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## Assisted Dying and End-of-Life Symptom Management

### KEY WORDS

Assisted dying  
End of life  
Palliative care  
Qualitative research  
Symptom management

This qualitative study aimed to describe symptom management strategies oncology nurses have used in responding to and preventing requests of terminally ill patients with cancer for assisted dying (AD). The study involved secondary analysis of written stories from 36 nurses who agreed to describe their experiences with a request for assisted dying. Of the 36 nurses, 12 refused to support patient requests for AD and described their attempts to control the circumstances of dying by controlling symptoms. The remaining 24 nurses denied ever receiving requests for AD and described symptom management practices believed to prevent such requests. Data were analyzed using Denzin's process of interpretive interactionism. Two themes emerged from the participant's stories: alternative strategies for AD and prevention of requests for AD. The participants shared many examples of clinical interventions and other features of nursing responses to relieve or prevent suffering including physical, emotional, and spiritual care practices; comfort and medication management; and service as teacher-advocate. Both the nurses who had received requests for AD and those who had not used a variety of similar symptom management approaches to alleviate suffering. In doing so, these nurses upheld current standards of both their professional and specialty organizations.

The lay public and healthcare professionals share an interest in improved care for the dying. Despite this interest, public opinion polls in the United States show ongoing support for the right of terminally ill individuals to pursue physician-assisted suicide and active euthanasia.<sup>1</sup> Although physician-assisted suicide was legalized in Oregon in 1997,<sup>2</sup> it is a morally objectionable act for many healthcare

providers. Because of the legal and ethical dilemmas associated with patient requests for assisted dying (AD), some healthcare providers may respond to such requests by instituting symptom management strategies designed to relieve suffering. Some palliative care providers assert that improved symptom management could virtually preclude patient requests for AD.<sup>3,4</sup>

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Because of the intimacy that characterizes the nurse-patient relationship, nurses who care for terminally ill patients encounter ethically challenging issues, including requests for assistance in prematurely ending life. Little is known about nurses' cognitive, affective, or behavioral responses to this ethical dilemma.

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## ■ Background

Poor symptom management at the end of life may be impel patient requests to end life via assisted suicide or active euthanasia.<sup>5</sup> The desires of terminally ill patients for hastened death have been associated with depression,<sup>6</sup> hopelessness,<sup>7,8</sup> pain,<sup>3</sup> and other symptom distress.<sup>9</sup> Experience in Oregon, the only state to legalize physician-assisted suicide, is contrary to these findings. Patient requests for lethal medication most frequently involve concerns about loss of autonomy, decreasing ability to participate in activities that make life enjoyable, and loss of control over bodily functions.<sup>10</sup> This finding may reflect sustained efforts in Oregon to improve palliative care.<sup>11</sup> The Oregon Death with Dignity Act<sup>2</sup> also requires that physicians inform patients of alternatives such as hospice, comfort care, and pain control. Patients believed to have a psychological condition that may impair judgment must be referred to a psychiatrist or psychologist for further evaluation.

A study of Washington state physicians also raises questions about the influence of poor symptom management on patient requests for assisted suicide. According to the report of Back et al,<sup>12</sup> physicians perceive that worries about loss of control, being a burden, being dependent on others, and loss of dignity most often precipitated requests for assisted suicide.

Given their role of providing care for the terminally ill, oncology nurses receive patient requests for assistance in hastening death. Survey research shows that nurses have diverse, often polarized, attitudes regarding the acceptability of assisted suicide and active euthanasia.<sup>13-15</sup>

A few studies have documented that some nurses have engaged in assisted suicide and active euthanasia. Kuhse and Singer<sup>16</sup> found that 85% of 218 Australian nurses who had received requests from physicians to engage in active euthanasia carried out that physician request. In this study, Kuhse and Singer<sup>16</sup> described active euthanasia as "taking active steps to end life (eg, through the administration of a lethal drug)."<sup>(p313)</sup> Asch<sup>17</sup> reported that 16% of 1139 critical care nurses had acted on patient or family requests for assistance with suicide or active euthanasia. In a survey of 441 New England oncology nurses, Matzo and Emanuel<sup>18</sup> learned that 30% had received requests for assisted suicide, and 20 respondents admitted to injecting drugs intentionally to end a patient's life. In Ferrell et al's survey of 2333 nurses<sup>19</sup>, 23% reported receiving a patient request for a prescription to end life, and 3% had engaged in active euthanasia. Although these studies show that nurses receive requests to hasten death, little information is provided regarding actions taken in response to these requests.

A request from a terminally ill patient to hasten death represents an ethical dilemma for some nurses. A nurse's response

to ethical dilemmas involves a moral reasoning process.<sup>20</sup> Omery<sup>21</sup> postulated that moral reasoning "intervenes between recognition and the reaction" to ethical dilemmas and reflects the operationalization of one's values.<sup>(p502)</sup> An ethical dilemma typically arises when an individual encounters conflicting and inconclusive evidence that a given act is neither clearly right nor wrong or must decide between 2 or more conflicting actions based on differing moral norms.<sup>22</sup> The response to such a dilemma could include responses such as moral uncertainty or distress,<sup>23</sup> ethically appropriate action, no action at all, or actions inconsistent with current professional standards and laws.

Ethical codes and position statements from professional nursing organizations address the importance of symptom management as a response to requests for AD. Table 1 summarizes codes and statements relevant to patient requests for AD. In addition to these documents, a variety of other guidelines and questions about the nursing role in AD have been published. The University of Pennsylvania's Center for Bioethics recently convened a 14-member multidisciplinary panel that examined the potential roles nonphysician health-care professionals could assume in assisting suicide where legally sanctioned.<sup>32</sup> Given that nurses are cited as key coordinators of multidisciplinary hospice care, the authors suggested that nurses could coordinate and oversee the process of assisted suicide. Other key roles included managing symptoms, prescribing drugs commonly used for assisted suicide (nurse practitioner only), lending emotional support, monitoring the dying process, and jointly reporting the assisted suicide with other involved practitioners via established channels and documents. Notably, 1 of 2 nurse panel members dissented from the paper.

In other literature, there is a general consensus that nurses should respond to requests for AD by examining their own beliefs and values about AD, listening to patient concerns and unmet needs, informing patients about all palliative care options, aggressively managing symptoms, and maintaining a nonjudgmental approach.<sup>33,34</sup> Valente and Trainor<sup>35</sup> offer nurses specific clinical practice guidelines, including aggressive symptom management directives, to use in assessing and managing requests for rational suicide among patients who are terminally ill.


Although poor symptom management may or may not provide the impetus leading to requests for AD, professional guidelines suggest that nurses should institute aggressive symptom management and other strategies in response to such requests. Despite the growing body of survey research showing that nurses do receive requests to hasten death, an in-depth understanding about nurses' experience of this ethical dilemma still is lacking.

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## ■ Methods

### Purpose

This qualitative study aimed to explore symptom management strategies oncology nurses have used in lieu of providing AD to terminally ill persons with cancer. The research question was

 **Table 1 • Ethical Codes and Position Statements Relevant to Patient Requests for Assisted Dying**

Organization	Document	Guidelines
American Nurses Association	<i>Code of Ethics for Nurses With Interpretive Statements</i> <sup>24</sup>	"Nurses may not act with the sole intent of ending a patient's life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations" (p8) Nurses are charged with alleviating suffering and providing supportive care to the dying.
American Nurses Association	<i>Position Statement on Active Euthanasia</i> <sup>25</sup>	"...moral opposition to actively taking a human life prohibits the nurse from participating in active euthanasia...[but] does not negate the obligation of the nurse to provide proper and ethically justified end-of-life care which includes the promotion of comfort and the alleviation of suffering, adequate pain control, and at time, forgoing life-sustaining treatments." <sup>(p 2)</sup>
American Nurses Association	<i>Position Statement on Assisted Suicide</i> <sup>26</sup>	"...the nurse should not participate in assisted suicide." <sup>(p1)</sup> Responses should include a nonjudgmental approach, a search for understanding the meaning of the request and personal discomfort with the request, provision of counsel, support, and palliative care programs to manage chronic, severe bio-psycho-social and spiritual distress, collaboration with other health care team members, and a commitment to nonabandonment.
Oncology Nursing Society	<i>The Nurse's Responsibility to the Patient Requesting Assisted Suicide</i> <sup>27</sup>	"...upholding the ethical mandates of the profession while simultaneously seeking to understand the meaning of the request...is important." <sup>(p442)</sup> Responses should include "a thorough and nonjudgmental multidisciplinary assessment of the patient's unmet needs, and prompt and intensive intervention for previously unrecognized or unmet needs." <sup>(p442)</sup>
Oregon Nurses Association	<i>Position Paper on the Nurses' role in the Death With Dignity Act</i> <sup>28</sup>	Articulates the patient's right to self determination. and to have decisions regarding end of life be respected. Includes nurses' responsibility to share information about legal choices and right to refuse to be involved in the care of a patient who has chosen assisted suicide. <sup>(p12)</sup>
Oregon Nurses Association	<i>Guidelines for RNs: Death With Dignity Act</i> <sup>29</sup>	Responses include providing care and comfort to the patient and family throughout the dying process and maintaining confidentiality of patient choice about end of life decisions. Allows nurses to be present during a patient's self administration of a lethal dose of medication. Prohibits patient abandonment by a nurse who does not morally agree with assisted suicide but allows transfer of responsibility for patient's care to another provider. <sup>(p13)</sup>
International Council of Nurses	<i>The ICN Code of Ethics for Nurses</i> <sup>30</sup>	Does not specifically address care of the dying but states that the nurse should "provide sufficient information to permit informed consent and the right to choose or refuse treatment." <sup>(p377)</sup>
International Council of Nurses	<i>Nurses' Role in Providing Care to Dying Patients and Their Families</i> <sup>31</sup>	Emphasizes the nurse's role in providing skilled care at the end of life and the patient's right to a dignified death. Does not address assisted suicide and active euthanasia.

this: What are the symptom management strategies oncology nurses use to prevent or respond to requests for AD from terminally ill patients with cancer?

## Operational Definitions

Assisted dying is defined as any provision of aid to end life intentionally. Such provision can include actively implementing euthanasia, advising a patient about specific strategies or available resources for ending life, assisting the patient with accomplishing suicide, or refraining from interventions to prevent or dissuade the patient from taking his or her life.<sup>36</sup> Terminal illness refers to an incurable disease expected to result in death within 6 months.

## Design

The study design involved a secondary analysis of qualitative data collected previously.<sup>36</sup> The process used was that of ana-

lytic expansion, a technique in which the researcher conducts a secondary interpretation of one's own database to answer new questions.<sup>37</sup>

Denzin's model of interpretive interactionism<sup>38</sup> served as the framework for answering the research question. Interpretive interactionism is an interactive, hermeneutical approach to the study of problems or life-altering experiences. Denzin<sup>38</sup> termed such experiences "epiphanies" because they manifest the meaning or essence of an important occurrence. The experience of an ethical dilemma such as a request for AD may represent an epiphany for some nurses. Denzin's model<sup>38</sup> is based on the premise that personal epiphanies occur within the context of the larger sociopolitical setting of life. As such, any research findings must be situated or understood within this larger setting and linked to the world of public policy, professional ethics, and organizational approaches to supportive care of the dying and their caregivers. One way to enhance this approach is to present a variety of voices drawn from differing

points in the phenomenon under study. Accordingly, this study included the voices of nurses who chose to participate in the project although they had not received requests for AD.

## Sample

Descriptions of symptom management strategies used to address requests for AD were obtained through analysis of written stories submitted by oncology nurses. A randomized, sequential mailing of 1600 study packets to national Oncology Nursing Society members yielded 76 responses. In the original study, the analysis addressed the nurses' experience of receiving requests for AD.<sup>36</sup> The investigator, however, also received correspondence from nurses who denied ever receiving requests for AD. These nurses described symptom management practices that they stated had prevented such requests.

The current study was a secondary analysis of the stories not previously analyzed from the perspective of symptom management. The sample for this analysis consisted of 36 stories from 24 nurses who had received no requests for AD but submitted commentary on symptom management practices and experiences with end-of-life care and 12 nurses who had received and denied requests for AD but countered with symptom management strategies. Hence, none of the sample for the current study stated that they had engaged in AD.

## Procedure

The study packet consisted of a study description, a demographic data sheet, and an invitation to describe one's experience of a request for AD from a terminally ill patient with cancer. Recipients who had not received a request for AD were asked to pass the study packet on to another nursing colleague who may have been interested in participating in the study.

The recipients who chose to participate were requested to submit a written response to the following directions:

- Describe a situation in which you received a request from a terminally ill patient with cancer to assist dying. This could be a situation in which you chose to assist or declined to assist. Assistance could assume the form of taking action to end life such as administering a lethal drug dose, advising a patient about specific strategies or available resources for ending life, assisting the patient with an act to end life, or refraining from interventions to prevent or dissuade the patient from taking his or her life.
- Describe your experience, including your thoughts and feelings at the time and in retrospect, as fully as you can. Please do not include any information or details that could reveal your own or your patient's identity.<sup>36(p42)</sup>

As data were received and reviewed by the researcher, submissions that reflected receipt of a request for AD were separated from those of respondents who indicated that they never had received a request for AD. Submissions were transcribed verbatim using a word processor program.

## Data Analysis

Denzin's method of thematic data analysis<sup>38</sup> was used to analyze the data. This method involved two processes: bracketing and construction. Bracketing is a process of analyzing written text to isolate and inspect key elements and structures of the participants' experiences with requests for AD. The researcher's preconceptions about the experience were articulated and set aside as much as possible so that the essential features of the experience could be seen unbiased by personal and contextual factors. Each story was reviewed for key words or statements specific to the study question. During the bracketing process, these key features were removed from their context and examined as components of the participants' experiences.

The key features then were assembled back into a coherent whole. Denzin<sup>38</sup> termed this process "construction," which included labeling textual phrases, ordering components as they occurred within the stories, examining how each component influenced the others, and developing themes as descriptions of how the components form a total picture.<sup>38</sup> Themes and textual passages were compared across all participants.

Throughout the study, an audit trail was maintained, which consisted of the raw data, data reduction, analysis, synthesis decisions, detailed construction notes and grids, and process notes. The researcher kept a study journal to capture thoughts, reflections, decision points, and activities. To enhance study trustworthiness further, an expert in qualitative research and oncology nursing served as a study auditor. This expert reviewed all components of the audit trail and journal to document that the analytical decisions, labeling of textual phrases, and themes were representative of the stories submitted.

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## ■ Results

Because of the risk that participation in an illegal action might be revealed by the original study participants, strict anonymity was maintained as required by institutional human subjects protection review. Participant demographic sheets were separated from written stories upon receipt by the researcher. Hence, demographics specific to this study's subset of participants are not available. The demographic profile of the 76 nurses in the original study sample shows a predominantly Christian group of women with a mean age of 46 years (range, 24–81 years). This group had experience, averaging 22 years (range, 3–54 years) of nursing practice and 15 years (range, 0.3–30 years) of oncology practice. Most of the nurses were employed full-time in direct care roles. The participants in the study resided throughout the United States.

Thematic analysis of participant stories showed two main themes: alternative strategies to AD and prevention of requests for AD. The nurses who received and denied requests for AD implemented alternative strategies to AD. Study participants who denied receiving requests for AD offered narratives describing prevention of requests for AD. The following 2 sections include thematic definitions and illustrative exemplars.

## Alternative Strategies to Assisted Dying

Palliative care measures and hospice referrals were implemented by the nurses who received and denied requests for AD. Their stories were characterized by alternative strategies to AD, defined as physical, emotional, and spiritual symptom management strategies used in response to patient or family member requests for AD. Pain management was a predominant issue. For example, one nurse stated:

I refused to give extra doses of morphine for that purpose [of ending life] but was readily available to provide medication to control pain, anxiety, or air hunger. I did readjust the IV dose as needed, based on clinical judgment, not to hasten the patient's death.

Similarly, a nurse shared an experience reflecting an initial encounter with a patient she was admitting to hospice care. The patient asked, "Can't you do something to end this pain and suffering now? Something that will end my life?" She responded that she could not fulfill that request, but said:

My presence and work will be to eliminate as much pain as possible and to keep you comfortable at home. Pain control starts today, and before I leave, you will feel less pain.

Another nurse shared her personal philosophy of end-of-life care as a response to requests for AD. She stated that her role is that of educator for families and patients. She then shared an example of how she managed both physical and emotional distress, describing her care of a dying man with AIDS and his estranged family. She described interventions used to help them overcome myths about morphine and addiction, to treat them with positive regard, and to assist the man in regaining a sense of self-esteem:

His family had convinced him that taking morphine for the pain would make him an addict. I took several days of his stay to change the thinking on all their parts. At one point, he even admitted to the shame of how he contracted AIDS. He felt that he didn't deserve to be free of pain. By the time of his death, he felt deserving of the treatment in the best manner possible, despite the feelings associated with his illness. Although we couldn't keep him pain free, he was at his comfort level.

Other nurses spoke of other responses to requests for AD, such as exploring patients' requests, identifying fears, and instituting measures to alleviate those fears. Often, nurses described fear of a potentially painful death as the patient's major concern. The following example epitomizes the stories of nurses who instituted aggressive symptom management to control physical and emotional symptom distress:

Delores admitted that it was pain that concerned her the most. We made an informal contract that day that I would work closely with her physician to provide pain and symptom management so that she, hopefully, would not reach the point of needing to take her own life. For the next several months, her family, physician, and I

worked diligently in adjusting medications to control her pain, anxiety, and depression.

One participant shared a spiritual care intervention. She described a dying patient that she admitted with uncontrolled pain and dehydration. She stated after she had initiated a morphine drip and felt she had controlled the patient's pain, he continued begging to be killed:

Addressing his fear, which became more obvious as the pain subsided, I asked him if he had a faith. He said he used to be a Catholic but he stopped believing in Christ many years ago. Then he looked directly at me and said, "I wish I did have a faith." I asked him if I could share my faith with him, and he eagerly asked me to. I told him about Christ who died for our sins that we might repent of our sins and ask him into our hearts to live with Him eternally. Mr C told me he feared death and had many questions about heaven and hell. After more discussion, he asked if I would pray that he would believe and spend eternity with God. I prayed and he repeated the prayer after me. He cried and thanked me.

This patient's symptom distress manifested as a spiritual crisis. His nurse responded to his plea to be killed by addressing the spiritual component underlying his fear of death.

One nurse summarized a philosophy that paralleled the opinions of many nurses who told stories of refusing requests and implementing palliative care:

Dying is hard work. In my 21 years, I have learned that hard work is needed to fight cancer. Work to treat and deal with side effects helps people get to a cure or to have time to live. Assisted suicide is against my beliefs, and I show patients plus family caring, help, assistance, explanations, and presence. Just being there is enough sometimes—often. Acceptance is vital to patients, not being a burden. Feeling a burden causes the need to have it be over, to die.

## Preventing Requests for Assisted Dying

Nurses also submitted stories associated with managing symptoms that prevent patient requests for AD. One nurse said, "I have been able to control pain and symptom management in my patients. Therefore, I have not been faced with this situation." The theme of preventing requests for AD was defined as perceived prevention of requests for AD via management of comfort care and medication needs, and via service as teacher and advocate. One nurse described this as follows:

In all of my years in end-of-life care and now practicing as a palliative care nurse practitioner, I have never had one of my patients request to die. I believe that because I have worked with very strong interdisciplinary teams and have learned to treat depression early on and know how to properly manage pain and symptoms, my patients die "healthy" deaths. I have witnessed horrible symptom management and have seen how pain, dyspnea, and unrelieved depression can promote suicidal ideation. Once symptoms become relieved, these thoughts become distant.

Other respondents included comments about managing morphine and other medications at the end of life:

Although I have never been formally asked by a patient to assist with termination of their lives as in advising strategies, I have given full doses of meds as opposed to partial orders actually written. Regardless of how obtunded a patient may be in their terminal state, they will continue to receive meds at times allowed for as long as I am caring for them.

Another nurse offered her perspective:

Chasing symptoms with polypharmacy is something I frequently see in many hospice programs. If I come to a juncture in my patient's care that dictates sedation for unrelieved symptoms after sequential trials of meds, I will offer terminal sedation for patients and families, should the need arise.

Terminal sedation is the use of sedatives to relieve extreme, intractable physical distress in the final days of life. Because the intent is to relieve suffering by rendering the patient unconscious and not to hasten death, the practice is ethically and legally supported as a symptom management strategy.<sup>39</sup>

Other comments about the nursing role in end-of-life care focused on the importance of patient counseling, teaching, and advocacy:

As a chemotherapy treatment nurse, I have often wanted to discuss hospice with various different patients who I believed would benefit from the hospice support team, along with their families and loved ones. I do believe in quality versus quantity, and the patients often need to be aware of other options, especially when so many treatments have failed and they are feeling miserable on a pretty regular basis. I believe nurses in my field need to be advocates. Similarly, I have helped rearrange pain management plans, defined "terminal" to patients, and discussed the merits of hospice on countless occasions. I have discussed at length the quality of eating, sleeping, moving, pursuing pleasurable goals, general "living" to multitudes of individuals in order for them to make an informed choice between life and death.

In summary, both the nurses who received requests for AD and those who did not shared many examples clinical interventions and other features of nursing responsibilities used to control suffering at the end of life. The first theme, alternatives to AD, represented symptom management strategies that nurses implemented in response to a patient or family request for AD. The second theme, preventing requests for AD, included symptom management strategies that nurses believed prevented patients from seeking AD.

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## ■ Discussion and Implications

Although one group of participants received requests for AD whereas the other did not, both groups shared many examples of using symptom control strategies to care for people within the context of dying. The interventions they used were consis-

tent with current recommendations to implement comfort care strategies in response to requests for AD.<sup>25–27,29,34,35</sup> The study participants instituted actions according to established standards in response to an ethically troubling patient request.

Despite the use of currently recommended strategies for end-of-life care, some of the nurses' stories reflected encounters with patients whose pain was poorly managed. For example, the hospice nurse's statement that "pain control starts today" raises several questions. Why did it take a patient's request for "something that will end my life" to initiate a program of pain management? Where were the nurses who had been providing care for this patient before the hospice nurse who was confronted with this desperate request? Expert pain management and other symptom control must remain a cornerstone of nurses' advocacy role in patient care.

Provision of competent symptom management is not a service available to all dying Americans. Nurses and their professional associations must continue their lobbying efforts to expand choices of skilled palliative care services for all and reimbursement for such services. Funding must be provided for mandatory palliative care skill training in both academic and service settings. In the study of Ferrell et al,<sup>19</sup> many oncology nurses indicated that their basic nursing education provided inadequate preparation for end-of-life care. The authors of the current study also express concern that nurses' comments suggested confusion about the intent of palliative care interventions, and that they may have misinterpreted such actions as hastening death. Although there is growing awareness within the academic nursing community of the need for improved end-of-life care, curricular changes and nursing competencies outlined by the American Association of Colleges of Nursing<sup>40</sup> must be adopted and implemented by nursing schools.

Improved end-of-life care is a priority area for nursing research efforts. Indeed, the Oncology Nursing Society and Association for Oncology Social Work Joint Position Statement on End-of-Life Care<sup>41</sup> emphasizes the need for more research on end-of-life care by observing that "biomedical, clinical, and behavioral research must be strengthened to provide a foundation for evidence-based practice and to define and measure outcomes other than death."<sup>(p1)</sup>

Currently, there is little nursing research to support measurable indicators specific to dignified dying and sensitive to individual patient preferences regarding symptom management and control over the dying process. Cancer nurses are ideally positioned to provide leadership in outcomes research for end-of-life care strategies. Such studies could include nurse-sensitive interventions designed to decrease symptom distress secondary to pain, dyspnea, constipation, fatigue, insomnia, nausea, and other symptoms that have an impact on well-being.

The current study included a subset of respondents who received requests for AD, denied those requests, and countered with symptom management strategies. Their stories did not show the reasoning process they used to formulate their responses. Did denial of the patient request and implementation of such strategies represent only one of numerous steps

the respondents took to explore a patient's request for AD? Did the denial represent a decision to uphold professional or even personal values regarding nursing's role in the care of patients who seek to control timing or circumstances associated with dying? Although refusal to participate in ending a patient's life is consistent with the American Nurses' Association Code and two position statements on AD,<sup>24-26</sup> is such a refusal consistent with the advocacy role of nursing and the value placed on a patient's right to self-determination?

Some nurses have questioned whether professional values or mandates should override a patient's request for AD.<sup>36,42</sup> Future studies on the reasoning processes nurses use to respond to ethical dilemmas posed by patient requests at the end of life could disclose more insight into choices and actions nurses select.

Given the recent legalization of physician-assisted suicide in Oregon and the potential for legalization of the practice in other states, could support for a patient's right to AD become consistent with the domain of nursing practice? Faber-Langendoen and Karlawish<sup>32</sup> suggested that nurses may be better suited than physicians to coordinate a multidisciplinary, collaborative process of assisted suicide. This idea is provocative yet understandable, given nursing's success in managing multidisciplinary care services and providing expert symptom management. Future studies of Oregon nurses' practices within the context of legalized physician-assisted suicide should add much to an understanding of the evolving controversy about the nursing profession and the role of nurses in managing end-of-life care.

Because there is potential conflict between the lay public's desire for AD and nurses' reluctance to participate directly in AD, the nursing profession should continue to address resulting ethical dilemmas. Nurses caring for the terminally ill may need guidance in resolving the conflict posed by patient autonomy and right to self-determination in contrast to the profession's mandates to relieve symptoms in lieu of participation in AD. Both individual patients' rights and nurses' values must be respected. Access to the Oregon Nurses Association position and other guidelines, use of ethics committees, and consultation with palliative care experts all are vital tools for clinical nurses to use in managing ethical dilemmas and symptom management needs at the end of life.<sup>29</sup>

Although 24 nurses in this study had not experienced requests for AD, they nevertheless took the time to write out and send lengthy explanations of their roles and experience with end-of-life care. Why did these nurses choose to respond although the recruitment cover letter asked them to pass the packet along to another colleague in the event that they had not received a request for AD? Some of these submissions may reflect a lack of attention to detail or a misunderstanding of the study question and directions. These nurses also may have been more skilled at palliative care and thus did not receive requests for AD because they managed patient and family needs at the end of life better than the other study participants. On the other hand, these nurses may have wanted to use the study as an opportunity to speak out with their opinions and concerns about AD and end-of-life care.

The nurses who had not received requests for AD presented a different voice in that they chose to tell their views despite their ineligibility to participate in the original study. The issue of AD is an emotional, polarizing topic for nurses and much of society at large. The responses submitted by these nurses may be a reflection of the ethical dilemma involved and their desire to join the dialogue regarding oncology nurses' quest to address symptom management issues that arise within the context of AD.

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## ■ Limitations

Overall, the sample consisted predominantly of white women from a Christian religious background. Potentially, this group may have represented a unique voice. Further study of nurses from other religious, ethnic, and specialty practice backgrounds is warranted. Inability to link an individual's age or level of experience to specific stories also created a limitation. Study findings about relations among acquisition of moral reasoning skills, clinical expertise, and experience are equivocal.<sup>43</sup> Conclusions cannot be drawn from this study about links between participant responses and length of work experience. The demographic profiles submitted represented only the point in time that the story was told to the researcher, not the time that the story actually occurred in the nurse's career.

To protect the identity of participants, anonymously submitted written stories were used. Such submissions prevented any attempt to clarify further the meaning or intent of information shared. Furthermore, the method of using a written story format may have influenced the response rate and participation because the time and energy required to write a story may have been too burdensome for some potential participants.

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## ■ Conclusion

This report explored oncology nurses' beliefs and experiences with the use of symptom management strategies to prevent or respond to requests for AD at the end of life. The findings suggest perceived success in improving care through symptom management strategies used by the nurses in the sample. Although the nursing profession supports patient empowerment to gain control in other health-related areas, this report shows that the nurses who received requests for AD did not support a terminally ill patient's self-determination for AD. This was manifested by refusal to engage in AD, and by initiation of physical, emotional, and spiritual symptom management strategies. Both nurses who had received requests for AD and those who had not used a variety of similar symptom management approaches to alleviate suffering. In doing so, these nurses were upholding current standards of both their professional and specialty organizations.

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