

SPECIAL ARTICLE

THE ROLE OF CRITICAL CARE NURSES IN EUTHANASIA AND ASSISTED SUICIDE

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Abstract Background. Euthanasia and assisted suicide have received considerable attention recently in medical literature, public discussion, and proposed state legislation. Almost all the discussion in this area has focused on the role of physicians. However, nurses — especially critical care nurses — may be in a special position to understand the wishes of patients and to act on this understanding.

Methods. I mailed a survey to 1600 critical care nurses in the United States, asking them to describe anonymously any requests from patients, family members or others acting for patients (surrogates), or physicians to perform euthanasia or assisted suicide, as well as their own practices.

Results. Of the 1139 nurses who responded (71 percent), 852 said they practiced exclusively in intensive care units for adults in the United States. Of these 852 nurses,

141 (17 percent) reported that they had received requests from patients or family members to perform euthanasia or assist in suicide; 129 (16 percent of those for whom data were available) reported that they had engaged in such practices; and an additional 35 (4 percent) reported that they had hastened a patient's death by only pretending to provide life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without the request or advance knowledge of physicians or others. The method of euthanasia most commonly described was the administration of a high dose of an opiate to a terminally ill patient.

Conclusions. As public debate continues about euthanasia and assisted suicide, some critical care nurses in the United States are engaging in such practices. (N Engl J Med 1996;334:1374-9.)

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EUTHANASIA is defined as administering medication or performing other interventions with the intention of causing a patient's death.¹ Unlike the practice of withholding or withdrawing life-sustaining treatments, which is generally well accepted in the United States, euthanasia remains illegal here and in nearly every other country in the world² — whether or not it is performed with the patient's permission. Still, the many theoretical discussions of euthanasia in the medical literature³⁻⁸ and several surveys of physicians' attitudes in the United States do not indicate a consensus: many accept the idea of euthanasia, in appropriate circumstances and with procedural safeguards, but many others do not.⁹⁻¹¹ In surveys of British¹² and Australian^{13,14} physicians, 7 to 29 percent admit having performed euthanasia. In a recent survey, 218 of 828 physicians in Washington State reported receiving requests for assisted suicide or euthanasia. These physicians satisfied 38 of 156 requests for assisted suicide and 14 of 58 requests for euthanasia.¹⁵

Professional nursing codes also prohibit euthanasia.¹⁶ However, in one study of 1210 oncology nurses in the United States, 47 percent indicated that they would vote to legalize physician-assisted death, and 16 percent indicated that they would, under a physician's order, administer a lethal injection to a competent, terminally ill patient who requested such assistance.¹⁷ In another study,¹⁸ 15 of 36 U.S. nurses reported agreeing with the decision of a resident physician to administer a deliberate lethal overdose of morphine to a 20-year-old patient dying of ovarian cancer.¹⁹

Little is known about the actual experiences and

practices of nurses. In a survey of 943 Australian nurses, 218 reported being asked by a physician to engage in euthanasia; of these, 85 percent reported complying with the request. Moreover, 16 nurses reported complying with a patient's request for euthanasia without having been asked by a physician to do so.²⁰ In a different survey of 278 Australian nurses, 52 (19 percent) reported taking active steps to bring about the death of a patient, often without being asked to do so by the patient or the patient's family.²¹

Given this evidence that nurses outside the United States may be as willing as physicians to engage in euthanasia, I conducted a study to examine the role of U.S. critical care nurses in euthanasia and assisted suicide. Critical care nurses frequently care for patients who wish to die, and these nurses are often in a position to hasten their deaths. And, like physicians, they may also be in a position to engage in such activities outside the practice setting, on behalf of friends or relatives who wish to die.

METHODS

Study Subjects

The subjects of this study were nurses practicing in intensive care units for adults in the United States. A random sample of 1600 subscribers to *Nursing* magazine who practiced in critical care settings was selected in order to represent a broad spectrum of attitudes and experiences. *Nursing* is the largest nursing journal in the world, with a circulation of nearly 500,000.

Survey Instrument

The survey consisted of eight pages and required about 10 minutes to complete. Because the terms "euthanasia" and "assisted suicide" can be unclear, subjects were provided with the following definition to use in responding to questions:

Active euthanasia and assisted suicide may mean different things to different people. For the purposes of this questionnaire, we use both these terms to reflect circumstances in which someone performs an act with the specific intent of causing or hastening a patient's death, but we exclude those acts that reflect the withholding or withdrawing of life-sustaining treatment. By this definition, we

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Supported by a grant from the University of Pennsylvania Cancer Center. Dr. Asch is the recipient of a Career Development Award from the Department of Veterans Affairs Health Services Research and Development Service.

would include such acts as providing an intentional overdose of narcotics or potassium chloride or providing explicit advice to patients about how to commit suicide but exclude such acts as withdrawing a mechanical ventilator, even though all these acts might result in the patient's death.

To address the subjects' experience with requests that they perform euthanasia or assist in a suicide, they were asked:

Have you ever been asked by a patient, family member, or other surrogate to administer a medicine to a patient or perform some other act with the intent of causing that patient's death — other than the withholding or withdrawing of life-sustaining treatment? (Examples of this kind of behavior include administering a lethal injection of potassium chloride, or a deliberate overdose of opiates. Examples of this kind of behavior would not include withdrawing a patient from a mechanical ventilator.)

To address the subjects' actual practice, they were asked:

While a critical care nurse, have you ever administered a medicine to a patient or performed some other act with the intent of causing or hastening that patient's death — other than the withdrawal of life-sustaining treatment? (Examples of this kind of behavior include administering a lethal injection of potassium chloride, only pretending to mix dopamine into the intravenous solutions, or increasing the dose or frequency of a morphine intravenous drip in a patient already unconscious. Examples of this kind of behavior would not include withdrawing a patient from a mechanical ventilator.)

The questions themselves did not contain the terms "euthanasia" and "assisted suicide." The examples, however, were of euthanasia. No example of assisted suicide was offered. Nevertheless, it is possible that the responses involved cases of assisted suicide as well as euthanasia.

In addition to being asked about requests they had received to engage in euthanasia or assisted suicide and about their own behavior, the subjects were asked about occasions when they had wanted to engage in the practice but did not do so.

Most of the questions asked subjects to quantify their experiences during their careers and during the previous 12 months. They were asked whether their actions were undertaken at the request of patients, patients' families, other nurses, or physicians or with the advance knowledge of these persons. The subjects were invited to provide any explanatory comments they wished.

Mailing

The initial surveys were mailed during January and February 1995, and two additional mailings of the same instrument to the same group of potential respondents followed at one-month intervals. As part of a related study of survey techniques, potential subjects were randomly assigned to one of two groups. One group received a coded postcard with the survey instrument, to be returned separately from the questionnaire. The use of this postcard minimized the mailing of new copies of the instrument to nurses who had already responded, while keeping specific responses anonymous. The second group of nurses did not receive postcards, so each subject in this group received three complete, identical packets. The characteristics of the respondents and their responses did not differ between the two groups. All mailings included stamped, addressed envelopes for the return of the instrument and instructions not to return more than one completed questionnaire. Surveys received more than six weeks after the final mailing were not included.

The completed surveys were anonymous. No identifying information was encoded on the instruments or return envelopes. The protocol was approved by the human subjects committees of the University of Pennsylvania and the Philadelphia Veterans Affairs Medical Center. In addition, the study was reviewed both by an independent board selected by a major nursing professional society and by two experts in the areas of nursing and bioethics.

RESULTS

Surveys were mailed to a total of 1600 nurses; 40 surveys were returned by the post office as undeliverable, and 1139 completed surveys were returned by the cutoff date, a response rate of 71 percent. Subjects were

excluded if they were not critical care nurses or did not practice in critical care settings (165 subjects), if they were not clinically active (67 subjects), or if they sometimes practiced in pediatric intensive care units (46 subjects) or emergency departments (9 subjects). After these exclusions, a total study sample remained of 852 nurses who practiced exclusively in critical care units for adults. Because of occasional missing data, not all results reported here are based on the entire sample of 852 subjects.

Selected characteristics of the final 852 subjects are shown in Table 1. All 50 states, Puerto Rico, and the District of Columbia were represented. On a scale of 1 to 5 on which they rated the importance of religion in their lives, the mean response of the nurses was 4.0, indicating a high level of religious feeling.

Requests for Euthanasia or Assisted Suicide from Patients and Surrogates

A total of 141 nurses (17 percent) reported receiving requests to engage in euthanasia or assisted suicide: 108 (13 percent) received requests from patients, and 101 (12 percent) received requests from family members or surrogates. Most nurses reported receiving three or fewer requests. Nineteen nurses (2 percent) reported receiving these requests outside a hospital or medical setting — for example, at a patient's home. On average, each nurse complied with 8 percent of the requests from patients and 12 percent of the requests from surrogates (this difference was not significant [$P=0.50$]).

Participation in Euthanasia or Assisted Suicide

Although 135 nurses answered yes to the question about participating in euthanasia or assisted suicide, 6 nurses were excluded from further analysis — 4 because their responses suggested a misunderstanding of the question and 2 because their answers were inconsistent. This left a group of 129 nurses (16 percent) reporting that they had participated in active euthanasia or assisted suicide at least once in their careers. Sixty-four (8 percent) reported having done so in the year before the study. Of the nurses who had performed such an act, 65 percent reported doing so 3 or fewer times and 5 percent reported doing so more than 20 times.

Some of these actions were taken at the request or

Table 1. Characteristics of the Respondents.

CHARACTERISTIC	VALUE*
Female sex (%)	95
Age (yr)	38±9 (38, 32–40)
Nursing experience (yr)	13±9 (11, 6–19)
Critical care nursing experience (yr)	9±6 (7, 4–12)
Critical care nursing/week (hr)	35±10 (38, 32–40)
Practice site (%)†	
Medical intensive care unit	49
Cardiac care unit	53
Surgical intensive care unit	44

*Plus-minus values are means ±SD. Values in parentheses are medians and interquartile ranges.

†Results total more than 100 percent because some sites have more than one function and some nurses practice at more than one site.

with the advance knowledge of patients, family members or surrogates, other nurses, or physicians. Table 2 shows the number of nurses who performed euthanasia or assisted suicide under these circumstances, as well as the total number of instances reported by all the nurses. Sixty-two nurses reported a total of 124 instances of euthanasia or assisted suicide in the preceding year, for a mean of 2 instances per nurse per year.

Not all reported instances of euthanasia or assisted suicide were in response to requests or performed with the knowledge of patients, family members, or surrogates. The questionnaire asked nurses to report the number of instances of these acts performed at the request of patients and the number performed at the request of family members or surrogates. Subtracting these responses from the total number of instances reported provides an estimate of the number of acts carried out without such requests. Although this design precludes a precise assessment of the number of nurses who reported engaging in euthanasia or assisted suicide without a request from either the patient or a surrogate, it could be calculated that at least 58 nurses (7 percent) had done so at least once. Some of these instances may have occurred with the advance knowledge of patients or surrogates and so may be cases of tacit consent. For example, one nurse described her participation in the following way:

Usually, the patient has either verbalized or written several requests to have his/her suffering ended. It's like we never planned it, but, having developed a relationship with the patient, we both knew when it was time. In some instances, the patient was unconscious, on an opiate drip, which I increased or failed to decrease when vital signs dropped. The only physician I've ever had an agreement with is an oncologist I work with, but it's mostly unspoken.

By a similar calculation, 62 nurses (8 percent) reported at least one instance of engaging in euthanasia or assisted suicide without a request from the attending physician. Again, some, but not all, of these instances occurred with the advance knowledge of physicians and

so may have involved tacit consent. Some of these 62 nurses reported also engaging in euthanasia or assisted suicide at other times at the explicit request of the attending physician.

Five nurses reported engaging in euthanasia or assisted suicide outside a hospital or other medical setting. One nurse wrote:

My 71-year-old father was dying of . . . cancer. . . . He did not wish to prolong his life. Morphine in pill form "controlled" his pain. He was at home. As he lay struggling for breath, I got liquid morphine from his physician and gave him as much as he could swallow. He was frothing at the mouth. I told him if he could hear me to try to swallow and that this would stop the struggle for a life he no longer wanted.

Other Actions to Hasten Death

In response to a separate question, 59 nurses (7 percent) reported having only pretended to carry out a physician's order or having engaged in some other clandestine practice in order to hasten a patient's death. For example, some nurses reported pretending to put vasopressors into the intravenous solutions given to patients with hypotension and instead administering only saline. Among these 59 nurses were 35 who did not answer yes to the earlier, more general question about their participation in euthanasia or assisted suicide. Although these actions may not all meet a narrow definition of euthanasia, altogether 164 nurses (19 percent) reported engaging in some act to hasten a patient's death.

Handwritten Comments and Explanations

Of these 164 nurses, 74 described their activities in handwritten comments. These descriptions varied in the level of detail provided. For example, only 24 of the 129 nurses answering yes to the question about participation in euthanasia or assisted suicide provided descriptions of actions or intent sufficient to meet the definition used in the question. Others portrayed a range of other activities, perhaps with different moral implications.

For example, nine nurses reported administering large doses of sedatives or opiates to patients while withdrawing them from mechanical ventilation. Although these activities may have been performed in part to hasten death, the central purpose was to relieve suffering for patients or their families when death was already an explicitly accepted goal. Such practices are standard in many critical care settings.

The most common method of euthanasia reported in the handwritten comments was the administration of a lethal dose of an opiate. Often, patients were described as close to death, and often there were explicit decisions not to resuscitate them. Some nurses interpreted dosing guidelines liberally or moved beyond them. One nurse wrote: "I have given morphine doses much higher than prescribed, and falsified narcotic 'waste' to disguise it."

Decisions Not to Perform Euthanasia or Assisted Suicide

A total of 342 nurses reported that they had at times wanted to engage in euthanasia but did not. They were

Table 2. Instances of Euthanasia or Assisted Suicide Reported by 827 Nurses.*

CIRCUMSTANCES	NO. OF NURSES (%)	NO. OF INSTANCES REPORTED†	
		EVER	DURING THE PAST YEAR
All cases	129 (15.6)	553	124
Outside a hospital or other medical setting	5 (0.6)	4	0
At the request of the patient	40 (4.8)	133	19
At the request of a family member or surrogate	72 (8.7)	264	67
At the request of another nurse	10 (1.2)	60	8
At the request of the attending physician	83 (10.0)	371	70
At the request of a physician not the attending physician	25 (3.0)	146	30

*This figure differs from 852 because of missing data.

†Data are for 127 nurses. Two of the 129 nurses who reported performing euthanasia or assisted suicide were excluded because they reported more than 100 instances each. Instances may be included in more than one category.

offered a number of possible explanations for the decision not to perform these acts. The most common explanations were a fear of getting caught, a concern that the practice might be illegal, and a concern that the patient's preferences were not fully understood. Many of the respondents expressed concern about losing their nursing licenses. Of the 164 nurses who reported engaging in some act to hasten a patient's death, 120 also reported forgoing such acts at some time. These nurses reported that their most important reasons for forgoing euthanasia or assisted suicide were a fear of getting caught (cited by 91 percent of the nurses), a concern that the practice might be illegal (83 percent), and a concern that the patient's preferences were not fully understood (80 percent).

DISCUSSION

As public debate continues over the social, moral, and professional issues surrounding euthanasia and assisted suicide, 19 percent of the nurses in this study reported engaging in these practices. Some reported doing so on several occasions, and some reported doing so without the knowledge of physicians, patients, or surrogates and without their request.

If these practices had been sporadic, they might be attributed to a few lone practitioners, operating beyond the margins of their profession. Although the moral appropriateness of an action should not be measured by its pervasiveness, some will find it hard to accept the conclusion that so many nurses in this sample were acting inappropriately. We need to find another explanation.

One possible explanation is that although these activities may have been undertaken with the intent to hasten death, they may nevertheless reflect a continuum of moral acceptability and professional practice. At one end of the continuum, perhaps, are nurses who report hastening death in hidden or deceptive ways — for example, by deliberately giving lethal overdoses of medications. Others practiced at the limits of their authority — for example, by titrating intravenous drips within prescribed ranges but beyond required doses. Some nurses appealed, either fully or in part, to the doctrine of double effect, arguing either that their intent was only to relieve suffering or that their intent was both to relieve suffering and to hasten death. Finally, some nurses reported hastening death by administering especially high doses of opiates while withdrawing patients from mechanical ventilation. In these cases, death was imminent and was an accepted goal.

Because so many different kinds of activities are reflected in the responses of the nurses, and because these activities may have different moral implications, it is difficult to ascribe a single meaning to the results or to take a single moral stance toward them. Furthermore, a weakness of the study was the failure to distinguish between euthanasia and assisted suicide in the questionnaire. In either case, however, the intent to cause death was explicit. Those who see the worst in these findings should recognize that in some cases nurses reported only hastening death after life support

was withdrawn. But those who see only innocent motivations should recall that the majority of the nurses who reported engaging in these practices also reported not engaging in them on some occasions for fear of getting caught. In the end, the range of activities described in this study may reveal the inadequacy of the term "euthanasia" and of the many professional and legal policies built on it.

Why were so many nurses in this study willing to perform euthanasia or assisted suicide? The nurses' handwritten comments help provide an explanation. A full discussion of these comments is not possible here, but recurring themes reported by the nurses include concern about the overuse of life-sustaining technology, a profound sense of responsibility for the patient's welfare, a desire to relieve suffering, and a desire to overcome the perceived unresponsiveness of physicians toward that suffering. Whether or not such goals justify euthanasia, they may reflect deeply held professional values. These values, when expressed through different practices, may be the source of the high professional regard nurses enjoy.

A related view is that these practices may represent an indictment of the behavior of some physicians. Although physicians increasingly accept the decisions of patients and surrogates to forgo life-sustaining treatment, in many cases they do not.²² Furthermore, some physicians may not be sufficiently responsive to patients' pain and suffering; they may, for example, underuse analgesia, referrals to hospices, and other means of comforting dying patients. Many nurses raised these issues in their comments:

Doctors need more bedside training — especially with patients and their families in the critical care setting. They should step into our shoes for about one month to get a much better idea of how much patients and their families are allowed to suffer.

At my institution, physicians "beat" the people God has already called.

I've often felt that the sign over a critical care unit should read: "Within Are Often Examples of Man's Inhumanity to His Fellow Man."

These comments are consistent with some of the results from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment, in which nurses' reports of the preferences of terminally ill patients did not change either the behavior of physicians or the outcome of treatment.²³ Similarly, a comparison of the results reported here with those of a survey of physicians in Washington State¹⁵ suggests that critical care nurses in the United States may be as willing to be involved in the practice of euthanasia and assisted suicide as are some physicians. This attitude may be explained by the close relationships nurses develop with severely ill patients.²⁴ Several nurses described the dilemmas they feel:

I have experienced tremendous frustration and anger with physicians who either stress the possibility of a good prognosis, giving false hope — or place their belief system above that of their patients. The physician spends 5 to 10 minutes

each day with the patient and then leaves me to carry out his orders and deal with the patient and his/her family for 8 to 12 hours. I'm left with the dilemma of carrying out orders that I believe — and sometimes know — are not in the patient's best interest or what the patient or family has expressed as their desires.

Comments such as these suggest latent disagreement between nurses and physicians. It would be a tragedy if, as a result of such disagreement, patients or nurses concluded that euthanasia or assisted suicide represented the best choice because potentially preferable options were undiscovered or seemed out of reach.

At the same time, many of the nurses who reported engaging in euthanasia said they did so at the request of attending physicians or other doctors. Such a finding raises many important questions: Were these physicians' requests based on requests from patients or surrogates? In asking nurses to participate in these activities, did physicians create difficult situations for the nurses? Unfortunately, this study cannot address these questions.

The reactions of the respondents to the survey were mixed. Many volunteered praise for the study and its goals. Some were grateful for a study they hoped would give voice to their concern. Others, however, were disturbed by the implication that nurses might be engaging in euthanasia. Although most of the respondents were supportive, it is likely that many of the nurses who were concerned or upset about the study simply chose not to respond to the mailings.

For this reason, the results of this survey are probably subject to nonrespondent bias. Nevertheless, the likely direction of such bias is unclear. The nurses most disturbed by the study might be those least likely to engage in these practices and also least likely to respond. Alternatively, as compared with the nurses who responded to the survey, the nonresponders might have been more likely to have engaged in euthanasia or assisted suicide but worried about disclosing that fact. Regardless of the direction of any nonrespondent bias, the high response rate suggests that such a bias could not have altered the findings much. Similarly, although the sample was designed to represent a broad range of critical care nurses, not all such nurses subscribe to *Nursing*. It is difficult to determine how representative of critical care nurses in the United States the final sample was. Finally, the results of this study are based on self-reports. Some respondents may have underreported or overreported activities, and some may have misunderstood questions. These limitations call for caution in interpreting the point estimates provided by this study; nevertheless, the broader implications of the study are likely to remain.

The issues surrounding euthanasia and assisted suicide are complex. On the one hand, in some cases the practice can appear to be a legitimate response to genuine human suffering. Permitting health professionals to carry out these activities may seem appropriate when the decision clearly fosters the patient's autonomy. From this perspective, the distinctions made between euthanasia and the withholding or withdrawing of life-sustaining treatment appear artificial and hard

to sustain. In most cases, the aims and consequences of these actions are the same. On the other hand, should euthanasia be sanctioned, it might become too easy an option. Subtle pressures, real or perceived, might influence patients to choose this path when better options remain. Maintaining legal and professional prohibitions against euthanasia or assisted suicide may limit such tragedies better than any procedural safeguards.

An argument often made against physicians' performing euthanasia is that patients may come to fear physicians or distrust their motivations. I do not believe the results of this study suggest that patients or the public should fear or distrust critical care nurses. On the contrary, I think a central finding of this study is that these nurses struggle to uphold important personal values under extremely challenging circumstances — often with little support from physicians. National opinion surveys reveal that the majority of the public supports policies that would allow euthanasia under certain circumstances.²⁵ The results of this study should prompt nurses, physicians, and other health care professionals to examine their practices more openly and collaboratively, with the aim of understanding and reducing disagreement over goals and plans.

Although the increased discussion of euthanasia in the United States itself signals some movement of professional and popular thought, only a few state initiatives suggest any organized movement at the level of public policy. Two recent Federal Appeals Court decisions challenging Washington and New York statutes prohibiting assisted suicide may herald broader acceptance of these practices.^{26,27} Nevertheless, practice often leads policy. Some may take the results presented here as a reason to permit euthanasia in specific circumstances — not just because the demand seems sufficient to result in the practice in any case, but also because by making procedures explicit, one can provide the oversight essential for protecting both patients and health care professionals.

Regardless of the policy implications of these findings, it is clear that the nurses in the study practice, often with little support, in extraordinarily difficult situations. In these complex environments, professional, moral, religious, and personal values frequently collide.

I am indebted to Christine Weeks for research assistance; to Janet L. Abrahm, M.D., Arthur L. Caplan, Ph.D., John Hansen-Flaschen, M.D., Judy Shea, Ph.D., Peter A. Ubel, M.D., and Sankey V. Williams, M.D., for their critical review of the manuscript; and to the many nurses who participated in this study.

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