Assisted Suicide/Aid in Dying: What Is the Nurse’s Role?

A policy dialogue presented at the American Academy of Nursing’s annual conference in Washington, DC.

ABSTRACT
This article presents the discussion that occurred during a policy dialogue on aid in dying (AID) presented at the American Academy of Nursing’s annual conference in October 2016. Panelists explored the arguments for and against the growing state expansion of AID legislation, and the role for nurses in assisting patients who request AID. Recommendations are offered and four expert commentaries respond to the points raised.

Keywords: aid in dying, assisted suicide, end-of-life care, nurse role in end-of-life care

This policy dialogue took place at the annual conference of the American Academy of Nursing in 2016 to explore the nurse’s role in assisted suicide and aid in dying (AID), one of the most controversial and contentious topics in health care today.

As Andrea Frolic noted in a presentation at the American Society for Bioethics and Humanities annual meeting on October 9, 2016, “This is an issue of the heart, the mind, and the social fabric.”

Also called “death with dignity,” “physician-assisted dying,” and “medical aid in dying” (MAID), AID is the focus of intense activity at the state level. At the time this panel was convened, five states—Oregon (1994), Washington (2008), Montana (2009), Vermont (2015), and California (2016), had approved AID; they were joined by Colorado and the jurisdiction of Washington, DC, later in 2016. Given the populations of these states, nearly one in five Americans now lives in a jurisdiction where AID is legal. In addition, according to the Death with Dignity National Center, 25 states are currently debating related legislation, making this an issue of national significance.

Ethicists are very interested in language and the way language frames, shapes, and influences an issue. Earlier discussions on providing assistance to hasten death focused on the terms “assisted suicide” and “physician-assisted suicide,” and one still sees this language, usually in articles opposing the practice. Canada has used the term MAID; most states have used the expression “death with dignity” or emphasized patient choice and control at the end of life.

We were privileged to have four panelists participate in this dialogue, each with a unique perspective on the issue:

Judith (Judy) Schwarz, PhD, RN, is the clinical director of End of Life Choices New York (www.endoflifechoicesny.org), a not-for-profit organization that provides information, advocacy, and support to incurably and terminally ill patients and their families who seek control of the circumstances and timing of death. She is a nationally recognized expert on the end-of-life option of voluntary stopping eating and drinking (VSED) as a means for suffering patients with decisional capacity to hasten death.
Lewis (Lew) Cohen, MD, is a consultation psychiatrist at Baystate Medical Center and professor of psychiatry at the University of Massachusetts Medical School–Baystate. Dr. Cohen conducts research into palliative medicine and chronic kidney disease and authored No Good Deed: A Story of Medicine, Murder Accusations, and the Debate over How We Die, about two nurses who were accused of euthanasia.

Margaret (Mimi) Mahon, PhD, CRNP, FAAN, FPCN was the senior NP in palliative medicine at the University of Maryland Medical Center in Baltimore at the time of the policy dialogue. She served on the Ethics Advisory Board of the American Nurses Association (ANA) from 2014 to 2017. She is currently with the palliative care team at the National Institutes of Health Clinical Center. Dr. Mahon notes that her remarks do not represent the opinion of the U.S. Government.

Senator Claire Ayer from Vermont was educated as an RN and holds a degree in environmental studies from Middlebury College. She has served in the Vermont Senate for over 14 years, and she currently chairs the Vermont Senate Committee on Health and Welfare. She was one of the lead authors of Vermont’s Death with Dignity legislation, shepherding it successfully into law.—Ann B. Hamric, PhD, RN, FAAN

JUDY SCHWARZ
I know a good deal about requests for assistance in dying because of the clinical work I have done for over a decade—which is to answer questions about end-of-life options posed by terminally and incurably ill patients and their families. End of Life Choices New York, previously known as Compassion and Choices of New York, is a not-for-profit, end-of-life advocacy and support organization whose mission is to improve care and expand choice at the end of life. All of the terminally ill patients I work with are enrolled in home hospice or are receiving palliative care. As many of you know, physical pain can usually be readily managed by these skilled clinicians. The calls I get are from decisionally capable patients who conclude that their suffering has become unbearable, and they seek information about end-of-life options that would enable them to hasten their death.

More than 10 years ago, I began to explore the difficulty many clinicians experience in distinguishing between morally and legally accepted clinical interventions that hasten dying, such as forgoing a life-sustaining treatment like mechanical ventilation, and other acts that also hasten dying but are labeled as suicide or assisted suicide. In those earlier days, many hospice nurses feared that having an open discussion of a patient’s desire for a hastened death might somehow encourage the patient to conclude that hastening death was morally acceptable—or that the nurse might inadvertently cross a legal or professional line by exploring this desire. Fortunately, much of that misplaced fear and anxiety has dissipated. But clinical uncertainty persists, despite growing numbers of position statements and guidelines that seek to assist nurses in clarifying their responsibilities to suffering patients who seek information about dying.

We now have accumulated data from 20 years of experience in Oregon, where citizens who are both terminally ill and decisionally capable can legally request a prescription for a lethal amount of medication. Because Oregon requires physicians who write these prescriptions to document their patients’ reasons for the request, their diagnoses, and other clinical details, we know that almost all who use the law are enrolled in hospice care and die at home with family or other loved ones in attendance. We also know that their reasons are not because of poorly managed physical pain but rather because of existential suffering, including exhaustion from having to endure the final stages of a terminal disease, lack of control, and fears about overburdening loved ones—reasons that cannot readily be mediated away.

There is also no doubt that those who take advantage of such laws are a self-selected minority of all terminally ill or dying citizens in those states. These individuals want to die as they have lived—“in charge” and making important decisions about the timing and circumstance of this important and final stage of their lives. In states with AID, the process to acquire a prescription for lethal medication takes time and perseverance.

New York State, where I work, does not permit AID, and of course, euthanasia is illegal and professionally unacceptable across the country. The options I discuss with those who seek information and support regarding control of the timing of death involve stopping all life-prolonging measures, including food and fluid. VSED is rarely anyone’s first choice to hasten death but often is the only legal option available to relieve suffering that has become intolerable. It requires a decisionally capable and very determined
patient who makes an informed and voluntary decision to fast “unto death.”7 Realizing this decision also requires family or other social support, caregiving help, and importantly, access to hospice or palliative oversight.5 7

The question. So the question remains, how should nurses respond to a request for information about patient-controlled dying when that request is made by a decisionally capable and suffering patient? I believe nurses should be well informed and able to respond to their patients’ questions about legal options that might permit patient-controlled dying in their state.

In states that have legalized AID, the information provided should include explaining the state law’s requirements to patients and their family members, the law’s pros and cons, and the assurance that the caregiving team will continue to provide excellent palliative and symptom management—whatever the patient’s choice.

Such discussions should be provided only after a thorough assessment of the reasons for the patient’s request and skilled efforts to remedy any symptoms of suffering that can be palliated. Most patients just want to know that choices exist and that they still have options, though they don’t often act on those choices. Up to 30% of patients who receive medication to hasten their death do not use it and in fact die as a result of their underlying disease.8

It should also be noted that no health care professional can be expected to provide information or support that conflicts with their personal conscience or strongly held values. If a professional feels morally unable to provide such information in response to patient requests, the patient should be transferred to a colleague who can.

Nurses need access to guidelines that are both clinically useful and comprehensive to help them navigate these emotionally, ethically, and professionally treacherous waters. These guidelines are needed both in the growing number of states that have legalized AID and in those that have not yet done so.

In the most recent national Gallup poll,9 70% of respondents believed that physicians ought to be allowed to provide AID to suffering and incurably ill Americans. [Editor’s note: since this discussion took place, Gallup has released results of another poll that puts that figure at 73%.10] Yet many other citizens and clinicians are opposed to such interventions for a variety of reasons, often involving strongly held religious values. One needs to be a careful consumer of seemingly factual stories of patients who describe their experiences in states that have passed AID legislation. For example, one woman stated that her insurance company refused to pay for chemotherapy but offered to pay for lethal medications. On closer examination, the facts did not support the conclusion.11

As the most trusted members of the health care team, nurses will increasingly be asked for information and support regarding patient-controlled dying. Nurses in all specialties need to be better prepared and professionally supported than they are currently.

LEW COHEN
Many proponents of assisted suicide are uncomfortable with the pejorative connotations of the word “suicide” and have been seeking a more palatable nomenclature. In 2006, the Oregon Department of Human Services went so far as to adopt a policy banning the expression “physician-assisted suicide” in favor of “aid in dying,” “death with dignity.”12

Personally, I believe we should become comfortable with all these terms, including “suicide”—a potent word describing a behavior that some people consider to be a sin, others a crime, and still others the ultimate expression of psychopathology. Conversely, there are many individuals who regard suicide as nothing less than a “fateful freedom” and ardently believe it should no longer be constrained by religion, law, or organized medicine.

Whatever term is chosen, since 1997 the U.S. Supreme Court has encouraged individual states to wrestle with the issue. In a ruling that combined cases from Washington State and New York, Chief Justice William Rehnquist wrote that the court’s decision “permits this debate to continue, as it should in a democratic society.”13

I believe that AID laws are going to be approved throughout the country for three reasons. First, there will be more celebrities, like Desmond Tutu and Britanny Maynard, who maintain that this should be an end-of-life option—taking its place alongside other death-hastening medical practices, such as withholding and withdrawing life support treatments, VSED, and the vigorous use of analgesics. Second, as baby boomers age and actively deal with their own or their parents’ deterioration, they are going to insist on having assisted dying as a choice. And third, America is
built on the fundamental values of autonomy and self-determination.

In the week leading up to his 85th birthday, Desmond Tutu, Archbishop Emeritus of Cape Town and a Nobel Peace Prize laureate, spoke about his dismay over the way his friend Nelson Mandela was artificially propped up for photo opportunities with visiting dignitaries while hospitalized. Witnessing Mandela's last days crystallized the archbishop's thinking, and he wanted to influence a debate over AID that was taking place in the United Kingdom's House of Lords. Tutu stated, “Now . . . with my life closer to its end than its beginning, I wish to help give people dignity in dying. Just as I have argued firmly for compassion and fairness in life, I believe that terminally ill people should be treated with the same compassion and fairness when it comes to their deaths. Dying people should have the right to choose how and when they leave Mother Earth. I believe that, alongside the wonderful palliative care that exists, their choices should include a dignified assisted death.”

Support grows. The growing support in U.S. public opinion polls for death with dignity reform is also apparent among medical professionals. In 2014, for the first time, a majority of U.S. physicians—54%—backed the rights of patients with an “incurable illness” to seek “a dignified death.” The survey included more than 17,000 respondents. NBC News quoted Arthur Caplan, head of the division of bioethics at NYU Langone Medical Center, as having observed, “[This] represents a remarkable shift. If physician opposition [to AID] continues to weaken, it is likely that despite fierce resistance from some religious groups and some in the disability community, more states will follow Oregon, Washington and Vermont, and legalize.”

Another factor that will inevitably lead to further legalization and extension of AID practices is our society’s demographics. The aging boomer generation is actively encountering the nightmare of dementing illnesses, and it is facing a worsening social situation created by harsh economic realities and the absence of family members who are willing or able to provide personal care. Susan Jacoby aptly observed, “My generation’s vision of an ageless old age bears about as much resemblance to real old age as our earlier idealization of painless childbirth without drugs did to real labor.”

Faced with ineradicable decay and the possibility of unrelenting suffering, it is reasonable to predict that our society is likely to reconceptualize suicide—shifting away from the oversimplified position that a wish to hasten dying equates with suicide, which in turn equates with mental illness—and to rewrite our laws and policies about end-of-life care options.

Americans increasingly want to be in control of their lives and their deaths to the fullest extent possible. The nation’s mores are evolving. Medicine has come to appreciate that death no longer means failure and it is a worthwhile goal to take steps to improve the quality of patients’ dying.” Arriving at decisions shaped mainly by respect for patient preferences is a welcome development. It is satisfying for me as a psychiatrist and palliative medicine researcher to know that there is a younger generation of Americans—laymen, nurses, and physicians—who instinctively feel these changes to be correct and who want professional organizations to reexamine previous guidelines of ethics and conduct.

MIMI MAHON

Requests for hastened death are uncommon in the careers of most nurses but challenging when they occur. Thoughtful, experienced people from a cross section of disciplines and professional organizations have developed position statements, and over the past few years many scholars have published data to guide discussion and decision making.

The ANA position statement on assisted death prohibits nurses’ participation in assisted suicide and euthanasia, in part because to do so is a contradiction of the ANA’s Code of Ethics for Nurses with Interpretive Statements. “The Right to Self-Determination” [Section 1.4 of Provision 1] states that nurses “may not act with the sole intent to end life.” The American Medical Association opposes physician involvement in hastening death. The American Academy of Hospice and Palliative Medicine has taken a position of studied neutrality but has expressed serious concerns about the practice. Hospice and Palliative Nurses Association position statements, also endorsed by the Oncology Nursing Society, advise that nurses not participate in assisted suicide.

As noted, the suffering that prompts requests for hastened death is more than physical. The most common reasons for requesting hastened death include concerns for loss of autonomy, loss of dignity, inability to enjoy life, fear of losing intellectual capacity, belief that one is unworthy or has a useless life, guilt about being or becoming a burden to family, or anticipating dependence. A common theme underlying many of these concerns is loss of control.

Data from Oregon confirms that fear of “loss of autonomy” and “decreasing ability to participate in activities that made life enjoyable,” rather than pain or other physical suffering, are the leading reasons

Margaret Mahon, PhD, CRNP, FAAN, FPCN
for a terminally ill patient to request a lethal prescription. One interpretation of this fear of loss of control is that many Americans are petrified of being abandoned by the health care system. People want the ability to take action when they feel that they have been or might be abandoned.

There are a number of problems with allowing these fears to determine public policy. For one thing, though many believe that death should be within our control, death is one thing that is very much beyond our control. In addition, some fears of suffering may be illusory. They may be based on outdated information or a subjective impression of the earlier suffering of a loved one—for example, “Grandpa died of lung cancer; he was in agony for months, and I’m not going that way.” Families may exaggerate fears of suffering: several researchers have found that family members often judge suffering as being greater than does the dying patient. Although we cannot alleviate everyone’s suffering, knowledge of palliative care allows us to alleviate most physical suffering, and often other burdens as well. Palliative care professionals focus not only on physical but also on psychological, spiritual, and interpersonal symptoms. We have an obligation to try and alleviate suffering as much as possible for all of our patients, but this is not “hastening death.” In fact, providing excellent palliative care is antithetical to hastening death.

We have to know who we’re treating. Do we want to hasten someone’s death because of the patient’s suffering—or because of our suffering? Patients worry about the burden an illness would place on family. Family members worry about a protracted process of dying, either because it takes too long, or

A Legislative Perspective: Senator Claire Ayer

I am an RN and have served in the Vermont Senate for over 14 years. I had a key role in the passage of Vermont’s aid-in-dying (AID) legislation, the “Patient Choice and Control at the End of Life Act.” It took 10 years to even mention AID in the Vermont Senate; this issue and the surrounding discussion has a strong emotional component, regardless of the facts. It took 12 years to pass the legislation, even with a bill patterned on Oregon’s, and many years of published experience from Oregon showing that the law was practiced as it was intended. Even contentious legislation such as recognizing marriage of gay partners did not take as long to enact. As discussed by other panelists, legislators must appreciate the power of words and how they frame discussion: opponents of the act used “suicide”; proponents used “aid in dying.” We deliberately framed our legislation as an issue of patient choice and control over one’s dying.

The primary countervailing state interests opposing the legislation are the interest in preventing suicide; the interest in preserving life; and the interest in protecting innocent third parties, like family members of those who might choose AID.

Although it is easy to see the logic of framing the issue in terms of suicide, suicide is fundamentally different from AID. Suicide is the rejection of life, a permanent solution to a temporary problem. Those who choose AID embrace life.

AID takes 45 to 60 days to follow the process, including making accurate diagnoses of a terminal condition and ensuring that there are no other medical options to change the outcome of death. Family survivors of patients who choose AID do not experience the adverse mental health effects suffered by family members of suicide victims. If we stop suicide, people may go on to productive lives. If we stop those who choose AID, we have just prolonged their deaths and added to their suffering. We need to promote rational choice that supports meaningful death.

When evaluating proposed laws in other states, I recommend looking at how the law is patterned (has the legislation been modeled on states with successful experiences?) and for the presence of safeguards (for example, how long is the waiting period? Is the diagnosis correct? Does the patient have capacity, no clinical depression, and full information about hospice and palliative care? Is there data tracking to ensure that vulnerable or minority patients are not being discriminated against in being denied treatment in states with AID? Are patients assured that they will receive excellent medical care when they are dying?).
because they fear the potential suffering of their loved one. Ferrand and colleagues found that 61% of requests for hastened death came from patients, 33% came from family or close friends, and about 6% came from nurses. 

Assisted suicide legislation is often referred to as “death with dignity laws.” The implication is that assisted suicide is the way to a dignified death. Our goal in health care should be that every person’s death is dignified. Palliative care and hospice providers work for each person’s dignified death, with a commitment never to hasten death. With the growth in these state legislative initiatives comes the responsibility to increase our knowledge about what is good palliative and hospice care.

**Words of caution.** A request for hastened death should never be taken at face value nor defended as preserving the autonomy of the patient. Rather, any request should be examined carefully. Ganzini and colleagues studied the frequency of depression and anxiety in people pursuing assisted dying in Oregon and found that “[a]mong patients who requested a physician’s aid in dying, one in four had clinical depression.” 

In a French study, one-third of all patients requesting AID were considered clinically depressed at the time of the request. 

We have to ensure that the decision made by a patient is truly autonomous and not governed by clinical illness that can be treated. There is an additional caution in supporting AID. In my career, I have been struck by the fact that all requests for hastened death made of me have come from affluent white people. Emanuel and colleagues found that people who request assisted suicide are typically old, white, and well educated. In the Oregon data, 97% of the patients who requested assistance in dying were white. African Americans accounted for 0.1% of requests; Hispanics 1.1%, and American Indians 0.2%. Those three minority groups accounted for only 1.4% of requests.

In health care, there are good reasons to limit ineffective treatments; however, members of certain cultural groups fear that health care professionals are depriving them of needed care and will take measures to end their lives when their care has become too complicated, too expensive, or if the treating team has lost interest. As Georgetown professor Patricia King stated in a discussion about assisted suicide legislation in Washington, DC, “Many in the black community distrust the health care system and fear that racism in life will translate into discrimination in death.”

Rev. Eugene Rivers, a minister from Boston, called DC’s legislation “back-end eugenics” designed to eliminate poor blacks. Officially sanctioning a provider’s role as a hastener of death will only worsen such fears.

An individual’s request for hastened death should never be taken as the end, but rather as the beginning of dialogue and interventions. We need to see such requests as opportunities to implement interventions that improve the lives of those who are suffering.

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**What Nurses Can Do**

- Become educated on aid in dying (AID) so that you can provide factual information to patients and their families. This includes becoming educated on hospice care and the process of AID if it is approved in your state, so that you can answer patients’ questions and help them clarify their choices.
- Work to clarify the distinctions between your personal values and professional obligations. Conscience-based objections, whether pro or con, and conscience-based refusals should be respected by your team colleagues and employer. If you feel morally unable to provide a patient with information, you should transfer the patient to a colleague who can provide such information.
- Keep channels of communication with patients and their families open. Patients and families who are struggling with this issue need to know that their concerns and questions can be openly discussed without negative judgment from their health care providers.
- Learn how to have “difficult conversations” with patients and their families. This is a skill that can be learned, and training is available.
- Identify resources that can help patients struggling with AID (a number are listed in this article), on both sides of the issue.
- Ensure that your patients know that stopping aggressive treatment does not mean stopping care. Avoid terminology that could lead patients or families to think that medical care would be stopped or patients abandoned based on certain choices they might make.
- Be informed about legislative initiatives in your state and make your voice, experiences, and perspective heard.
- Request and support the development of guidelines, particularly in hospice settings, for caring for patients at the end of life. Such guidelines are needed in all states, regardless of the status of AID legislation.
request for hastened death is never casual, and the suffering is real. We must continue to strive to improve end-of-life care.

**COMMENTS**

Following the conference, and after developing this article, we invited experts from various groups to respond to the points we raised. Some of these experts attended the policy dialogue, but some did not. We received 11 commentaries, and selected the four below.

**Response submitted on behalf of the American Nurses Association Center for Ethics and Human Rights Advisory Board.** We are grateful to the American Academy of Nursing Expert Panel on Bioethics for tackling a sensitive and controversial topic. While there are various perspectives with subtle nuances, it is clear that discussion of AID cannot be reduced to an artificial dichotomy. The range of opinions among the public and among nurses was well represented in this panel discussion.

We need to promote rational choice that supports meaningful death.

We firmly agree with Dr. Schwarz that nurses must be knowledgeable and prepared to respond to patients requesting AID. Nurses need ethical and legal guidance and support for decision making, especially in states where AID is legal. The prevalence of AID legislation is increasing. Nurses must continue to provide compassionate care to all patients and address patient problems while respecting the patient’s decisions without judgment. This includes informing patients of the legal options at the end of life without bias, judgment, or coercion. Nurses must share information that is truthful and scientifically based, rather than the biased or inflammatory stories sometimes portrayed in the media.

Dr. Mahon successfully articulates the role of palliative care at the end of life. Palliative nursing care affirms life and is an evidence-based practice that focuses on individualized delivery of care. Dr. Cohen’s comment regarding the “vigorous use of analgesics” may suggest an inappropriate use of medications. The importance of recognizing the comprehensive therapeutic skills of palliative care professionals should also be noted in the context of this discussion. The intent to provide therapeutic medication should not be confused with administration intended to end a patient’s life.

The ANA Ethics Advisory Board agrees with the stated recommendations and offers the following additional recommendations: First, conscientious objection is morally and ethically acceptable, but it must be timely and appropriate to avoid patient abandonment. This sentiment is captured by our Canadian colleagues who recently drafted a framework on AID to guide nurses to “take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised.” Second, every patient deserves effective and equitable treatment and care, regardless of race or socioeconomic or other demographic factors. Nurses must be aware of cultural considerations at the end of life in order to provide individualized care. Third, nurses must respect patient autonomy and act to minimize patient suffering by striving for optimal end-of-life care. Finally, nurses must understand employer policies and procedures on AID.

We concur with Dr. Cohen’s statement highlighting the responsibility of professional organizations to examine guidelines of ethical conduct. The ANA is actively engaging in broad discussions to further analyze and explore careful language and definitions at the crux of this debate, such as the meaning of “participation” and “hastening death.” In 2018, the ANA will be updating its current position statement *Euthanasia, Assisted Suicide, and Aid in Dying.* This is an opportunity to strengthen the support for nurses and further clarify ethical expectations of nurses caring for individuals who consider or participate in AID.

**Assistance in Dying: An Important and Narrow Question for Nurses: Helen Stanton Chapple, PhD, MA, MSN, RN, CT, Creighton University.** The panel’s charge is both important and narrow: to offer guidance to nurses in responding to their patients’ queries about hastening death. Such guidance is important to both the patient’s and the nurse’s well-being. In the hospital, clinicians are reluctant to recognize a dying situation and respond to it. It seems irrelevant when their patients can still speak and make eye contact. (By contrast, hospice home care nurses are quite used to responding.) Therefore, the context of the conversation matters. It raises existential questions for the nurse in terms of one’s own mortality and that of the patient. How real and close is death to either of them? What is the meaning of the mutual and individual suffering embedded in this particular dying situation? But the question is also narrow in that it concerns an extremely small subset of all the dying patients even a hospice nurse might encounter. The vast majority of dying patients are not acknowledged to be so until they are far too sick to express an opinion about how their dying process should go. In fact, only by becoming dead can some patients prove that they were, in fact, previously dying.

The rescue endeavor is so ingrained in our culture and our health care system that, more often, nurses are dealing with an ambiguous picture—some things
are getting better and some things are getting worse. Nurses often identify the dying situation first and suffer the moral distress that comes with continuing to treat patients aggressively who, we are sure, will not survive this hospitalization. Bedside clinicians find themselves caught in the crosshairs when rescue medicine—the desperate expression of an affluent society able to recruit technology to deliver physical salvation—and dying—the cruel reality of the human condition—face off. Nurses become proxies for the rest of U.S. society, which cannot reimagine a health care system based on something more balanced for its members than the unending pursuit of more time alive.

In health care’s rescue-dominated atmosphere, identifying dying situations is itself a challenge. As death becomes tangible, we must stand up to it rather than run in the other direction. For nurses that means continuously pointing the team toward the primacy of patient goals in planning care.

In Awareness of Dying, published in 1965, Glaser and Strauss urged us to work toward open awareness of dying because it holds the best possibility for attending to the needs of the dying patient. Patients who face death and are able to verbalize their wishes for AID enjoy this open awareness, as do their caregivers. It is a gift. But they make up a tiny percentage of the 2.5 million persons who die yearly in the United States, many of whom continue to die badly. Access to AID is not the “fix.” Open awareness of ambiguity, of the possibility that this patient might be dying, is a skill more needed by nurses than crafting an ethical role and response when assistance in dying is broached.

**Marsha Fowler, PhD, RN, FAAN, Azusa Pacific University.** The advantage of any dialogue is that it brings together differing perspectives to shed light on an issue; this dialogue does just that. At the same time, by virtue of time constraints, most public dialogues cannot be comprehensive or systematic. Thus, this dialogue does not touch upon several salient ethical concerns in the discussion of assisted suicide or AID. In this brief space, I will identify three areas that require further consideration.

First, religious perspectives are often treated dismissively, with an inaccurate presumption that all strongly held faith prohibits AID. There is rarely any substantive analysis of theological arguments that undergird different religious perspectives, some of which are universal and not tied to particular theological points. By religious arguments, I am referring to learned, theological perspectives and not to general, precritical perspectives found among laity. In part because religion does play a role in clinical decision making for a large segment of many societies, it is all the more incumbent upon ethicists to understand religious or theological ethical perspectives.

A second, related issue is the role of culture, particularly that of more atomized cultures vis-à-vis cultures or societies that are communitarian in nature, wherein decision making is family, kinship-network, or community based. This discussion is particularly important in the face of increasing demographic diversity. Los Angeles, for example, is one of the most diverse cities in the world: it has now reached a Latino and Hispanic (as well as Spanish-language) plurality. The bioethics community is, itself, dramatically less diverse than its sociocultural context. This warrants a full examination, not only of the role of culture (of which religion is a part) in the formulation of bioethical theory, but also of how that plays out in specific clinical issues such as AID.

A third area of concern is that no distinction is made between the critically different questions: should society authorize AID? If so, should physicians be involved, and how? And if so, should nurses be involved, and how? (Though the discussion is different, one can ask these same questions about euthanasia.) Modern nursing’s ethical corpus has long and enduringly proscribed nurse participation in aiding death, specifically by giving a drug. Lystra E. Gretter’s Florence Nightingale Pledge states, “I . . . will not take or knowingly administer any harmful drug.” It is a paraphrase of the Hippocratic oath and, in this case, applies to both AID and euthanasia. The ANA’s current version of its **Code of Ethics for Nurses with Interpretive Statements** proscribes nurse participation in intentionally taking a human life. This applies to AID, euthanasia, and legally authorized capital punishment. Space does not permit a discussion of why, but for nurses, it is “no” to any form of participation in taking life.

Whether AID should be legally and socially permissible is an entirely different question, even for nurses. If AID continues to be authorized across the country, perhaps society should also create a new category of nonnurse caregiver, a “registered Charon” who ferries us across the stormy waters of life to the place of departed persons.

**Christine Grady, PhD, RN, FAAN, Department of Bioethics, National Institutes of Health Clinical Center.** Four thoughtful speakers and lively discussion ensued at the timely and important policy dialogue on bioethics at the American Academy of Nursing’s 2016 conference. My sense from this dialogue and the written summary on assisted suicide or AID is that nurses across many settings feel a critical need for constructive guidance and opportunities for dialogue. Nurses understandably have mixed emotions and varied information about AID.

First, public and professional attitudes are clearly changing to support giving terminally ill persons more choice over the timing, location, and manner of their own deaths. As noted, almost one in five Americans has access to AID, given the populations of the five states where AID for terminally ill patients is legal; additional jurisdictions are considering it.
Wide acceptance of a patient’s right to refuse or withdraw life-sustaining therapies and increased use of terminal sedation and VSED, coupled with changing demographics, anxieties over the devastation of demening illnesses, and recognition that terminal illness is indeed sometimes accompanied by unremitting suffering, are all likely to continue to move the needle in the direction of more choices at the end of life.

Second, although end-of-life and palliative care have significantly improved patient experiences, it remains true that seriously and terminally ill persons can suffer or experience “unbearable” suffering. As panelists noted, suffering often includes some physical suffering, although much of this can be treated, but also loss of meaning; loss of autonomy, control, and ability to think; weakness; inability to enjoy life; feeling like a burden; and fear about future suffering. Unbearable suffering is a key construct in international AID initiatives and a common reason that people ask for help to die. 14 Although many can imagine a state of unbearable suffering, it is a difficult notion to define, standardize, or measure. Continued research to further our understanding and find effective methods of preventing and alleviating suffering is essential. Nurses and other health care professionals must learn to probe and respond to the experiences and fears of suffering persons and do their utmost to relieve physical, psychosocial, spiritual, and other sources of suffering. In some cases, this may not be enough.

Panelists and others noted that words matter. “Assisted suicide” and “aid in dying” are thought to reflect opposition or support, respectively, for these initiatives. Alternative descriptions that might reflect our commitment to respecting patients’ choices and caring for them regardless of their choices might be “patient-directed” or “patient-controlled” dying.

What are nurses to do? The first principle, articulated in Provision 1 of the ANA’s code for nurses, is “The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.” 21

Details fleshed out in interpretative statements describe a relationship of trust between nurses and patients and nurses’ obligation to provide services according to patient needs. In the context of AID, nurses should be well informed, compassionate, nonjudgmental, and responsive to patient fears, suffering, and needs. The bulleted items in the box, What Nurses Can Do, provide a valuable start. ▼

Ann B. Hamric is a professor emeritus at Virginia Commonwealth University in Richmond. Judith K. Schwarz is clinical director at End of Life Choices New York in New York City. Lewis Cohen is a consultant psychiatrist and a professor of psychiatry at Baystate Medical Center and the University of Massachusetts Medical School—Baystate in Springfield. Margaret Mahon is an NP with the Pain and Palliative Care Service at the National Institutes of Health Clinical Center in Bethesda, MD. Contact author: Ann B. Hamric, abhamric@vcu.edu. The authors have disclosed no potential conflicts of interest, financial or otherwise.

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