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Attitudes of Clinically Practicing Registered Nurses in Southern Mississippi Toward Physician-Assisted Death

Robin E. Smith
University of Southern Mississippi

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The University of Southern Mississippi

Attitudes of Clinically Practicing Registered Nurses in Southern Mississippi Toward
Physician-Assisted Death

by

Robin Smith

A Thesis
Submitted to the Honors College of
The University of Southern Mississippi
in Partial Fulfillment
of the Requirements for the Degree of
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Approved by

Janie Butts, D.S.N., RN
Professor of Nursing

Susan Hart, Ph.D., RN, Chair
Department of Collaborative Nursing Care

David. R. Davies, Dean
Honors College

Abstract

Problem

The purpose of this study is to discover unique themes related to the attitudes of nurses in Southern Mississippi toward physician-assisted death (PAD).

Methods

This study is a qualitative, inductive content analysis. The sample comprised three registered nurses currently practicing in Southern Mississippi. The researcher guided each participant's one-hour interview with questions, then recorded and transcribed the texts for data analysis; and coded and analyzed data. Themes were selected if there was inter-rater agreement of 100% between the researcher and thesis adviser.

Results

The interview questions focused on (a) the presence or absence of support for legalization of PAD, (b) acceptability of, or preference for PAD, and (c) what recurring factors, if any, influence the participants' attitudes toward PAD. Extrapolated themes were (a) patient autonomy, (b) religion and Christianity, (c) ethical gray area, (d) education, (e) nursing the dying, and (f) external influences.

Discussion

Each participant agreed that PAD was a complex ethical dilemma, rather than a black or white issue. Findings suggested that support for PAD is present among nurses in Mississippi, but a lack of support is likely to be more prominent. Religious faith and professional experience were cited as external influences on attitudes toward PAD, and religious faith was a direct determinant of opposition towards PAD. A knowledge deficit regarding PAD was apparent for all participants. More research with a larger sample size is necessary for definitive and representative conclusions.

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Chapter 1: Introduction

Presently, euthanasia and physician-assisted suicide are debated in Australia, Belgium, Canada, Colombia, Germany, India, Israel, Italy, Japan, Luxembourg, the Netherlands, Russia, Spain, Switzerland, and the United Kingdom. The only countries to legalize both practices are the Netherlands, Luxembourg, and Belgium. Colombia and Japan do not have definitive legislation declaring the practices legal. In Colombia, the practices were ruled legal by the courts but the ruling was never ratified by congress. In Japan, the practices are illegal in the Japanese Criminal Code, but the Nagoya High Court Decision of 1962 established that a patient's life could be ended if the situation met six requirements (Euthanasia, 2010).

When researching the practices of euthanasia and physician-assisted death, the Netherlands is the country most frequently cited in the literature. Euthanasia and physician-assisted death were permanently legalized first in the Netherlands. Critics and supporters looked first at the execution and effect of euthanasia and physician-assisted suicide on the Dutch. The Dutch model has been borrowed and customized, serving as a landmark decision and as the framework for similar legislation in Luxembourg, Belgium, and the U.S. state of Oregon. For these reasons, this thesis will briefly introduce the evolution of euthanasia and physician-assisted suicide in the Netherlands and the eventual birth of physician-assisted death in the United States.

Definitions

An important difference between euthanasia and physician-assisted suicide (PAS) is that with PAS the patient actively administers the lethal dose of medicine once the physician prescribes it. The physician's prescription and patient self-administration are

requirements in the practice of PAS. In the United States, PAS is now more appropriately known as physician-assisted death (PAD) since Oregon stopped associating suicide with its death with dignity legislation in 2006 (Svenson, 2010).

The term euthanasia, sometimes known as mercy killing, has come to mean a good or painless death. Euthanasia is the intentional and purposeful act of causing the immediate death of another person, such as a person with a terminal illness (Patel, 2004). There are two major types of euthanasia: active and passive (Butts, 2013). Usually active euthanasia involves the physician personally administering the medication to terminate the patient's life. Active euthanasia is differentiated from passive euthanasia, which is the decision to withdraw or refrain from initiating life-saving measures, such as feeding tubes and ventilators, when caring for dying patients. Active euthanasia is further classified as voluntary, involuntary, or non-voluntary (Benedict, Pierce, & Sweeney, 1998). When a patient is mentally competent and explicitly requests for the termination of life, it is considered voluntary active euthanasia; this term is mostly associated with the practice of PAS. Involuntary active euthanasia is when interventions that end a mentally-competent patient's life are used but were performed without express consent of the patient (Patel, 2004), such as a death of a death row prison inmate. Non-voluntary euthanasia involves life-terminating interventions administered to a patient who was not mentally competent and incapable of making such a request (Benedict et al., 1998). This prospectus will refer to the terms active euthanasia, PAS, and PAD when discussing policy in the United States.

Euthanasia and PAS in the Netherlands

History and legislation

In the Netherlands, suicide and attempted suicide are not punishable by the Dutch Penal Code (Benedict et al., 1998). However, in 1886 the practices of euthanasia and assisted suicide became punishable by law (Patel, 2004). While the stance on euthanasia and assisted suicide in the code has never been eliminated or modified, the Dutch passed legislation in 2001 that legalized the medical practices of euthanasia and PAS provided that doctors follow all of the necessary requirements (Patel, 2004).

In 1865, *The Law on Medical Practice* brought organization, standardization, and professionalism to Dutch doctors and formed a professional organization that would gradually come to unite almost all practicing physicians in the Netherlands. Historically, governmental and professional regulation of the medical profession was rare, and supervision of practice in regard to end-of-life decisions was nonexistent (Weyers, 2006). Doctors in the Netherlands sometimes performed active euthanasia per request as early as the 1970s, with the toleration of the Dutch courts (Weyers, 2006; Patel, 2004). As a result, in the 1980s the Prosecutorial Authorities began encouraging doctors to report acts of active euthanasia by creating guidelines to follow for reporting and investigating cases. In addition, cases of active euthanasia presented to a prosecutor were deferred to a committee whose responsibility was to decide whether or not to prosecute (Weyers, 2006). In 1984, the requirements of careful practice were developed after the Netherlands Supreme Court established circumstances under which active euthanasia could be justified; while active euthanasia was still not technically legal, doctors who followed the stipulated requirements and reported to the appropriate authorities would be protected against prosecution (Weyers, 2006).

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In April of 2001, the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* was passed in the Netherlands, making it the first and only country to legalize active euthanasia and PAS. While this legislation legalized both active euthanasia and PAS, according to Patel (2004), active euthanasia is more commonly practiced than PAS. In the Netherlands, physicians administer two injections when performing active euthanasia: the first induces the patient into a comatose state and the second injection stops the patient's heart. The law encompasses both terminally ill adults and minors. Patients ages 16 through 18 can make their own decision but must involve their parents in the process; patients between the ages of 12 and 16 require parental consent for active euthanasia (Patel, 2004).

In order to avoid prosecution, a physician must comply with the due care criteria and the reporting requirements stipulated in the law. In the due care requirements, as stipulated in the *Termination of Life on Request and Assisted Suicide Act (2001)* (a) the patient must make a "voluntary and well-considered" (Article 2) request, (b) the physician must be convinced the patient's suffering is "lasting and unbearable" (Article 2), (c) the physician must explain the course of illness and all treatment options available to the patient, (d) the physician and the patient must believe there is no other reasonable alternative for the situation, (e) the physician must consult one other independent physician who has "given his written opinion on the requirements of due care," (Article 2), and (f) the physician must terminate the patient's life or assist in the suicide with due care (Article 2). In addition to the due care requirements, the physician must file a report with the appropriate authorities, indicating whether the death was by way of euthanasia or assisted suicide (Patel, 2004). The *Termination of Life on Request and Assisted Suicide*

Act(2001), also enables patients to request euthanasia as an advanced directive should they ever progress to be too physically or mentally incompetent to make end-of-life decisions (Patel, 2004).

Support and Criticism

Proponents for legislation concerning active euthanasia and PAS offer two primary arguments. De Haan (2002) referred to these supportive stances The Joint View and The Pure Autonomy View. The Joint View advocates that legalization of active euthanasia is necessary when considering the ethical principles of beneficence and autonomy (de Haan, 2002). Beneficence is best described as promoting and doing good as opposed to harm, while autonomy is a patient's right to self-determination (Benedict et al., 1998, p. 38-39). In the words of de Haan (2002), "If a patient makes a voluntary, well-considered and sustained request for euthanasia, he decides it autonomously. Moreover, since he is suffering unbearably and hopelessly, euthanasia is in his interest" (p. 169). The Pure Autonomy View considers a patient's right to autonomy the only necessary justification for the practices of euthanasia and physician assisted suicide. In other words, patients enduring unbearable and hopeless suffering have a right to a premature death per their request, as long as their case meets the remaining requirements of the euthanasia act (de Haan, 2002).

Despite 86 percent of the Dutch supporting the legalization of active euthanasia and PAS (Patel, 2004), many people do not agree with the practice and have presented multiple criticisms of the policy. For example, critics make a "slippery slope" argument that the legalization of active euthanasia and PAS will inevitably lead to "accepting euthanasia and assisted suicide without a patient's consent ... , or for incompetent, disabled, and elderly patients who are not terminally ill" (Patel, 2004, p. 42). Another

criticism of active euthanasia and PAS is that Dutch doctors perform the procedure for anyone who asks (Patel, 2004). Finally, Mullens (1995) referenced the belief of many English and North American physicians who argue that “good research and good palliative care cannot exist in a climate that openly accepts euthanasia” (p. 1851).

PAD in the United States

Support and Criticism

After the death of Janet Adkins and several others in Michigan by way of Dr. Jack Kevorkian and his suicide machine, physician assisted death (PAD) became a national, public issue (Strate, Zalman, & Hunter, 2005). In response to this ethical dilemma, Michigan's State Legislature created the Michigan Commission on Death and Dying (MCDD) in 1993 with the purpose of examining the issue of “voluntary self-termination” (Strate et al., 2005, p. 25) and to suggest a legislative action. The MCDD delegates divided into three major factions: (1) the personal autonomy faction, (2) the disabilities factions, and (3) the sanctity-of-life faction. The personal autonomy faction was in favor of legalizing PAD and argued that palliative care may not ease the suffering of all patients with diagnoses such as amyotrophic lateral sclerosis (ALS) and cancer. The disabilities faction was primarily concerned about “societal discrimination against vulnerable groups” (Strate et al., 2005, p. 27), the potential for physician abuse of the law, and a slippery slope effect should PAD be legalized. The sanctity-of-life group advocated that PAD equated to killing human beings and the desire for the right to physician assisted death is the same as suicidal ideation, which is “nearly always irrational and due to a diagnosable illness such as depression” (Strate et al., 2005, p. 27).

The sanctity-of-life faction also argued that legalization of PAD threatens traditional medical values and reflected society's lack of respect for the value of human life (Strate et al., 2005). These factions embody the same arguments for and against PAD seen today in the United States as well as in other countries where the debate over PAD and euthanasia are taking place (Rich & Butts, 2004; Patel, 2004; de Haan, 2002).

Legislation

In the United States, PAD is legal in Oregon, Washington, and Montana; similar legislation has been debated in Illinois, Michigan, Rhode Island, Wisconsin, Hawaii, California, New Hampshire, and Maine (Jecker, 2009; Lisko, 1998; Quill, 2008). Oregon's Death With Dignity Act (DWDA) was passed in 1997; Washington followed with Initiative 1000 in November of 2008, and Montana's judicial system declared in December 2009 that PAD "was protected conduct" (Svenson, 2010, p. 9). Montana currently has no legislative parameters guiding the practice of PAD, and Washington's Initiative 1000 is modeled after Oregon's DWDA. Oregon's DWDA specifies the population who may initiate a written request for PAD as "An adult who is capable, is a resident of Oregon and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die" (Death with Dignity Act, 1999, §2.01). The statute also delineates the responsibilities of the attending physician. Some of the primary responsibilities include (a) confirmation that the patient is terminal and competent and the request is voluntary, (b) request that the patient provide proof of residency, (c) instruct the patient on medical diagnosis, prognosis, risks of the lethal medication, probable results of the lethal medication, and available alternatives, (d) provide a referral to a consulting physician

who will confirm the diagnosis and determine whether the patient is competent and the request is voluntary, and (e) inform the patient about the opportunity to retract the request at any time (Death with Dignity Act, 1999).

Oregon's DWDA and Washington's Initiative 1000 is a response to aging populations, advancements in medical technology, and rapidly increasing health care costs (Strate, Zalman, & Hunter, 2005; Quill, 2008). In addition, some individuals desire more than the current end-of-life decisions available to them. Palliative care and hospice continue to be the mainstay of treatment for terminal patients. Quill (2008) acknowledges the improvements to both palliative care and hospice in recent years but argues that "Despite state-of-the-art palliative measures, there will remain a relatively small number of patients whose suffering is insufficiently relieved" (p. 17). In the United States, life is prolonged by way of artificial nutrition and hydration, advanced cardiac life support, chemotherapy, dialysis, and respirators. However, choosing to discontinue or refrain from initiating life support and thereby hastening death is considered as legal and ethical as choosing to prolong life on life support. Many U.S. citizens are advocating for their right to a dignified death that they can control (Svenson, 2010).

American Nurses Association's Position on Euthanasia and Alleviation of Suffering

The American Nurses' Association (ANA) is particularly concerned with the issue of PAD and the effect on the nursing profession if nurses are to participate in such a practice. As Tuten (2001) states, "As nurses, we have been taught that suicide is a cry for help ... someone who feels devalued and unworthy of life. We regard suicidal ideation as a sickness in need of care or cure" (p. 60). The ANA issued a position statement on euthanasia and PAD in 1994. A revised position statement concerning registered nurses'

roles and responsibilities in providing care and counsel at the end of life was issued in 2010. In their most recent position statement, the ANA stated, "patients asking for assistance in dying...may, in reality, be voicing their desire for autonomy, pain relief, a release from existential despair, emotional support, nursing presence, support for their families, and/or spiritual sustenance" (2010, p. 17). The ANA (2010) concluded in their position statement that regardless of the reason for the patient's request or the legality of the issue, the ANA's code of ethics "expressly forbids the intentional taking of human life" (p. 17) As the ANA determines the national scope of practice for nurses, the organization's stance on PAD might create a conflict for clinically practicing nurses who support PAD but must remain within their scope of practice. The issue of PAD is prominent and relevant in today's society. Tuten (2001) writes, "physician-assisted dying is now in the realm of medical practice, social acceptance and public policy. We, as nurses, need to talk about it" (p. 64).

Nurses' Attitudes on Euthanasia, PAS, and PAD

When viewed individually, the majority of studies analyzing nurses' attitudes on euthanasia, PAS, and PAD present a majority of nurses who favor legalization of hastening the death of a terminally ill patient in some situations. However, synthesized data of nurses' attitudes in literature reviews show inconsistencies in nursing support for euthanasia, PAS, and PAD (Berghs et al., 2005; Verpoort, Gastmans, de Bal, & de Casterle, 2004). No current research has been found on the attitudes of nurses in Mississippi regarding such practices.

Some variability exists in research about factors that influence nurses' attitudes on euthanasia, PAS, and PAD (Gielen et al., 2009; Asai, Ohnishi, Wagata, Tanida, &

Yamazaki, 2001). However, the majority of studies seem to agree that the three most influential characteristics on attitudes are age, nursing specialty, and religion (Gielen et al., 2009; Asch & DeKay, 1997; Berghs et al., 2005; Cartwright, Steinburg, Williams, Najman, & Williams, 1997; Ganz & Musgrave, 2006; Kitchener, 1998a; Kitchener, 1998b; Musgrave, Margalith, & Goldsmidt, 2001; Parpa et al., 2010; Sprung et al., 2006; Verpoort, Gastmans, & de Casterle, 2004; Verpoort, Gastmans, de Bal, & de Casterle, 2004; Whitney et al., 2001). Many studies also seem to agree that no significant relationship exists between attitudes and gender, marital status, years of practice, and level of education (Berghs et al., 2005; Ganz & Musgrave, 2006; Kitchener, 1998a; Kitchener, 1998b; Verpoort, Gastmans, & de Casterle, 2004; Verpoort, Gastmans, de Bal, & de Casterle, 2004).

Phenomenon of Interest

Industrialized countries all over the world are in conflict over end-of-life decisions for terminally ill patients. The right to refuse and discontinue treatment is an acceptable and ethical practice as well as the practice of palliative sedation. Palliative sedation is the use of narcotic pain relievers, such as morphine, to keep a terminally ill and suffering patient comfortable even if the amount given may hasten the patient's death (Verpoort, Gastmans, & de Casterle, 2004; Quill, 2008). However, practices such as voluntary refusal of nutrition and hydration, voluntary active euthanasia, PAS and PAD are complex. Today the debate continues on whether the right to life and liberty should guarantee the right to die at the time and in the way of one's choosing. The purpose of this study is to discover unique themes related to the attitudes of clinically practicing registered nurses living in Southern Mississippi towards PAD.

Researcher Bias

Biases from this researcher come from professional and personal experiences. Despite very little clinical experience with suffering and a prolonged death, my personal attitude towards PAD is a risk for researcher bias. The findings of the current literature on nurses' attitudes toward PAD that I have read are an additional potential source of researcher bias in this study.

Significance of the Study

With recent advancements in medical technology, the focus of Western medicine is to cure and keep alive as long as possible. In some circumstances, patients may wish to refuse or withdraw curative or life-preserving treatment. In other circumstances, patients who are terminally or incurably ill and endure prolonged and unbearable suffering may wish to hasten their deaths with the assistance of their physician. Such practice is known as PAD and is legal in the states of Oregon, Washington, and Montana, and many other states currently debate similar legislation (Jecker, 2009; Lisko, 1998; Quill, 2008). Since nurses are at the bedside more than any other healthcare professional, it is prudent that the attitudes of nurses toward PAD are known in preparation for adoption of the practice in other states.

An abundance of current literature has analyzed the practice in Oregon in addition to active euthanasia and PAS in the Netherlands. Studies have analyzed the impact of the legalization of PAD on palliative care and the quality of death and dying of terminally ill patients who pursue PAD (Lindsay, 2009; Smith, Goy, Harvath, & Ganzini, 2011). Literature can be found on the population of patients who pursue PAD (Wineberg & Werth, Jr., 2003) in addition to studies analyzing health care professionals' attitudes and

opinions regarding the practice and its legalization (Asch & DeKay, 1997; Berghs, de Casterle, & Gastmans, 2005; Kitchener, 1998a; Whitney et al., 2001). The ANA firmly states that any intervention with the intent to hasten a patient's death goes against the profession's ethical code, but some nurses believe PAD is acceptable and even preferable in certain situations (Kitchener, 1998a; Kitchener, 1998b; Bendiane et al., 2007; Ganz & Musgrave, 2006). In separate studies, Kitchener (1998a), Asch and DeKay (1997), and Ganz and Musgrave (2006) surveyed a sample of nurses about their attitudes and support or opposition to PAD; other research has examined the influence of variables such as religion, and area of specialty on nurses' attitudes towards PAD (Berghs et al., 2005; Gielen, van den Branden, & Broeckaert, 2009), but no study has looked at Mississippi nurses and their views concerning PAD. This study aims to begin closing this gap in knowledge by discovering if Mississippi nurses support PAD as an end-of-life practice, in what situations do they deem PAD an appropriate alternative, and what factors contribute to their attitudes concerning PAD.

Chapter 2: Literature Review

Current empirical research conducted on PAS, PAD and euthanasia have generally sought to explain two major problem areas: (a) the attitudes of health care professionals and lay persons toward these potential end-of-life options, and (b) factors that determine or significantly influence aforementioned attitudes.

Attitudes Regarding PAD, PAS, and Euthanasia Internationally

Kitchener (1998a) surveyed 1,218 Australian nurses from the Australian Capital Territory about their attitudes regarding voluntary active euthanasia and PAS. Seventy-two percent supported voluntary active euthanasia and 71% supported PAS. Sixty-nine percent of nurses believed the law should be changed to allow voluntary active euthanasia in some circumstances and 67% believed the same for PAS. Sixty-six percent of nurses indicated they would be willing to provision of voluntary active euthanasia if it were legal, and 63% were willing to support the patient through the process (Kitchener, 1998a).

Cartwright, Steinburg, Williams, Najma, and Williams (1997) studied the knowledge, attitudes and beliefs of critical care nurses throughout Queensland, Australia using a postal questionnaire. Of 231 critical care nurses, 57% believed doctors should be allowed to help terminally ill patients die if they believed their life had such poor quality, 66% believed some patients would still request a hastened death even if their pain was adequately controlled, 67% believed the law should be changed to allow the option of active euthanasia for terminally ill patients, 76% rejected the notion that euthanasia destroys the trust between a patient and caregiver, and strong support was found for legal,

documented policies on death and dying (Cartwright, Steinburg, Williams, Najma, & Williams, 1997).

Ganz and Musgrave (2006) also analyzed critical care nurses attitudes towards PAD. They surveyed 71 Israeli critical care nurses using an adaptation of the Nurses' Attitudes Regarding PAD Questionnaire. Five vignettes measured the degree of support for PAD, degree of willingness to be present during PAD, and willingness to perform PAD. The study found that 50%-67.2% of nurses supported PAD, 42%-65.7% of nurses agreed to be present during the death of the patient, and 10% of nurses agreed to perform PAD (Ganz & Musgrave, 2006).

Musgrave, Margalith, and Goldsmidt (2001) studied the attitudes of Israeli oncology and nononcology nurses towards PAD using the original Nurses' Attitudes Regarding PAD Questionnaire. The sample consisted of 71 oncology nurses and 52 maternity and nursery nurses. The majority of both groups, 53%-73% of oncology nurses and 70%-80% of nononcology nurses, supported PAD. The vignette with a patient suffering unbearably received the most support for PAD from both oncology and nononcology nurses. When oncology nurses and nononcology nurses were combined, 63% supported legalization of PAD (Musgrave, Margalith, & Goldsmidt, 2001).

Bendiane et al. (2007) conducted a nationwide survey of French district nurses to determine their opinions towards euthanasia. Of the 602 nurses in the sample, 65% agreed with the statement, "Euthanasia should be legalized for patients with a terminal illness or incurable condition" (p. 709). This study also found greater support for euthanasia from French nurses than French physicians (Bendiane et al., 2007).

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Sprung et al. (2006) studied the attitudes of ICU physicians and nurses, patients who have survived the ICU, and families with loved ones who did not survive the ICU regarding end-of-life decisions in the Czech Republic, Israel, the Netherlands, Portugal, Sweden, and the United Kingdom using a questionnaire. The total sample contained 528 physicians, 629 nurses, 330 patients, and 412 families. All subsamples ranked quality of life greater than value of life, but nurses and physicians did so more than patients and families. However, 69% of physicians and 65% of nurses thought value of life was more important than quality of life in regard to their patients. Sprung found that physicians and nurses wanted active euthanasia as an option if terminally ill and in pain slightly less than patients and families, and a greater desire for active euthanasia was found among all subsamples except families if permanently unconscious. (Sprung et al., 2006).

Asai, Ohnishi, Wagata, Tanida, and Yamazaki (2001) surveyed doctors and nurses of the Japanese Association of Palliative Medicine regarding their attitudes towards, and experiences of voluntary euthanasia. Unlike the aforementioned studies that found the majority of healthcare professionals supported a hastened death for terminally ill patients, in Japan, healthcare professionals who support voluntary euthanasia are the minority. The study surveyed 366 doctors and 145 nurses. Of this sample, 33% of doctors and 23% of nurses agreed that voluntary euthanasia was sometimes right, 26% of doctors and 21% of nurses agreed the Netherlands's situation should be introduced in Japan, 22% of doctors and 15% of nurses agreed medical or nursing organizations should approve of voluntary euthanasia, and 26% of doctors and 14% of nurses agreed the law should be changed to legalize voluntary euthanasia (Asai, Ohnishi, Wagata, Tanida, & Yamazaki, 2001).

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Parpa et al. (2010) surveyed the attitudes of healthcare professionals, relatives of advanced cancer patients, and the public regarding euthanasia and PAS in Greece. The sample consisted of 215 doctors, 250 nurses, 218 relatives and 246 lay people. When asked if the law should be changed to allow terminal cancer patients to hasten their death, 47% of doctors, 45.2% of nurses, 49.1% of relatives and 52.8% of lay people agreed (Parpa et al. 2010).

A qualitative, grounded theory study conducted by Verpoort, Gastmans, and de Casterle (2004) explored the views of Flemish palliative care nurses on euthanasia. Data saturation was reached after 12 face-to-face interviews, and transcriptions were coded using QRS NUD*IST N4. Verpoort et al. (2004) found that it was difficult for Flemish palliative care nurses to form a clear opinion because support for euthanasia depended on the individual dying process, and support for euthanasia was less acceptable in the case of mental suffering than in physical suffering. Palliative care nurses also firmly believed that adequate palliative care can remove the need for euthanasia, euthanasia is only acceptable when palliative care no longer help the patient, and legalization of euthanasia requires specific regulatory boundaries (Verpoort, Gastmans, & de Casterle, 2004).

In addition to the aforementioned individual studies, two literature reviews have synthesized the findings from international studies of nurses' attitudes towards euthanasia. Verpoort, Gastmans, de Bal, and de Casterle (2004) synthesized the findings of 15 publications from Australia, Canada, Finland, Israel, Japan, the Netherlands, and the U.S. Nurses' support for legalization of euthanasia was found to vary from study to study and ranged from 14%, 47%, 62%, 63%, and 78%. The number of nurses who considered euthanasia ethically acceptable also varied and ranged from 23%, 31%, 62%

and 70%. Common arguments found to be in favor of euthanasia included the patient's right to die with dignity and the presence of a hopeless situation. Arguments against euthanasia included the following: the primary care objective is to alleviate discomfort and not to kill, quality palliative care can eradicate the need for euthanasia, religious and moral objections, and potential abuse of practice. Comments on quantitative studies found that many nurses believe more talk is required on the subject and a need exists for more palliative care education (Verpoort, Gastmans, de Bal, & de Casterle, 2004). Similar results were found by Berghs, de Casterle, and Gasmans (2005) when they synthesized the findings of 30 different studies. The quantitative studies found that nurses' support for euthanasia ranged from 14%-78% in studies using the same questionnaire, whereas support ranged from 23%, 44%, 50%, 60%, and 61% in studies using a different questionnaire. The number of nurses who thought euthanasia was ethically justified ranged from 21-70%, and support for euthanasia was found only in certain circumstances. In all studies that presented a clinical situation in which the nurse had to perform euthanasia, support dramatically fell. The qualitative studies found that nurses who feared accepting euthanasia will negatively impact the trust in a nurse-patient relationship and that nurses believed more reflection on the profession's position was needed (Berghs, de Casterle, & Gastmans, 2005).

As the two literature reviews reveal, much inconsistency in the amount of nurses' support of euthanasia, PAS, and PAD exists. A major reason for the inconsistency is the variable definitions of euthanasia, PAS, and PAD used between studies. Another significant reason for inconsistency is the differences between cultures. For example, the countries studied in the Western hemisphere tended to find a majority of nurses support

hastening the death of a terminally ill patient in certain circumstances (Rurup et al., 2006; Bendiane et al., 2007; Ganz & Musgrave, 2006; Musgrave et al., 2001; Sprung et al., 2006; Parpa et al., 2010), but the nurses who support hastening the death of a terminally ill patient are a minority in Japan (Asai et al., 2001). Other factors that contribute to the variability between studies include individual instrumentation, sample demographics, and the degree of acceptance or legality of hastening the death of a terminally ill patient.

Despite the variability between studies and the questions regarding individual study reliability and applicability, support for hastening the death of a terminally ill patient in some situations exists. Other common factors include the need for more discussion regarding the nursing profession's position on euthanasia, PAS, and PAD; more discussion regarding the role of nurses in these end-of-life practices; and the need for more research in the area of nurses' attitudes towards euthanasia, PAS and PAD.

Attitudes Regarding PAD, PAS, and Euthanasia in the U.S.

Miller et al. (2004) conducted a study of Oregon hospice nurses and social workers regarding assisted suicide. They mailed a questionnaire to all hospice nurses and social workers in Oregon and received completed questionnaires from 306 nurses and 85 social workers. When compared to nurses, social workers reported a higher level of support for the Oregon DWDA and for patients who might request a lethal prescription. Of the entire sample of nurses and social workers, 95% believed their hospice agency should either be supportive of a patient's choice for assisted suicide or remain neutral. Of the 306 nurses, 48% supported Oregon's DWDA while 36% opposed the legislation and 16% were neutral, and 16% of the nurses said they have become more supportive of the

DWDA since its passage in 1994 compared to 9% of nurses who have become more opposed to the act since its passage (Miller et al., 2004).

Asch and DeKay (1997) studied the practices and attitudes of U.S. critical care nurses regarding euthanasia. The sample consisted of 1,139 critical care nurses across the country. The study found that only a minority of these nurses believed euthanasia was unethical, but most of them would not assist in the suicide of another or identify a physician who would (Asch & DeKay, 1997).

Whitney et al. (2001) conducted a nationwide survey of U.S. physicians and members of the American Medical Association (AMA) House of Delegates attitudes on PAS. The sample consisted of 658 physicians and 315 AMA delegates. Results of the study included 45% of physicians believed PAS should definitely or probably be legal while 34% believed it should definitely or probably be illegal and 22% were uncertain. Legalization of PAS was favored by 24% of AMA delegates and opposed by 62% while 15% were uncertain. Fifty-five percent of physicians and 58% of AMA delegates believed PAS should neither be legal nor illegal, but a confidential matter between physician and patient (Whitney et al., 2001).

Much less current research is available concerning U.S. nurses' attitudes regarding PAD, PAS and euthanasia, and the existing applicable research focuses primarily on Oregon where PAD has been legal since 1997. Because hastening the death of a terminally ill patient is defined, regulated, and accepted under different terms in the U.S. than in other parts of the world, it is difficult to apply international studies to the U.S.

Influential Factors on Attitudes Regarding PAD, PAS, and Euthanasia

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Some variability exists between studies regarding factors contributing to attitudes regarding hastening the death of a terminally ill patient. For example, most studies suggest a correlation between religion and support for PAD, PAS, and euthanasia; more religious nurses are less supportive of such practices (Kitchener, 1998b; Sprung et al., 2006; Rurup et al., 2006; Bendiane et al., 2007; Ganz & Musgrave, 2006; Musgrave et al., 2001; Berghs et al., 2005; Verpoort, Gastmans, de Bal, & de Casterle, 2004; Parpa et al., 2010; Asch & DeKay, 1997). However, Cartwright et al. (1997) found that of their sample of Australian critical care nurses, 50% stated their religious beliefs in no way influenced their beliefs regarding end of life care. Similarly, Asia et al. (2001) found that only 3% of Japanese nurses based their attitudes towards euthanasia on religious beliefs and 85% of Japanese nurses related their view of euthanasia to secular ethical principles.

Despite some existing variability, religion, specialty, and age are the most common factors found to influence nurses' attitudes regarding PAD, PAS and euthanasia (Verpoort, Gastmans, & de Casterle, 2004; Kitchener, 1998b; Bendiane et al., 2007; Berghs et al., 2005; Verpoort, Gastmans, de Bal, & de Casterle, 2004). Berghs et al. (2005) stated a correlation was found between religion and practice in the studies included in their literature review, and that younger nurses were more likely to support hastening the death of a terminally ill patient while those nurses who had frequent contact with terminally ill patients were most against it. Bendiane et al. (2007) found that nurses ages 50 and older and those who believed in a god who masters destiny have less support for PAD, PAS, and euthanasia while those nurses who frequently discussed end-of-life options with patients were more supportive of such practices. Verpoort, Gastmans, and de Casterle (2004) found that those nurses who strongly opposed euthanasia became more

accepting with experience in palliative care and those nurses who strongly supported euthanasia became less accepting with experience in palliative care. Kitchener (1998) found greater support for active voluntary euthanasia in nurses younger than 40; Agnostic, Atheist or Anglican; and practicing in critical care or mental health while palliative care nurses were the only subsample where the majority did not support euthanasia. Finally, many studies agree that no statistical relationship is present between attitudes regarding PAD, PAS, and euthanasia and factors such as level of education, work experience, length of practice, gender, and marital status (Musgrave et al., 2001; Verpoort, Gastmans, de Bal, & de Casterle, 2004).

Gielen, van den Branden, and Broeckaert (2009) composed a literature review of studies specifically analyzing the relationship between religion and nurses attitudes towards euthanasia. Gielen et al., (2009) reviewed 347 articles and concluded there was “no unanimous agreement among the identified articles about the influence of religion...on attitudes towards euthanasia” (p. 307). However, data was synthesized from international studies, and cultural differences may account for lack of unanimity. Of the twelve studies reviewed that measured nurses' attitudes in the U.S., eight cited religion as a significant reason to oppose PAD (Gielen, van den Branden, & Broeckaert, 2009).

Attitudes of Mississippi Nurses Regarding PAD

Although many international studies have analyzed nurses' support regarding PAD, PAS, and euthanasia, these studies have limited applicability to the U.S. or Mississippi due to varying terminology definitions, preferences of practice, cultural values and degrees of acceptance. Euthanasia and PAS are illegal in the United States. Only PAD under the specifications of the Oregon DWDA, and more recently

Washington's imitation legislation, are legal in the U.S. As a result, literature analyzing U.S. nurses' attitudes towards PAD have focused on Oregon's nurses. In the future, PAD may become a national practice in the U.S., and currently no research exists on Mississippi's nurses' attitudes on PAD. The purpose of this study is to begin filling this void of knowledge by conducting a miniature qualitative content analysis and interviewing a sample of Mississippi nurses about their attitudes towards PAD and what influences those attitudes.

Chapter 3: Methodology

Method of Inquiry

The goal of this study is to explore how clinically practicing registered nurses in Mississippi view PAD. A qualitative, inductive content analysis was conducted with the aim of discovering unique themes related to Southern Mississippi nurses' attitudes toward PAD. This study examined the presence or absence of support for legalizing PAD; in what context, if any, might PAD be acceptable or preferred if legal, and what recurring factors, if any, influence the participants' attitudes toward PAD.

Participants

Due to the time constraints and smaller scale of this project, the study sample consisted of only three participants. All participants are currently practicing registered nurses living in Southern Mississippi. A snowball method was used to select participants. The only requirements for participation in this study included (a) registered nurses currently practicing in a clinical setting defined as a hospital, independent hospice, or home health; and (b) exposure to a prolonged death at some point during professional career.

Setting

Interviews were conducted in a place of convenience for the participants. Only the researcher and the participant were present during the interview.

Data Collection, Analysis and Storage

The researcher conducted one interview with each participant. These interviews were tape recorded and then transcribed into texts for data analysis. The verbalizations were transcribed literally rather than in summary.

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The unit of analysis used for this study is the individual themes found in the interview transcripts. All transcripts were coded, and conclusions were drawn from the coded data. Demographic data were utilized to speculate whether any relationship exists between demographic variables and attitudes toward PAD for the purpose of suggesting potential future research areas. Field notes conducted during the interviews, interview tapes and transcriptions, and demographic data obtained from the participants were filed by the researcher and will be kept for a maximum of five years.

Instrumentation

The researcher used an interview guide during data collection to ensure relevant responses from participants (see Appendix A). The interview guide was developed by the researcher under the guidance of a thesis adviser. The tool was not piloted before implementation in this study. Research concerning PAD is limited in the United States and novel in Mississippi, and as a result an appropriate interview tool that has been previously tested could not be found within the time constraints placed on this study. A demographic data form was given to the participants to fill out before initiation of the interview (see Appendix B). Due to the small sample size of this study, relationships cannot reasonably be implied between demographic variables and attitudes toward PAD. However, the data obtained by demographic survey in concert with interview responses may suggest areas of future research.

Human Subjects Protection

Approval for research was obtained from The University of Southern Mississippi's Institutional Review Board (see Appendix C). Participants were asked to sign a form indicating voluntary, informed consent to participate in the study. The

participants were given an overview of the purpose of the study in addition to risks and benefits of participation both orally and in writing on the informed consent form (see Appendices D & E). Anonymity and confidentiality were maintained. Participants were assigned a code name to put on all data collected in order to protect the participants' right to confidentiality. Collective findings from this study were disseminated by written and verbal communication. All field notes, tapes, and transcriptions are locked away by the researcher and will remain so for a maximum of five years and then will be destroyed. No risks or harmful effects are foreseen. Minimal inconvenience of the participants in completing the one-on-one interview was anticipated. Minimal psychological discomfort was considered a risk when participants recalled their experience with terminal patients.

Limitations

A disadvantage of the qualitative method of research includes the threats to its internal and external validity, including transferability, credibility, dependability, and confirmability. However, no research pertaining to PAD in Mississippi exists. As a result, a qualitative approach is more appropriate in order to discover what attitudes, presence, desire or need, if any, exists in Mississippi. Secondly, a quantitative approach would require a survey of a significant population of nurses. The survey tools in current research were conducted in territories where euthanasia, PAS and/or PAD are legal and consisted of questions that are inappropriate to ask where the practices are illegal. Revising an existing survey tool would nullify the validity of the instrument. Finally, the time required to revise or create a survey tool acceptable to a local hospital's review board is incompatible with the time constraints of this project. As a result, the researcher decided

to conduct a small-scale qualitative content analysis to explore the subject of PAD in Mississippi and illuminate avenues of future research.

Generalizing ability of the findings to practicing registered nurses is not possible because of the small sample size of this study. Other limitations of this study include limited time dedicated to persistent observation and no use of referential adequacy or member checks. However, the interview questions were evaluated to ensure they are open-ended and not leading, the transcriptions were read thoroughly several times over to ensure no data are overlooked, peer-debriefing was utilized to hold the researcher accountable during the course of the study and reduce researcher bias, and an inter-rater agreement of 100% was obtained while coding the transcriptions.

Chapter 4: Results

The goals of this study are to identify the presence or absence of support for legalizing PAD; in what context, if any, might PAD be acceptable or preferred if legal, and what recurring factors, if any, influence the participants' attitudes toward PAD. While no acceptable or preferred context for PAD was identified in any of the interviews, measurable variables from the interviews include support, presence of need or desire for PAD in Mississippi, and factors that influence opinions toward PAD. In addition, five themes were identified using an inter-rater agreement of 100%. These themes include (a) patient autonomy and choice, (b) religion, (c) presence of a fine line or grey area, (d) perception of dignity, and (e) education.

Support of PAD in Southern Mississippi

Of the three participants interviewed, two are opposed to the practice of PAD and one is in support of the practice. Interview C, who is in support of PAD, stated he is "perfectly okay" with PAD, citing his belief in the right to "choose your own destiny." He continues to reference the patient's right to autonomy by explaining, "You have the right to choose your physician. You have the right to choose your treatment options. Why should you not have the right to choose the way you're going to die when you know it's coming?"

Interviews A and B were both against PAD as an end of life option. Interview A agreed with many common criticisms offered against PAD. Beginning her response with, "First of all I don't think you could deem anyone not depressed who knows they're fixing to die of a chronic illness," interview A continued by expressing her fear of PAD leading to the "slippery slope" and that practicing PAD goes against a doctor's oath to do no

harm. Interview B voiced that she is unwilling to have such an act on her conscience, and firmly expressed that PAD is still suicide regardless of the patient's situation.

Presence or Need of PAD in Southern Mississippi

Interview B was the only participant who had never come across any patient who had desired the physician to prescribe or give them medication to actively end his/her life. As a result, Interview B expressed that she did not recognize a need for PAD in Mississippi. Interview A stated that she can recall one patient who expressly asked for a doctor to give him medicine to kill him. When asked if Interview A felt PAD was needed or desired in Mississippi, she responded, "I don't think there's a need here ... you know in sixteen years of nursing I've only had one patient say that." Interview C also stated that he had seen patients ask for a physician to give them medicine to end their life. When asked if Interview C believed PAD was needed as an end of life option in Mississippi, he responded, "My opinion is that it's probably needed but not wanted." Interview C also expressed his belief that PAD would be utilized "occasionally" if it was legal in Mississippi.

Influential Factors

The factors found to influence an individual's opinion of PAD include (a) religious belief, (b) patients' rights, (c) nursing experience, and (d) education. Interviews A, B and C all cited religious belief as a factor influencing one's support of PAD. Interviews A and B referenced their own religious views when explaining why they were in opposition to PAD. Interview C believed religion was the "biggest kicker" when asked why others might oppose PAD in Mississippi. Interviews A and B both mentioned patients' rights and nursing experience as influences on their opinion of PAD. Finally,

interview C discussed education as a reason patients might support or oppose PAD. He explained, “you have a significant number of people that just don’t understand the disease process, and despite patient education they’re not going to understand it, and you have to do your best to work around it. But those that do get it, that [PAD] would be an option that they would choose.”

Patient Autonomy and Choice

Interviews A, B, and C all discussed the importance of patient autonomy and choice, regardless of their stance on PAD. In regards to end of life care and life support in general, Interview A stated, “I think the patient has a right to make decisions about how far they want you to go...” Interview B was asked if she believes patients have a right to PAD despite her opposition to the practice. She responded, “If there’s a physician willing to do it [PAD], and that’s what the patient wants, and they chose to see that physician for that reason, then that is their prerogative.” Interview C agreed with Interview A that all end of life considerations, including methods of life support and PAD, are the personal choice of the patient.

A need for advanced directives was identified as a subtheme under the theme of patient autonomy and choice. Interviews A, B and C each addressed the lack of patient education regarding advanced directives and the need for every patient to have something in writing when it comes to life support decisions.

Religion

All interviews cited religion as an influence on support of PAD. Interview A expressed her belief that “God has given us the knowledge to create medications, but I don’t think we need to do his job for him.” Interview B also referenced her religious

beliefs when asked why she was opposed to PAD. She stated, "I think that it's wrong for anyone to end their own life. ... that doesn't change that it's wrong. Still sin. And I would consider that a sin – ending your own life – I would consider that a sin." Interviews A, B and C each made a reference to Mississippi belonging to the "Bible Belt" when explaining why they believed Mississippi as a state and a culture would resist PAD as an end of life option. Interview C mentioned that some religions view suicide as a "pass straight to hell," but he also expressed his belief that PAD promotes peace and comfort at the end of life, a sentiment that should complement religious doctrine. He states, "Most ministers, I would think that they want peace for their congregation and the body to be at peace and pain free."

Presence of a Fine Line or Grey Area

Interviews A, B and C each discussed the presence of a "fine line" between PAD and more accepted end of life options, including the liberal administration of pain medication to keep a patient comfortable when death is approaching. Interview A stated, "there's a fine line between enough pain medication [to keep a patient comfortable] and a lethal dose." Interview B voiced, "I mean, who's to say if the morphine is actually hastening their death or not. I mean, I think that you should keep the patient as comfortable as possible, but it's a fine line." Interview C discussed the difference between PAD and comfort measures, "The fine line between assisted suicide – assisted suicide is the patient having the capability to do it themselves. Comfort measures are a caregiver ... for them trying to create the most comfort they can for their patient."

Within this theme, the importance of intent was identified as a subtheme.

Interviews A and C both discussed the importance of intent when differentiating PAD

from providing enough morphine to keep patients comfortable during their last days. Interview A explained, "If I know you're going to die in a day or so and you're just in excruciating pain I would probably give you a lethal dose. To get you comfortable. Wouldn't necessarily intentionally you know I'm fixing to go make this person stop breathing, but if you're going to die in six months then no I don't think you should be allowed to do that." Interview C expressed a similar belief when he stated, "Suicide is taking medicines with the intent to kill; comfort measures is you're making comfortable until they expire ... You're not assisting anyone with suicide."

Perception of Dignity

Interviews A and B offered a different perspective to a frequent argument for legalizing PAD: preserving patient dignity. When told that research shows many patients requesting PAD do so in order to preserve their dignity, interview A responded, "Their dignity needs to be protected, but that's what the nursing staff is there for. ... Dignity is keeping me clean, keeping me covered, keeping my hair brushed ... I think you can preserve someone's dignity without hastening their death." Interview B firmly enforced her belief that PAD equates to suicide by stating, "I know they're wanting to keep their dignity, but when it comes to an issue of pride, and they're wanting to go ahead and end their life while they still have their dignity, I think that is still suicide."

Educational Deficit

The final theme identified relates to both a lack of patient education and a lack of family education. Interviews B and C identified areas of patient education they believe are lacking in Mississippi. Specifically, interview B addressed the need for all patients to be educated in advanced directives, and interview C explained that Mississippi as a

region suffers from an “educational barrier” that inhibits understanding of disease processes and treatments. Interviews A, B, and C each addressed aspects of family education that need improvement in Mississippi. Interview A discussed the inefficient use of intensive care resources, stating, “I think, you know, for health care, we have got to find a way to make it where we are not putting the ninety-eight year old on the ventilator in the ICU and spending thousands and thousands of dollars.” Interview B addressed a lack of family education in regards to basic end of life care options, explaining, “A lot of times you will have to attend to the family as well because they don’t understand, you know, exactly what is going on. . . . You have to explain what hospice is and a lot of them don’t understand because a lot of them think that’s a death sentence.” Finally, interview C also addressed an educational deficit in patient families by expressing, “I walk in and I see someone suffering and I just don’t understand it. The majority of what I see, you know, once again, a lack of education. They [the family] don’t understand what they’re [the patient] is going through.”

Relationship between Demographic Factors and Support of PAD

A short demographic survey was given to each participant at the conclusion of their interview. The following demographic variables were examined for any potential relationship with support of PAD: age, gender, nursing specialty, frequency of interaction with terminally ill patients, years of practice, level of education, and religious affiliation. The only potential relationships identified were between gender and support for PAD and between nursing specialty and exposure to PAD. Of the three participants, both women were in opposition to PAD and the only man was in support of PAD. The two participants who have seen a patient request for PAD in practice both worked primarily in

ICU care whereas the one participant who had never encountered a request for PAD worked in the emergency room and home health.

Chapter 5: Conclusions

The purpose of this study is to identify the presence or absence of support for PAD among the registered nurses of Southern Mississippi. Other goals of this study include identifying a preferable context for PAD as an end of life option and what factors influence attitudes regarding PAD. The findings of this study do not indicate any situation where PAD might be an acceptable end of life option, while several other studies have identified support for PAD in some circumstances (Kitchener, 1998a; Cartwright, Steinburg, Williams, Najma, & Williams, 1997; Musgrave, Margalith, and Goldsmidt, 2001; Verpoort, Gastmans, & de Casterle, 2004).

Need and Support of PAD in Southern Mississippi

Only one participant of the sample of three nurses in this study supported PAD as an end of life option for terminally ill patients, and only one of the three nurses expressed a need for PAD as an end of life option in Southern Mississippi. Specifically, Interview C expressed that PAD is “probably needed but not wanted,” and that the practice would be utilized “occasionally” if legal in Mississippi. A similar belief was found in a study conducted by Cartwright, Steinburg, Williams, Najma, and Williams (1997) where 66% of the sample of nurses believed some patients would still request a hastened death even if their pain was adequately controlled. Interview C’s response demonstrates that PAD is desired in Mississippi, albeit by a minority of this study’s sample, and these results indicate further research is needed to identify the degree of need for PAD in Mississippi.

Relationship between Religion and PAD

In this study, all three participants cited religion as a reason for opposition to PAD. This finding is supported by a literature review conducted by Verpoort, Gastmans,

de Bal, and de Casterle (2004) that found religious and moral objections to be a common argument against euthanasia. Many other studies suggest a correlation between religion and support for PAD, PAS, and euthanasia, where more religious nurses are less supportive of such practices (Kitchener, 1998b; Sprung et al., 2006; Rurup et al., 2006; Bendiane et al., 2007; Ganz & Musgrave, 2006; Musgrave et al., 2001; Berghs et al., 2005; Parpa et al., 2010; Asch & DeKay, 1997). This study shared similar findings, as all three nurses declared PAD was probably not wanted by a majority of Mississippians due to its strong religious culture.

Other Influential Factors

Patients' rights, nursing experience and education are other influential factors found to influence nurses' attitudes toward PAD in this study. Potential relationships were also identified between a nurse's gender and support of PAD and a nurse's area of specialty and exposure to PAD. Since this study only included three participants, the results cannot definitively conclude that relationships exist. However, several studies support the finding that nursing specialty influences nurses' attitudes regarding PAD, PAS and euthanasia (Verpoort, Gastmans, & de Casterle, 2004; Kitchener, 1998b; Bendiane et al., 2007; Berghs et al., 2005; Verpoort, Gastmans, de Bal, & de Casterle, 2004). In addition, Bendiane et al. (2007) found that nurses who frequently discussed end of life options with patients were more supportive of PAS, PAD and euthanasia, and Kitchener (1998) found greater support for such practices from nurses practicing in critical care or mental health while palliative care nurses were the only subsample where the majority did not support euthanasia. While this small Mississippi study cannot conclude the existence of such a relationship independently, the support of the

aforementioned findings necessitates further research to explore the possibility of a relationship between nursing specialty and the attitudes of Mississippi nurses' toward PAD.

Grey Area, Need for Education, and an Issue of Dignity

Minor themes found in this study include the presence of a fine line or grey area when it comes to the issue of PAD, an educational deficit related to end of life care, and the dignity of terminally ill patients. Verpoort et al. (2004) also found the issue of PAD, PAS and euthanasia to be a grey area when their study's sample of Flemish palliative care nurses found it difficult to form a clear opinion on the issue because support for euthanasia depended on the individual dying process and acceptability varied depending on the situation. Berghs, de Casterle, and Gastmans (2005) also found that support for euthanasia was present only in certain circumstances. In regards to education, Verpoort, Gastmans, de Bal, and de Casterle (2004) also found an educational deficit in regards to palliative care. Finally, Verpoort, Gastmans, de Bal, and de Casterle (2004) found a common argument for euthanasia was a patient's right to die with dignity. This perspective differs from the findings of this study, where two of the three nurses believed that a patient's dignity was important but did not justify the use of PAD as an end of life option.

Limitations of this Study

The most significant limitation of this study was the small sample size of only three participants. While reoccurring themes were identified in the interviews, this study cannot claim that data saturation had been reached in the sample of nurses. As a result, the findings of this study are not accurately representative of the population of registered

nurses in Mississippi, and this study cannot conclude that Mississippi nurses agree or disagree with nurses sampled in similar studies. The findings of this study are compared to other studies for the purpose of suggesting areas of future research regarding PAD in Mississippi. Secondary limitations of this study include terminology that differs from comparable studies, unique instrumentation, sample demographics and the illegal status of PAD in the state of Mississippi.

Areas of Future Research

In this study, one of three sample nurses expressed a probable need for PAD in Mississippi. As a result of this need, future research should inquire about the desire for PAD among the terminally ill population of Mississippi. The theme of religion and the connection between nursing specialty and support of PAD should also be explored further, since the findings of this study, though inconclusive, agree with several studies of a much larger scale. The education of Mississippians regarding PAD and its practice in Oregon is another potential research subject. Finally, this study should be duplicated with a larger sample of nurses so results can more accurately represent the population of nurses in Mississippi.

References

- American Nurses Association. (2010). *American Nurses Association position statement on registered nurses' roles and responsibilities in providing expert care and counseling at the end of life*. Accessed June 19, 2012, on the World Wide Web: <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements>
- Asai, A., Ohnishi, M., Wagata, S.K., Tanida, W., & Yamazaki, Y. (2001). Doctors' and nurses' attitudes towards and experiences of voluntary euthanasia: Survey of members of the Japanese Association of Palliative Medicine. *Journal of Medical Ethics, 27*, 324-330.
- Asch, D.A., & DeKay, M.L. (1997). Euthanasia among U.S. critical care nurses: Practices, attitudes, and social and professional correlates. *Medical Care, 35*(9), 890-900.
- Bendiane, M.K., Galinier, A., Favre, R., Ribiere, C., Lapiana, J.M., Obadia, Y., & Peretti-Watel, P. (2007). French district nurses' opinions towards euthanasia, involvement in end-of-life care and nurse-patient relationship: A national phone survey. *Journal of Medical Ethics, 33*, 708-711. doi: 10.1136/jme.2006.018374
- Benedict, S., Pierce, A. G., & Sweeney, S. (1998). Historical, ethical, and legal aspects of assisted suicide. *Journal of the Association of Nurses in AIDS Care, 9*(2), 34-44. doi: 10.1016/51055.3290(98)80059-9
- Berghs, M., de Casterle, B.D., Gastmans, C. (2005). The complexity of nurses' attitudes toward euthanasia: A review of the literature. *Journal of Medical Ethics, 31*, 441-446. doi: 10.1136/jme.2004.009092

- Butts, J. B. (2013). Ethical issues in end-of-life nursing care. In J. B. Butts & K. L. Rich, *Nursing ethics: Across the curriculum and into practice* (3rd ed., pp. 243-286).
- Cartwright, C., Steinburg, M., Williams, G., Najman, J., & Williams, G. (1997). Issues of death and dying: The perspective of critical care nurses. *Australian Critical Care, 10*(3), 81-87.
- Death with Dignity Act, §2.01 & §3.01 (1999).
- de Haan, J. (2002). The ethics of euthanasia: advocates' perspectives. *Bioethics, 16*(2), 155-172.
- Euthanasia. (2010). International perspectives legal status of euthanasia and assisted suicide. Retrieved from <http://euthanasia.procon.org/view.resource.php?resourceID=000136>
- Ganz, F.D., & Musgrave, C. F. (2006). Israeli critical care nurses' attitudes toward PAD. *Heart Lung, 35*(6), 412-422.
- Gielen, J., van den Branden, S., & Broeckaert, B. (2009). Religion and nurses' attitudes to euthanasia and physician assisted suicide. *Nursing Ethics, 16*(3), 303-318. doi: 10.1177/0969733009102692
- Jecker, N. S. (2009). Physician-assisted death in the Pacific Northwest. *The American Journal of Bioethics, 9*(3), 1-2. doi: 10.1080/15265160902717685
- Kitchener, B.A. (1998a). Nurses attitudes to active voluntary euthanasia: A survey in the ACT. *Australian and New Zealand Journal of Public Health, 22*(2), 276-278.
- Kitchener, B.A. (1998b). Nurse characteristics and attitudes to active voluntary euthanasia: A survey in the Australian Capital Territory. *Journal of Advanced Nursing, 28*(1), 70-76.

- Lindsay, R. A. (2009). Oregon's experience: Evaluating the record. *The American Journal of Bioethics*, 9(3), 19-27. doi: 10.1080/15265160802654137
- Lisko, E. A. (1998). Oregon task force's guidelines for physician-assisted suicide are likely to have broad impact. Accessed June 9, 2012, on the World Wide Web: <http://www.law.uh.edu/healthlaw/perspectives/Bioethics/980305Oregon.html>
- 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, 685-691.
- Mullens, A. (1995). The Dutch experience with euthanasia: Lessons for Canada? *Canadian Medical Association Journal*, 152(11), 1845-52.
- Musgrave, C.F., Margalith, L., & Goldsmidt, L. (2001). Israeli oncology and nononcology nurses' attitudes towards physician-assisted dying: A comparison study. *ONF*, 28(1), 50-58.
- Parpa, E., Mystakidou, K., Tsilika, E., Sakkas, P., Patiraki, E., Pistevou-Gombaki, K.,...Gouliamos, A. (2010). Attitudes of health care professionals, relatives of advanced cancer patients and public towards euthanasia and physician assisted suicide. *Health Policy*, 97, 160-165. doi: 10.1016/j.healthpol.2010.04.008
- Patel, K. (2004). Euthanasia and physician-assisted suicide policy in the Netherlands and Oregon: A comparative analysis. *Journal of Health & Social Policy*, 17, 37-55. doi: 10.1300/J045v19n01_02
- Quill, T.E. (2008). Physician-assisted death in the United States: Are the existing "last resorts" enough? *Hastings Center Report*, 38(5), 17-22.

- Rurup, M.L., Onwuteaka-Philipsen, B.D., Pasman, H.R.W., Ribbe, M.W., & van der Wal, G. (2006). Attitudes of physicians, nurses, and relatives towards end-of-life decisions concerning nursing home patients with dementia. *Patient Education and Counseling*, *61*, 372-380. doi: 10.1016/j.pec.2005.04.016
- Smith, K.A., Goy, E.R., Harvath, T.A., & Ganzini, L. (2011). Quality of death and dying in patients who request physician-assisted death. *Journal of Palliative Medicine*, *14*(4), 445-450. doi: 10.1089/jpm.2010.0425
- Sprung, C.L., Carmel, S., Sjøkvist, P., Baras, M., Cohen, S.L., Maia, P.,...Henderson, B. (2006). Attitudes of European physicians, nurses, patients, and families regarding end-of-life decisions: The ETHICATT study. *Intensive Care Med*, *33*, 104-110. doi: 10.1007/s00134-006-0405-1
- Strate, J. M., Zalman, M., & Hunter, D. J. (2005). Physician-assisted suicide and the politics of problem definition. *Mortality*, *10*(1), 23-41. doi: 10.1080/13576270500030974
- Svenson, A. G. (2010). Montana's courting of physician aid in dying: Could Des Moines follow suit? *Politics and the Life Sciences*, *29*(2), 2-16. doi:10.2990/29_2_2
- Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Article 2 (2001).
- Tuten, M. (2001). A death with dignity in Oregon. *ONF*, *28*(1), 58-65.
- van Alphen, J. E., Donker, G. A., & Marquet, R. L. (2010). Requests for euthanasia in general practice before and after implementation of the Dutch euthanasia act. *British Journal of General Practice*, *60*, 263-267. doi: 10.3399/bjgp10X483931

- Verpoort, C., Gastmans, C., & de Casterle, B. (2004). Palliative care nurses' views on euthanasia. *Journal of Advanced Nursing*, 47(6), 592-600.
- Verpoort, C., Gastmans, C., de Bal, W., & de Casterle, B.D. (2004). Nurses attitudes to euthanasia: A review of the literature. *Nursing Ethics*, 11(4), 349-365. doi: 10.1191/0969733004ne708oa
- Weyers, H. (2006). Explaining the emergence of euthanasia law in the Netherlands: How the sociology of law can help the sociology of bioethics. *Sociology of Health & Illness*, 28(6), 802-816. doi: 10.1111/j.1467-9566.2006.00467.x
- Whitney, S.N., Brown, B.W., Brody, H., Alcsér, K.H., Bachman, J.G., & Greely, H.T. (2001). Views of United States' physicians and members of the American Medical Association House of Delegates on physician-assisted suicide. *Journal of General Internal Medicine*, 16, 290-296.
- Wineberg, H., & Werth Jr., J.L. (2003). Physician-assisted suicide in Oregon: What are the key factors? *Death Studies*, 27, 501-518. doi: 10.1080/07481180390197642

Appendices

Appendix A

Interview Guide

1. Discuss in detail your take on the complexity of a situation involving a perpetually suffering, terminally ill patient in regards to the patient's needs, the family's needs, the nurse's role, and the nurse's needs.
2. Explain in detail what physician-assisted death means to you.
3. In your professional career, what experience(s) comes to mind when discussing physician-assisted death? Please describe in detail this experience, in addition to your role of involvement and the feelings this experience invoked.
4. Discuss your personal stance on physician-assisted death, as practiced in Oregon under its Death With Dignity Act.
5. Discuss your view on physician-assisted death becoming a legal end-of-life option in Mississippi, and what is your perspective on how physician-assisted death would fit in this Southern region of the U.S.?
6. Describe what personal experience, characteristics, or beliefs contribute to your attitude towards physician-assisted death? Please explain in detail what personal experience, characteristics, or beliefs contribute to your attitude towards physician-assisted death.

Appendix B

Demographic Data Questionnaire
Research: Mississippi Registered Nurses' Attitudes Toward Physician-Assisted Death

1. Age in years _____

2. Gender: (circle one) male female

3. Nursing specialty _____

4. In your specialty, how frequently do you interact with terminally ill patients and their families? (Circle one)

Rarely Infrequently Often Frequently All the time

5. Years of practice _____

6. Level of education: (circle one) ADN BSN advanced degree:

7. Religious affiliation: _____

Appendix C

**Human Subjects Research Application
The University of Southern Mississippi
Institutional Review Board**
irb@usm.edu

Name Robin Smith Phone 985-707-8448

E-Mail Address Robin.E.Smith@eagles.usm.edu Campus ID
771209

Mailing Address (address to receive information regarding this application):

23 Whitestone
Ct Hattiesburg MS 39402
Street City State Zip Code

College/Division College of Nursing Dept. _____

Department Box # 5095 Phone 601-266-5454

Title Attitudes of clinically practicing registered nurses in Southern Mississippi towards physician-assisted death

Funding Agencies or Research Sponsors none

Grant Number (when applicable) n/a

New Project

Dissertation Thesis

Renewal or Continuation: Protocol

_____ Change in Previously

Approved Project: Protocol # _____

Researcher Name (type)

DATE

Advisor Name (if applicable) (type)

Department Chair Name (type)

Appendix D

ORAL PRESENTATION

Title: *Attitudes of Clinically Practicing Registered Nurses in Southern Mississippi Toward Physician-Assisted Death*

The following information will be verbally presented to each participant before the informed consent signature is obtained:

1. **Purpose:** The purpose of this research is to discover unique themes related to the attitudes of clinically practicing registered nurses living in Southern Mississippi towards physician-assisted death.
2. **Description of Study:** The researcher will interview you and other participants to explore the attitudes of registered nurses towards physician-assisted death. The interviews will be audio taped by way of digital recorders, and the researchers will compare your attitudes with other participants regarding physician-assisted death.
3. **Benefits:** Benefits include (a) the discovery and dissemination of new knowledge and findings from the study for the nursing profession and (b) insight into Mississippi registered nurses attitudes towards physician-assisted death, a potentially viable end-of-life option for terminally ill patients.
4. **Risks:** You should not experience any risks or harmful effects during the interview. You may have minimal inconvenience in completing the one-on-one interview. You may also experience minimal psychological discomfort when you recall experiences with terminal patients. The information you provide in the interviews will be maintained confidentially by Robin Smith for no more than 5 years, and only the researcher and thesis adviser will have access to the digital recordings and the transcripts. Data will be destroyed after that timeframe.
5. **Confidentiality:** Anonymity will be maintained; in other words at no time will your name or the information you provide be revealed to anyone other than the researcher. The researcher will change or assign a false name or a number to your interview when the information you provide is transcribed in written format. Confidentiality will be strictly maintained. The findings from this study will be shared with others in the nursing profession by written or verbal communication only as a group with no identifying information that would reflect your name or personal information.

6. **Participant's Assurance:** This project has been reviewed by the Human Subjects Protection Review Committee, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about your rights as a research participant should be directed to the Chair of the Institutional Review Board at 601-266-6820. Participation in this project is completely voluntary, and participants may withdraw from this study at any time without penalty, prejudice, or loss of benefits. Any questions about the research should be directed to *Robin Smith, undergraduate student and researcher conducting this study, at The University of Southern Mississippi, Telephone 985-707-8448, E-mail Robin.E.Smith@eagles.usm.edu.*

Signature of Person Giving Oral Presentation

Appendix E

Consent (Short) Form
THE UNIVERSITY OF SOUTHERN MISSISSIPPI
AUTHORIZATION TO PARTICIPATE IN RESEARCH PROJECT
(Short Form - to be used with oral presentation)

Participant's Name

Consent is hereby given to participate in the research project titled *Attitudes of Clinically Practicing Registered Nurses in Southern Mississippi Toward Physician-Assisted Death*. The purposes and procedures of this study were explained by:

(researcher name).

Information was given about all benefits, risks, inconveniences, or discomforts that might be expected.

The opportunity to ask questions regarding the research and procedures was given. Participation in the project is completely voluntary, and participants may withdraw at any time without penalty, prejudice, or loss of benefits. All personal information is strictly confidential, and no names will be disclosed. Any new information that develops during the project will be provided if that information may affect the willingness to continue participation in the project.

Questions concerning the research, during or after the project, should be directed to *Robin Smith, undergraduate student and researcher conducting this study, The University of Southern Mississippi, College of Nursing, cell phone (985) 707-8448, E-mail*

MISSISSIPPI REGISTERED NURSES' ATTITUDES TOWARD PAD 48

Robin.E.Smith@eagles.usm.edu. The project and this consent form have been reviewed by the Human Subjects Protection Review Committee, which ensures that research involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820. A copy of this form will be given to the participant.

Signature of participant

Date

Signature of Person Explaining the Study

Date