

2018

Pre-Licensure Nursing Student Attitudes Toward Physician-Assisted Suicide

Stephanie K. Cox
University of Central Florida

 Part of the [Other Nursing Commons](#), and the [Palliative Care Commons](#)
Find similar works at: <https://stars.library.ucf.edu/honorsthesis>
University of Central Florida Libraries <http://library.ucf.edu>

This Open Access is brought to you for free and open access by the UCF Theses and Dissertations at STARS. It has been accepted for inclusion in Honors Undergraduate Theses by an authorized administrator of STARS. For more information, please contact STARS@ucf.edu.

Recommended Citation

Cox, Stephanie K., "Pre-Licensure Nursing Student Attitudes Toward Physician-Assisted Suicide" (2018). *Honors Undergraduate Theses*. 387.
<https://stars.library.ucf.edu/honorsthesis/387>

PRE-LICENSURE NURSING STUDENT ATTITUDES
TOWARD PHYSICIAN-ASSISTED SUICIDE

by

STEPHANIE K. COX

A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Nursing
in the College of Nursing
and in the Burnett Honors College
at the University of Central Florida
Orlando, Florida

Summer Term, 2018

Thesis Chair: Norma Conner, PhD

© 2018 Stephanie K. Cox

ABSTRACT

Physician assisted suicide (PAS) has been a legalized presence in the United States since Oregon first passed the Death with Dignity Act in 1994. Now PAS is legalized in six states and it is realistic that nurses may encounter PAS during their career. This project explores pre-licensure nursing student attitudes toward PAS.

A mixed method design incorporating descriptive correlation and thematic analysis of an open-ended question was used. Surveys were sent to 550 nursing students enrolled in the UCF nursing program asking participants to complete the 34-question survey. This survey included a 12 item “Domino scale” on student nursing opinions toward physician-assisted suicide, and a 23-item demographic scale.

Complete, usable results were obtained from 231 participants. Demographic data revealed that the typical participant was between 18 and 25 years of age (80%), female (82%), single (87%), white (69%), in their first two semesters of the nursing program (60%), and unemployed (56%). The total scores for the Domino scale indicated a mean of 40. Regression analyses found that participant experience of someone having asked for help with PAS, and participant religiosity were significant predictors ($F = 9.82, p = .0019$; and $F = 160.36, p < .0001$) respectively of nursing student opinions on PAS as measured by the Domino scale. Qualitative analysis produced the following themes related to participant opinion on the nurse’s role in PAS: ways nurses can help with PAS, nurses should not be involved with PAS, clarification and delineation of the PAS process, the preservation of autonomy, the need for more education and inaccurate assumptions of PAS.

This study showed that nursing students are moderately in support of PAS and willing to provide care to patients who are terminally ill regardless of a his or her personal decisions regarding PAS. Participants also comment that they desire additional education. Suggestions for further education, practice enhancements, research and policy development are discussed.

DEDICATION

This thesis is dedicated to my family.

To my dad, thank you for always telling me that I can do anything. If it wasn't for your crazy jokes and bottle caps I fear I might forget.

To my mom, thank you for your overwhelming and unconditional support. You have repeatedly helped me succeed at everything I do.

To Kelly, Amanda and James, thank you for surviving life with me. You all have been some of the best siblings anyone could ask for. And of course, Marc! You and Daniel have been a blessing to both my sister and my family.

To Grandmother, thank you for always being there to support me. I can't remember a time when you weren't on the front rows cheering me on.

To Pam and Bob, I appreciate your guidance as you continue to tell me I am more than I give myself credit for. Playing small doesn't serve the world.

Thank you for continually being here for me. I love you all.
Stephanie

ACKNOWLEDGEMENTS

I would like to acknowledge the College of Nursing Faculty for their persistence and direction as each of you offered me a superior nursing education that helped develop me into the student that I am today. Several of you have had to deal with me more often than you may have liked, but, you were always there to direct me toward success. This program was an experience that I will never forget that has helped prepared me for an exceptional career.

I am also eternally grateful to my committee Dr. Conner and Dr. Loerzel. You accepted this endeavor without question and were constantly available to fix my endless questions and complications.

Dr. Loerzel, thank you for your attention and innovation throughout this adventure. You have helped encourage me to accomplish something I never thought possible.

Dr. Conner, thank you for your leadership and expertise. Your supervision of this project has provided it with invaluable insight that I never would have been able to achieve on my own.
I am honored to have worked with you.

Finally, to the students and friends I have made during this program. This program has brought me challenges and situations I would have never expected to encounter. You have taught me the true meaning of teamwork, we survived it together.

Thank you.

Table of Contents

Chapter One: Introduction	1
Background	1
Purpose of the Study	10
Research Questions	10
Chapter Two: Methods and Procedures	11
Design.....	11
Subjects	11
Inclusion and Exclusion Criteria	12
Procedure.....	12
Instruments	14
Data Analysis	15
Chapter Three: Results.....	17
Demographic Data.....	17
Table 1: Select Demographic Characteristics	19
Table 2: Select Additional Descriptive Characteristics.....	20
Quantitative Analysis	20
Analyses of Domino Scale	20
Analyses of Research Questions	22
Research Question 1: Pre-licensure nursing students’ opinions	22
Research Question 2: Pre-licensure nursing students’ comfort level.....	23
Research Question 3: Pre-licensure nursing students’ prior experiences.....	23
Research Question 4: Pre-licensure nursing students’ demographic factors	24
Qualitative Analysis	24
Research Question 5: What ways do nurses participate in PAS	24
Ways Nurses Can Help with PAS	24
Nurses Should Not be Involved with PAS	29
Clarification and Delineation of the PAS process.....	31
The Preservation of Autonomy	33
The Need for more Education	35

Inaccurate Assumptions of PAS.....	37
Chapter Four: Discussion.....	40
Attitudes Toward PAS	40
Comfort Levels on PAS	42
Education on PAS	44
Limitations	45
Nursing Implications	47
Recommendations for Future Research	50
Summary	51
Appendix A: Informational Letter.....	52
Appendix B: Physician-Assisted Suicide Survey.....	54
Appendix C: Domino Survey Approval Letter	60
References	62

LIST OF TABLES

Table 1: Select Demographic Characteristics19
Table 2: Select Additional Descriptive Characteristics.....20

CHAPTER ONE: INTRODUCTION

Background

Physician-assisted suicide (PAS) was first legalized in the United States when Oregon passed the Death with Dignity Act (DWDA) in 1997. Although now legal in six states, PAS has continued to be an unsettling topic for U.S citizens and health professionals alike (Altmann & Collins, 2007). Physicians and nurses use a team approach in assisting patients who are terminally ill through the dying process, but PAS provides a legal dichotomy. While the law allows for physicians to assist patients in an early death, the American Nursing Association (ANA) stands firm in its belief that PAS is not part of the nursing role (ANA, 2013). This dichotomy provides physicians with both a route of action and a legal right to practice PAS; while nurses receive little advice or support. This division in policy leaves nurses without an exact direction when it comes to the care of terminally ill patients in states with legalized PAS.

The American Nurses Association (2013, p. 4) defines PAS as "an end-of-life care option in which mentally competent, terminally ill adults request their physician provide a prescription for medication that the patients can, if they choose, self-administer to bring about a peaceful death." The ANA stipulates that PAS requires that the patients be the last actor in bringing about their own death. This idea differs from euthanasia or "mercy killing" in which the physician ends the patient's life through a lethal injection. The ANA (2013) does however, support the patient's right to withdrawal or refuse life-sustaining medical treatment, nutrition or life-prolonging therapies allowing themselves to die from their underlying medical conditions rather than a specific suicide action. The

withdrawal of or refusal of treatment is now recognized legally throughout the U.S. as an autonomous right of patients. In the 2013 position statement, the ANA states the PAS “is incompatible with the professional role integrity and violates the social contract the professions have with society (p. 7).” They conclude that “nurses’ participation in assisted suicide and euthanasia is strictly prohibited (p. 9).” Regardless of their own beliefs, the ANA does admit that legalization will bring on more requests by patients and families that may force ethical dilemmas. To prevent compromised care, they urge that nurses should be aware of their situation and personal beliefs. If confronted with such a dilemma, nurses should seek other expertise and resources to aid in providing the best patient outcome (ANA, 2013).

Oregon was the first to pass the Death with Dignity Act in November of 1994 by a 51% to 49% vote. The act was immediately tabled for review. This was not the first time PAS had been proposed, but now the people of Oregon planned on implementing it. U.S. District Judge Michael Hogan was unsure of the bill's constitutionality (Altmann & Collins, 2007). In 1997, almost three years later, the act passed. The sequential requirements in the Death with Dignity Act are specified below:

To request a prescription for lethal medication in order to commit suicide, the patient must be:

- An adult of 18 years of age or older.
- A resident of Oregon.
- Capable to make and communicate health care decisions.
- Diagnosed with a terminal illness that will lead to death within six months.

To receive a prescription, the following steps must be satisfied:

- The patient must make two verbal requests to his or her physician, separated by a minimum of 15 days.
- The patient must then provide a written request, witnessed by two people.
- The prescribing physician and a consulting physician must confirm diagnosis and prognosis.
- The prescribing physician and a consulting physician must determine if the patient is capable.
- The patient must be referred for counseling if either physician believes the patient's judgment is impaired due to psychiatric or psychological disorder.
- The patient must be informed of all alternatives.
- The prescribing physician must request, but not require, that the patient notify the next of kin of their request. (Altmann & Collins, 2007, p. 48)

Laws allowing PAS have since extended to Washington in 2008, Vermont in 2013, California in 2015, District of Columbia 2016, Colorado in 2016, and Hawaii in 2018 (DWD, 2018). In 2009, the Montana court initially ruled that there was nothing about PAS that was considered illegal (Friend, 2011; Jones & Paton, 2015; Petrillo, Dzeng, Harrison, Forbes, Scribner, & Koenig, 2017). More recently, Montana laws have been under debate to decide if they should continue to allow PAS. According to Frank (2016), additional bills regarding PAS were pending in several additional states' legislatures including Minnesota, Massachusetts and Iowa. He expected that in 2017 an additional twenty to twenty-five states are likely to encounter this growing issue. While not all PAS bills mirrored Oregon's Death with Dignity Act, the majority included an extensive review process involving a diagnosis of a terminal illness by at least two physicians, a

witness of the patient's request for PAS, a review of competency, and a waiting period before providing the prescription (Altmann & Collins, 2007).

Nurses are essential in the care of the dying. The conventional role of nurses with regard to patients at the end-of-life mainly focuses on providing comfort measures (Dillworth, Dickson, Mueller, Shuluk, Yoon, & Capezuti, E, 2016). Dillworth, et al. (2016) conducted a study on nurses' perspectives of patients during end-of-life care. The study showed that nurses believe that their job during this time should involve relief of suffering and concentrate on the patient's psychosocial or spiritual issues. Instead, this study showed that the nurses were forced to focus on communication and to advocate for the patients' wishes. For many patients, their care fell below par when it came to gaps in advanced planning or conflicting interests between the patients and the families. Regardless of the situation, nurses first have a duty to advocate for the patient. Often, they are even more involved with the patients than the physicians. Patients showing interest in PAS will likely first question their nurses. Early literature supports that nurses have frequently been receiving requests. A study in Oregon after the DWDA passed showed two-thirds of 244 nurses had discussed PAS with at least one patient that year (Miller, Harvath, Ganzini, Goy, Delorit, & Jackson, 2004). A similar study showed that of 306 nurses surveyed, 122 had received a request for lethal medication (Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002). The literature reviewed revealed a contradiction in nurses' general attitudes towards PAS. In the study by Miller et al. (2004), it was recorded that while only 48% of nurses officially support PAS, a sizable percentage would continue to care for patients who requested a lethal prescription. A similar study by Matzo & Emanuel (1997) further confirms this conclusion. This finding

is related to a potential ethical conflict between a nurses' own views and abandoning their patients. Miller et al. continued that 36% of nurses oppose PAS and 22% were not comfortable discussing PAS with patients. Reasons for opposing PAS range from religious and moral values, to focusing on lack of acceptable palliative care as the main problem. A final 16% were neutral on the issue. Overall, the literature agrees that nurses must understand their personal views and be acquainted with the laws related to practice in their state. Already six states allow PAS. The problem therein lies with the ability of the general population to decide upon the legality of PAS with or without the opinions of medical personal. Studies have shown the citizen population to have higher levels of support compared to the more reserved opinions of physicians and nurses (Braverman, Marcus, Mercurio, Kopf, & Wakim, 2017). As more states are passing the laws, other states are beginning to ask the same questions. As more states continue to legalize PAS, nurses are finding themselves involved in conflicting positions. Nurse practitioners in Oregon can currently prescribe the medications used in PAS. Although they are not currently allowed to do so to end a patient's life, it is rational that one day the law will include nurse practitioners with physicians (Altmann & Collins, 2007).

One gap identified from the literature is research on nursing attitudes toward PAS in the United States. While there are several instances of research from 1996 to 2005 mainly focusing on either Oregon or Washington, the research since that time has been sparse. Clymin, Jacobson, Jablonski, & Feldt performed a study in Washington that focused on how informed nurses were about the laws of PAS (2012). This study showed that nurses experience a deficit of knowledge regarding the DWDA. Washington state passed and implemented the DWDA in less than a year with few opportunities for formal

education of nurses on the new policy. This is only a single study in which nurses' perspectives have been over-looked during implementation of PAS. Clymin et al. urges that this is an opportunity for more research. While she acknowledges that there are multiple studies on PAS and the DWDA, there are fewer considering specifically nurses' involvement. Nurses continue to be on the frontlines of PAS. They are necessary to counsel both patients and physicians alike. Nurses who have a thorough understanding of the laws and regulations of PAS will be more prepared to offer patients reassurance and counsel during their time of need (Clymin et al., 2017). Other studies related to PAS focus on variable topics such as the families of the patients, the physicians, or the relationship between religion and PAS.

The identified gap begins to close in early 2016 with several studies done on PAS as it slowly begins to regain attention. One study addressing physician opinions toward euthanasia and PAS found that more than half (54%) of physicians were supportive (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016). This is commented to be an increase in positivity compared to older studies. A study by Rhee, Callaghan, Allen, Stahl, Brown, Tsoi, McInerney & Dumitru reviewed the medical student perspective on PAS (2017). This study revealed that students found the main dilemmas of PAS to be the destruction of the healing image and the lack of safeguards that might allow for the abuse of the system. Additional studies included physician perspectives regarding PAS (Braverman, Marcus, Mercurio, Kopf, & Wakim, 2017), and a pilot study on patient perspectives on PAS (Hizo-Abes, Siegel, & Schreier, 2018). There are still no recent further studies to address specific nurse, or nursing student perspectives on PAS.

Since the Death with Dignity Act initially passed in Oregon in 1997, a recorded 1,327 patients have requested and received a lethal prescription in the United States. Of those patients, 65% went on to ingest the medication and subsequently end their lives (Gostin & Roberts, 2016). Studies have shown that despite the negative connotation, patients are still actively requesting PAS. In 1996, a survey of Oregon physicians showed that 187 out of 570 physicians who received requests for a lethal prescription had written one despite the Death with Dignity Act not having passed until 1997. A further 124 physicians reported that the medication was taken by the patients (Lee, Nelson, Tilden, Ganzini, Schmidt, & Tolle, 1996). Recorded rates of actual deaths in Oregon after receiving lethal prescriptions range from forty-eight to eighty-one percent (Emanuel et al., 2016). This was reported due to death before ingestion or complications with medications. In Oregon, "The most common patient concerns reported by physicians are fears about losing independence (87%), inability to participate in enjoyable life activities (83%), loss of dignity (82%), and fear of losing control over bodily functions (58%) (Ersek, 2005, p. 50)." In 1996, a Washington state study found that 99 doctors had received one or more requests for PAS for a total of 207 cases (Back, Wallace, Starks, & Pearlman). Of the 207 cases, 38 patients received a prescription, and 21 patients went on to take the medications. Washington would not go on to legalize physician-assisted suicide until 2009. Even with these results, death by PAS account for less than 0.4% of all deaths in Oregon and Washington (Emanuel et al., 2016).

PAS is not a perfect system. Currently, the standards for PAS require extensive review of the patients before they can become verified candidates (Altmann & Collins, 2007). Patients labeled "terminally ill" have no exact time limit for their illness.

Physicians cannot guarantee when the patients will die. Not all patients in hospice die upon discharge. Periodically, patients return to more conventional care for several months or even years before returning to hospice care. The National Health Statistics Report (2011) recorded that 15.6% of hospice patients were discharged either due to a stabilization of their condition or transfer to another facility.

There is always a chance that the PAS option will be abused. Mary Friend speaks of a case in 1997 where a patient ended her life by PAS. After review, it was discovered that the patient had changed from her primary physicians just before her death. The primary physicians had a conflicting diagnosis when compared with the prescribing doctor. This led to questions about the patient's ability to "shop around" until she obtained her desired outcome (Friend, 2011). A review of patient-physician relationships showed the length of time physicians participating in PAS had known their patients ranged from twelve weeks to less than one (Emanuel et al., 2016). This idea goes hand in hand with the required psychiatric evaluations. Ultimately, the diagnosis of competency comes from the discretion of the physician, a physician who is only human. The process of taking the medication also has a risk. A study in Oregon showed the average time between ingesting the lethal prescription and death of the patient was twenty-five minutes. The greatest time of death after ingestion was 104 hours which is more than four days (Emanuel et al., 2016). Technical problems such as difficulty swallowing, vomiting or seizures were also reported to occur (< 10%). Five percent of patients recorded regurgitated their medication, and only one patient died two weeks later due to their illness rather than the prescription (Volker, 2007).

Nurses are at an opportune point in patient care to advocate and provide for the patient's wishes regarding PAS. There is a need to educate and advocate for the patients especially those who are in a sensitive terminal stage of illness. Nurses might know patients for months before they are declared to have a terminal status, many times they have extensive relationships with both patients and families. This only deepens the burden a nurse might encounter of leading someone down the wrong path or having to help patients who have differing beliefs from their own. Identifying nursing predispositions toward physician-assisted suicide can help prepare nurses for impending PAS scenarios and guide nurses in unclear ethical situations.

PURPOSE OF THE STUDY

The purpose of this study was to evaluate pre-licensure nursing student attitudes toward the practice of physician-assisted suicide.

Research Questions

1. What are pre-licensure nursing student opinions about physician-assisted suicide?
2. What is the pre-licensure nursing student's comfort level with providing care for a patient interested in physician-assisted suicide?
3. Are pre-licensure nursing students' prior experiences with death and dying predictive of their opinions of physician-assisted suicide?
4. Are pre-licensure nursing students' demographic factors predictive of their opinions of physician-assisted suicide?
5. In what ways do nurses think they should participate in PAS?

CHAPTER TWO: METHODS AND PROCEDURES

Design

This study used a mixed method design using both descriptive correlational and thematic analysis. A survey was uploaded into Qualtrics and made available to nursing students enrolled in any of the following University of Central Florida campuses including Orlando, Daytona, and Cocoa who are part of NUR 3165, NUR 3167, NUR 3225 or NUR 4257 at the Orlando campus or NUR 3028 or NUR 4227 at either the Cocoa or Daytona campuses. The research was completed through the Honors in the Major program under the supervision of Dr. Norma Conner.

Subjects

The approximately 550 pre-licensure baccalaureate nursing students enrolled in the University of Central Florida Nursing programs during the Spring 2018 semester, were invited to participate in the study through an informational email. All students enrolled in NUR 3165, NUR 3167, NUR 3225 or NUR 4257 at the Orlando campus, or NUR 3028 or NUR 4227 at either the Cocoa or Daytona campuses during the Spring semester of 2018, were given the option to participate.

The course instructors were given an introduction and explanation of research letter (appendix A) to post for the students in their classes. This letter informed the students about the research that was being conducted and gave them a link to participate in the survey. All course instructors involved had agreed to offer 1 extra credit point for participation in the survey or completion of an alternative assignment for those opting out of the study.

Inclusion and Exclusion Criteria

Inclusion criteria: Participants in the study were at least 18 years of age; an undergraduate nursing student and were currently enrolled with the University of Central Florida College of Nursing in one of the following classes: NUR 3165, NUR 3167, NUR 3225 or NUR 4257 at the Orlando campus or NUR 3028 or NUR 4227 at either the Cocoa or Daytona campuses.

Exclusion criteria: Graduate students and students in other completion BSN programs such as the RN to BSN or the concurrent program as well as students who were currently licensed as RNs were excluded. The survey included a question in the demographic section asking if the participant was already licensed as an RN that helped exclude these participants.

This study did not include vulnerable populations including; adults unable to consent, individuals who are not yet adults (infants, children, teenagers), pregnant women or prisoners. However, pregnant women were not excluded from this survey research.

Procedure

Proposal approval was obtained from the HIM committee. Subsequently, approval was obtained from the University of Central Florida's Institutional Review Board. During the spring of 2018, a convenience sample of 550 pre-licensure baccalaureate nursing students enrolled at any of the following University of Central Florida campuses including Orlando, Daytona, and Cocoa who are part of NUR 3165, NUR 3167, NUR 3225 or NUR 4257 at the Orlando campus or NUR 3028 or NUR 4227 at either the Cocoa or Daytona campuses, received an email informing them of the research being conducted with an optional link to a survey. This link led to an informational letter

explaining participation in the survey (Appendix A) and a link to an online survey (Appendix B) previously uploaded in Qualtrics. The survey was opened for a period of two weeks to all nursing students enrolled in the University of Central Florida College of Nursing during the Spring of 2018.

Consent was implied by completion of the survey. At any point in time, a student could abstain from completion of the survey. Each participating class was offered one point of extra credit for student participation in the survey. A unique identifier was added to the end of the survey and sent to the professor so that the student may receive their extra credit while their answers remained anonymous. An alternative assignment was offered for the same one point of extra credit should a student not want to participate in the study. The alternative assignment was a 300-word essay on the student's personal opinions concerning PAS that was emailed directly to the professor to obtain the extra credit and maintain anonymity.

All information collected during this survey was kept confidential. Responses were directly downloaded from the Qualtrics survey site into an excel file and analyzed using Statistical Analysis System (SAS) software. After the sample missing pattern summary determined data were missing at random, the sample was narrowed to only those participants without missing data. Frequencies and all other study statistics were run on the remaining 231 participants data. Frequencies determined all data was within the expected ranges. Responses to question 25, "In what ways do you think nurses should participate in physician-assisted suicide?" were extracted into a word document with each participant response being assigned a number. The written responses were treated as data and analyzed using a thematic analysis. No predetermined codes were

established, codes for each participant response were compared, and similar code categories were grouped under larger themes. The themes that were derived are presented here with exemplar quotes from participants.

Instruments

The Opinions about Physician-Assisted Suicide scale had a total of 12 questions. This survey was developed by Domino, Kempton, and Cavender (1997) and is also known as the "Domino" scale. The Domino scale was designed to examine nursing student opinions toward physician-assisted suicide. This scale used Likert type questions with SA (strongly agree), A (agree), NS (not sure), D (disagree), and SD (strongly disagree). Permission to use this tool and upload it online into Qualtrics was obtained from the author (Appendix C).

The Domino scale has been extensively tested through several studies including a study specifically focused on college students. (Domino, Kempton & Cavender, 1997). This instrument was also replicated in a dissertation in 2005 on nursing student attitudes toward physician-assisted suicide (Butler, 2005, p 224). Due to the nature of this research, the survey was not designed to have a definitive scoring. To facilitate interpretation of the data, the Domino scale recommends totaling questions one through eleven to yield a scoring for the total data. The exception is question twelve which cannot be clearly labeled as a pro or con (Domino et al., 1997, p 250). This scoring allows that a high score (possible range 11-55) represents a more positive view toward PAS while a low score signifies a more negative attitude (Domino, Kempton & Cavender, 1997).

This scale was tested for reliability in several settings with the most relevant being a group of 118 non-nursing college students ages eighteen to fifty-three. The

second study was a group of 30 adult caregivers aged fifty-two to sixty-eight. The final study was 21 elderly individuals with life-threatening terminal conditions. The scale in each separate study demonstrated excellent reliability with Cronbach's alpha of .93, .92 and .90 respectively.

The remaining 23 questions in this study focused on developing a profile of the research participants. These questions gathered information on the participants experiences with death and dying and their comfort level or basic demographic questions including age, race, religious preferences, and educational background (Appendix B). Additional questions included multiple choice, yes or no, visual analog scales from 0 to 100. Due to the controversial nature of this topic, two open-ended questions were used so that participants could offer direct opinions on PAS without constrained answer choices. The two open-ended questions addressed in what ways the participants think nurses should participate in physician-assisted suicide and if the participants had any additional comments they would like to share regarding their opinions on PAS. One additional question was included to obtain consent for participation in the survey.

Data Analysis

This study used descriptive statistics to present the scores from the Domino scale and demographic data. Content analysis was used on the open-ended questions pertaining to care of the patients who request PAS. A correlational matrix was used on all the continuous variables including; comfort in care, hours of literature read, hours of course content, identified need for more education, importance of end-of-life care, importance of religion and the Domino Scale. There was a correlational matrix created between student experiences and the Domino scale. Chi square analysis were used to identify associations

between categorical variables. Variables found to be significantly associated with the Domino Scale were put into a stepwise regression analysis.

Data from the open-ended questions were analyzed using thematic qualitative analyses. The data was coded first within each participant response. These codes were then grouped into larger themes. The PI and her thesis chair analyzed data independently and then came to a consensus on themes. These themes include; ways nurses can help with PAS, nurses should not be involved with PAS, clarification and delineation of the PAS process, the preservation of autonomy, the need for more education and inaccurate assumptions of PAS. The analyses of the data were not based on simply a positive or negative view of PAS although the phrasing may indicate the respondent had a specific persuasion.

CHAPTER THREE: RESULTS

The purpose of this study was to determine pre-licensure nursing students' opinions on Physician-Assisted Suicide (PAS). Furthermore, this study was used to determine if previous experiences, comfort level of the nurse, or demographics were able to significantly predict nursing student opinions on PAS. Of the 328 individuals who began the surveys, 19 completed less than 40% of the survey. These were removed. Four participants indicated that they already held a license as an RN, they were also removed leaving 305 participants. Of the 305 remaining surveys, 74 had some amount of missing data. The missing data on the 74 removed surveys consisted of a total of 105 missing data points 96 of which were visual analog responses leading the research to determine some technical issues may have been encountered during survey completion. A sample missing pattern survey was run on the 305 surveys, it was determined that data was missing at random limiting bias in removing the 74 questionnaires with missing data points. The remaining 231 surveys were used in data analysis.

Demographic information on age, gender, marital status, ethnicity, semesters of clinicals, length of time in nursing school, religiosity employment and employment in a health care field can be found in Table 1. The remaining multiple-choice questions on the participants' experience with death, care of the terminally ill, and relationship to a person who had committed suicide, personal experience with PAS, and hours of education on PAS can be found in Table 2.

Demographic Data

Out of the 231 eligible participants, the average participant was between 18 and 25 years of age (n=186, 80%), female (n= 189, 82%), single (n=202, 87%), white (n=

159, 69%), in their first two semesters of the nursing program (n= 139, 60%), and unemployed (n= 130, 56%). Of those who were employed (n=101, 44%), only 37% (n=37) were employed in the healthcare field.

Fifty-five percent (n= 127) indicated a religious affiliation, although specific details about the religion were not sought. When asked on a scale of 0 (not influential) to 100 (very influential) how influential religious beliefs were on participant opinion on PAS, the mean score was a 30, indicating little influence.

The majority of participants (77%) selected they had less than 5 hours of education on EOL care or patients who are terminally ill and most indicated (78%) they had read less than 5 hours on PAS outside of a classroom setting. Participants were asked how much education they thought they needed on PAS on a scale of 0 (I do not need education on PAS) to 100 (I need more education on PAS). The mean score was 75 with the median answer of 80 indicating that participants felt they need some further education. The following item asked participants on a scale of 0 (not important) to 100 (very important) how important will EOL care be in your future nursing career. The mean score was 82 with a median score of 90 indicating EOL care to be of high importance.

Results of the demographic variables are displayed in Tables 1 and 2.

Table 1. Select Demographic Characteristics of Sample (N = 231)

Variable	N	Percentage
Age		
18-25	186	80.52
25-35	36	15.58
35-45	7	3.03
45+	2	0.87
Gender		
Male	42	18.18
Female	189	81.82
Marital Status		
Married	29	12.55
Single	202	87.45
Ethnicity		
White	159	68.83
Black	5	2.16
Native American	3	1.3
Asian	22	9.52
Hispanic	28	12.12
Multiracial	9	3.90
Other	5	2.16
Semesters of Clinicals		
1 – 2 semesters	152	65.80
3 – 4 semesters	61	26.41
5 + semesters	18	7.79
Length of Time in Nursing Program		
1 semester	65	28.14
2 semesters	74	32.03
3 semesters	31	13.42
4 semesters	26	11.26
5 + semesters	35	15.15
Religiously Affiliated		
Yes	127	45.02
No	104	54.98
Currently Employed		
Yes	101	56.28
No	130	43.72
Currently Employed in The Health Care Field		
Yes	37	83.98
No	194	16.02

Table 2. Additional Descriptive Characteristics of Sample (N = 231)

Variable	N	Percentage
Lost Someone to Death		
Parent	18	7.79
Relative	168	72.73
Friend	30	12.99
No	15	6.49
Taken Care of Terminally Ill		
Yes	102	44.16
No	129	55.84
Know Anyone Close to You Who committed Suicide		
Yes	52	22.51
No	179	77.49
Been Asked to Help With PAS		
Yes	5	97.84
No	226	2.16
Literature Read on PAS		
0 – 5 hours	184	79.65
5 – 10 hours	38	16.45
10 – 20 hours	9	3.9
Taken a Class on Terminally Ill		
Yes	88	38.10
No	143	61.90
Hours of Course Content on Care of Terminally Ill		
1 hour	81	35.06
5 or less hours	97	41.99
15 or less hours	37	16.02
1 semester	16	6.93

Quantitative Analysis

Analysis of Domino Scale

A further breakdown of results from some items of the Domino scale are included to clarify possible influences in scores. This group includes items 7, 9, 11 and 12. Question 7 was included in total scores to remain consistent with the domino scale recommendations, but the researchers found the question to be decidedly vague. Question 9 inquired about PAS for a child which is not currently legalized in any U. S. states. Question 11 asks about euthanasia rather than PAS. Question 12 was not included for the total scores since it asks more about the policy for PAS than an opinion on the matter.

Domino Question 7: *PAS should be decided solely on medical grounds and not on moral issues.*

This item was deemed vague in terms of the participants opinion toward PAS. While agreement was considered in favor of PAS, the question focuses on whether the participant believes PAS to be solely a medical issue or if it is also a moral issue. This was the most evenly split of the all of the Domino scale responses. Thirty-six percent of participants were in favor that PAS should be decided based solely on medical issues, 34% responded that PAS should be not be decided solely on medical issues and should include moral issues. The remaining 30% responded they were unsure if PAS is solely a medical or moral issue.

Domino Question 9: *If a child were seriously ill, with no possibility of having a normal life, the parents should be allowed to request PAS.*

Of all of the scored Domino scale items, this item was the most strongly opposed. Almost half of participants (46%) disagreed with this statement indicating that it would not be acceptable for parents to request PAS for their child, even if that child was seriously ill. More than a fourth (27%) agreed that if the child were seriously ill, a parent could request PAS. The additional 27% indicated they were unsure if a parent could request PAS for a seriously ill child.

Domino Question 11: *It would be OK for a physician to actually administer a lethal dose of a substance to a patient who requested it.*

This question focuses on the euthanasia rather than on PAS. Over half (52%) of participants indicated that it would be okay for a physician to administer a lethal dose to

patients. Thirty percent disagreed that it would not be okay for a physician to administer a lethal dose. Eighteen percent remained unsure.

Domino Question 12: *PAS is more acceptable if performed by other professionals, such as a nurse or a pharmacist.*

This question was withdrawn from the composite score for the Domino scale since it does not have an inherent positive or negative opinion of PAS. Sixty-eight percent disagreed that PAS is not more acceptable if performed by professionals other than physicians.

Seven percent agreed that PAS is more acceptable if performed by a nurse or a pharmacist. The remaining fourth (25%) of participants responded that they were unsure which type of health care professional would make PAS more acceptable.

Analysis of Research Questions

Research Question 1: *What are the pre-licensure nursing students' opinions about physician-assisted suicide?*

Results of the Domino Scale responses were used to answer this question. Standardized alpha scores for all items were .88 and all factors were .75 or higher. The same method used in determining a total score in the Domino scale was used in this study (items 1 and 2 were reverse scored, item 12 was excluded) to yield a total score range of 16 to 55. The total score results were mean = 40 (SD 8.07), the median = 40, and mode = 38. Participant scores were considered less favorable of PAS if the overall score fell below the average (33) of the total possible range, and more favorable if the participant scored above the average. The sample mean score of 40 was above the benchmark of 33 and therefore students indicated a more favorable opinion of PAS. Results of the Domino

scales were arranged in percentages to find that 63% were in favor of PAS with 20% opposed to PAS. The remaining participants (17%) were neutral.

Research Question 2: *What is the pre-licensure nursing students' comfort level with providing care for a patient interested in PAS?*

The comfort level of nurses participating in PAS was determined by demographic item 5: *How comfortable are you taking care of a patient who has requested physician-assisted suicide?* This question was answered by students using a Visual Analogue Scale where the participant could select from a range of 0 (not comfortable) to 100 (very comfortable). Overall participant mean = 73 (SD = 26), the median response = 80, mode = 100.

Research Question 3: *Are pre-licensure nursing student's prior experiences with death and dying predictive of their opinions of physician-assisted suicide?*

The independent variables of nursing students' prior experience with 1) a loss of someone to death, 2) caring for someone terminally ill, 3) someone close to the student committing suicide, and 4) someone close to them asking for help with PAS, and educational experiences of 5) number of hours spent reading on PAS, 6) taking a course on end-of-life, death and dying or the care of the terminally ill, and 7) number of hours of course content on the care of the terminally ill, were regressed in a stepwise manner onto the dependent variable of their total score on the Domino Scale. A forward and backward stepwise regression analysis yielded the same results. Only whether or not they had been asked by someone close to them for help with PAS was positively correlated with the participants Domino score ($F = 9.82, p = .0019$).

Research Question 4: *Are pre-licensure nursing student's demographic factors predictive of their opinions of physician-assisted suicide?*

The independent variables of nursing students' demographic factors of 1) number of semesters of clinical experiences completed, 2) length of time in nursing program, 3) gender, 4) age group, 5) marital status, 6) race, 7) religious affiliation, 8) likelihood of religious affiliation influencing opinion on PAS, 9) employment status, and 10) employment in healthcare field, were regressed in a stepwise manner onto the dependent variable of their total score on the Domino Scale. A forward and backward stepwise regression analysis yielded the same results. Time in the nursing program approached significance on predicting the Domino Score ($F = 2.16, p = .0733$), and only having a religious affiliation was significantly predictive of their Domino score ($F = 160.36, p < .0001$). These results indicated that religiosity had a negative correlation with domino scale scores indicating participants who were influenced by religion were also found to be opposed to PAS.

Qualitative Analysis

Ninety-two percent of the 231 participants responded to the open-ended question 25, "In what ways do you think nurses should participate in physician-assisted suicide?" Although some responses are edited grammatically, no phrasing was changed to preserve the integrity of the responses.

Research Question 5: *In what ways do nurses think they should participate in PAS?*

Ways Nurses Can Help with PAS

This theme was the most direct answer to the research question presented. Most responses brought up actual aspects of nursing care such as patient comfort and

advocacy. Other comments brought up dealing with EOL aspects or family members. Some participants were focused on making sure that nurses ensured that PAS was the right choice for the patient.

Comfort

Many respondents felt that it is a nurse's responsibility to carry on with their normal duties despite the patient's condition. These comments were to the point that like with every patient, it is a nurse's job to care for their patient. The nursing care at this point centered around the idea that a patient be well informed and comfortable. Examples are provided below.

“Nurses should act as patient advocates in addition to provide education and lend a compassionate ear to their patients.”

“... Nurses should play the same role they play in all other fields of nursing: caring for the patient, providing education, witnessing consent, supporting the patient and their family...”

Advocacy

Many respondents commented that it is a nurse's duty to be an advocate for his or her patient. These responses expressed the importance of a nurse communicating the patient's chosen route of care. Participants did not always indicate restrictions on advocacy for patients who had or had not requested PAS. This idea included that the nurse would speak with doctors and family members to ensure their wishes were carried out acceptably. Examples are provided below.

“I think that nurses should advocate for the patient's needs, to ensure that their voice and opinion is heard...”

“I believe it is our role to advocate for our patients...”

End-of-Life-Care

Several comments were concerned about this being the patient’s end-of-life. The participants thought that as a nurse, it was their job to make sure patients had all their affairs in order and were able to live out their last hours with as much quality of life as possible. Examples are provided below.

“I think the nurses should be there to ensure the client is as comfortable as possible, to calm their fears, and to help the client live the best last few moments of their life as possible.”

“I think nurses should participate in the sense of that they would be attentive to the patients’ needs and giving them everything they can ask for, doing everything that they can for them (within reason) to make their last few moments worth it.”

Family members

Many participants commented on how the nurse would provide for the family. When caring for a patient, it is important to realize that the family is a huge support system for a patient and as such are a significant aspect of patient care. In a situation such as PAS, the patient is terminal and likely dealing with several very serious issues. The participants agreed that PAS is not a decision to be made alone and it was the nurses’ job to make sure the families were involved and educated. Examples are shown below.

“(The nurse would participate) with consoling the patient and their family and helping with any requests within reason and scope of practice.”

“I think nurses should be there to support the patient during this time as well as the family.”

Right choice for the patient

Some comments indicated that participants did not consider the patient’s decision for PAS as a final option. Many wanted to be sure that the patient was serious in his or her decision. Participants also wanted to ensure the patient was an actual candidate who had considered all other options. This idea went hand in hand with ensuring the patients were well informed about PAS and had made this choice in mental competency.

Examples are provided below.

“(Nurses should participate) to help with the assessment portion to see if they (the patient) have any doubts and find them help or options that could change their decision.”

“Nurses should be able to communicate with patients who are thinking about PAS. It’s important to hear the patients reason to this decision, as well as offer resources to either help change their mind, or to help them with their wish of PAS. I think nurses should help give alternative options and asses the patient before helping a patient learn about PAS.”

“(Nurses should participate) in patient education and making sure the patient knows all the options and receives emotional and mental support in an effort to see if their decision is based off anything that has a change.”

Medication Administration

Some participants indicated that nurses should be involved through the whole procedure. They went as far as to state that nurses themselves should be able to administer a lethal medication. Some participants even commented that they didn’t see how a lethal medication would be different than any other medication. Examples are provided below.

“... Honestly as with any medication I don’t see why administering the correct lethal dose to the correct patient could not be done by a nurse/two-nurse verifier team...”

“I think they (the nurse) should be allowed to deliver the meds for it and be able to educate pts about their options in PAS. I think PAS should be treated like any medication regimen and nurses should participate in it within the already set scope of practice.”

“... I do believe a nurse should be able to administer it and provide end of life care for patients that choose to die. If a patient is on hospice, we can administer an ordered dose of pain medication even if we think a patient will die from it. I understand that this is different from elective death, but the outcome will be the same no matter who delivers the lethal medication whether it is a doctor, nurse, or the patient themselves.”

Nurses Should Not be Involved with PAS

This theme presented that nurses should not have any involvement in PAS. This theme does display a negative disposition toward PAS. Responses ranged from statements indicating that nurses should not participate with the patient at all, to indicating that nurses may take care of the patient but should not participate in any aspect of PAS. Other comments indicated that the participant thought that PAS was not the role of the nurse. There were an additional 8% of participants who chose not to respond to this item. Due to the phrasing of question 25, it might be assumed that a lack of response was indicative of disapproval of nurses' participation with PAS. Lack of responses may also have been related to the participants inability to answer if they felt they had not yet had time or sufficient information to form complete opinions. Examples are shown below.

Nurses should not be involved with PAS

Comments included that nurses should not be allowed to participate in PAS in any way. Participants may be uncomfortable with the idea or simply have contradicting beliefs. Some statements include ideas of “ending someone’s life”, or the lack morality behind PAS. One participant was passionate enough to compare PAS to murder. Religion or personal values are often indicated for the participants reasoning behind their decision. Examples are provided below.

“I don't think they (nurses) should (participate) at all ever. Murder is murder and helping someone commit suicide in my view, at this time, wouldn't be different then helping someone commit murder. To say there is no hope for a cure is a false statement as medical breakthroughs happen every day. Either the disease will take them when the patient denies further medical intervention, or a new treatment or

therapy will come out. The focus of medical professions should be to remove the red tape so that they can better treat their patient.”

“... I for myself know that suicide or PAS is morally wrong and not what God intended for us to do. The nursing code of ethics also clearly states that we should not participate in PAS, so I am patently against any participation by Nurses or anyone but the individual (because I respect agency). I still think we should work to prevent it from a public health standpoint.”

“... I personally do not believe in participating or involving myself with this process. It is against my beliefs and I would not take part in helping someone end their life.”

Nurses should not participate in the actual administration of PAS

Other comments indicated that they did not believe nurses should participate in PAS but thought it was still important to care for the patient regardless of their decision. One participant mentioned that a nurse’s role was to save lives and prevent death, PAS would be a direct contraindication to that nursing image. Examples are provided below.

“Nurses should maintain their respected roles of patient care. In no way should they be required or given the option to administer a lethal dose...”

“I think nurses should be part of the process. I think nurses should promote the patient to make the best decision for their situation; however, as nurses our purpose is to save lives and prevent death or further illness. Therefore, I believe nurses should provide education and support for the patient considering PAS.”

PAS is not within nursing scope of practice

Some participants urge that participation with PAS was conflicting with the nursing scope of practice. PAS was mentioned to be a ‘huge’ decision that is more qualified to a physician. Other participants were quick to give the nurses roles such as preparing the patient or setting up the room, while distancing the nurse from the actual procedure. Many focused on the actual act of the administration of the lethal medication as not a nursing role. Examples are provided below.

“I think this is a huge decision and the act should be completed by the physician. I feel this is not the role of the nurse.”

“I don’t think we should. This is such a crucial aspect of life (i.e. the end of it) that a physician should do it. I think we can be there to help in a non-medical way, like with paperwork.”

“In its current umbrella, I do not believe that nurses should participate in physician-assisted suicide. It is just that - PHYSICIAN assisted and I don't think nurses should involve themselves other than providing appropriate care and education.”

Clarification and Delineation of The PAS Process

There were frequent comments that were concerned about the actual process of PAS. These thoughts centered around the what the qualifications would be for the patient. Many participants agreed that the patient must be terminal and mentally competent. The participants also commented that the process should first be legal and strenuous enough that it would disclude any whimsical patients.

Qualifications

Participants agreed that nurses who participated should be part of the screening process. The comments indicated that it was nurses who were responsible for assessing if the patient truly wanted PAS, checking if the patient was mentally competent, helping to educate patients and families on the process and generally overseeing the process. An additional group of participants did not care as much that it was a nurse who oversaw these tasks as long as there were advanced steps that would ensure an aspect of safety to the process. Examples are provided below.

“Should PAS be allowed, with many regulations and laws, nurses should provide patients with all other alternative options. They should participate in referring patients requesting PAS to have extensive psychological or psychiatric evaluation, to make sure that it is something they really want and that they understand the outcomes...”

“I think nurses should educate the patient on their decision. Nurses should also make sure that the patient is competent enough to make that decision...”

Legality

Several participants were concerned about the legality of PAS. Although they came from varying opinions, participants included the addendum that these opinions were pending on the idea that PAS had already been legalized. Examples are provided below.

“If physician-assisted suicide were to become legal, I think nurses should be able to educate the patient on PAS, provide comfort, and respect the patient's decision...”

“In states where PAS is allowed, and in situations where a patient is receiving PAS, a nurse would be qualified to administer the drug/etc... ”

Patient self-administration of lethal medication

Only a few participants commented that the patients themselves should self-administer their medication. This is interesting since self-administration is the definition of PAS. One participant even commented that administration from by medical personnel would risk their mental health. Examples are provided below.

“Anything except administration. Health care professionals should never have to administer PAS personally. In my opinion, it would put the health care professional’s mental health at risk to do so.”

“... In reference to the actual administration of the medication, I think it should be a voluntary decision by the patient to self-administer.”

“... I do not think nurses should be involved in administering or advocating for PAS. It should be strictly up to the patient.”

The Preservation of Autonomy

Autonomy is one of the four pillars of medical ethical standards. This important aspect conveys that PAS is a choice. Review of these responses found that this choice was dichotomous between if it was the patient’s choice or the nurses. Some participants commented that it was important nurses could choose to participate based on their comfort level. Other participants thought it was the nurses’ responsibility to support and advocate for the patient.

Autonomy for the patient

An important nursing duty is preserving the autonomy of the patient. If they should sign a DNR or refuse a bath it is the nurse's job to preserve that patient's right to do so. Participants commented that this was a comparable situation. Many comments used the idea that nurses should be "unbiased" or "non-judgmental". Regardless of the nurses' personal beliefs on PAS, it was indicated that it is their responsibility to respect the patient's choices and preserve that autonomy. Examples are provided below.

"Nurses can respect the wishes of a patient just as we do when they sign a DNR. We should ensure we assess their mental capacity, all relevant medical documents, and factors before we allow someone to request a PAS. It should be treated slightly more seriously as a DNR with more paperwork and evaluations but should be respected as such."

"Nurses should be supportive of a patient's choices about their medical care whether the nurse agrees with it or not."

"Being the support system for the patients, being positive and non-judgmental for the patient's decision. Having to take back your view points and help be their light for their last days."

Autonomy for the nurses

The other half of participants indicated that PAS was an extraordinary situation. Comments specified that the nurse had the rights to their own autonomy in which they could choose whether to put themselves through this type of situation. Participants

thought it important that the nurse be comfortable in participating in PAS before they had to involve themselves. Examples are provided below.

“I believe that if nurses are comfortable participating in PSA and chose to do so, they should be involved in the education of the patient and preparing the patient before they receive a lethal dose of medication...”

“They should not have to compromise their morals, nurses should not be forced into preparation or administration of lethal drugs.”

“... Nurses or nurse practitioners should have the voluntary decision on whether to be involved in the process of ordering a lethal dose of medication for a patient who met the requirements...”

The Need for More Education

One of the more popular topics in this section was the need for more education. There are several sides to this, some participants were focused on the idea that it was the nurses job to educate the patient and the families. The other side of the issue is that they thought the nurses should receive special education before they were qualified to participate in PAS. Other participants thought that they themselves did not have enough experience with PAS to form an opinion on the matter.

Education for the Patients and Families

Participants commonly thought that nurses are responsible for educating patients on their care. Participants expressed that nurses should be able to step up and offer

information on PAS if it were requested. This included education for both patients and families. Examples are provided below.

“They should educate the client family on all of the medical and legal implications of PAS...”

“I think the nurse is responsible to educate the patient, make sure patient fully understand what their decision entails, get patient consent, make sure patient is competent enough to make this decision, support the patient's decision, make the patient comfortable while under their care.”

“I think nurses should help educate patients on PAS and help prepare them for the event of PAS...”

Education for the study participants themselves and nurses

Study participants considered PAS participation to be a serious step. It was indicated that nurses should have some sort of experience before helping patients considering PAS. Comments included that nurses should go through a class or certification before being allowed to educate and work with patients requesting PAS. Several study participants stated that they felt they were uneducated on PAS and were not able to form a clear opinion on the matter. Many still included their thoughts but argued that they would need to do more research on PAS before being absolutely sure in their decisions. Others refrained from commenting at all since they were not sure about PAS. Examples are provided below.

“I think individuals who help with PAS should have some sort of extra education and certification. Regardless if it a nurse or physician... “

“I need more education on physician-assisted suicide. I feel that it's not the issue of who administers the lethal injection (physician, nurses, PAs), but if it's justified. My experience of taking care of multi-organ failure patient in adult 2 clinical made me feel that it's a torture for her to be kept alive. She was not able to eat, talk, sit or do anything, but she was able to blink her eyes with tears to signal that this was not the way she wanted to live. But again, I have very limited education on this topic. It might be a more coherent thought with more education and experience.”

“I have not read much literature on PAS, but at the moment and based on what I do know, I am not a fan of the idea. I feel that there are better ways to help a patient with the dying process than providing them with PAS. If PAS was legal in the U.S., I do not feel that I would be comfortable participating in the process as a nurse (especially since I am hoping to be a pediatric nurse). However, I plan on learning more about this topic so that I am well-informed.”

Inaccurate Assumptions of PAS

An interesting aspect of this data set was the participants inaccurate characterization of PAS. This was an ancillary theme that may be attributed to the lack of education participants had on PAS. In the previous section some participants commented that they thought they did not understand PAS enough. This group, however, created

comments based on what they thought PAS was, but in fact many of these ideas are realistically inaccurate.

Euthanasia

Some participants commented on aspects of PAS that are closer to euthanasia. Several commented that it would be appropriate for either the doctor or the nurse to administer the medication, PAS is specifically defined as the patient self-administering the medication. This distinction is of fundamental moral importance. If the patient were unable to self-administer, they would no longer be eligible for PAS. Examples are provided below.

“In states where PAS is allowed, and in situations where a patient is receiving PAS, a nurse would be qualified to administer the drug/etc. if it is something they are ethically comfortable with.”

“I think that the nurse can assist in the administration of the physician-assisted suicide method (such as administering the lethal dose) ...”

“Nurses should continue providing palliative care, but the administration of said lethal medication should be done by a physician.”

Under medical supervision

Another group of participants seemed to allude that the patient would die under medical care and even compared PAS to a procedure. A study by Hartogh, claims the physician would only be present at twenty-eight percent of PAS deaths and has no obligation to be there at all (2017). In reality, it is more accurate that the patient would be

released home with a prescription to be taken at a time of their choosing. If the patient could not be released home, they would likely still be released to a long-term care facility or palliative care before being allowed to take their prescription. Although the family may be present, there would theoretically be not be medical personnel there at the time of the patient's death. Examples are provided below.

“we (nurses) should be a part of monitoring them and assuring they are comfortable as they die. ...”

“... Bedside RNs can monitor the patient before, after, and during and perform regular nursing duties.”

“In an ideal situation, ONE nurse would be assigned to ONE patient to help the physician assess the patient's ability to make such a drastic decision. That nurse would also stand alongside that same patient to support whatever decision he or she made. Not only would the nurse be this patients number one advocate, but he or she would also attend to any care that patient needs throughout his end of life journey. At that time, the patient's comfort would become the top priority.”

CHAPTER FOUR: DISCUSSION

The purpose of this study was to evaluate pre-licensure nursing student attitudes toward the practice of physician-assisted suicide. A total of 550 nursing students enrolled in the University of Central Florida BSN nursing program were asked to participate. Of those students, 231 students completed the survey and were able to contribute to the results. Although there are optional classes on EOL offered at both the undergraduate and graduate level, the UCF nursing curriculum mainly includes modules on end-of-life-care without a specific class offered on the subject.

This study was conducted through a one-time survey during the Spring semester of 2018. Students were in varying levels of the program and had differing levels of experience with end-of-life-care and terminal illness. Both quantitative and qualitative questions were asked to analyze student opinions and experiences.

Attitudes Toward PAS

Participant opinions on PAS indicate that they were moderately supportive of PAS (63%) as an option at the end of life. This finding is not necessarily consistent with the previous literature. While the majority of studies previously done on PAS show some favor, this study had a much stronger positive reflection toward PAS than other nurses or nursing students. In the study by Miller et al. (2004) only 48% of nurses officially supported PAS. Another study on nursing student attitudes in Arkansas, found that a large portion of participants remained neutral (63%) with only some indicating a positive opinion (16%) and the

remainder remaining negative (21%) (Butler, 2005). A study in Washington on nurses' knowledge and implications of PAS indicated strong support (46%) with only some in opposition (26%) (Clymin et al., 2012).

While the more current literature shows some growing support, the prior studies focused on physician opinions and did not include specific nursing opinions (Emanuel et al., 2016). The literature continues to show congruencies with this study in relation to explanations for disagreement to PAS. Butlers (2005) study in Arkansas on nursing students not only found a positive correlation between participants who indicated less importance on religion and favored PAS but also found a positive correlation between participants indicating strong religion and a negative attitude toward PAS. Although participants indicated religiosity to be of little importance (30%), the most common reasons stated for opposed opinions toward PAS were religiosity and personal beliefs. This could be related in part to an overall lack of religiosity with only half (55%) indicating any religious affiliation. Previous studies found that nurses who were strongly against PAS felt compelled to resign from the entire institute (Clymin et al., 2012). This study found nurses preferred to refuse personal involvement with PAS but did not find any statements relating to resignation. Ultimately, this study found an increase in percentages of participants indicating favor toward PAS which could be due to the growing legal status of PAS in the United States. The majority of the comparable studies were done more than ten years ago making them less current and with expected differences. As society continues to challenge ethical issues, it

is only reasonable that PAS will gain further attention. It will be important to monitor similar data for further changes as the model of PAS continues to change.

Comfort Levels on PAS

Participants also responded that they were moderately comfortable providing care for a patient interested in PAS. This may indicate that nursing students place patient autonomy and the end-of-life nursing care at a high level of importance. This was congruent with qualitative data where participants commented that nurses had a right to their own autonomy and that “nurses should not be forced” to participate in care they are not comfortable with. This finding is also consistent with similar study findings in the literature. Qualitative data simultaneously showed that participants found nurses responsible for care of their patients despite their personal beliefs. The literature agrees with indications that nurses thought it was important to continue to care for a patient who had requested PAS. In a study reviewing attitudes of Oregon hospice nurses, almost half (45%) of participants had already agreed to care for a patient who had actively requested PAS (Miller et al., 2004). The current study found that continued care for a patient contemplating for PAS included actions such as provision of comfort, EOL care, and advocacy. The findings began to get more obscure as participants talked about who was responsible to education and participate in the actual PAS process. Some participants indicated they thought this was the responsibility of physicians while others maintained that nurses were capable. Some participants thought it was part of the nursing role to talk patients out of PAS or wanted to review all of the patient’s options to make sure nothing

had been missed. Others indicated that they would excuse themselves from further care of the patient based on their personal beliefs or ideals. Of the nurses who disagreed with PAS, some still took it upon themselves to direct patients to information on PAS. This was congruent with previous studies where, of the nurses who disagreed with PAS, just under half (40%) opted to direct patients toward proper information as long as they themselves were not required to be involved in PAS (Clymin et al., 2012). Despite the findings that nurses were moderately comfortable caring for patients who had requested PAS, there was a congruent theme found in this study and the literature of nurses' autonomy. This theme suggests that participants felt a nurse should have the right to refuse any patient he or she are not comfortable caring for.

Regression analysis of several student factors onto student opinions of PAS resulted in only prior experience with someone close to the student asking for help with PAS, and religious affiliation as significant predictors of PAS opinion. This study showed positive correlation ($F = 9.82, p=.0019$) between the domino scale and students who stated they have had several experiences with death and patients who are terminally ill. These results are somewhat congruent with the literature. Previous studies found a positive correlation with critical care or hospice nurses with one study showing as much as 62% support by critical care nurses compared to 43% of other nurses (Evans, 2015, Miller et al., 2004; Asch, 1996). One study found conflicting results that those who indicated experience with terminality were more permissive in beliefs toward PAS (Butler, 2005). Religiosity was also predictive of a negative correlation with PAS.

This was congruent with the literature as the most common reasons stated for disapproval were personal and ethical values (Clymin et al., 2012; Butler, 2005).

Qualitative results dovetailed with some of the quantitative findings. For example, on average participants commented they would be moderately comfortable (mean = 73) taking care of patients requesting PAS. This theme was accompanied by an influx of recommended tasks nurses might have when taking care of a patient including comfort measures and EOL care. Indications that on average participants thought they required a moderate amount of information (mean = 75) on PAS were paired with several comments on participant discomfort in answering items due to lack of education. Questions regarding experience with terminality were accompanied with personal anecdotes from participants about their experiences. Importance of EOL care was given high scores (mean = 82) and was reflected in the overwhelming effort participants took in replying to the open-ended questions. Finally, while only some participants indicated religious affiliation (55%), it was revealed in several comments that personal beliefs and religiosity were common reasoning for participants who showed opposed opinions on PAS. This matching of qualitative and quantitative data demonstrates that answers remained congruent within the survey.

Education on PAS

Many participants commented that they themselves or nurses need further education on PAS and EOL. According to one study, students have less than 15 hours spent on EOL care (Loerzel and Conner, 2016). This is congruent with the current study with only seven percent of students claiming to have more than 15

hours of course content on care of terminally ill. While the current study found that students were moderately comfortable caring for a patient who requested PAS, Loerzel and Conner (2016) found that, upon further reflection, students were uncomfortable initiating conversations about death and even feared they would communicate the incorrect information.

The current UCF nursing curriculum only offers one elective class on EOL care with additional content embedded throughout other classes. This may not be sufficient education to create competency in dealing with EOL situations. There's also little evidence that practicing nurses receive additional education on EOL care from their employer and EOL care is not a part of the continuing education classes required by the state to maintaining licensure.

Limitations

Sample Size

While 231 participants are a considerable response group, it is less than half of the originally polled 550 students. The sample size also showed that there was a disproportionate representation of some of the minority groups that may have prevented the development of significant data. Recommendations for future research may include enhancing the sample size with equal representation of the minorities. This may include a population of students from different schools or even different states to better represent all groups.

Definitions

Before taking the survey, no definitions were provided to participants for either PAS or euthanasia. While this reinforced the participants need for more education, it may

have also affected the opinions of students on PAS. Other basic definitions such as terminality and end-of-life may have been included as well to help establish a complete understanding of the PAS situation before asking participants to formulate opinions.

Dates and Time Frame

The survey was open for the students for two weeks during the semester. Due to time limitations, one of these weeks was over spring break vacation. Although the study still achieved sufficient results, there may have been some bias due to this timing. It would have been recommended to complete this survey on a more consistent timeline. Additionally, although teachers were given the dates the survey was open for, those dates were not included in the student informational letter. Students may or may not have had clarification of when the survey was open. This oversight may have led to fewer participants accessing the survey before the close date.

Refinement of the Survey Tool

Refinement of the survey tool may have led to fewer missing data groups and a more accurate portrayal of student factors. While reviewing the data, it became evident that several of the questions from the demographic survey were phrased awkwardly. These wordings could have led to different interpretations of some answers. The survey should have included more simplistic wording to cover all viewpoints. It would have also been reasonable to allow participants to skip some questions based on their answers to other questions so that they did not need to answer with the same idea twice. Finally, there were several visual analog questions that may have been more difficult to access on some platforms (mobile cell-phone) than others which could have added bias to the data. Data were analyzed to ensure that the missing answers were random, and the accepted

data would have no bias. Regardless, it would be recommended to avoid this type of question to obtain a more consistent data group.

Nursing Implications

Education

While it is evident that additional education related to PAS is necessary to clarify student understanding of PAS versus similar, related but separate concepts, efforts to promote cognitive understanding of PAS need to be supplemented by educational opportunities that impact the affective realm on knowledge development. Specific EOL classes should be offered to nursing students to begin preparing them for the inevitable situations they might come across in practice. Simply combining EOL issues with other technical material inhibits in depth discussions and hinders the formation of full values behind EOL material. Competent nursing includes a prominent focus on EOL care. The nursing curriculum should be supplemented with specific EOL modules, clinical scenarios and discussions that could aid students in forming ideals for working with patients who are terminally ill. This would help prepare students for all EOL scenarios, including PAS, and help them fill a more encompassing role as a nurse.

It is understood that nurses will more than likely encounter EOL during their career. Due to this, education should not stop at the student level. Continued education is something that could be made mandatory for licensure renewal. It would be beneficial to offer routine education pertaining to EOL with additional opportunities to learn about PAS.

Policy

With the compact license making it easier for nurses in the United States to travel, state laws and procedures are becoming more important on a national scale (NCSBN, 2018). Nurses may reasonably participate in travel assignments or graduate and move to states that do support PAS and find themselves without any background to support these legal policies. Although neither the ANA or the AMA currently support medical personnel participation in PAS, it is not practical to disassociate themselves from legal standing policies they do not agree with. The ANA needs to further address and prepare nurses to work with PAS in all states. The argument still stands that PAS is not congruent with the health and healing role but, nurses are and will continue to encounter patients who are requesting and participating in PAS. Even as nursing students, participants were eager to share detailed descriptions of their encounters with terminal patients and their inability to participate with them. Nurses are at the front lines of the issue and should have their opinions heard. As such, they should be urged to participate legally as PAS laws continue to be debated so that these laws will be created to support nurses.

Although PAS is not currently legalized in Florida, many participants admitted that they were willing to help patients who requested PAS but were not sure of how the process would go. It is necessary for all nursing students and nurses to have a firm foundation in understanding statutes by state. Like any procedure, PAS should have a well implemented and tested method that nurses can default upon when approaching the scenario. Hospitals and medical centers

that support PAS should offer regular classes and even certifications on PAS, especially in states in which it is currently legalized.

Practice

The nursing role includes caring for a plethora of patients including those we may not agree with. Although PAS is an extraordinary situation, the qualitative data showed that most participants agreed that they should continue to care for their patient at least on a nursing level. Even still, this should not be a surprise for nurses. Hospitals and medical establishments that support PAS should prepare nurses even up to informing them before hire, that they might encounter patients requesting PAS. In this way, nurses can begin to prepare themselves mentally for this difficult scenario before they even have to encounter it. Should they be unwilling to participate in PAS, they can distinguish at that moment that they prefer to work in a different area to avoid involvement. Furthermore, nurses should not deal with this alone. Floors that have encounters with PAS should have dedicated personnel that nurses can question or refer to for extra information. Ethics boards, experienced nurses and written policies should be available for review to anyone who has questions.

The ANA has continued to refrain from involvement in PAS. This is a national guide for nurses to refer to in all situations of practice that is devoted to advancing nursing practice and policy. Currently the ANA does not offer any professional opportunities for nurses to learn how to handle the topic of PAS in the care of patients at EOL. It is of vital importance for nurses to have a policy to adhere to at the risk of poor patient outcomes. Whether or not the ANA agrees

with this change in procedure, this policy needs to be more thoroughly acknowledged to give more complete recommendations and advice for nurses who might be encountering PAS issues.

Overall, this study found that there is some anxiety in the implementation of the PAS process that should be addressed. It would be necessary to clarify roles and responsibilities for patients who request PAS. It may also be beneficial to have a specialty PAS nurse who would educate and prepare for patients in regard to their interests in PAS in the same way hospice nurses deal with patients who are terminal that choose palliative care.

Recommendations for Future Research

End-of-life care is changing as PAS becomes more prevalent in the United States. Nurses are predisposed to making choices through collaborations with other nurses, experiences and research. Nurses need to know and understand their roles, so they are prepared to interact with patients who ask about PAS. While PAS is still slowly making a legal presence, nurses are struggling to find peers with sufficient experience or appropriate direction and are liable to be forced into unpracticed decisions. Moreover, PAS studies reveal that there is a lack of education and understanding of PAS despite its legality. Further research in this area could help establish firm policies and procedures for nurses who encounter PAS.

Research should also look into the decision-making process of a nurse who is encountering a PAS situation. Nurses have several choices they might consult if they feel uncomfortable making a decision. Sometimes it is as simple as collaboration with a peer or a charge nurse, other times ethical boards can be involved. Research into this area

could reveal areas for improvement and the quality of assistance a nurse would be able to obtain during a difficult situation. Research could also ignite foundational classes and modes of formal education for nurses who work in areas where PAS is legalized. Further research might find if and how formal education on PAS would affect nursing student opinions. While it should be expected that many beliefs are more deeply founded and will not be changed through clarification of the process, it would be informative to see the effect thorough understanding would have on student opinions. Research in this area could lead to further definition of nursing roles and expectations. Investigating these simple conditions could help nurses develop a solid groundwork for dealing with these sensitive situations.

Summary

As PAS has been passed in some states in the United States, it is important for nurses to learn and understand PAS so that they might begin formulating policies to approach this issue. Despite individual opinions, it is urgent that nurses play a part in understanding this expanding nursing role and have an active voice in the continued impact of PAS. As PAS continues to be legalized without boundaries, it puts an elevated risk for misinterpretation and abuse. Buckley (2018) urges that “It is important that states and the nation as whole view PAS not as an alternative to treatment, or a replacement for hospice or palliative care.” It is not enough to be simply in favor of or against PAS. While this study showed growing support for PAS by nursing students, it is evident that the majority of nurses agree to have a continued role in patient care despite any opinions. What is left is to focus this new role into an established and supported policy so that nurses may continue to have a healing impact on their patients.

APPENDIX A: INFORMATIONAL LETTER
APPENDIX A
INFORMATIONAL LETTER



EXPLANATION OF RESEARCH

Title of Project: Pre-Licensure Nursing Student Attitudes Toward Physician-Assisted Suicide

Principal Investigator: Dr. Norma Conner

Other Investigators: Stephanie Cox

You are being invited to take part in a research study. Whether you take part is up to you. You are being asked to participate in this research study since you are a student at the UCF College of Nursing enrolled in either the Basic or Accelerated BSN nursing program at either the Orlando, Cocoa or Daytona campuses. This survey will pertain to [YOUR CLASS].

This survey consists of 35 questions and will only take approximately 10 to 15 minutes to complete. Your participation is voluntary. However, [YOUR INSTRUCTOR] has agreed to offer you 1 extra credit point in [YOUR COURSE] if you choose to participate. To ensure confidentiality, we will ask you to create a unique identifier that you will email to your instructor. Once the survey period is over, I will send the unique identifiers to the instructors to verify your participation. At no time will I, the researcher, have access to your names or grades in the course. In addition, your instructor will not have access to your answers on the survey.

If you would like to participate, please follow this link: [PAS Survey Link](#)

If you should choose not to participate, you may complete a 300-word essay on your opinions about PAS to receive the same extra credit. This essay will be emailed directly to your professor for their review. You must be 18 years of age or older to take part in this research study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints please feel free to contact us at any time:

Stephanie Cox
UCF, College of Nursing
Stephaniecox@knights.ucf.edu

Dr. Norma Conner
UCF, College of Nursing
Norma.Conner@ucf.edu
407-823-2744

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

Thank you for your consideration,

Stephanie Cox

Dr. Norma Conner

APPENDIX B: PHYSICIAN-ASSISTED SUICIDE SURVEY
APPENDIX B
PHYSICIAN-ASSISTED SUICIDE SURVEY

1. We thank you for your interest in this survey. By answering these questions, you are consenting to participate. Please click “yes” to continue.
 - a. Yes
 - b. No

Opinions About Physician-Assisted Suicide (PAS)

We would like your opinions about physician-assisted suicide or PAS. PAS involves a patient who wishes to end his/her life and seeks the assistance of a physician in order to do so. Furthermore, PAS involves some action (for example, giving the patient a substance to end their life), rather than some inaction (for example, allowing a patient to die by not carrying out surgery). Please indicate your opinion (there are no right or wrong answers) on the items below by using this response scale:

SA = strongly agree, A = agree, NS = not sure, D = disagree, SD = strongly disagree

1. In general, I believe that a physician would never be morally justified in helping someone end their life.
 - a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
2. A person, no matter how ill, does not have the right to end their life.
 - a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
3. If a person is seriously ill, with no reasonable possibility of a cure, then PAS is acceptable.
 - a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
4. If I were seriously ill, with no reasonable possibility of a cure, I would consider PAS.
 - a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
5. It would be important to determine that a person requesting PAS is mentally competent.
 - a. SA

- b. S
 - c. NS
 - d. D
 - e. SD
6. I would favor laws to make PAS legal in the US.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
7. PAS should be decided solely on medical grounds and not on moral issues.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
8. I think PAS is acceptable for the elderly who have a serious medical condition.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
9. If a child were seriously ill, with no possibility of having a normal life, the parents should be allowed to request PAS.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
10. It would be OK for a physician to prescribe a lethal dose of a substance for a patient, if the patient requested it.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD
11. It would be OK for a physician to actually administer a lethal dose of a substance to a patient who requested it.
- a. SA
 - b. S

- c. NS
 - d. D
 - e. SD
12. PAS is more acceptable if performed by other professionals, such as a nurse or a pharmacist.
- a. SA
 - b. S
 - c. NS
 - d. D
 - e. SD

Demographic Questionnaire

1. Have you ever lost someone to death?
 - a. Parent
 - b. Child
 - c. Relative
 - d. Friend
2. Have you ever taken care of someone who was terminally ill?
 - a. Yes
 - b. No
3. Has anyone close to you committed suicide?
 - a. Yes
 - b. No
4. Have you ever been asked by a patient or someone close to you for help with PAS?
 - a. Yes
 - b. No
5. How comfortable are you taking care of a patient who has requested physician-assisted suicide?
 - a. 0 (Not Comfortable) – 100 (Very Comfortable)
6. How much literature have you read on PAS?
 - a. 0 – 5 hours
 - b. 5 – 10 hours
 - c. 10 – 20 hours
 - d. 20 or more
7. Have you had a class in end-of-life care, death and dying or care of the terminally ill?
 - a. Yes
 - b. No
8. How much course content have you had on care of the terminally ill?
 - a. 1 hour

- b. 5 hours or less
 - c. 15 hours or less
 - d. 1 semester
9. To what extent do you feel the need for additional education on PAS?
- a. 0 (I do not need education on PAS) – 100 (I need more education on PAS)
10. How important do you think end-of-life care will be to your future nursing career?
- a. 0 (Not Important) – 100 (Very Important)
11. Do you currently hold a license to practice nursing?
- a. Yes
 - b. No
12. How many semesters of clinicals have you completed?
- a. 1 – 2 semesters
 - b. 3 – 4 semesters
 - c. 5 or more semesters
13. How long have you been in the nursing program?
- a. 1 semester
 - b. 2 semesters
 - c. 3 semesters
 - d. 4 semesters
 - e. 5 or more semesters
14. What is your gender?
- a. Male
 - b. Female
 - c. Transgender
 - d. Other
15. What is your age group?
- a. 18 – 25
 - b. 25 – 35
 - c. 35 – 45
 - d. 45 and older
16. What is your marital status?
- a. Married
 - b. Single
17. What is your race?
- a. White
 - b. Black
 - c. Pacific Islander
 - d. Native American
 - e. Asian

- f. Hispanic
 - g. Multiracial
 - h. Other
18. Are you religiously affiliated?
- a. Yes
 - b. No
19. How likely are your religious beliefs to influence your opinions on physician-assisted suicide?
- a. 0 (Not Influential) – 100 (Very Influential)
20. Are you currently employed?
- a. Yes
 - b. No
21. Are you currently employed in the health care field?
- a. Yes
 - b. No

Open Ended

1. In what ways do you think nurses should participate in physician-assisted suicide?
2. Do you have any additional comments you would like us to know about your opinions on physician-assisted suicide?

APPENDIX C: DOMINO SURVEY APPROVAL LETTER
APPENDIX C
DOMINO SURVEY APPROVAL LETTER

11/26/2017

Physician-Assisted Suicide - Stephanie Cox

Physician-Assisted Suicide

Domino, George - (gdomino) <gdomino@email.arizona.edu>

Wed 11/1/2017 8:27 PM

To: Stephanie Cox <StephanieCox@knights.ucf.edu>;

Thank you for your request. I am afraid my assistant (JM) made a mistake and thought you were requesting a copy of the Suicide Opinion Questionnaire. There is no charge for the PAS. The full scale can be found in the journal Omega for 1996, vol. 34, pgs. 247-257. You are welcome to reproduce the scale for your study.

I have your check which I can tear up or return to you at your Titusville address. Please let me know.

Good luck with your project. If possible, I would appreciate a copy of your results when the project is finished.

George Domino, Ph.D.
Professor Emeritus of Psychology
University of Arizona

REFERENCES

- Altmann, T., & Collins, S. (2007). Oregon's death with dignity act (ORS 127.800-897): a health policy analysis. *Journal of Nursing Law, 11(1)*, 43-52.
- American Nursing Association. (2013, April 14). Position statement. Retrieved from <http://www.nursingworld.org/euthanasiaanddying>
- Asch, D. A. (1996). The role of critical care nurses in euthanasia and assisted suicide. *The New England Journal of Medicine, 334(21)*, 1374-1379.
- Back, A. L., Wallace, J. I., Starks, H. E., & Pearlman, R. A. (1996). Physician-Assisted suicide and euthanasia in Washington state. Patient requests and physician responses. *Journal of American Medical Association, 275(12)*, 919-925.
- Braverman, D. W., Marcus, B. S., Mercurio, M. R., Kopf, G. S., & Wakim, P. G. (2017). Health care professionals' attitudes about physician-assisted death: An analysis of their justifications and the roles of terminology and patient competency. *Journal of Pain and Symptom Management, 54(4)*, 538.
- Buckley, T. (2018). Physician assisted suicide: An end of life care option that should be available to all dying patients. *Seton Hall Law*. Retrieved from <file:///C:/Users/Boomer/Desktop/HIM/Sources/Physician%20Assisted%20Suicide%20An%20End%20of%20Life%20Care%20Option%20that%20Shoul.pdf>
- Butler, C. (2005, January). Attitudes toward physician-assisted suicide: a survey of nursing students in Arkansas. *Attitudes Toward Physician-assisted Suicide*, p. 224.
- Callahan, D., & White, M. (1996). The legalization of physician-assisted

- suicide: creating a regulatory Potemkin village. *University of Richmond*, 30(1), 1-83.
- Center for Disease Control and Prevention. (2017). Chronic disease prevention and health promotion. Retrieved from <https://www.cdc.gov/chronicdisease/index.htm>
- Clymin, J., Jacobson, D., Jablonski, A., & Feldt, K. S. (2012). Washington state death with dignity act a survey of nurses' knowledge and implications for practice part 2. *Journal of Hospice & Palliative Nursing*, 14(2), 141-148.
- Death with Dignity. (2018). *Death with dignity around the U.S.* Retrieved from <https://www.deathwithdignity.org/take-action/>
- Domino, G., Kempton, S., & Cavender, J. (1997). Physician assisted suicide: A scale and some empirical findings. *OMEGA – Journal of Death and Dying*, 34(3) 247-257.
- Dillworth, J., Dickson, V. V., Mueller, A., Shuluk, J., Yoon, H. W., & Capezuti, E. (2016). Nurses' perspectives: hospitalized older patients and end-of-life decision-making. *Nursing in Critical Care*, (2), 1. doi:10.1111/nicc.12125
- Emanuel, E. J., Onwuteaka-Philipsen, B. D., Urwin, J. W., & Cohen, J. (2016). Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA, The Journal of the American Medical Association*, (1), 79.
- Ersek, M. (2005). Assisted suicide: unraveling a complex issue. *Nursing*, 35(4), 48-52.
- Evans, L. (2015). Nurses' attitudes to assisted suicide: sociodemographic factors. *British Journal of Nursing*, 24(12), 629-632.

- Feldman, J., & Finguerra, L. (2001). Managed crisis care for suicidal patients. In J. M. Ellison (Ed.), *Treatment of suicidal patients in managed care* (pp. 15–38). Washington DC: American Psychiatric Press, Inc.
- Frank, J. N. (2016). Physician-assisted suicide up for debate in states: what role should physicians have in states where assisted suicide is allowed? *Medical Economics*, (9), 36.
- Friend, M. L. (2011). Physician-Assisted suicide: Death with dignity? *Journal of Nursing Law*, 14(3/4), 110-116. doi:10.1891/1073-7472.14.3.4.110
- Ganzini, L., Harvath, T. A., Jackson, A., Goy, E. R., Miller, L. L., & Delorit, M. A. (2002). Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *The New England Journal of Medicine*, 347(8), 582-588. doi:10.1056/NEJMsa020562
- Gostin, L. O., & Roberts, A. E. (2016). Physician-Assisted dying: A turning point? *Journal of The American Medical Association*, 315(3), 249-250. doi:10.1001/jama.2015.16586
- Hartogh, G. (2017). Two kinds of physician-assisted death. *Bioethics*, 31(9), 666-673.
- Hizo-Abes, P., Siegel, L., & Schreier, G. (2018). Exploring attitudes toward physician-assisted death in patients with life-limiting illnesses with varying experiences of palliative care: a pilot study. *BMC Palliative Care*, 17.
- Jones, D. A., & Paton, D. (2015). How does legalization of physician-assisted suicide affect rates of suicide? *Southern Medical Journal*, 108(10), 599-604. doi:10.14423/SMJ.00000000000000349

- Lee, M. A., Nelson, H. D., Tilden, V. P., Ganzini, L., Schmidt, T. A., & Tolle, S. W. (1996). Legalizing assisted suicide-views of physicians in Oregon. *The New England Journal of Medicine*, *334*(5), 310-315.
- Loerzel, V. W., & Conner, N. (2016). Advances and challenges: Student reflections from an online death and dying course. *American Journal of Hospice & Palliative Medicine*, *33*(1), 8-15.
- Matzo, M. L., & Emanuel, E. J. (1997). Oncology nurses' practices of assisted suicide and patient-requested euthanasia. *Oncology Nursing Forum*, *24*(10), 1725-1732.
- Miller, L. L., Harvath, T. A., Ganzini, L., Goy, E. R., Delorit, M. A., & Jackson, A. (2004). Attitudes and experiences of Oregon hospice nurses and social workers regarding assisted suicide. *Palliative Medicine*, *18*(8), 685-691.
- National Council of State Board of Nursing (2018). *Enhanced Nurse Licensure Compacy (eNLC) Implementation*. Retrieved from <https://www.ncsbn.org/enhanced-nlc-implementation.htm>
- Petrillo, L. A., Dzung, E., Harrison, K. L., Forbes, L., Scribner, B., & Koenig, B. A. (2017). How California prepared for implementation of physician-assisted death: A primer. *American Journal of Public Health*, *107*(6), 883-888.
doi:10.2105/AJPH.2017.303755
- Rhee, J. Y., Callaghan, K. A., Allen, P., Stahl, A., Brown, M. T., Tsoi, A., & ... Dumitru, A. G. (2017). A medical student perspective on physician-assisted suicide. *Chest*, *152*(3), 475-477. doi:10.1016/j.chest.2017.06.007
- Volker, D. (2007). The Oregon experience with assisted suicide. *Journal of Nursing Law*, *11*(3), 152-162.

Weiser, J. K. (2018). The slippery slope of legalization of physician-assisted suicide.

Annals of Internal Medicine, 168(9), 683. doi:10.7326/L18-0018