

Aid in Dying: Implications for Nurses

The practice is now legal in nine states and the District of Columbia.

It goes by many names—“assisted suicide,” “aid in dying,” “death with dignity.” Whatever the terminology, it’s one of the most controversial and contentious topics in health care. Despite the heated debates and discussions, the practice is slowly but surely gaining a legal hold in the United States, and this has significant implications for nurses who work in end-of-life care.

Oregon was the first state to legalize aid in dying, in 1997. Since then, Washington, DC, and seven other states—California, Colorado, Hawaii, Maine, New Jersey, Vermont, and Washington—have enacted statutes based on Oregon’s Death with Dignity Act. Although Montana doesn’t have a dedicated law, in 2009 its supreme court ruled that nothing in state law prohibited a physician from honoring the wishes of a terminally ill, mentally competent adult who wished to hasten their death. Approximately one-fifth of Americans now reside in a jurisdiction in which aid in dying is legal.

All state laws require that patients have a prognosis of six or fewer months to live. This must be confirmed by two physicians, and the lethal dose must be self-administered by the patient.

ETHICAL OBLIGATIONS AND DECISIONS

Last year the American Nurses Association (ANA) issued a revised position statement to provide guidance on ethical decision-making in response to a patient’s request for an assisted death. The ANA does not support or oppose current laws but seeks to address the ethical questions and challenges nurses are increasingly confronted with as access continues to expand in the United States.

“Nurses will first need to understand the laws and then explore their thoughts about participating if a patient makes the request,” says Lisa Vigil Schattinger, MSN, RN, founder and executive director of Ohio End of Life Options, an organization that supports the legalization of aid in dying in that state. “Providing education to nurses, so they understand what the laws are and what they are not is paramount in enabling nurses to make an informed decision on whether they would opt to participate under the guidelines outlined in the last ANA statement.”



Sally Scales, a Canadian citizen, ended her life under Canada’s medical assistance in dying law, which went into effect in 2016. Here she holds a photo of herself as a nurse in earlier years. Photo courtesy of Martha Wickett / Black Press Media.

Schattinger says nurses must learn how a state’s law works when patients try to access it. “There are important details in fulfilling the steps required to qualify, and each state’s law is slightly different.” At times, she says, nurses may avoid having conversations with patients about accessing this type of care. Yet, “nurses may sometimes need to explore the concept that death is a part of life and that health care at the end of life involves providing care in accordance with each patient’s personal values, beliefs, and preferences.”

Nurses have the right to conscientiously object to being involved in the process. The ANA notes that those who work in regions in which aid in dying is legal are obligated to let their employers know of their objections, so appropriate assignments can be made. But even if nurses don’t agree with an aid in dying law, the ANA’s position statement stipulates that they “remain objective when discussing end-of-life options with patients who are exploring medical aid in dying.” The ANA’s guidance also says nurses “have an ethical duty to be knowledgeable about this evolving issue” and to “be aware of their personal values regarding medical aid in dying and how these values might affect the patient–nurse relationship.”

In Ohio, says Schattinger, “we have been advocating for an overall understanding that death is a part of life and that people need to explore and understand their end-of-life wishes long before they are in a health crisis scenario. Then they need to document those wishes and have conversations about them with their family, loved ones, faith leaders, and health care team.”

THE NURSE'S ROLE

In 2016, Canada legalized medical assistance in dying across the country. Unlike in the United States, Canadian patients have the option of a health care practitioner administering the lethal substance. Canadian law allows both physicians and NPs to administer the medication, and NPs can also prescribe for patients who opt for self-ingestion.

Hospice RNs often have the most contact with terminally ill patients.

In the United States, only physicians can prescribe the necessary medications and act as a consultant (the second opinion). However, nurses are positioned to play a significant role in this process if they choose to. “Almost all hospice nurses, in states where this is legal, will care for a patient who makes a request for aid in dying at some point,” says Thalia DeWolf, RN, CHPN, the clinical care coordinator at Bay Area End of Life Options, a California-based practice devoted to patients who are considering their options, including aid in dying. “This is very patient-driven, and nurses are often the first ones in that line of communication.”

DeWolf has been working at Bay Area End of Life Options for the past three years. During this time, her role caring for patients who've requested aid in dying has become increasingly complex she says, noting she has screened more than 2,000 e-mail and phone inquiries and cared for more than 350 patients through the end of their lives, which can sometimes involve years of care and guidance.

“I have been at the bedside—without a doctor—of over 175 patients and their families as they took aid in dying,” she told *AJN*. “I've developed best practices to improve the nursing care of these

patients, as well as our own version/process of very dignified non-oral (rectal) self-administration of aid in dying medications.”

DeWolf emphasizes that hospice RNs often have the most contact with terminally ill patients and their families, making them ideally suited to care for patients who've chosen to self-administer medication under a state's aid in dying law. “Shouldn't this part of care for patients who are eligible . . . be in [the] hands of hospice nurses while the ‘doctoring part’—reviewing eligibility and writing the prescription—be in the physician's hands?”

HELPING PATIENTS MAKE INFORMED DECISIONS

Keith Seckel, ADN, RN, CHPN, director of nursing at Timberhill Place, an assisted living facility in Corvallis, Oregon, considers himself to be an advocate and educator, translating “medicalese,” so residents can make informed decisions.

“I see myself, first and foremost, as an advocate for my residents, and an educator for them and their families, as well as staff here,” he says. “We've had residents die on hospice, as well as residents who were not on hospice when they died. We have yet to have a resident here take medical aid in dying meds, but if they wished to, we would support their choice.”

Prior to his job at Timberhill Place, Seckel worked for more than 11 years in home hospice and palliative care. “Many hospices are relaxing some of their stricter policies, and I support that, while at the same time understanding some of the safety nets that are built in,” he explains. Some, for example, have rules against staff members participating in aid in dying and don't permit a nurse to be in the room when a patient ingests a lethal dose of medication. “These stricter policies were designed to protect staff,” Seckel notes. “As an example, what if a staff member was present and observing and saw a family member ‘help’ someone finish the meds. What would that staff member's obligation be, as a mandatory reporter?”

He fully supports being a conscientious objector. “It is important for employers to both provide services within the law but also protect their staff who wish to opt out,” he says. “It's a delicate dance at times—speaking one's truth while withholding judgment of another's reality or choices. On the best of days, emotions can rise, and communications can be challenging, especially in such literal ‘life or death’ matters.”

Seckel tries to “land on the side of empathy and agreeing together that at the end of the day, we all want the same thing—whatever is best for the person facing the end of their own life.”—*Roxanne Nelson* ▼