LETTERS TO THE EDITOR

Physician-Assisted Suicide Creates a Missed Opportunity

I am a hospice nurse with Legacy Visiting Nurse Association in Portland, OR, and a teacher and coordinator of a program for Japanese nurses for Portland State University. I have been doing hospice nursing for 12 years (after 18 years of hospital nursing) and teaching pain management in this area for about as long. I also happen to be a pastor's wife.

I found the Forum Focus article, "A Death With Dignity in Oregon," by Mavis Tuten, RN, OCN® (*Oncology Nursing Forum* [*ONF*], Vol. 28, pp. 58–65) to be thoughtful, articulate, and scholarly. Tuten's compassion was quite evident in her reflections on her relationship with her patient, PH.

Regarding the subhead "About Suicide and the Sanctity of Life," I would like to add one thought. My religious misgivings about physician-assisted suicide are not based on the sanctity of life as much as on missed opportunity. As a Christian, I know what the Bible says about how anyone can turn at any time and accept Christ as Savior and, as the Bible puts it, "pass from death into life." I have seen people do this moments before death. Every moment of life is an opportunity to put one's trust in Christ and have the joyful future that was provided through his sacrifice on the cross for us. My grief over the cutting short of this opportunity is what causes my distress concerning physician-assisted suicide.

Thank you for your thoughtfully written article. Your openness to look at all issues prompted me to write with this one point of clarification.

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The Author Responds

I appreciate that you took the time and effort to articulate your convictions on the issue of physician-assisted suicide (PAS). Your concern that PAS might cut short an opportunity is somewhat echoed in Kass' (1995) comment that "the choice of death is not one option among many, but an option to end all options" (p. 232).

The arguments for and against Oregon's Death With Dignity (DWD) Act are many, varied, often personal, and frequently passionate. Religious convictions have generally entered the debate in opposition to suicide, physician assisted or otherwise. Many, but not all, of these contentions are premised on the idea that life is holy, that it belongs only to God, and that it must be held in sacred trust. But, it is important that we hear the diversity of beliefs that consider the taking of a life to be a grievous error and a sin.

To be complete, a discussion of the theological positions on suicide would need to include a multitude of religious traditions and an historical analysis of the development, over centuries, of specific beliefs and practices. Almost every religious tradition that prohibits suicide has historically allowed, and even sanctified, suicide in particular settings. And in the debates on the DWD Act in Oregon, few, if any, religious traditions, Christianity included, have been so consistent or unified that they could easily be identified or accused, as a body, of being either an ally or enemy of DWD.

On a personal level, I consider it vital that we, as humans, be involved with issues that affect the most vulnerable among us, and I consider it relevant that we, as nurses, be especially immersed in disputes that affect the sick and the dying. Even though we might prefer to avoid difficult ethical dilemmas, it is essential that we verbalize our thoughts, listen to the voices of others, and engage in honest dialogue with one another. As human beings, we often have the choice, when faced with a moral quandary, to remain comfortably distant and silent or to be fully present and take a stand.

In our role as nurses, however, we often find that we have a different problem. When we are in the immediate presence of the sick and dying, we stand, in the fullest sense of the word, right alongside the patient. It is a unique position and a difficult role. No simple or universal directive can tell us when, at the bedside of a dying patient, it is better to listen or to speak, to understand or to take a stand, to hold a hand or to reject it, to accept another's beliefs or to change it, to comfort another, or to challenge the other.

But away from the bedside of the dying, we can and should be discussing such issues. The legalization of physician-assisted dying means that nurses, especially Oregon hospice nurses such as yourself, may be positioned intimately and essentially at the side of a dying patient who is choosing to control the time, place, and means of his or her own death. Nurses must formulate an understand-

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ing of healing and caring in such situations. I respect and value that you have added your perception and your voice to the dialogue.

I thank you for writing, and I thank you for your kind words and thoughtful insight.

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Kass, L.R. (1995). Death with dignity and the sanctity of life. In J.D. Moreno (Ed.), *Arguing euthanasia. The controversy over mercy killing, assisted suicide, and the "right to die"* (pp. 221–236). New York: Touchstone.

Reader Questions Pain and Peritumoral Injection

I would like to commend Eric Zack, RN, MSN, OCN®, on his continuing-education article, "Sentinel Lymph Node Biopsy in Breast Cancer: Scientific Rationale and Patient Care," which was published in the July 2001 *ONF* (Vol. 28, pp. 997–1005). At my institution, physicians administer periareolar intradermal radionuclide (sulfa colloid) in the quadrant of the lesion, in sentinel lymph node (SLN) mapping, approximately one to two hours preop. For some women, it is quite painful for a brief duration. I noticed that Zack's article mentions no pain with peritumoral injection in four quads. Is the patient sedated? Is local anesthetic used first? Several techniques have been reported in the literature, and as a patient advocate, I am interested in knowing if a less painful yet equally reliable method can be used. EMLA® cream (AstraZeneca Pharmaceuticals LP, Wilmington, DE) helps sometimes; however, application one to two hours before injection is a logistical problem at times (e.g., right time, right location on the breast, required prescription for home application before outpatient procedure). Any additional information, sources, or insight would be appreciated.

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The Author Responds

This question is an excellent one but very difficult to respond to. Currently, I am unaware of any formal analgesic protocol for reducing the pain that women must undergo for this procedure except for the topical EMLA cream, which has its drawbacks as you mentioned. Additionally, EMLA cream works mostly on cutaneous nerve endings, whereas these needles purposely penetrate much deeper structures. I believe that many breast surgeons do premedicate women with diazepam (based on their weight) to help them relax prior to injecting the sulfa colloid solution. Local anesthesia with lidocaine is contraindicated because of the potential effects of altering the lymph node uptake of the sulfa colloid, which, in turn, would adversely affect the lymphatic mapping process. Another precipitating factor includes the location of the tumor. Periareolar injection near the tumor obviously will create more pain than a more lateral approach with the needle because of the presence of significantly more nerve endings.

One final note, with the Joint Commission on the Accreditation of Healthcare Organizations' renewed focus on pain control, it will be interesting to see what efforts develop in response to this very question. Realistically, I believe that sentinel lymph node biopsy first needs to become the standard of care in staging early breast cancers before this problem becomes addressed, but I agree that this unresolved issue must be addressed. I applaud your efforts in being a patient advocate and suggest that you continue to investigate some beneficial solution within your institution.

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