

Table 1. Sociodemographic data of the respondents

No.	Codename	Age	The length of service in a care home	Education	Province	Attitude towards euthanasia
1	2	3	4	5	6	7
1	W1	40	5	Higher	Silesian	Positive
2	W2	52	30	Secondary	Lodz Voivodeship	Positive
3	W3	42	18	Higher	Silesian	Positive with reservations
4	W4	43	12	Higher	Silesian	Positive
5	W5	44	9	Higher	Lesser Poland	Positive
6	W6	55	1	Secondary	Silesian	Positive
7	W7	55	33	Secondary	Silesian	Positive
8	W8	54	7	Higher	Silesian	Negative
9	W9	23	0.5	Secondary	Opole Voivodeship	Positive with reservations

1	2	3	4	5	6	7
10	W10	33	8	Secondary	Podlaskie	Ambivalent
11	W11	49	18	Higher	West Pomeranian	Negative
12	W12	31	4	Secondary	Greater Poland	Positive
13	W13	52	9	Vocational	West Pomeranian	Positive
14	W14	63	19	Secondary	Świętokrzyskie	Positive; supports WD/WH
15	W15	44	5	Higher	Świętokrzyskie	Negative
16	W16	36	1.5	Secondary	Świętokrzyskie	Positive in specific cases
17	W17	41	13	Higher	Silesian	Positive
18	W18	43	22	Secondary	Świętokrzyskie	Ambivalent
19	W19	56	5	Secondary	Silesian	Positive
20	W20	64	5	Secondary	Silesian	Ambivalent

Source: Author's own study.

Research results

The analysis of the interviews indicates that fifteen out of the twenty surveyed women supported the legalisation of euthanasia, three were opposed, and two expressed ambivalent views. The respondents' attitudes are deeply rooted in their professional, emotional, and biographical experiences. Given the chosen research method – the unstructured interview – the participants developed the theme of euthanasia at their own initiative and according to their individual needs. Some provided extensive justifications for their opinions, linking them to the trajectories of their own lives.

The most frequently recurring themes included the observation of elderly people's suffering and the accompanying sense of helplessness in being unable to alleviate it. The respondents' statements reveal an association between euthanasia and the preservation of dignity at the end of life. Several participants also related this issue to their own futures. When asked 'What do you think about euthanasia?', one respondent replied:

> That it should exist [euthanasia – author's note]. Because I myself would not want to suffer, to lie for weeks… Weeks, sometimes months, in bed, just fading away. I would like to have the possibility to decide to end my life. Maybe I said it like that now, but it is well thought through. I had thought about it before. When you look at people who suffer – really suffer – you cannot bear to watch. If I had the opportunity, I would put those people to sleep. (W7)

This statement expresses not only care and compassion for residents, but also anxiety about the respondent's own future. Daily exposure to the suffering of elderly people represents a heavy emotional burden (Hochschild, 2009), making the experience of late old age vividly tangible. In a society where the final stage of life is rarely discussed and most people do not care for seniors, work in a care home becomes an exceptional experience, revealing states that are collectively considered as taboo. In this context, euthanasia appears as a form of control over the inevitability of death, as well as a way of preserving one's agency.

The wish to be able to choose euthanasia at a personally appropriate moment was echoed by other respondents. Their statements clearly show that the issue extends beyond their residents; the right to decide when to end one's life was also discussed at the personal level, i.e. as something relevant to their own future.

> For myself, I would like to be able to make that decision while I am still conscious. (W9)

The respondents' views on euthanasia were shaped by both professional and private experiences. Direct contact with suffering – whether at work or among close relatives – reinforced in some the belief that assisted dying should be permitted.

> My father was 42 when he died of bone cancer. When he was still conscious and before he was given such high doses of morphine, you know what he said to my mother? 'If you love me, kill me'. Because he was aware. People who have cancer, who know there is no cure, are aware of what it means. You can endure only up to a point. Some people tolerate pain better than others. But at that moment, he had the right – he should have had the right – to say 'enough'. (W6)

All respondents who supported euthanasia mentioned the suffering of dying individuals as a decisive factor in their stance. Although euthanasia is illegal in Poland, they believed that the decision to end one's life in the case of serious illness should belong to the suffering person and that it constitutes a human right. The interviews reveal a tension between state law and human rights understood through the prism of empathy and individual freedom (Jameton, 1984; Tronto, 2013).

> I, who see people's suffering, really know… you know what I think? If nothing can be done anymore, if this person has truly been struggling for years, tied to the bed – unable to eat properly, comb their hair the way they want, get dressed, or speak – then euthanasia, I think, would not be a bad thing here. (W17)

Several respondents criticised the routine use of life-prolonging interventions in situations they perceived as clearly end-of-life (e.g. resuscitation attempts, tube feeding, transfusions). In their narratives, the preferred solution was the possibility of withholding or withdrawing life-sustaining treatment (WD/WH) and of avoiding futile or disproportionate therapy, rather than an active/passive framing of euthanasia. Conceptually, WD/WH is distinct from euthanasia because it does not involve an intention to cause death; it involves refraining from non-beneficial interventions while allowing death to occur from the underlying illness (Materstvedt et al., 2003; Radbruch et al., 2016; Cholbi, 2017).

> I am absolutely in favour. If a person suffers greatly – for example, Ms Basia[1] in the current care home – I believe she dreams of saying goodbye to life. I was thinking about this recently. In hospital, where now very old people are constantly admitted – some over 90 – a grandmother was admitted, at the very end of her life. And what did the procedural hospital do for her? A nasal feeding tube, because she could no longer eat on her own. Blood transfusions, because her parameters were poor – keeping her alive by force. And she had bedsores in her bottom and everywhere, 'blooming' as I say. At that moment, jokingly, I said to the doctor who ordered those procedures: if I ever end up here like that, in such a condition, please – no tube, no transfusion, just 50 units of insulin under the tongue. (W2)

Some respondents worked in both care homes and hospitals. This dual experience often reinforced their position on euthanasia. The following respondent shared the view that burdensome life-prolonging therapies deprive people of the right to die with dignity:

> I have said it openly – I told my children that if something happens, please let me go with dignity. Because I will no longer help you in any way; I will be the one suffering, and you will have to watch it. Why? It happens so often. I had a patient who had terrible bedsores – on her heels, her hips – and after a hip operation, you could see the prosthetic joint. Should it be like that? Is that a dignified death? (W14)

Continuing, the same respondent referred to medical interventions, emphasising that the existing medical and institutional procedures prolong life at the expense of its quality. In analytical terms, this account is best understood as support for withholding or withdrawing futile or disproportionate treatment (WD/WH), rather than as support for euthanasia.

> It is a very individual matter. In such cases, it is clear that the person would have died long ago without medicine – much earlier. But now, with all the drips and interventions, life is artificially sustained. We do not let that person go. We do not allow them to die. (W14)

Several respondents stated that their views on euthanasia had been shaped by their professional experience. Daily encounters with illness, death, and the loss of autonomy were key sources of ethical reflection. Such work experiences can also lead to chronic psychological strain similar to what is defined as moral injury, i.e. a sense of being forced to witness suffering without being able to intervene (Shay, 1994).

> Many people, I tell you, often say they would like to die already, that they don't want to suffer anymore, that if they had known earlier or had the strength, they would have ended their life themselves. I have heard many such stories from residents. (W12)

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[1] The names have been changed to ensure the anonymity of the interview participants.

These statements show that working in a care home entails constant confrontation with the extreme conditions of human life – experiences that most members of society encounter only indirectly. In this sense, care home employees possess a specific, practical knowledge of suffering and death – knowledge unavailable to those not engaged in care work (Hochschild, 2009). Perhaps for this reason, even those with doubts often referred to the right to choose, recognising the inevitability of death while rejecting the necessity of meaningless suffering. In such cases, the legalisation of euthanasia appeared as an expression of respect and, paradoxically, as an extension of care itself.

> In some cases, I think yes. But not in all. It should be very carefully verified. We have two men who have been lying completely motionless for two years, unable to move a finger, unable even to close their mouths. In such cases, I believe euthanasia should be legal, because all they do is suffer. (W9)

> I think I also have doubts… From my point of view, when I see people who truly suffer, then yes – absolutely. But then: where is the boundary that we can decide whether to end someone's life? And then I'm arguing with myself… Sometimes I try to be very gentle so that what I have to do around that person hurts as little as possible. So on the one hand, yes, I'm in favour. But on the other, I have… I don't know… doubts. (W18)

The multidimensional nature of the respondents' attitudes is also reflected in ambivalent statements, where women struggle to reconcile compassion with religious beliefs:

> I am a believer, and I would be lying if I said otherwise. There is so much suffering, so much pain, that it should be allowed. Similar to abortion, there may be situations where such a decision should be permitted. Because that suffering is terrible – for the person and for the family. And I know I might be offending God right now, but I cannot lie. (W13)

One respondent who opposed euthanasia also referred to the issue of suffering, seeking a compromise between compassion and her moral convictions:

> I think it should not exist at all. But sometimes that suffering should be shortened a little – that's just my reflection. (W15)

Discussion

The findings of this study indicate that care home employees, working primarily with elderly residents, have formed their opinions on euthanasia through professional experience. Their perspectives are not based solely on ideological or religious beliefs; rather, it is their daily contact with suffering individuals that has become the source of reflection on the boundaries of care and human dignity.

Care home employees perform not only physical but also emotional labour, which requires them to maintain empathy under systemic constraints. In this sense, their attitudes towards euthanasia constitute a form of moral reflection grounded in practice rather than an abstract contemplation of life and death.

The respondents' statements also reveal the relevance of moral distress (Jameton, 1984), i.e. a sense of inner conflict resulting from the obligation to act according to procedures which, in their view, prolong suffering. As research among nurses has shown, such experiences can lead to compassion fatigue, professional burnout, and a loss of meaning in one's work (Arends et al., 2022; MacTavish, Dupuis, 2025).

Importantly, the interviews reveal a terminological slippage: some respondents used the term "euthanasia" when describing the withholding/withdrawing of life-sustaining treatment and the avoidance of futile therapy. Given the persuasive and normative weight of end-of-life terminology, this article analytically distinguishes euthanasia from WD/WH and interprets the respondents' accounts accordingly.

In the context of the ethics of care (Tronto, 1993; 2013), it can be observed that the respondents' attitudes reflect a need to integrate care with autonomy, which is a model of care that combines empathy with respect for the patient's decisions. Although the care home employees do not explicitly refer to ethical theories, their statements articulate an understanding of care close to a relational model of morality: care does not only mean sustaining life but also recognising the right to pass away.

The study further suggests that religion is not a factor that unequivocally determines attitudes towards euthanasia. However, since this theme appeared distinctly in only one statement, it requires further examination and deeper analysis in future research. It may be hypothesised that attachment to value systems characteristic of a given faith is subject to reinterpretation when individuals experience suffering themselves or are exposed to the pain of others (Kellehear, 2007).

From the perspective of care home employees, the findings demonstrate that the discussion on euthanasia in Poland cannot be limited to legal or moral dimensions alone but must take into account the realities of care work. It is within these institutions that the consequences of population ageing, the underfunding of the social care sector, and the lack of systemic emotional support for staff are most visible. The respondents' statements bear witness not only to their views but also to their daily confrontation with helplessness in the face of suffering – a situation in which neither law nor ethics provides clear answers.

The study thus extends Polish debates on euthanasia – which have so far focused mainly on medical professionals and the general public – by foregrounding the situated moral reasoning of long-term care workers (CBOS, 2013; 2021; Stępkowska, Reniec, 2023). In doing so, it empirically links the ethics of care (Tronto, 1993; 2013), emotional labour (Hochschild, 2009), and moral distress (Jameton, 1984; Pauly, Varcoe, Storch, 2012) with concrete institutional contexts, showing how macro-level regulations are interpreted and sometimes contested in everyday practice.

Conclusion

Euthanasia remains a marginal and moral taboo subject in Poland, even though population ageing and the growing number of chronically ill individuals both prompt broader reflection on death. This article has sought to show how care home employees (women) who rarely take part in public debate formulate their views on euthanasia on the basis of everyday exposure to suffering and institutional constraints.

The value of experiential knowledge for care home staff

The respondents' accounts point to the need for organisational and ethical support for care home staff who routinely accompany residents in prolonged dying processes. Their experiential knowledge highlights how institutional procedures (including those towards life-prolonging interventions) can generate moral distress and emotional strain. Creating spaces for ethical reflection, supervision, and training on end-of-life decision-making – including how to recognise and avoid futile or disproportionate treatment – may help staff navigate these tensions (Pereira, Linzer, Berry, 2023; MacTavish, Dupuis, 2025).

The value of experiential knowledge for euthanasia discussion

For the broader euthanasia discussion, the data shows that support, ambivalence, or opposition is often articulated through a close observation of suffering and through frustrations with invasive, non-beneficial interventions. The findings therefore underline the importance of conceptual clarity in public and policy debates: euthanasia (ending a life on request) should not be conflated with withholding/withdrawing life-sustaining treatment (WD/WH), palliative sedation, or the prevention of futile therapy (PTAiIT, TIP, 2025). Including the perspectives of long-term care workers can enrich debates that in Poland have so far focused mainly on legal analysis, physicians, and the general public.

By foregrounding these tensions, the article contributes to both international and Polish discussions on euthanasia and assisted dying by introducing the underrepresented perspective of long-term care workers. Future research could examine how moral distress, institutional constraints, and the taboo status of euthanasia shape not only private opinions but also the willingness to speak publicly.

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Cierpienie, opieka i granice życia: opinie pracownic domów opieki na temat eutanazji

Streszczenie: Artykuł przedstawia wyniki badań jakościowych dotyczące opinii na temat eutanazji wśród kobiet zatrudnionych w domach opieki, w których przeważają osoby starsze. Celem analizy jest pokazanie, jak doświadczenia zawodowe i osobiste, a także ekspozycja na cierpienie wpływają na kształtowanie się opinii na temat eutanazji. W artykule omówiono wyniki badań empirycznych opartych na teoretycznych ramach etyki opieki (Tronto) oraz pracy emocjonalnej (Hochschild), a także rozważano kwestię krzywdy moralnej (Shay). Wyniki wskazują, że większość respondentek popiera legalizację eutanazji, uzasadniając swoje stanowisko wiedzą na temat procesu umierania i doświadczeniem towarzyszenia innym w cierpieniu.

Słowa kluczowe: eutanazja, praca opiekuńcza, etyka opieki, praca emocjonalna, domy opieki, starość, cierpienie, zawody sfeminizowane