

Understanding Physician Assisted Suicide: A Literature Review

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Introduction

Abstract

Death and dying are difficult subjects for people to talk about, both for themselves and for their loved ones. It is unfortunate that so many terminal illnesses come with a lot of pain. When it has been determined that someone's life is coming to an end, one would hope that it can be as peaceful as possible. Two options for end of life care include continuous palliative sedation and physician assisted suicide. This article will discuss physician assisted suicide in depth in order to expand understanding of the treatment.

Background

According to the American Academy of Hospice and Palliative Medicine, physician assisted suicide (PAS) is defined as a "physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life" (American Academy of Hospice and Palliative Medicine, 2016). Patients must meet a series of criteria in order to be eligible to receive this treatment. The criteria include: (1) an age of at least 18 years old; (2) have a terminal illness with six months or less to live; and (3) live in one of six states where PAS is legalized (deathwithdignity.org). While doctors provide the lethal prescription for the patients, it is at the patient's own hand when the medication is administered. Doctors cannot administer the medication to patients themselves. This would be considered euthanasia, which is not legal in the United States. Physician assisted suicide is legal in six states: Oregon, Washington, Vermont, California, Washington D.C., and Colorado. Montana legalized PAS through a court ruling (State-by-state guide to physician-assisted suicide, 2017).

The American Academy of Hospice and Palliative Medicine defines palliative sedation as “the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms” (American Academy of Hospice and Palliative Medicine, 2016). When palliative sedation is implemented, the patient receives high doses of sedative medications to bring them to a state of unconsciousness. In this state of unconsciousness, the patient does not feel pain from their illness, nor can the patient do any conscious activities, including eating or drinking by themselves. Often patients will be under continuous palliative sedation (CPS). Continuous palliative sedation keeps patients in this state until they pass away painlessly by natural recourse.

While both PAS and CPS are implemented to make the dying process easier on people, the main difference between the two is their intent. PAS is intended to end the person’s life, and thus end their suffering. CPS is intended only to end a person’s suffering up until the end of their life.

Physician assisted suicide was first practiced in the United States by Dr. Jack Kevorkian. The media gave Kevorkian the morbid nickname: Dr. Death. During the 1990s, Kevorkian estimates that he assisted in approximately 130 suicides over 8 years (HBO Films, 2010). Kevorkian was a medical pathologist practicing in Michigan, which had not, and still has not, legalized physician assisted suicide. The state did not have laws against suicide or any medical assistance thereof. Kevorkian was very careful with how he practiced, in order to remain within the limits of the law. He ensured that his patients clearly expressed their desire to die and that the patients themselves were the ones to administer the medication. Kevorkian build his own “death machine” that allowed the patient’s to self-administer medication by pulling a string (HBO Films, 2010). Kevorkian would call the police after the death. He was arrested after the deaths

but was unable to be charged, due to the lack of specific laws against what he was doing. Although many considered his actions to be morally wrong, they were not technically illegal. In September of 1998, Kevorkian deviated from his usual technique by administering the lethal substance to his patient, Thomas Youk, a gentleman afflicted with amyotrophic lateral sclerosis (ALS) (HBO Films, 2010). Youk was unable to administer the medication to himself due to the degenerative nature of his disease. Kevorkian injected Youk because he believed that what he was doing was the right thing at the request of his dying patient. His arrogance showed more as he also submitted the videotape of this act to 60 Minutes, where it was aired in November of 1998. Kevorkian was charged with second degree murder and was convicted in 1999 after only a 2-day trial, (HBO Films, 2010).

Dr. Kevorkian is an example of why physician assisted suicide needs to be regulated as a legitimate medical practice. Without proper legislation, Kevorkian practiced on his own terms. While working around the law and avoiding jail time, Kevorkian developed a bit of a god complex. His arrogance grew with every suicide he assisted with. He felt that he was completely in the right and the law could not touch him. This gave him the confidence to perform euthanasia on television without fear of facing any repercussions. If Michigan had solid laws on physician assisted suicide, Kevorkian may not have done what he did. He practiced the way he did because he was testing the law, trying to push things to the limit. He based his practice on his own morals rather than the laws in place, which is a dangerous thing. This led to him ending Youk's life- and to his own incarceration.

Physician assisted suicide is a complex topic. It brings up medical, spiritual, and emotional issues. In the United States, PAS has been met with a lot of opposition. Brittany Maynard is probably one of the most widely known cases of PAS. At 29, Maynard was

diagnosed with terminal brain cancer. The tumors in her brain were very aggressive and caused Maynard a lot of pain. There was no cure for her disease, she was given only 6 months to live. In those 6 months she would become more and more sick, less like herself. She moved from California to Oregon, the first state to legalize PAS, in order to be eligible for the *Die with Dignity Act* (Maynard, 2014). In November of 2014, Maynard ended her life with the lethal prescription she was prescribed. Maynard was a strong advocate for PAS. Her unique story got a lot of media attention, which made the topic of PAS more widely known. California was the fourth state to legalize PAS in June of 2016. One of the first patients to benefit from California's new law was Betsy Davis. Davis was diagnosed with amyotrophic lateral sclerosis or ALS. ALS is a neurodegenerative disease that causes slow paralysis. Those diagnosed with ALS usually die of suffocation due to the paralysis of their diaphragm. Davis decided that she did not want to die that way, with her death she, "wanted to celebrate her life — eating favorite foods, listening to favorite music and reliving favorite memories with those who meant the most to her — then slip away surrounded by love and support" (Bever, 2016). Davis threw a party with her friends and family for her last day. She died on her own terms.

Palliative sedation is a more common practice. Palliative sedation is legal throughout the entire United States. Still, there are "considerable variations with regard to PST in clinical practice" (Schildmann and Schildmann, 2014). There are different definitions, indications, and guidelines with palliative sedation. Published guidelines for palliative sedation differ from each other in clinical and ethical aspects. Research shows that additional guidelines are necessary for palliative sedation in order to have a more uniform understanding of the process.

Research Questions

Why do patients choose physician assisted suicide as an end of life treatment? How do politics and media portrayal affect people's opinions on physician assisted suicide? Is there a lack of education with physician assisted suicide which gives the treatment a negative connotation? Are personal morals the main reason for opposition to physician assisted suicide?

Purpose

The purpose of this literature review is to educate the nursing community on physician assisted suicide through its comparison to palliative sedation. It is the responsibility of nurses to always educate themselves. Healthcare is an ever changing field. Every day new research emerges that may change preferred treatments or a protocol that has been followed for years. There is not a plethora of research on the subject of physician assisted suicide. Many nursing schools will cover the topic briefly but do not have the liberty of time to go into the intricacies on the treatment. In just the last three years, three more states have legalized physician assisted suicide. It is possible that many more states might start adopting the practice. This paper will serve as an informative resource for nurses to expand their knowledge on end of life procedures.

Background Information

Legislation

Physician assisted suicide (PAS) is not currently legal throughout the entire United States of America. It is a state regulated policy that is legalized in six states. The legislation that allows PAS is referred to as the Death with Dignity Act. Involvement in the Death with Dignity Act is completely voluntary. No physicians or patients are required to participate in this treatment. It is up to individuals to decide whether it is right for them, whether that means a treatment to receive or extend. Some patients may wish to receive PAS but their primary physician does not provide this treatment, they would have to seek a different physician.

As mentioned earlier, there are three criteria patients need to meet to be eligible for PAS. The criteria include: (1) an age of at least 18 years old; (2) have a terminal illness with six months or less to live; and (3) live in one of six states where PAS is legalized (deathwithdignity.org). If a patient meets these three criteria, they are eligible for PAS but may not necessarily receive PAS. The patient must be able to self-administer and ingest the medication (Death With Dignity.Org, nd.). Two physicians are required to determine that all of these criteria are met. California, Colorado, Oregon, and Washington require that you prove residency with legal documentation including a driver's license or state issued identification card, a recent state tax return, a document showing residency via renting or owning, or a state voter registration. The District of Colombia and Vermont's Death with Dignity Act does not specify how residency must be proven (Death With Dignity.Org, nd.). There is no minimum requirement for length of residency. A patient could have moved to Washington the day before and still meet the residency requirement. The attending physician will determine the patient's residency is valid.

In order for patients to receive the treatment, they must request the treatment. Patients must start with an oral request which they can make at any time (Death With Dignity.Org, nd.). The first oral request often comes at times when patients are discussing end of life with their physicians. Oral request can be rescinded at any time; it is not a binding contract. After the first oral request, physicians will verify that the patient meets all of the eligibility requirements. Physicians are required to inform patients of other end of life alternatives including hospice and palliative care (Death With Dignity.Org, nd.). "If either physician determines that your judgment is impaired in any way, e.g. by a mental illness or depression, they must refer you for a psychological or psychiatric evaluation" (Death With Dignity.Org, nd.). After the first oral

request comes the first waiting period, which are a minimum of 15 days. Patients must make a second oral request after the waiting period (Death With Dignity.Org, nd.). Patients must also submit a written request. The written request is made using the statutory form included in each state's legislation (Death With Dignity.Org, nd.). Most states do not require the written request to be submitted at a particular time. In the District of Columbia, patients are required to submit the written request between the two oral requests (Death With Dignity.Org, nd.). The written request needs to be witnessed, "by two individuals, at least one of whom is not related to you, entitled to any portion of your estate, or an employee of the health care facility caring for you" (Death With Dignity.Org, nd.). This means that patient's physicians are ineligible to be a witness, as well as any nurses who may be providing care. It is important to remember that any of these requests, both oral and written, may be rescinded at any time. District of Columbia, Oregon, Vermont, and Washington require a second waiting period. The physician is required to wait 48 hours from the time he or she received the written request before writing the prescription (Death With Dignity.Org, nd.). This second waiting period does not apply to patients in California or Colorado.

After meeting eligibility requirements, making requests, and going through waiting periods, physicians may write prescriptions for their patients. The prescription must be handled in a way that follows procedure. The prescription may never be handed to patient directly. The physician may dispense the medication themselves or deliver the prescription to the pharmacy by mail (Death With Dignity.Org, nd.). Certain states legislation allows the prescription to be delivered to the pharmacy in other ways. In California and Colorado, the prescription may be electronically delivered. In the District of Columbia, the prescription may be electronically delivered or faxed (Death With Dignity.Org, nd.). Patients then have the option of what to do

with the prescription. Some patients choose to never fill the prescription. Some patients choose to fill the prescription but never take the medication. It is entirely up to the individual.

The medication is a very large dose of sedatives, barbiturates, usually given in a powdered form. “The lethal dose prescribed is typically 9 g of secobarbital in capsules or 10 g of pentobarbital liquid, to be consumed at one time” (Fass and Fass, 2011). This medication has a very bitter taste; it is suggested to patients to have a sweet drink available to mask the bitter taste. The medication must be consumed within two minutes in order to be effective. “Most patients fall asleep peacefully about 10 minutes after drinking the life ending medication, and die in 1-3 hours. In about 5 percent of patients, it takes longer than 6 hours to die, but they sleep comfortably the whole time, until death ensues” (Death With Dignity.Org, nd.). Pharmacists recommend taking this medication on an empty stomach to increase its effectiveness. Since this may cause nausea or vomiting, patients should also be instructed to take an antiemetic, an anti-nausea medication, about an hour before to prevent any vomiting (Fass and Fass, 2011).

Patients have to decide when is the right time to take the medication. They will often use their family members as a resource to help make the best decision, but the decision is theirs alone. It is important to remember that patients who are choosing to take the prescription have reached their limit of suffering. They have been living with their disease and symptoms and have finally reached a point of intolerance. They are choosing to end life on their terms, before their suffering increases and their quality of life worsens even more. When patients decide to take the prescription, they must have the ability to swallow four ounces of liquid, as that is how the medication is ingested. California requires its patients to fill out a Final Attestation Form, 48 hours prior to ingesting the medication (Death With Dignity.Org, nd.). No other states require this form or one like it.

There are three cases where patients will be unable to take the medication even after obtaining the prescription. The first is if the patient has progressed to coma or death, they would not be able to ingest the medication. The second would be if the patient loses brain function. If the patient has lost capacity to make cognitive decisions, i.e. due to dementia or a brain tumor, they would no longer qualify to take the medication. The day patients plan to take the medication, they must ask for it and be knowing of what it is for. The third scenario is if a patient is unable to swallow four ounces of liquid within two minutes or less (Death With Dignity.Org, nd.). The patient may lose the ability to swallow from a progressive neurological disease such as amyotrophic lateral sclerosis (ALS). Unfortunately, if a patient falls under one of these three categories they will be unable to take the medication, but they are still able to pursue other end of life options.

The Death with Dignity Act protects physicians and pharmacists involved with PAS as long as they follow the laws properly. The Death with Dignity Act also protects patients as long as they follow the laws properly. While suicide does affect a person's life insurance, the Death with Dignity Act protects patients from this issue. "The cause of your death on your death certificate, for the documentation by the life insurance company, will be listed as the disease that your doctors expect will cause your death in the next weeks or months" (Death With Dignity.Org, nd.).

Palliative sedation also has guidelines that need to be followed. There are less restricting guidelines for palliative sedation because it is considered a legitimate medical practice legal throughout the entire United States. Palliative sedation should be used as an end of life care to relieve unnecessary suffering. It is often used when traditional opioid-based therapies are inadequate in patients with dyspnea, delirium, nausea, pain, or other physical symptoms (Olsen,

Swetz, Meuller; 2010). Palliative sedation may be considered by patients or a patient's health care proxy.

Palliative sedation is accepted by many professional medical organizations as a legitimate practice. It is considered ethically sound as long as it meets four basic criteria. It should be used after interdisciplinary evaluation of the patient. No one physician should be deciding this is the correct course of treatment for a patient. It should be used if other treatments intended to relieve suffering have failed or are likely to fail. It should be used where the expected outcome is not to shorten life, but to relieve suffering. It should be used only for the actual or expected duration of symptoms (AAHPM Board of Directors, 2014).

The best choice of drug for palliative sedation is debatable. A few years ago, Michael Jackson's doctor received negative attention for his use of propofol which caused the singer's death. As discussed earlier, barbiturates are used for physician assisted suicide and therefore are often considered too deadly for palliative sedation. "Most centers use a midazolam-based regimen for PS because of the drug's short half-life, relatively benign adverse effects, ease of intravenous or subcutaneous administration, and generally good efficacy. Other programs that use primarily barbiturates, either alone or in combination with other agents, have also reported good results" (Olsen, et. al., 2010). Opiates are not used for the purpose of sedation. Opiates can be used adjunctively during palliative sedation for analgesic effects.

The level of sedation achieved during palliative sedation should be equal to the level of suffering the patient is experiencing. Patients should not be sedated any further than they need to be comfortable. Providers need to select the minimal therapeutic dose of sedatives for their patients. Minimal sedation allows patients to interact with family members and reduces the risk of adverse effects of medication (Olsen, et. al., 2010). Often patients who choose to be treated

with palliative sedation are experiencing intense suffering and do end up requiring heavy sedation.

Palliative sedation can be practiced in hospitals, nursing homes, or hospice settings including a home care setting. For patients reaching end of life, being able to die in a setting other than a hospital is often a comfort. If palliative sedation is being used as an end of life treatment, patients are no longer receiving lifesaving treatments. “Because patients receiving palliative sedation are typically close to death, most patients will no longer have desire to eat or drink. Artificial nutrition and hydration are not generally expected to benefit the patient receiving palliative sedation” (AAHPM Board of Directors, 2014). It is important to remember that palliative sedation is not a permanent treatment. At any time, patients or their health care proxies can decide to stop palliative sedation and continue life saving measures.

Ethical Principles

There are four main ethical principles that the practice of nursing must follow: autonomy, beneficence, justice, and veracity. Autonomy is the right for people to make their own decisions. Beneficence is doing good. Justice is giving care fairly to all patients and veracity is the principle of telling the truth (Chally & Loriz, 1998). These four ethical principles are essential to safe and fair healthcare. If nursing practices do not abide by these four ethical principles, they should not be practiced.

Physician assisted suicide is an autonomous treatment because the patient has to be the one to request and to take the medication. The medication cannot be administered to the patient by a provider or a nurse. If a nurse does not provide a patient with proper information about PAS or coerces a patient against it, they are not allowing the patient to make an autonomous decision.

Palliative sedation can be done at the patient's request or at their healthcare proxy's request. In this sense, PAS is more autonomous than PS because only the patient themselves can make the decision to have this treatment.

Since PAS is intended to end someone's life it can be argued that it goes against beneficence, but that is not the case in the practice of nursing. The nurse's role in PAS would be to educate the patient on the treatment and help connect the patient to a provider who may practice PAS. This process of education may help put the patient's mind at ease, and alleviate some of the emotional suffering that comes with dying. The nurse does not do anything in the process of PAS that inflicts harm. If a nurse did not discuss the topic with a patient when requested, that would be doing more harm. Palliative sedation is also beneficent. It is intended to end suffering and thus follows the guidelines of doing good.

Justice needs to be followed in both physician assisted suicide and palliative sedation. PAS has a strict set of guidelines in order to qualify for this treatment. As long as a patient meets all the guidelines he or she will be eligible to receive the treatment. Physicians who practice PAS should not use any other guidelines to decide which of their patients should receive PAS. Similarly to PAS, palliative sedation also has qualifying guidelines. If patients meet these guidelines, they can receive PS regardless of socioeconomic status.

Veracity has to do with being honest with patients. In states where physician assisted suicide is legalized, it should be discussed with the patient along with other palliative options. If a nurse is morally opposed to physician assisted suicide, he or she is still ethically obligated to discuss this option with his or her patients. Veracity should also be practiced with palliative sedation. Patients who are facing end of life need to be aware of all available treatments to them.

Nurses practicing in hospice should educate patients and their families on palliative sedation as an end of life treatment.

Conscientious Objection

In healthcare there is a concept of conscientious objection. This is defined as “the rejection of some action by a provider, primarily because the action would violate some deeply held moral or ethical value about right and wrong” (Lachman, 2014). If a nurse believed that a treatment violated what is right, he or she may consciously object to executing that treatment. Conscientious objection cannot be specifically defined, which is where issues arise. Members of the health care team can use conscientious objection as a way to act on their prejudices. In respect to physician assisted suicide, conscientious objection may be prevalent for people who are religious. According to Lachman, some reasons conscientious objection can be accepted if there is plausible rationale, is a violation of a deeply held conviction, or the treatment is not essential to your work (Lachman, 2014). A nurse may have a deeply held conviction that participating in PAS is wrong. He or she should not be forced to participate, but they need to ensure that the patient still receives the treatment. If a patient makes a request for information about PAS, the objected nurse must ensure that another nurse or a palliative consultant gets the patient their information.

Professional Nurses Organizations’ Positions

The Hospice and Palliative Nurses Association (HPNA) released a position statement on palliative sedation as a means of end of life care. In the position statement they cite the ANA’s Code of Ethics to show support for palliative sedation as an end of life treatment. “The use of medication to promote comfort and relieve pain in dying patients is supported by the American

Nurses Association (ANA) who state, ‘achieving adequate symptom control, even at the expense of life, thus hastening death is ethically justified,’” (Dahlin & Lynch, 2003). The HPNA supports the use of palliative sedation on the basis of treating painful, refractory symptoms without the intent to end the patient’s life, only the patient’s suffering. The HPNA following the code of ethics laid out by the ANA, support the use of palliative sedation even if death is a secondary effect. This policy emphasizes the importance of intent. Palliative sedation is supported because of its intent to relieve suffering not end life. If a patient’s life is ended while undergoing this treatment, that would be ethically justified because it was a secondary effect and not the intended effect.

The American Nurses Association (ANA) does not agree with physician assisted suicide.

The ANA released a position statement about the topic:

The American Nurses Association (ANA) prohibits nurses’ participation in assisted suicide and euthanasia because these acts are in direct violation of *Code of Ethics for Nurses with Interpretive Statements*, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at the end-of-life. (ANA Center for Ethics and Human Rights, 2013).

Throughout this position statement, the ANA makes a point to state that if nurses participate in physician assisted suicide in states where it is not legalized, they are going against the code of ethics and can be criminally charged. Throughout the statement the ANA does not say much about nurses working in states where physician assisted suicide is legalized. The ANA recommends, “collaborate with local nursing organizations in states where assisted suicide is legal to educate nurses regarding what professional obligations do and do not exist when nurses in those states are present at such requests” (ANA Center for Ethics and Human Rights, 2013).

The position statement on PAS is from April of 2013; the ANA has not released an updated statement. In 2013, physician assisted suicide was still widely opposed in the United

States. Oregon was the only state to have legalized PAS. Montana had legalized PAS through a court case once in 2009, but had not fully legalized the practice (State-by-state guide to physician-assisted suicide, 2017). Since the ANA released this statement, six other states have legalized PAS. This statement is outdated and incomplete. It does nothing to guide nurses who practice in areas where PAS is legalized. The ANA only states that they do not agree with physician assisted suicide, not how to approach it from a nursing standpoint. Further recommendations from the ANA is needed in the scope of nursing. It is of utmost importance for nursing to stay up to date on the current state of the world. If legislation on PAS is changing, the ANA's position on PAS must also change. Nurses who practice in states where PAS is legalized and practiced have no professional guidelines on the treatment.

Method of Review

A systematic review of the literature was performed to identify primary research studies in English that focused on physician assisted suicide (PAS). Inclusion criteria were listed as the following:

- a. Primary research articles, quantitative or qualitative
- b. Articles that focused on patient attitudes towards PAS
- c. Articles that focused on health personnel attitudes towards PAS
- d. Articles that focused on knowledge about PAS
- e. Articles that focused on the practice of PAS
- f. Articles that focused on the quality of death with PAS

Exclusion criteria were listed as the following:

- a. Articles that were not primary research articles
- b. Articles that were not published within the last ten years

- c. Articles that discussed euthanasia without discussing PAS

Database Searches

CINAHL and MEDLINE databases were searched for this systematic review. Initial search, with no limits, of *physician assisted suicide* resulted in 15,631 articles. Keywords searched included: *physician assisted suicide*, *physician assisted death*, *euthanasia*, *death with dignity act*, *qualitative*, and *quantitative*. These results mostly fell under three main domains: (1) patient attitudes, (2) life experiences, and (3) attitude of health personnel. This categorization yielded: 605 articles about patient attitudes, 492 articles about life experiences, and 442 articles about attitude of health personnel, resulting in a total of 1,539 articles. Results were further searched to primary research studies resulting in 131 articles. After limiting the search to full text articles published within the last ten years, 21 articles remained.

Articles were excluded for reasons such as discussing only euthanasia without mention of physician assisted suicide, not being primary research articles, and not being relevant to this paper. Many articles came from other countries where euthanasia is legalized as well as physician assisted suicide. These articles would discuss euthanasia rather than PAS. Through thorough review of the abstracts, 14 articles were selected for this review.

Study Characteristics

A total of 14 articles was identified. The timeframe in which these studies were published ranged from 2009 to 2016. Within this seven-year range, approximately 64% (9 of 14) were from the last 5 years (>2013). A relevant subcategory of these articles would be country of origin, because different legislations exist among different countries and different cultures influence this research topic. The majority of these articles came from outside of the United States ($n = 4$), Netherlands ($n = 3$), Germany ($n = 2$), New Zealand ($n = 2$), Canada ($n = 1$), Norway ($n = 1$), and

United Kingdom ($n = 1$). The units of analysis for this paper were attitudes ($n = 9$) and experience ($n = 5$). The articles regarding attitude were further broken down to be attitudes of patients ($n = 2$), health personnel ($n = 2$), and laypersons ($n = 5$). Of the articles regarding experience, some were in direct response to the practice of PAS ($n = 4$) one was based on knowledge on end-of-life care ($n = 1$). Of the 14 articles ~85% ($n = 12$) were quantitative ~15% ($n = 2$) were qualitative. Of the two qualitative, one was grounded theory and one was thematic analysis.

Theoretical Perspectives of Studies

One of the qualitative studies use grounded theory. *Why do older people oppose physician-assisted dying? A qualitative study*, used an inductive approach without citing a specific framework. The other qualitative article, *Euthanasia and physician-assisted suicide in dementia: a qualitative study of the views of former dementia carers*, analyzed its data using Braun and Clarke six phases of thematic analysis.

All of the 12 quantitative articles analyzed data through the use of descriptive statistics. Four of the quantitative articles used the chi-square test to analyze their data. Two of the articles used logistic-regression. One used parametric and non-parametric measures. One used MANOVA (multivariate analysis of variance). Four of the articles did not specify how they analyzed their data.

Description and Critique of Methods

As mentioned previously, ~85% of the literature examined were quantitative studies and the remaining ~15% were qualitative studies. The use of quantitative studies for this research topic are appropriate. Quantitative studies are an effective way to gage the knowledge of a large group of people. Through quantitative studies researchers were able to gather information on

attitudes towards, knowledge about, and experience with PAS. The articles using quantitative methodology are helpful in adding to the body of knowledge, even when the results of the research do not statistically support the hypotheses.

The use of qualitative studies for this research topic was also appropriate. Qualitative research is a comprehensive way of studying attitudes towards PAS. When given the opportunity to communicate their opinions rather than select options, research participants were more fully able to express their views. Qualitative data is critical to this database of knowledge.

Both the quantitative and qualitative studies encompassing this literature review have added depth to this subject. The data collected in this review will be outlined as following... Table 1 examines the attitudes towards PAS of patients. Table 2 examines the attitudes towards PAS of health personnel. Table 3 examines the attitudes towards PAS of laypersons. Table 4 examines knowledge on the subject of PAS. Table 5 examines experience with PAS.

Results

Attitudes

Two articles discussed the attitudes of patients towards physician assisted suicide (PAS). Both of these articles were quantitative studies. The article by Booij et al. studied the presence of end of life wishes in patients with Huntington's disease(HD). The researchers surveyed 134 patients who tested positive to be an HD gene carrier This research article discusses all end of life wishes with patients including advance directives; for the purposes of this review only results regarding PAS will be discussed. The researches asked the participants wishes concerning care and wishes concerning PAS. The researchers found that 86 of the 134 patients surveyed had thoughts regarding PAS at some point during the disease process. The respondents who had thoughts on PAS were found to have higher education and lower motor scores than patients who

had wishes for care only. The researchers also found a trend between considering oneself religious and wishes regarding care only (Booij, Tibben, Engberts, Marinus, and Roos, 2014). This study shows that a majority of patients with a debilitating disease, such as Huntington's disease, do consider PAS at some point during the disease process. This shows that there should be more available information on the subject for patients to consider.

The article by Maessen et al. researched if certain factors affected patients with amyotrophic lateral sclerosis (ALS) opinions on PAS. These factors included quality of care, quality of life, symptoms of depression, and disease characteristics. The study consisted of 102 patients diagnosed with ALS who were determined to have six months or less to live. The participants were given questionnaires every three months until their time of death. The researchers found that 31% of patients specifically asked their physician about PAS. No significant differences were found in symptoms, coping styles, or stages of disease of the patients who requested PAS and the patients who did not. Within the study, 22% of the patients died as a result of PAS. The researchers found no significant differences in the depressive symptoms or quality of life in patients who requested PAS and who did not (Maessen et al., 2014). This study is interesting because it shows no real difference between patients who requested PAS and those who did not. This suggests that PAS needs to be considered for all patients and determined on a patient by patient basis.

Table 1
Attitudes of Patients

Author/Title	Year	Origin	Purpose	Design	Sample	Results
Booij et al. "Thinking about the end of life: a	2014	Germany	Explore the presence of end- of-life wishes	Quantitative Survey: questionnaire	134 patients genetically proven status of	86 out of the 134 respondents had wishes

common issue for patients with Huntington's disease"					HD gene carrier	concerning PAS at some point in the disease process
Maessen et al. "Euthanasia and physician-assisted suicide in amyotrophic lateral sclerosis: a prospective study	2014	Germany	Determine if quality of care, symptoms of depression, disease characteristics, and quality of life of patients with amyotrophic lateral sclerosis (ALS) are related to requesting euthanasia or physician-assisted suicide	Quantitative Survey: questionnaire	102 patients diagnosed with ALS with a life expectancy of 6 months or less to live	31% of patients requested PAS 21% of patients died via PAS No significant differences in disease symptoms, depressive symptoms, or quality of life in patients who requested PAS and patients who did not

Two articles in this review discuss attitudes of health personnel on PAS. The article by Kouwenhoven et al., studied physician's experiences and attitudes towards the choice between euthanasia and PAS. This study took place in the Netherlands where both practices are legalized. The study surveyed 793 physicians including general practitioners, medical specialists, and elderly care physicians. The participants were sent a questionnaire which could be completed electronically or by mail. The researchers found that 36% preferred euthanasia, 34% preferred PAS, and 25% had no preference between the two. A majority of the physicians agreed that PAS underlines the patient's autonomy. 53% of the physicians responded that PAS can take a long time until death, and 48% responded that the patients often cannot take the lethal drink by themselves. 31% of physicians who have performed euthanasia for patients responded that they had not discussed the possibility of PAS with said patients. Reasons for not discussing PAS

included the physical inability of the patient, the physician's unfamiliarity with PAS, and the physician's belief that PAS is an unreliable method. "Although most Dutch physicians think PAS underlines patient autonomy and responsibility, the option of PAS instead of euthanasia is often not discussed with the patient. Expected technical problems and unfamiliarity with PAS play a role" (Kouwenhoven et al., 2014). This study emphasized the need for more education about PAS, especially for physicians. Some physicians did not offer PAS to their patients, even though it is legalized, because they did not know much about it. There is a disconnect between the belief that PAS is an autonomous decision for patients, but physicians never giving their patients the option.

The article by Tomlinson et al. explored the views of former carers of people with dementia on PAS. A total of 16 former carers participated in this qualitative study. The participants were given semi-structured interviews. The researcher found that a majority of participants ($n = 13$) supported the right to PAS in patients with dementia. Participants believed it was the individual's right to determine their own death. The participants stressed several factors that needed to be addressed including the patient's capacity, strict safeguards, and recognition of the impact of PAS on other people. Over half of the participants would want the option of PAS. The majority of participants felt unable to make this decision for another person. The majority of participants believed that if a patient was considering PAS, it would be helpful to talk with a health professional (Tomlinson, Spector, Nurock, and Stott, 2015). This study shows that direct experience with someone with a debilitating disease may merit support for PAS.

<p><u>Table 2</u> <u>Attitudes of Health Personnel</u></p>
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Author/Title	Year	Origin	Purpose	Design	Sample	Results
Kouwenhoven et al. “Euthanasia or physician-assisted suicide? A survey from the Netherlands”	2014	Netherlands	To study physician’s experiences and attitudes concerning the choice between euthanasia and PAS	Quantitative Survey: questionnaire	793 physicians	36% preferred euthanasia 34% preferred PAS 67-69% agreed that PAS underlines the patient’s autonomy 31% who performed euthanasia did not discuss PAS with patients
Tomlinson et al. “Euthanasia and physician-assisted suicide in dementia: A qualitative study of the views of former dementia carers	2015	United Kingdom	Explored the views of former carers on assisted dying in dementia	Qualitative Semi-structured interviews	16 former carers of people with dementia	13 carers supported PAS in patients with dementia

Five articles studies layperson’s attitudes towards PAS. Kopp studied the influence of death attitudes and knowledge of end of life options on physician-assisted suicide. A survey was sent through the mail which yielded 300 adult respondents from Arkansas. The survey assessed knowledge on end of life options. 61% of participants understood that patients can legally refuse life sustaining treatments, but only 1/3 of participants correctly responded that patients can legally withdraw life sustaining treatment. About 80% of participants correctly responded that euthanasia is illegal but fewer respondents, 2/3, recognized that PAS is illegal in their state. This survey also studied predictors of PAS attitudes. The researcher found that a higher income

yielded more positive attitudes towards PAS while a higher church attendance yielded more negative attitudes towards PAS. Individuals who expressed belief in an afterlife tended to show less support for PAS but more knowledge on end of life options. Knowledge of end of life options, which were assessed at the beginning of this survey, were associated with negative attitudes towards PAS (Kopp, 2009). This study shows a need for more education on end of life options. Those participants that were more knowledgeable on end of life options were able to make an informed decision, which is highly important to this subject.

The article by Magelssen et al. studied how question wording and order affected attitudes towards PAS. The researchers sent out surveys electronically. 3,050 responses were included in this study. The researchers found their results to be statistically significant. The contextual version produced a greater assent to legalization than the concept-focused version. The contextual version evoked sympathy by portraying the patient great pain. It also emphasized the rationale to be avoiding suffering and reassured the decision would be thoroughly evaluated. The concept-focused version used wording with negative connotations such as intentional killing. “The suggestion that AD[assisted death] could be offered even for individuals with mental illness or people who are merely tired of life apparently made the proposal to legalize AD for terminal and chronic disease less controversial and more socially acceptable” (Magelssen, Supphellen, Nortvedt, and Materstvedt, 2016). This study emphasizes that the way options are presented to patients strongly influences their opinions. This suggests that there needs to be neutral language regarding difficult end of life options.

The article by Malpas et al. researched what factors caused older people’s opposition to PAS. This qualitative study consisted of 11 older adults from New Zealand. The participants were interviewed with open ended questions to discover their reasoning for opposing PAS. The

researchers found there were four main themes for opposing PAS. (1) Personal experience with healthcare, dying, and death (2) “slippery slope” worries (3) concern about potential abuse and (4) religious reasoning and beliefs. Five individuals referenced experience of good dying which reinforced their belief that PAS is unnecessary. Eight participants conveyed concerns about future laws with PAS. Fears included threat to autonomy, that other may be able to request PAS for a patient besides the patient themselves i.e. a healthcare proxy. Seven participants feared the normalization of PAD. They feared that it may become expected of older people so as not to be a burden on family or society. Eight participants feared that the vulnerability of older adults could make them a target of persuasion, where they could be talked into the treatment without actually wanting it. Four participants stated that their religious beliefs guided their thinking in different areas of life but did not dictate their views on PAS. On the contrary, two participants believed that their faith did not give them the authority to request PAS, it is not their choice to make (Malpas, Wilson, Rae, and Johnson, 2014). This study gives an insightful look to the older population. Many of the fears expressed by these participants could be relieved with more education and discussion on end of life options. For instance, many of these participants feared that they could be persuaded into the treatment. “You can easily put something in front of somebody; you can confuse them and put it in front of them to sign” (Malpas et al, 2014). The legislation behind PAS prevents this from happening. Safeguards are in place to prevent this kind of abuse including the requirements for verbal requests, written requests, and waiting periods. Older adults could use more education so that there is less fear.

The article by Rae et al. studied New Zealanders’ Attitudes toward physician assisted dying in the context of various parameters of patient suffering. At the time of this study no forms of physician assisted dying are considered legal. This study was conducted by an anonymous

questionnaire sent to 677 participants. The questions regarded physician assisted dying which includes physician assisted suicide and euthanasia. The researchers found that 78% of participants felt physician assisted death was appropriate in certain situations. 82% of participants felt that it should be legalized. 75% of participants felt physician assisted death was appropriate when the patient was suffering from loss of dignity. Of the participants that felt physician assisted suicide should be legalized, 65% felt it should be legalized only for those suffering unbearably with little hope of recovery. 46% of those that support legalization felt that mental illness should be an exclusionary criterion (Rae, Johnson, and Malpas, 2015). This study shows that there is support for physician assisted suicide. Although this study took place outside of the United States, it is a good survey of the general public of New Zealand.

The study by Tucker et al. examined the relationship between interpersonal risk factors of suicidal desire and PAS attitudes. 199 college students were surveyed for this study. The questions were outlined by the interpersonal-psychological theory of suicidal behavior. Perceived burdensomeness and thwarted belongingness are considered to be interpersonal risk factors for suicide. This study found participants with increased feelings of perceived burdensomeness and thwarted belongingness had more accepting attitudes towards PAS. This study found that demographic variables commonly associated with consideration of hastened death such as age, religion, gender, and marital status did not predict significant variance of PAS acceptance (Tucker, 2014). This study takes a look at factors not previously studied. The association between interpersonal risk factors for suicide and acceptance of PAS is an interesting connection. It is important to note that individuals who have interpersonal risk factors for suicide are not necessarily depressed or suicidal.

<i>Attitudes of Laypersons</i>						
Author/Title	Year	Origin	Purpose	Design	Sample	Results
Kopp “The influence of death attitudes and knowledge of end of life options on attitudes towards physician-assisted suicide”	2009	United States	To study the influence of death attitudes and knowledge of end of life options on attitudes towards PAS	Quantitative Survey: by mail	300 adults from Arkansas	More knowledge on end of life options yielded less support for PAS Higher income yielded more support for PAS More religious involvement yielded less support for PAS
Magelssen et al. “Attitudes towards dying are influenced by question wording and order: a survey experiment	2016	Norway	To demonstrate and measure the effect of question wording and context on respondents’ stated attitudes	Quantitative Survey: electronic	3,050 Norwegian citizens	Contextual version yielded more support for PAS Concept-focused version yielded less support for PAS
Malpas et al. “Why do older people oppose physician-assisted dying? A qualitative study”	2014	New Zealand	Explore the reasons some healthy older New Zealanders oppose physician-assisted dying in order to inform current debate	Qualitative Interviews	11 older adults	4 central themes (1) personal experience with healthcare, death, and dying (2) “Slippery slope” worries (3) Concern about abuse (4) Religious reasoning and beliefs

Rae et al. “New Zealanders’ attitudes toward physician-assisted dying”	2014	New Zealand	Examine New Zealanders’ attitudes towards assisted dying in the context of various parameters of patient suffering, and as a policy issue	Quantitative Survey: anonymous questionnaire	677 participants from the electoral roll	78% felt it is appropriate in certain situations 82% felt it should be legalized 65% felt it should only be accessible to those suffering unbearably with little hope of recovery 46% felt mental illness should be an exclusionary factor
Tucker et al. “Does the experience of interpersonal predictors of suicidal desire predict positive attitudes toward physician assisted suicide?”	2014	United States	Examine the relationship between PAS attitudes and interpersonal risk factors of suicidal desire	Quantitative Survey: questionnaire	199 college students	Interpersonal risk factors of suicidal desire were associated with acceptance of PAS Demographic variables did not predict significant variance of PAS acceptance

Knowledge

One study focused on the knowledge about end of life practices. The study by Hesselink et al. surveyed medical students in the Netherlands to test their knowledge of the euthanasia act and their opinion of quantity and content of education on end of life care in curriculum. The euthanasia act has legislation for both euthanasia and physician assisted suicide, which are both legal practices. A total of 176 medical students completed the questionnaire. 55% of students

considered the quantity of end of life care education to be moderate, 35% rated it as good. 50% of students rated the content of end of life care education to be moderate, 47% rated it as good. The students were asked eight questions about the euthanasia act. Only 14% were able to correctly answer six to seven of the eight questions correctly (Hesselink, Pasman, van der Wal, Soethout, and Onwuteaka-Philipsen, 2010). Although this study took place outside of the United States, its results are interesting. It is concerning to see that the majority of students rate their education on these practices as only moderate. This study could provide an insight into our own medical schools. A survey should be sent to medical students in the United States to test their knowledge on end of life care.

Table 3
Knowledge

Author/Title	Year	Origin	Purpose	Design	Sample	Results
Hesselink et al. "Education on end-of-life care in the medical curriculum: students' opinions and knowledge"	2010	Netherlands	Investigate opinions of medical students regarding quantity and content of education on end of life care in the curriculum and medical students' knowledge on different aspects of the euthanasia act	Quantitative Survey: questionnaire	176 medical students	55% rated quantity as moderate 35% rated quantity as good 50% rated content as moderate 47% rated content as good 14% were able to correctly answer 6-7 questions out of 8 about the euthanasia act

Experience

Four articles did studies with people who have direct experience with physician assisted suicide. The study by Berendsen et al. researched if barriers exist for patients with lower education level to receive physician assisted death. The researchers collected surveys from 147 general practitioners. The general practitioners filled out demographic information, age, gender, education level, of the patients that they performed physician assisted death on. The researchers found that women aged 65+ with primary education received less physician assisted death than women with secondary education. There were no significant differences found for younger women, women with tertiary education, or any male subgroups (Berendsen, Joeloem Singh, Schuling, and Bosveld, 2014). The distinction could be due to several factors such as memory bias or religious beliefs in older adults. This survey raises a concern. More research needs to be done on the distribution of physician assisted deaths. If there is a distinction between treatments provided and gender or education level, that is a blatant violation of the ethical principle justice.

The study by Ganzini et al. researched why people requested PAS. This study surveyed family members of Oregon citizens who made explicit requests for physician assisted suicide. The survey had family members rate the importance, from 1-5, of 28 possible reasons their loved one requested PAS. The researchers found that the most important reasons, median of 4 or greater, for requesting PAS were: (1) wanting to control the circumstances of death and die at home, (2) worries about loss of dignity and future losses of independence, (3) quality of life, and (4) self-care ability. No physical symptoms were rated higher than a median of 2 in importance. The least important reasons for requesting PAS included financial concerns, depression, and poor social support. (Ganzini, Goy, and Dobscha, 2007). This study shows that reasons for requesting PAS are usually not due to physical symptoms. Many patients request PAS due to psychosocial

issues. Interventions to help patients maintain independence and self-care in their home may help reduce the requests for PAS.

The article by Inghelbrecht et al. studied the roles of nurses in physician assisted death. This study surveyed nurses in Belgium, where euthanasia is legalized. The researchers surveyed 1,678 nurses who reported caring for one or more patients that received physician assisted death. These nurses were then included if they cared for a patient who received life-shortening drugs with his/her explicit request (euthanasia) or received life-shortening drugs without his/her explicit request. Of these 1,678 nurses, 248 were included in the final data analysis. 128 nurses cared for patients who received euthanasia. 120 nurses cared for patients who received life-shortening drugs without his/her explicit request. The researchers found that more than half of the nurses were involved in the physician's decision making process about the use of life ending drugs. According to Belgium's euthanasia law, nurses must be involved in the physicians' decision making process. These results show that that was not always the case. In 12% of the euthanasia cases, the life-ending drugs were administered by the nurse. In the cases where patients received life-ending drugs without explicit request, 45% of the life-ending drugs were administered by the nurse. In both cases, the nurse acted on the physician's orders. This study found that factors strongly associated with nurses administering life-ending drugs included being a male nurse working in a hospital and the patient being over 80 years old (Inghelbrecht, Bilsen, Mortier, and Deliens, 2010). In this survey, nurses who administered the life-ending drugs were acting outside of the domains of nursing. For patients who requested euthanasia, those drugs must be administered by a physician. Those 12% of nurses all reported acting under physicians' orders, but they were still acting outside of their scope of practice. The nurses who administered

life-ending drugs in patients who did not explicitly request it were also acting outside of the scope of nursing. These findings could be generalizable to practices elsewhere in the world.

The study by Smith et al. studied the quality of death and dying in patients who requested PAS. This study surveyed family members of terminally ill Oregonians. A total of 147 family members was surveyed. 84 family members of patients who requested PAS and 63 family members of those who never pursued a lethal prescription. Of the 52 patients who requested and received the lethal prescription, 32 died of PAS. There was no difference found in overall quality of death between those who requested PAS and those who did not. The researchers found some differences in specific categories. In symptom control and preparedness for death, patients who requested PAS reported greater symptom control, particularly in regards to control over surroundings. Those who requested PAS were more prepared for death in that they were more likely to have said goodbye to loved ones. Those who requested PAS were less likely to have spiritual services before death than those who did not. Those who requested PAS reported that discussions of end of life wishes had a positive impact on the patient compared to those who never pursued PAS (Smith, Goy, Harvath, and Ganzini, 2011). The overall quality of death in patients who request PAS is no worse than those who do not pursue PAS. Family members rated some areas as better than those who did not request PAS, including symptom control and preparedness for death.

Table 5
Experience

Author/Title	Year	Origin	Purpose	Design	Sample	Results
Berendsen et al. "Physician-assisted death is less	2014	Netherlands	To discover any differences in patients receiving	Quantitative Survey: questionnaire	147 general practitioners	Women 65+ with primary education received less

			frequently performed among women with a lower education: a survey among general practitioners”	PAD due to their demographic			PAD than those with secondary education No distinction in younger women No distinction in male subgroups
Ganzini et al. “Why Oregon patients request assisted death: family members’ views”	2007	United States	To learn from family members why their loved ones requested PAS	Quantitative Cross sectional survey	83 family members	Most important reasons (median ≥ 4): 1. Wanting to die at home 2. Worries about loss of dignity and future losses of independence 3. Quality of life 4. Self-care ability Least important reasons: 1. Financial concerns 2. Depression 3. Poor social support	
Inghelbrecht et al. “The role of nurses in physician assisted deaths in Belgium”	2010	Canada	Exploring the attitudes of nurses toward end of life decisions with a possible or certain life-shortening effect and their involvement in those types of decisions	Quantitative Survey	248 nurses	50% of nurses were involved in the physician’s decision making process In euthanasia cases, 12% of nurses administered the life-ending drugs	

						In cases without patient's explicit request, 45% of nurses administered the life-ending drugs
Smith et al. "Quality of death and dying in patients who request physician-assisted death"	2011	United States	Investigate the quality of death and dying of terminally ill Oregonians as perceived by family members, and consider whether those who requested PAS that differ objectively and subjectively from those who requested PAS but were unable to access it, and those who never requested PAS	Quantitative Survey: by mail	147 family members of patients: 84 who requested PAS 63 who never requested PAS	No difference in overall quality of death in patients who request PAS and those who do not Patients who request PAS have higher ratings on symptom control and preparedness for death than those who do not request PAS

Discussion

Patient Perspective

Patients often choose palliative sedation for painful physical symptoms. The most common reasons for patients choosing palliative sedation are dyspnea, delirium, nausea, and pain (Olsen, 2010). Patients choose physician assisted suicide for differing reasons. Gazini et al.

found that the most important reasons were wanting to die at home, worries about loss of dignity and independence, quality of life, and self-care ability (Gazini, 2007). These differences in reasons to choose end of life options are insightful.

Psychosocial pain should not be considered less than physical pain. Patients who want to choose PAS for loss of self-care ability and quality of life should not be considered less than patients who choose palliative sedation for dyspnea. Suffering is suffering, whether it is physical or mental. Patients who choose PAS for psychosocial reasons are suffering just as badly as patients with painful physical symptoms. It is important to remember this and not to pass judgement on patients.

Loss of independence and self-care ability are two big reasons for choosing PAS. Measures to promote independence and self-care should be initiated in patients facing end of life. Loss of dignity is a huge stressor and source of suffering for patients. By promoting independence, quality of life is increased.

The study by Smith et al. investigated the quality of death in Oregonians who requested PAS and those who did not. The researchers found no significant difference in the quality of death. The researchers did find that patients who requested PAS had a greater symptom control and readiness for death (Smith, 2011). This research suggests that patients who request PAS have a greater understanding of end of life. They are more ready for end of life than other patients. This could be from several factors including: personal attitudes toward death, education on end of life, education from health care providers, or the process of requesting PAS itself. Since PAS requires the patients to make several requests for ending their life, that may make patients more prepared for end of life. More research is needed to determine why patients requesting PAS have better symptom control and readiness for end of life.

Education

Education is needed for the general public. Generally, unless someone or one of their loved ones are facing end of life, people do not know much about end of life practices. The lack of knowledge on end of life practices can make facing end of life that much more stressful and frightening. The study by Malpas et al., which explored why older New Zealander's opposed PAS, illustrated how misconceptions can cause fear and mistrust of PAS as an end of life option (Malpas et al., 2014). The common slippery slope worries and concern about abuse are misconceptions that could be cleared up with more education. Although this study takes place in New Zealand, it is likely that there are older people in the United States with similar fears. There are many safeguards in the laws about PAS that prevent anyone but the patient from requesting PAS as an end of life treatment. The requirement for two oral requests and one witnessed written request prevents abuse from health care proxies. The study by Kopp found that people with more knowledge on end of life options yielded less support for PAS (Kopp, 2009). This research suggests that there may be some people who support PAS without fully understanding all end of life options. More education can provide people with the opportunity to make informed decisions on the best end of life practice for them. There needs to be more research on the relationship between knowledge of end of life options and attitudes towards PAS to prove that this connection is legitimate.

More education may also be needed for health professionals. The study by Hesselink et al. which surveyed medical students in the Netherlands had some concerning results. In the Netherlands both physician assisted suicide and euthanasia are legalized. They are both regular practices and medical students should have good knowledge on these end of life options that their patients may request one day. The researchers found that only 14% of students were able to

correctly answer six to seven of eight questions on the euthanasia act (Hesselink et al, 2010). This shows a lacking in education on important end of life options. It would be helpful to have a similar study conducted in the United States, in states where PAS is legalized, to see if there is the same lack of knowledge on end of life options. Since PAS is only legalized in some states throughout the United States, this makes education problematic. Health professionals may go to school in a state where PAS is not legalized, but eventually practice in a state where PAS is legalized. Death and dying should be taught on its own as an individual class. PAS should be taught, at least briefly, in all states. This would ensure the education of doctors and nurses who may one day treat a patient requesting PAS. The study by Kouwenhoven et al., also from the Netherlands, surveyed physician's preferences on end of life options. The researchers found that the majority of physicians felt that PAS is more autonomous to patients than euthanasia. The researchers also found that 31% of physicians who performed euthanasia never discussed PAS with their patients (Kouwenhoven et al., 2014).

Nursing Perspective

The American Nurses Association's (ANA) position on physician assisted suicide is outdated. Since the release of the statement in 2013, six other states have legalized PAS. The ANA offer no position for nurses working in these states where the practice is legalized, instead urging those nurses to reach out to local nursing organizations. The research by Inghelbrecht et al. revealed many nurses practicing outside of the realms of the profession in Belgium (Inghelbrecht, 2010). If the ANA does not update their position to offer guidelines and support to nurses in the United States practicing where PAS is legalized, there is a great chance of nurses practicing outside the realm of the profession. If individuals do not have support and guidelines, such as Dr. Kevorkian, they are more likely to act inappropriately than those with clear

guidelines and support. It is possible for the ANA to take a position where they do not support the practice of PAS but support those nurses involved where it is legalized. The ANA's position on palliative sedation is more supportive. The ANA gives clear guidelines of when palliative sedation is ethical. This gives support to nurses working with patients who use palliative sedation as an end of life treatment. The clear ethical guidelines prevent nurses from acting out of their scope of practice.

Discussed earlier in this paper was the concept of conscientious objection. With conscientious objection in place there is an option for nurses whose personal morals do not align with PAS. As long as the nurse in question ensures that their patient is connected with another nurse or healthcare worker who can provide the information requested, they do not have to participate in PAS. Conscientious objection cannot be specifically defined. Conscientious objection is considered valid if the practice is a violation of a deeply held conviction (Lachman, 2014). One of the most common reasons for people opposing PAS is religious conviction. This aligns with conscientious objection as a reason for nurses to not participate in PAS. Another specification of conscientious objection is that the practice must not be essential to the area of work (Lachman, 2014). Nurses working in hospice who have patients facing end of life every day may not be able to use conscientious objection as a valid reason because end of life options are essential to their patient care. The ANA would be a great resource to define whether conscientious objection could be used validly for hospice nurses practicing where PAS is legalized.

Research Questions Revisited

Why do patients choose physician assisted suicide as an end of life treatment?.

Research has shown that patients choose physician assisted suicide for four main reasons: Wanting to die at home, worries about loss of dignity and future losses of independence, quality of life, and self-care ability (Ganzini et al., 2007).

How do politics and media portrayal affect people's opinions on physician assisted suicide?.

The research found for this thesis did not satisfy this research question. Further research would need to be done to attest how politics and the media affect the public's opinions on physician assisted suicide.

Is there a lack of education with physician assisted suicide which gives the treatment a negative connotation?.

There is a lack of education regarding physician assisted suicide. There are many misconceptions surrounding the treatment. Research by Malpas et al. conveyed older New Zealanders opposing PAS because of slippery slope worries and concern about abuse (Malpas et al., 2014). Their lack of education on PAS gave it a negative connotation.

Are personal morals the main reason for opposition to physician assisted suicide?.

Religious beliefs are very important personal morals for many people. Research found that more religious involvement yielded less support for PAS (Kopp, 2009). The idea that religious involvement causes less support for PAS came up in other research articles as well. Malpas et al. found that religious beliefs were one of the four main reasons older adults opposed PAS (Malpas et al., 2014). The research by Booj et al. found that patients in their study who chose care only, rather than requesting PAS, had higher religious belief than those patients who chose to request PAS (Booj et al., 2014).

Recommendations

Physician assisted suicide is most often chosen when patients feel they are losing autonomy and dignity. Measures to prevent a decline in self-care should be implemented to the fullest extent to prolong good quality of life. More research is needed to determine why patients requesting PAS are more ready for death, so that patients who do not request PAS can have the same readiness for end of life. More education is needed. The general public needs more education on end of life options so informed decisions can be made and misconceptions can be cleared up. Healthcare professionals need more education so they fully understand end of life options and provide the best care to their patients. The American Nursing Association needs to update their position on PAS to offer support to nurses practicing where PAS is legalized.

More research is needed to give greater insight onto the extent of knowledge on and experience with emerging end of life practices such as physician assisted suicide. Besides the prolific cases that make the news, there is not much knowledge on how many patients are engaging in PAS. Quantitative studies are especially useful for this topic. More quantitative studies should be done to track the number of people engaging with PAS. How many patients are requesting PAS? How many patients are receiving PAS? Longitudinal studies would be very helpful for this research to show how these rates are changing over time. Is there an increase in PAS engagement? These longitudinal quantitative studies would show the demand for PAS which would impact the policies surrounding this practice. It is only legal in a few states, but if quantitative studies showed high and increasing demand, that would be good evidence for legalizing PAS in other states.

The studies in this review which researched patient and family perspectives about PAS were very insightful. Qualitative studies are especially useful in gaining insight into why people make certain decisions. More qualitative studies should be done with patients and family

members of patients choosing PAS in order to fully understand why they believe this is the right choice for them. With greater understanding of the PAS process there may be greater support in terms of legalizing PAS in other states.

Physician assisted suicide is a relatively new and often misunderstood end of life treatment. Currently, there are not many primary research studies on PAS. More research will provide statistics on how many patients are choosing this treatment and greater insight as to why patients choose PAS. More research and greater understanding can have a larger impact on policy creation.

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