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When Patients Request the Prohibited: A Qualitative Exploration of Relatives' Experiences in French Palliative Care Units

Daniel Fischer[1]*, Laura Meier[1], Thomas Braun[2], Stefan Koch[2], Felix Roth[1]

[1]*Department of Integrative Nursing Research, University of Freiburg, Freiburg, Germany.*
[2]*Department of Palliative Clinical Sciences, Karlsruhe Institute of Technology, Karlsruhe, Germany.*

Abstract

In places where both euthanasia and assisted suicide are forbidden by law, such as France, almost nothing is documented about the way an end-of-life patient's explicit request for these acts influences the patient's family members. To examine the personal experiences of family members whose loved ones are in the final phases of a life-threatening disease, admitted to a Palliative Care Unit (PCU), and who have asked for euthanasia or assisted suicide, all within the French setting in which these procedures are not legally allowed. We conducted a qualitative investigation across five French PCUs over a full 1-year period. Applying grounded theory principles, we carried out semi-structured interviews with relatives of patients who had directly voiced a request for euthanasia or assisted suicide to medical staff. Two separate interviews were arranged: the initial one within 48 hours of the first request (D1) and the follow-up interview 7 days afterward (D7). Detailed face-to-face conversations were held with relatives of patients seeking euthanasia or assisted suicide. These took place in PCUs located in a specific area of France and occurred before the enactment of the French Claeys-Leonetti Law. The data underwent thematic analysis.
A total of ten semi-structured interviews were completed. Five families, comprising the patients and their relatives, participated in the research, resulting in 8 relatives being interviewed. Talks held between the patients and their family members regarding the request for euthanasia or assisted suicide differed markedly depending on the family. Five central themes surfaced: criticizing the conditions at the end of life; longing for a calm and serene death; differing extents of backing and help offered for the request; personal beliefs that endorse euthanasia and assisted suicide; and limits together with obstacles. Family members generally show understanding toward requests for euthanasia and/or assisted suicide. Even so, accepting and discussing such demands is a tough, emotionally heavy responsibility that can create considerable strain. Virtually every relative goes through some form of distress, yet the manner in which this distress appears can vary widely from person to person. We recommend that healthcare staff recognize the specific nature of this distress and encourage both patients and their relatives to speak openly about these concerns while addressing the request in an active, forward-looking way.

Keywords: Assisted suicide, Euthanasia, Palliative care, Qualitative research, Relatives' experiences, Terminal illness

Introduction

During a severe illness, some patients ask for euthanasia or assisted suicide (EAS) because of the distress they are enduring and then disclose this wish to a family member or caregiver [1-3]. Apart from the patients, relatives commonly observe the many hardships that accompany the terminal phase. Research in this area underscores the fragility, mental pressure, and pain felt by the patient's close family [4-6]. As a result, assisting both the patient and the family has become an integral element within the broad definition of palliative care [7]. Although the

Corresponding author: Daniel Fischer
Address: Department of Integrative Nursing Research, University of Freiburg, Freiburg, Germany.
E-mail: ✉ daniel.fischer@outlook.com
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subject of EAS requests from the perspective of relatives or caregivers has not been thoroughly examined [2], relatives have been included in some studies. The bulk of the existing information stems from nations that have legalized at least one form of assisted dying, such as Canada, Oregon in the United States, Switzerland, Belgium, and the Netherlands [8].

In countries that have legalized euthanasia and/or assisted suicide, the bulk of research centers on what families go through when a sick relative undergoes medically assisted death. These investigations examine how relatives become involved and provide support both before and during EAS. A few of them also indicate that relatives can sometimes influence the patient's final decision to proceed [8-11]. Other publications focus on the stories of grieving families and illustrate how EAS affects them [8, 12, 13]. Several of these works review different stages of the bereavement journey and supply practical ideas for supporting people through grief.

Much less is documented concerning patients—and the families supporting them—who have voiced a wish to die or requested EAS yet have stopped short of carrying it out. A single study from the United States looked at the two-way connection linking the patient's desire for death, the way relatives reacted, and whether accelerated death eventually happened or not [14]. Its authors reported that, within their group, "patients who expressed the wish to die and those who acted on that wish differed mainly in family support for hastening death" [14]. This matches the conclusion of another piece of research, which found that opposition by the family serves as a "common predictor of patients not achieving a physician-assisted suicide" [15]. Yet another American investigation contrasted how much family members participated in hastened death in Washington state, where assisted suicide is banned, versus Oregon, where the practice has been permitted since 1994 [11]. The team identified several participation patterns: complete refusal to join in; readiness to stay present only if they did not have to take an active role; or full engagement (which included collecting details, getting a prescription, arranging the steps, and similar actions). Furthermore, they pointed out that in places where assisted suicide is against the law, "patients and families have the additional tasks of negotiating with healthcare providers for information and prescriptions for lethal medications, with (or without) overt support" as well as "managing the environment" or "preparing back-up plans in case of complications" [11].

Regardless of the legal rules in force, the position of family members is always intricate; however, in nations such as France, where euthanasia and assisted suicide are outlawed, the question of how relatives react emotionally to these kinds of requests tends to be ignored [8]. The current research examines real-life encounters of family members who must deal with these scenarios. The goal was to grasp the experiences of relatives of patients who have reached the advanced stage of a grave illness, are staying in a Palliative Care Unit (PCU), and are asking for EAS inside the French environment, where the practice continues to be unlawful.

Materials and Methods

The presentation of this study adheres to the Consolidated Criteria for Reporting Qualitative Research [16, 17].

Research team

This multidisciplinary research group included five women. Among them, two held PhDs (FMN, a psychologist, and AC, a social anthropologist), one was an MD with a PhD specializing in palliative care (MG), and two held master's degrees in human and social sciences (HT and CDC). Both the physician and the psychologist maintained active clinical positions in PCUs, while one researcher also worked as a nurse (AC).

Setting and recruitment

Within a wider research initiative titled "Requests for Euthanasia and Assisted Suicide" (DESA), we performed a qualitative investigation running from October 2014 through November 2015. DESA represented a multicenter, forward-looking, qualitative project encompassing 11 PCUs across two French regions. In every case, the plan was to include three individuals: (1) the patient who had openly asked for EAS, (2) the healthcare provider who had been informed of the request, and (3) a family member selected by the patient. Although the full project gathered data from patients, relatives, and healthcare staff, the present article reports only results from relatives and draws on 5 PCUs.

We held thorough face-to-face conversations with family members of patients who had requested EAS. These interviews occurred in PCUs located in a single French region and took place before the adoption of the French Claeys-Leonetti Law. When patients consented, they personally identified which relatives would join the study. Relatives were enrolled only after they voluntarily agreed to take part. All relative names used here are fictitious **(Table 1)**.

Table 1. Characteristics of patients and their relatives.

Relative – name	Sex	Age	Relationship to patient	Interview day 1	Interview day 7	Patient code	Patient sex	Patient age	Medical condition	Family context	Ongoing nature of the request
Alice	F	44	Daughter	Yes	Yes	A	F	69	Lung cancer	Married; 2 children; residing at home	Yes (both verbal and written requests for 3 years)
Arthur	M	70	Husband	Yes							
Ben	M	61	Brother	Yes	Yes	B	F	70	Metastatic colon cancer	Separated; 2 children; residing at home	Yes
Charles	M	73	Son	Yes		C	F	95	Gastrointestinal bleeding and polyarthritis	Widowed; 2 children; living in a nursing home (EHPAD)	Yes (for 12 years)
Cathy	F	70	Daughter		Yes						
Debbie	F	62	Daughter	Yes		D	F	84	Breast cancer	Widowed; 3 children; residing at home	Yes (expressed daily)
Danielle	F	65	Daughter		Yes						
Emily	F	46	Daughter	Yes		E	F	75	Metastatic colon cancer	Widowed; 2 children (one deceased); residence not specified	Yes (expressed daily since hospitalization)

EHPAD, a French care home for dependent older people.

Data collection

We relied on convenience sampling, adding participants step by step as patients named relatives and those relatives gave their consent. Two in-person meetings were arranged for each family member: the first on the day after the request was made (D1) and the second exactly one week afterward (D7). An interview outline specifically designed for relatives was developed using insights from the published literature, earlier research projects, and the team's professional knowledge and practical experience.

The goal was to explore three main areas: (1) how the family member first responded when hearing the request; (2) the nature of their connection with both the patient and the palliative care staff; and (3) their personal outlook on dying, euthanasia, and assisted suicide. The outline followed thematic sections and began with the following opening prompt: "You kindly accepted to join this research project about the request your loved one shared with the medical team; could you describe what happened?". Every interview was conducted on-site inside the PCU by two researchers (FMN and AC). All sessions were audio-recorded, stripped of identifying details, and transcribed in full. Observational notes were recorded both during the interviews and immediately afterward. The interviewers had no previous relationship with any participant. Healthcare professionals and patients introduced them to relatives as simply researchers working in a clinical context.

Data analysis

We gathered and examined the material following grounded theory principles. Our overall strategy was influenced by ethnographic methods that aim to form ideas and assumptions directly from real-world observations [18, 19]. Three researchers (AC, FMN, CDC) performed a thematic analysis using the approach proposed by Braun and Clarke, each handling a separate layer of coding independently [20]. The resulting interpretations were reviewed together by the whole team and confirmed by every author. Given the highly sensitive subject matter, neither the transcripts nor the conclusions were returned to the participants for review. While some themes had been expected beforehand, many others surfaced naturally from the data during repeated examination. We explored diverse and multifaceted scenarios, even though the group of relatives remained small. Recruitment challenges forced us to end the study before full data saturation was reached (see Section "Limitations and strengths"). To approach saturation, we conducted comparative analyses across the three participant groups (patients, healthcare professionals, and relatives). A complete description of the analytical steps appears in an earlier publication [21].

Results and Discussion

Description of the sample

Eleven patient requests were recorded over the 1 year. Of these 11 cases, relatives could be interviewed in only 5 instances. The remaining six patient situations could not be included for the following reasons: relatives did not reply to the invitation to participate (2/6); relatives had not been told about the request (2/6); relatives were grieving (1/6); or it was impossible to arrange an in-person meeting with the relative (1/6). Recruiting family members proved challenging for several additional reasons (see Section "Limitations and Strengths"). Eight relatives participated in the interviews. In three cases, two family members were interviewed; in two, only one. In total, 10 semi-structured interviews were conducted (6 at D1 and 4 at D7). The interviews ranged in duration from 17 to 62 minutes. For the second interview, patient E had died before day 7, so neither the patient nor her family members were interviewed on D7. The relatives (5 females and 3 males) consisted mainly of the patients' sons and daughters (6/8), and all patients in this article were female. The demographic details of the participants are presented in **Table 1**.

Except for one case, all families expressed their views on the care and assistance offered by the palliative care team. They reported a generally positive encounter despite the emotionally demanding nature of their interactions with healthcare staff. Five relatives observed an improvement in the patient's psychological condition and/or more effective control of pain and resistant symptoms. Several relatives spoke of a "sense of safety" or "reassurance" for both the patient and themselves after entering the unit. Four of them praised the attentive listening and constant availability of the care providers, while two also highlighted the team's skill and compassion. Relatives further portrayed the PCU as "a special environment" (Charles), "an extraordinary opportunity" (Alice), or "a true blessing" (Debbie).

Nevertheless, the purpose of palliative care remained unclear for some. Alice mentioned that she and her family were uncertain about "what options exist at the end of life" and what kind of assistance they could anticipate from the staff. Even though every participant was aware that euthanasia and assisted suicide are prohibited under French legislation, two of them continued to hope for some form of "assistance to end life." One patient herself appeared confused on this point. According to Emma, her mother was pleased about being admitted to the PCU because she believed she would be granted euthanasia there. Participants displayed widely differing statements and levels of understanding regarding euthanasia and assisted suicide. Relatives did not consistently separate the two concepts; for instance, Debbie remarked: "euthanasia or assisted suicide — it doesn't really matter what name you use."

Conversations surrounding the request for EAS differed substantially across families. Three families spoke with the patient about the request frequently, or even daily. Danielle, for example, noted: "We discuss it every single day […] especially for Mom, we talk quite a lot." In contrast, another family had not addressed the topic for several weeks, as Ben described. In one instance, relatives repeatedly tried to raise the subject. Still, the patient avoided the discussion, possibly linked to the relative's own stance on euthanasia: "She doesn't seem eager to talk about it. I tried again gently, but you can tell she's not interested […] she knows I oppose euthanasia, so that might have discouraged further conversation" (Cathy).

In two families, an unspoken rule surrounded the request. Relatives chose not to introduce the topic themselves and instead waited for the patient to start the conversation: "She mentions it, but we never do. […] I would never feel comfortable bringing it up with her directly" (Alice); "I thought it was better to let her raise the issue rather than pressuring her" (Ben).

Thematic analysis

The following five themes emerged from the various ways family members reacted to and backed the patient's request for EAS.

Theme 1—Denouncing end-of-life conditions

Relatives strongly criticized the circumstances surrounding the patient's final days, often viewing the situation as illogical or deeply wrong. One daughter commented: "It's true that some older people grow weary of living. In those cases, should their wish be respected? […] why not?" (Debbie). Her sister raised further concerns about people at the end of life and the purpose of ongoing sedation: "What feels completely wrong is […] keeping the person alive longer […] why continue for another three days […] what is the point […] I don't understand why we let someone remain unconscious like that — why can't they pass away sooner when we know nothing more can be done?" (Danielle).

Two relatives drew comparisons between the end-of-life treatment of humans and animals: "Once more, being treated even worse than an animal while people deny this option (euthanasia) just doesn't seem humane!" (Alice). The brother of one patient stated, "When a dog is suffering, we don't allow it to endure pain!" (Ben).

Participants insisted that it was unacceptable to let individuals die under such distressing conditions: "Is it really humane to leave people in that state? Especially when we know she is going to die regardless" (Alice); "this matters a great deal because we simply cannot abandon people like that — not for the family and not for the

patient either" (Emily); "there are situations that shock me deeply; how can human beings just look away and allow things like this to continue?" (Ben).
Relatives considered the final stage of life meaningless in these conditions, leading them to criticize it openly. At the same time, none of them expressed any negative judgment toward palliative care, which all who mentioned it described favorably.

Theme 2—Desire to have a peaceful death
Desire for the loved one to have a peaceful death
All relatives hoped their family member would experience a calm and dignified passing. Speaking of her mother, Alice said: "Her biggest fear is suffocating to death, and she desperately wants to avoid that ending." Another daughter believed euthanasia could deliver a gentle conclusion: "a soft death without violence" (Debbie). Four relatives stressed their strong preference for a death free from pain, as one patient's brother expressed: "Without any suffering at all. Just letting it happen quietly… That is what I wish for with all my heart" (Ben).

Desire for a peaceful death for themselves
Many relatives felt they should have the right to make decisions about their own death and retain some control over how it unfolds. This reflection also involved imagining their personal future dying process. Two relatives expressed this view clearly, including Alice, who stated, "Cancer has struck almost everyone in my family, so I realize there is about a 90% chance it could happen to me one day. I have no children, […] I would face it completely alone, and yes, I want the reassurance that I will not have to die in such a terrible way." In this light, the possibility of euthanasia acted as a form of safeguard. Simply knowing the option exists could ease mental burden even if it is never used, as Alice explained: "It is very comforting to know it is available, even if we never actually choose it. We have quite a few Swiss friends who belong to those organizations […] I understand that only around 10% of registered members eventually use the option, but the guarantee itself is important […] That the possibility is there in case the worst scenario unfolds."

Past experiences of violent death
The longing for a peaceful death — both for the patient and for themselves — was often strengthened by earlier encounters with traumatic or agonizing deaths. Six relatives described other family deaths they had witnessed, and two of these accounts were particularly distressing. Ben, for instance, was only 17 when his father died of lung cancer. He remembered the choking episodes vividly: "he was writhing on the floor in agony," describing the whole experience as "a nightmare." He explicitly connected his sister's current situation to those painful memories: "I cannot bear the thought of my sister going through anything like that — not like what happened to my other sister, ending up like a lifeless shell!" (Ben). Another relative recalled a harrowing event: "My grandmother suffocated right in front of me. I do not ever want to live through that again" (Alice).

Theme 3—Different levels of support and accompaniment for the request of EAS
All family members understood the patient's wish to avoid pointless prolongation of life and the exhaustion that comes with it. Still, the degree of support and emotional response from relatives differed considerably. Five relatives did not personally want the patient to die, yet they set aside their own feelings to honor the request and respect the patient's final preferences. Arthur explained his position this way: "[…] I have always promised my wife that I would never do anything to interfere with […] her own choices."
Providing this support sometimes caused significant inner conflict. Emily described the tension she felt between wanting to keep her mother close and accepting her mother's wish: "Even though she is going to leave us, I know it is what she needs — it is necessary for her — but for me it is going to be extremely painful [cries] when she is gone. […] Even if euthanasia had been allowed, I would have agreed to it because, hard as it is for me, it represents the only real solution left for her. There are no other options […]."
One relative fully agreed with the patient's desire for euthanasia, mainly because he feared a painful death and found it increasingly difficult to keep offering care. Ben hoped for a gentle passing for his sister while also questioning whether the timing was right: "I think that even if she asked for euthanasia today, she might not actually be prepared for it yet."
In one family, a clear mismatch existed between the relatives' beliefs and the patient's values. Charles was willing to accept euthanasia under certain conditions, especially if his mother's health declined to a state he found intolerable ("I did not want her to linger on like a vegetable […]. That was where I drew the line"). His sister Cathy, however, understood the patient's tiredness of life but could not support the repeated requests: "I do get that […] she is exhausted from living […]. But I do not believe she should ask me to participate in actions I cannot agree with!"

Theme 4—Values in favor of EAS

Among the relatives in our group, several actively supported the patient's personal values and, in some cases, asserted a general right to die. Four relatives emphasized the principle of personal autonomy: "Just as Mom often says, we should have the right to … manage our own life the way we choose" (Danielle); "[…] having a genuine choice and freedom to decide is fundamentally about personal liberty" (Alice); "When someone who is fully conscious asks for it, it is their life — it belongs to them. […] When you reach the stage where there is no hope left, and suffering is constant, I believe the choice should be available" (Ben); "[…] I would argue that any viewpoint can be defended, but in the end, everyone must decide according to their own conscience" (Debbie).
For two relatives, euthanasia and assisted suicide were perfectly compatible with compassion. Debbie viewed it as an act of love, while Ben saw it as a humane response to a loved one's suffering: "I believe it can also be a profound expression of love that you offer to someone dear to you […]" (Debbie); "[…] that doctor who stood trial […] what he did was genuinely humane! […] When you truly care for someone, you do not want their suffering to drag on endlessly […]" (Ben). Conversely, when relatives placed their own values ahead of the patient's wishes and refused to support the request, two participants considered this behavior selfish. Ben referred to a prominent French legal case: "that young man in a coma whose parents refuse to stop life support […] in my eyes that is pure selfishness." Danielle expressed a similar idea more broadly: "Yes, I see that as lacking real love — it comes across as selfish."
Finally, four relatives clearly demanded legal recognition of the right to die. Alice, working as a lawyer, framed euthanasia as a matter of dignity and the freedom to control one's own body. Like Danielle, she drew a comparison with the right to abortion: "It represents a personal right tied to human dignity and bodily integrity. You already have the legal right to choose abortion […]" (Alice); "Just like women in the past who had to hide their abortions, […] the right to die should mean being able to pass away peacefully with loved ones nearby instead of having to travel abroad. […] It would be far preferable if […] assisted suicide were fully legal, allowing us to handle everything calmly and openly […] in complete legality, without constantly hovering on the edge of what is permitted!" (Danielle).

Theme 5—Boundaries and barriers
Most relatives who supported the idea of EAS indicated they would accept it if the practice were legalized in France. Debbie, for instance, stated: "If it could be carried out here in our own country, we would definitely agree." Five of them had also considered arranging the procedure abroad — mainly in Switzerland or Belgium — at the patient's request. Alice explained: "It was entirely her idea. She asked me to search all the relevant websites for information on Switzerland and Belgium, and I followed through with those steps, though they ultimately led nowhere."

In reality, all five relatives who explored foreign options found the processes impractical. Three highlighted the lengthy and complex administrative requirements, while two others noted that the patient's fragile health made international travel impossible. Two participants also mentioned financial limitations. Ben noted the substantial expense of assisted suicide in Switzerland, which he could not cover despite his willingness to do so. Arthur expressed discomfort with what he saw as profit-driven bureaucracy: "We had seriously looked into going to Switzerland […] where the rules are far more progressive than in France […] But we soon discovered a very commercial aspect to it. The money itself wasn't the main issue; it was disturbing to see how much the whole process revolved around financial transactions. On top of that, you had to go through multiple consultations and compile an entire medical dossier from scratch. When you are already exhausted by the situation, starting all over again in another country feels overwhelming."
In one situation, the two sisters turned to a French organization that advocates for the right to die with dignity. Together with their mother, Danielle and Debbie became members of the "Association pour le Droit de Mourir dans la Dignité." In another case, the repeated and insistent nature of the mother's requests pushed Alice to contemplate more extreme and illegal solutions: "We have considered every possibility. Acquiring a weapon… A friend of mine is a farmer, so we asked around about veterinary options… We have thought of everything. I even wondered about going out on the street to find heroin. I don't know — we have explored every idea imaginable to help her find relief at the very end."
Finally, although some relatives could imagine legal assisted dying as an option, actively taking part in any form of secret or illegal euthanasia remained completely unacceptable to them, regardless of their personal views on the topic: "We have no intention of ending her life with our own hands" (Alice); "I could never give her an injection to make her pass away […]" (Cathy); "She told me 'it would be better for me,' and I replied 'yes, I understand you are suffering, Mom, but I cannot do it… It is not possible. Even though I know how much pain you are in, I cannot bring myself to do it. The guilt would be unbearable, no matter how much you are suffering — I just wouldn't be able to live with it" (Emily).
The findings from this study build on and extend earlier publications [21, 22] by demonstrating that relatives are generally receptive and understanding of the patient's desire for EAS. In the present research, only one relative opposed the request, even though she clearly understood the underlying reasons. This stance appeared to stem primarily from a fundamental opposition to euthanasia and assisted suicide on ethical grounds. Such a conflict of

values between the patient and the family member created a major obstacle to open communication, leading the request to go unanswered within the family. The patient's longstanding wish — lasting more than 10 years — may have further contributed to this dynamic.

In contrast, our results indicate that in five cases, relatives chose to back the request for euthanasia and/or assisted suicide out of respect for the patient's final preferences, despite not wanting the patient to die. Some set aside their convictions without personally endorsing the request, placing the patient's values above their own. This approach often generated internal conflict and emotional distress, arising either from remaining silent or from the sense of reluctantly "yielding."

Other relatives gradually came to support the request after the patient helped them recognize its legitimacy, eventually becoming advocates for euthanasia and assisted suicide themselves. This convergence of values between patient and family seemed to develop through ongoing, regular conversations. Consistent with two previous studies, relatives felt a strong obligation to honor the patient's final wishes concerning assisted dying [15] and that "personal values and respect for the values of others played a central role" [23].

In the end, two family members accepted the request not primarily to respect the patient's wishes, but because euthanasia aligned with their own personal values and beliefs, provided certain conditions were satisfied. These symbolic boundaries related either to the timing of death (for example, "turning into a vegetable" or entering a prolonged dying phase) or to the manner of dying (one relative strongly preferred a calm death, whether natural or medically assisted, due to an intense fear of a violent end).

These four distinct positions illustrate the diverse ways in which families receive and respond to the patient's expressed request. Analysis of the relatives' accounts also shows that family members frequently challenge or openly criticize the conditions of end-of-life care. It can be inferred that by voicing these criticisms, relatives are attempting to reclaim an active role in the situation. Observing a loved one's final days without being able to offer meaningful help is profoundly difficult and distressing. By speaking out about these conditions, they may regain a feeling of influence and control. Serving as the patient's advocate likely helps them feel more connected to their loved one, while allowing them to imagine a better outcome and seek greater acknowledgment of the patient's unbearable suffering [21].

Relatives also repeatedly voiced a deep wish to prevent a violent or painful death and to achieve a calm, dignified passing — what Castra [24] termed "a pacified death" — both for the patient and for themselves (by projecting into their own future end-of-life). This often led them to view euthanasia and assisted suicide more favorably. This finding aligns with a recent systematic review that concluded: "witnessing the patient's suffering become intolerable throughout the course of the illness was a major factor motivating family members to support the request for assisted dying" [23]. Furthermore, having personally witnessed a loved one's violent or traumatic death emerged as a powerful reason for some relatives to endorse or actively champion EAS.

Many relatives openly advocated for the right to die, emphasizing principles such as self-determination, human dignity, and the freedom to control one's own body. This complements our previous observation that patients themselves seek to regain a sense of autonomy despite the constraints imposed by medical care [21].

In some cases, relatives regarded euthanasia and assisted suicide as expressions of humanity, love, or compassion, and they viewed refusal to support such requests as selfish. This viewpoint is consistent with results from other research [25, 26]. Additionally, both relatives and patients sometimes contemplated going beyond legal limits [21] by reaching out to pro-euthanasia groups, investigating options abroad, or considering services in countries where euthanasia and/or assisted suicide are authorized — even when these alternatives felt unsuitable or unrealistic to them.

Overall, these findings suggest that relatives experience suffering in every situation, although the form and intensity of that suffering differ markedly from one individual to another. It may appear as broken family communication, value conflicts, anxiety about a violent death, exhaustion from continuing end-of-life caregiving, despair linked to the patient's repeated requests in a context where EAS remains illegal, or internal emotional strain caused by placing the patient's values above their own feelings.

In this setting, relatives often criticize end-of-life conditions without blaming the PCU itself, largely because they fear a painful death and remain uncertain about what palliative care can realistically offer. We therefore recommend that healthcare professionals provide clear explanations of palliative care goals to both patients and their families. This should include outlining available options, such as respecting the patient's choice to refuse or discontinue treatment; focusing exclusively on symptom relief without aggressive interventions to prevent future complications; reassuring the patient about thorough symptom control; and, when appropriate, discussing the possibility of deep, continuous sedation.

Furthermore, it is crucial to establish a relationship of trust with patients and families while maintaining an empathetic, accessible attitude. Healthcare providers could also take the initiative to openly discuss any desire to die, as proposed by Kremeike *et al*. [27] A proactive approach involves asking directly and honestly about wishes for death in a suitable setting, allowing ample time for attentive listening and emotional expression, setting aside personal or team-related taboos, and carefully exploring the underlying reasons for the wish (such as pain, overall suffering, fear of a violent death, loss of meaning, and similar concerns). Through this, professionals would be

better equipped to support both patients and relatives with a more targeted response to the request [28]. They could additionally serve as mediators, facilitating dialogue between the patient and family members, and thereby helping to improve quality of life for those confronting the physical, psychological, social, and spiritual difficulties associated with life-threatening illness.

On the limitations side, the very frail condition of the patients, combined with the emotional fragility of grieving families, shortened the overall research timeline and sharply reduced the number of interviews that could be completed. The sample has aged considerably because data collection occurred between October 2014 and November 2015, well before the 2016 Claeys-Leonetti Law introduced expanded rights in French palliative care. Enrolling family members proved particularly difficult owing to frequent non-responses, unclear explanations about the project, and the limited number of relatives actually nominated by patients. Participation relied almost entirely on healthcare staff forwarding information to the research team, while the investigators themselves had only restricted access to patients and families; this lack of direct contact likely created a significant recruitment obstacle. The study was ultimately terminated before data saturation was reached due to persistent enrollment challenges. Although family members were followed at one-week intervals, no further observations were possible beyond that brief window. Those who agreed to participate may have held more favorable attitudes toward euthanasia and assisted suicide than relatives whom the patients never selected. As a result, the study may have overlooked the voices of individuals who felt more uncertain, firmly opposed, or simply reluctant to share their thoughts on these sensitive topics. The group studied was also quite narrow in scope, as all patients discussed here were women aged 65 or older. Certain personal backgrounds raise important questions about prior life events, family histories, and interpersonal dynamics; other samples might well have yielded different patterns.

As for strengths, the present work enriches our understanding of the larger setting in which patients voice requests for euthanasia and/or assisted suicide. It delivers useful knowledge about how family members live through and react to such requests, covering their immediate responses, personal conceptions of death, and deeper convictions concerning euthanasia and assisted suicide. Moreover, the research illuminates the wide range of suffering relatives can experience in these circumstances. It also generates meaningful data from a palliative care population that is typically hard to reach and even harder to involve in studies. In contrast to most international research on the topic, this article examines how a request for assisted dying is voiced, received, and dealt with inside families in a country where euthanasia and assisted suicide continue to be illegal.

Conclusion

Study participants recounted their encounters with a patient who had asked for euthanasia and/or assisted suicide in a nation where these acts remain forbidden, and during a period before the Claeys-Leonetti Law, when no lawful alternatives were available. A large number of relatives openly condemned end-of-life conditions as meaningless and unacceptable, often motivated by a strong dread of a painful or violent death and by uncertainty regarding the true purpose and possibilities of palliative care. Relatives commonly chose to back their loved one's request, frequently appealing to ideas of individual autonomy or human dignity. Even so, talking about these requests proved emotionally taxing and created substantial distress for family members, affecting both their personal equilibrium and family relationships. In certain cases, relatives sought ways to respond to the request so the patient would not be left in a situation both parties considered intolerable, which only intensified their own emotional strain. We strongly recommend that healthcare professionals take an active role in discussing these requests openly, recognize the different forms of suffering involved, and offer targeted support to patients and their families to reinforce and improve palliative care services.

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