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Nursing's Role in Physician Aid in Dying:
Assisting Suicide or Providing Death with Dignity

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The professional role of nurses' customarily makes them the medical professional with the closest contact to the patient. Nurses build a relationship with their patients, acting as their caretaker, advocate, and companion providing them with the most compassionate care possible. Therefore, when a patient is tormented by terminal illness the nurse is privy to their pain and suffering. End of life care in the United States is primarily provided by hospice and palliative care. However, for some terminally ill patients these care options prove to ineffectively provide relief from pain and suffering. Yet, they do not desire having to endure an undignified and uncomfortable death, becoming a victim of their terminal illness. Michigan native Dr. Jack Kevorkian also referred to as "Dr. Death", was the first American Physician to become known for involvement in physician aid in dying. Kevorkian aided in an estimated 100 deaths before he was arrested for violating Michigan law against assisted suicide (Bernstein, 2015). Although Kevorkian's practices may have been ahead of the times, his sentiments and the desire of terminally ill patients' to have control in the end of their lives continues to exist to this day.

Although not legal in all fifty states the possibility of physician assisted suicide or aid in dying does exist for terminally ill residents in some parts of the U.S. The notion of physician aid in dying requires us to consider whether we have the right to determine how and when we die. As a future nurse, it is important to understand the issues surrounding physician aid in dying, the profession's opinion on the matter, and my personal views about it. The purpose of this paper is to examine physician aid in dying, including the legal and ethical implications of the practice, how the nursing profession is impacted by it, and my view on the practice.

Definitions and Concepts

The language used to explain end of life options is often ambiguous, leading to misconceptions and confusion. In order to establish understanding for this paper the following terms are clarified.

Aid in Dying

Aid in dying, or physician assisted death, is the preferred terminology to use when referring to the practice more commonly known as physician assisted suicide. All of these phrases regard the same process that “allows a mentally competent, terminally ill adult to legally request a prescription for life-ending medication from their physician. The medication must be self-administered” (Compassion and Choices, 2016, Aid in Dying, para. 2). Aid in dying is the preferred language because although the person is ending their life as one would when committing suicide they are not choosing to die as one does when they commit suicide. Rather the terminally ill person is already dying. Instead, they are choosing to aid their death by hastening the process via legal medical means.

Euthanasia

The difference between aid in dying and euthanasia is who is performing the act of medication administration. “Euthanasia is the intentional ending of a person’s life upon their request, performed by a medical healthcare professional” (Compassion and Choices, 2016, Euthanasia, para. 1). The practice of euthanasia is illegal everywhere in the United States.

Hospice and Palliative Care

“Palliative care is any form of care or treatment that focuses on reducing the severity of symptoms rather than delay progression of the disease or provide a cure” (Lewis, Dirksen, Heitkemper, Bucher, 2014, p. 141). The primary focus of palliative care is to provide relief from

suffering. The practices of hospice and palliative care are not separate entities; rather hospice is a function of palliative care. “Hospice exists to provide support and care for persons in the last phases of a terminal disease” (Lewis et al., 2014, p. 142). Palliative care and hospice both provide patients with comfort care and relief from symptoms. The difference between the practices is that a patient enrolled in palliative care may also be receiving curative measures and a hospice patient has stopped curative treatments (Lewis et al., 2014).

Palliative Sedation

Palliative sedation is comfort measure provided to “relieve severe, intractable symptoms that cannot be controlled while keeping the patient conscious” (Compassion & Choices, 2016, Palliative sedation, para. 1). It is delivered by “the intentional administration of sedatives in such dosages and combinations as required to reduce the terminal patient’s consciousness to adequately control symptoms” (Broeckaert as cited in Woods, 2004, p. 245). A misconception is that palliative sedation is euthanasia because the patient is often receiving no treatment other than sedation until death. Although the medications administered for palliative sedation do have side effects that may hasten the death of the patient that is not the intention of palliative sedation, as it is when medication is administered in euthanasia.

Terminal Illness

A terminal illness is an “irreversible, incurable condition that in the near future will result in death or a state of permanent unconsciousness from which you are unlikely to recover” (American Cancer Society, 2015, Terminal illness, para. 1). The life expectancy of a patient to classify them as terminally ill varies by source. For the purpose of this paper the definition of aid in dying laws that define terminal illness as one with an expectation of death within six months will be followed.

Voluntary Stopping of Eating and Drinking

Voluntary stopping of eating and drinking (VSED) refers to a patient's intentional decision to stop oral intake with the knowledge that VSED will lead to their death. Any informed and competent patient has the right to stop all life-prolonging measures; included in these measures is natural or artificial hydration and nutrition. This practice is often implemented in concordance with palliative sedation.

The Oregon Experience

Physician aid in dying is currently legal in five U.S. states Oregon, Washington, Vermont, Montana, and California. The practice is most commonly associated with Oregon, the first state to legalize physician aid in dying. The Oregon Death with Dignity Act (ODDA) was a ballot initiative that first passed into law in 1994; however further legal challenges prevented the law from being enacted until 1997. The law established clear policies regarding physician aid in dying including who can request aid in dying, the process by which you request it, requirements of healthcare providers and the designation that euthanasia is illegal. In addition the ODDA requires annual reports to be produced by the Oregon Public Health Department. The reports provide a framework for aid in dying, giving insight into physician aid in dying by revealing the patient demographics, reasons for use, trends of use, and the aid in dying process.

Requesting Physician Aid in Dying

The Oregon Death with Dignity Act established safeguards to prevent mistreatment of physician aid in dying. In order to obtain a prescription for the medication a patient must meet all of the criteria set forth in the act and follow the process for requesting. The patient must be "18 years or older, a resident of Oregon, deemed mentally competent and capable of making

healthcare decisions, and diagnosed with terminal illness with death expected within 6 months” (Westfeld et al., 2009, p. 161). In addition, the patient must be able to self-administer the medication. It is the self-administration of medication that distinguishes aid in dying from euthanasia, which is illegal. The same criteria are required for residents of Washington and Vermont under their respective death with dignity acts.

The process of requesting medication requires an eligible patient to make two oral requests and one witnessed written request. At any time during the process a patient may withdraw their request. The person who will be ingesting the medication must make all requests. After the first oral request, two physicians one attending to the case and one consulting, must determine that the person requesting the prescription fits all five criteria with no exceptions. If either physician suspects the patient is not of sound mind, they may require a psychological consult to be done. After the first oral request is approved the patient must wait a minimum of fifteen days before submitting the second oral request. After the second oral request is approved the patient must provide the attending physician with a written request for aid in dying by providing the statutory form included in the state’s death with dignity act. Two individuals must witness the written request, one of the witnesses must be of no relation to the patient and the physician cannot serve as a witness. The witnesses provide testimony to the patient’s desires and attest that the patient is making the decision of their own volition. If a patient is deemed eligible and they are compliant with the process they may obtain a prescription for lethal medication to provide them aid in dying.

Role of Healthcare Providers

Healthcare providers have the right to refuse to participate in aid in dying; this right is protected by the death with dignity act. Upon a patient’s initial request for aid in dying it is the

role of the provider to try and ascertain the meaning behind the request. In addition, the provider should counsel them about other end of life care options such as hospice and palliative care ensuring that they are making a well-informed decision. The attending and consulting physicians are responsible to determine if the patient meets the criteria to request aid in dying. They must also ask the patient to inform their family about their request for aid in dying, but the patient is not legally obligated to do so. Healthcare providers have to report the writing of a prescription for lethal medication to the Oregon Public Health Department. It is illegal for anyone including nurses and physicians to administer the medication prescribed. Healthcare providers are often the first people a patient discusses their consideration of aid in dying with. Therefore, it is instrumental that nurses and physicians alike are informed about the practice, understand their personal beliefs about it, and knows alternatives to aid in dying.

Patient demographics

“Since the law was passed in 1997, a total 1,545 people have had prescriptions written under the Oregon Death with Dignity Act, and 991 patients have died from ingesting the medications” (Oregon Health Authority, 2016, p. 2). When this number is compared to total number of deaths in Oregon, it is small. According to the annual reports produced by the Oregon Health Authority (OHA) the number of prescription recipients has increased each year, with 218 people receiving a prescription in 2015 compared to 24 patients in 1998. Data shows that patients are commonly white (96.6%), well educated (45.5% have a baccalaureate degree or higher), and are enrolled in hospice (90.5%) (OHA, 2016, p. 5). The majority of patients are suffering from cancer, but other underlying illnesses include amyotrophic lateral sclerosis, HIV/AIDS, heart disease, and chronic lower respiratory diseases. End of life concerns have been similar each year; the most commonly reported concern is loss of autonomy followed by inability to engage in

activities that make life enjoyable, and loss of dignity. Patient concern over financial implications of treatment has only been reported for 3.1 percent of all deaths (OHA, 2016, p. 6). Patients informed their family of their decision in 93.5 percent of all deaths and 94 percent of all deaths occurred at home (OHA, 2016, p. 6).

Experience of healthcare providers

Regardless of personal beliefs healthcare providers are entwined in the death with dignity process. Healthcare providers are allowed to refuse to participate in physician aid in dying, but must be prepared to answer a patient's questions about the process and provide therapeutic intervention by being present and listening to the patient. Although physicians are the only providers legally capable of writing a prescription for physician aid in dying, nurses and social workers are often the first to be asked about the process by the patient. A study of Oregon nurses and social workers found that "two thirds reported caring for a patient who had discussed physician aid in dying as a potential end of life option" (Miller et al., 2004, p. 686). The study also found that "95% of the nurses and social workers believed their hospice agency should be supportive of a patient's choice for assisted dying or remain neutral to the issue" (Miller et al., 2004, p. 687). Ganzini et al. (2001) found that "51% of their physician sample would support or strongly support ODDA, 32% opposed the practice and 17% did not oppose or support the practice" (p. 2366). Hospital chaplains are another care provider impacted by the issue. A study of Oregon chaplains found that religious beliefs were the biggest reason chaplains opposed ODDA, but regardless of beliefs they would support the patient until death or discharge (Goy, Carlson, Simopoulos, Jackson, Ganzini, 2006). Although there is support for the issue among healthcare providers an important facet of the issue is what a provider should do if they do not support the patient's decision. If they are unable to care for the patient the healthcare provider

should inform their employer and is responsible for helping the patient find a provider who can properly address their needs.

Ethical considerations

The experience of Oregon with physician aid in dying provides a framework for the issue. To provide further context it is necessary to look at the ethical issues surrounding the practice. Proponents of physician aid in dying cite the importance of patient autonomy, mercy, and not abandoning our patients in their time of need. While those who oppose the issue discuss the ethical values of nonmaleficence, professional integrity and the concept of the slippery slope.

Autonomy

The argument in support of physician aid in dying recurrently discusses a patient's right to autonomy. In Oregon 92% of all aid in dying patients report loss of autonomy as an end of life concern, 89% of patients in Washington report the same concern (Oregon Health Authority, 2016; Washington State Department of Health, 2014). Autonomy "is the right to self-determination, professional practice reflects autonomy when the nurse respects patients' rights to make decisions about their health care" (American Association of Colleges of Nursing, 2008, p. 27). Healthcare providers acknowledge that a patient's description of their disease symptoms, pain, or suffering is the most accurate. In all aspects of medical care a competent patient has the right to make autonomous healthcare decisions. This includes the right to stopping life sustaining treatment or to stop intake of food or water in order to hasten one's death. Supporters of the practice ask, why a dying patient is questioned because they want to determine when they have suffered enough and to be given the means to stop their suffering. "An autonomous decision to hasten one's death is a profoundly important decision for a terminally ill person that involves his or her most significant values" (Preston, Gunderson, Mayo, 2004, p. 40). Some patients wish to

use all life sustaining measures until their demise, while others wish for comfort care, and others want the control physician aid in dying gives them over the length of their suffering and timing of their death.

Opponents of the issue argue that terminally ill patients are not of sound mind to make autonomous decisions regarding care due to their condition. A patient who wishes to participate in physician aid in dying is assumed to be overwhelmed with grief or depression. Yet, this judgment and stigma does not exist for the patient who wishes to stop life sustaining treatment or requests their code status to be 'do not resuscitate' (DNR). In these cases, the patient's wishes are respected. Despite the fact that stopping treatment, being of DNR code status, or using lethal medication to end life can all ultimately lead to death. Therefore, if providers believe in a patient's autonomy then they must accept that the greater the weight of a decision, like the decision to hasten death with aid in dying, the more important it is for the patient to reflect on their values and to be able to decide. According to the ethical principle of autonomy it is a provider's job to support a patient's wishes. A provider does not have to agree with a patient's decision, but rather they must not impose their views upon their patient.

Mercy

Advances in medicine allow people to live lives of greater longevity. However the longevity provided by medical advancement does not always coincide with a happier, healthier life for people with terminal illness. This extended life span for the terminally ill brings about the question that "if tomorrow will be worse than today, one day after another until the end, why not die today" (Angell, 2004, p. 19)? Physician aid in dying provides a merciful solution to this question for patients who do not want to endure this existential suffering. Mercy in medicine is illustrated by the ethical principle of beneficence defined as "compassion; taking positive action

to help others; the desire to do good, it is a core principle of patient advocacy” (American Nurses Association, 2011, p. 1). By understanding a patient’s decision to request aid in dying, supporting them through the process and advocating for a patient’s right to participate in aid in dying nurses and other healthcare professionals act mercifully and according to the principle of beneficence. Proponents of the practice reason, “assisting patients to die after aggressive attempts to manage psychosocial distress and physical symptoms is a compassionate, ethical, beneficent act” (Ersek, 2004, p. 51). Data from Oregon death with dignity patients’ reveals that for the majority of patients existential suffering is much more distressing than their pain or bodily decline. Reports show that loss control of bodily functions is a concern for only 48% of all patients and inadequate pain control is a concern for only 25% of patients; while losing the ability to do activities that makes life enjoyable is a concern for 90% of patients (OHA, 2016, p. 6). This data supports the claim that aid in dying is a merciful solution for unnecessary suffering that is not solely related to treatable symptoms.

Opponents of aid in dying argue that this practice is not merciful and is unethical because it causes providers to abandon their patients. However, a patient who requests aid in dying is not forced to take prescribed medication and may rescind their request at any time. Aid in dying patients are able to continue receiving other types of healthcare including hospice care. In Oregon 90.5% of aid in dying patients are enrolled in hospice indicating that the majority of patients are not abandoned but instead are receiving continuing compassionate care (OHA, 2016, p. 5). Consider that a family pet is rarely allowed to suffer until their dying breath; rather we mercifully end their misery by euthanasia. If we value the quality of life of our pets so highly how can we not also value the quality of life of our family and friends just as highly?

Nonmaleficence

Nonmaleficence is the avoidance of harm or hurt. “Included in this principle is deliberate harm, risk of harm, and harm that occurs during the performance of beneficial acts” (Burkhardt & Nathaniel, 2014, p. 71). Opponents of physician aid in dying state that aid in dying violates nonmaleficence because harm occurs despite the beneficence of the act. In addition, they contend that physician aid in dying violates the professional integrity of healthcare providers, as well as the nursing and medical code of ethics. The traditional role of healthcare providers is to preserve and protect human life; physician aid in dying modifies this role. According to the Code of Ethics for Nurses “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” (as cited in American Nurses Association, 2013, p. 2).

Proponents of the practice state that it is inaccurate to say physician aid in dying is unethical due to nonmaleficence; because this argument contends that a provider is causing harm because they are killing their patient. However an important factor to consider is that the patient who requests aid in dying is not asking for their life to be terminated, this patient is already dying. Therefore, providing them aid in dying is not killing them but rather giving them control over an inevitable death. Is it not more harmful to force a patient to suffer because aid in dying is incorrectly deemed to be killing?

The Slippery Slope

Opponents of physician aid in dying maintain that legalizing the practice will be the first step on a ‘slippery slope’ to euthanasia and other morally intolerable practices. Therefore, we must never legalize physician aid in dying. Oregon has practiced physician aid in dying for 19 years. Yet, euthanasia is still illegal in this state despite ample time to slide down the ‘slope’. Opponents also claim that legalizing physician aid in dying will cause pressure on vulnerable

groups such as the terminally ill, disabled, or elderly to request aid in dying. Proponents of the issue do not deny that there is risk for abuse as there is risk for abuse with any medical practice. However, strict safeguards are set forth to define who may receive physician aid in dying in order to prevent these vulnerable groups from requesting aid in dying heedlessly and to prevent abuse.

In the Netherlands both the practice of physician aid in dying and euthanasia are legal. Opponents state concern that the United States will follow in the footsteps of the Netherlands first legalizing physician aid in dying and eventually euthanasia. However, the choice to legalize euthanasia in the Netherlands was not due to sliding down a ‘slippery slope’ because aid in dying was being abused or unregulated. The debate to legalize euthanasia in the Netherlands began in 1973 and continued until 2002 when the Supreme Court established legislation and criteria to be met for euthanasia to be legalized (van Delden, Visser, Borst-Eilers, 2004). The criteria set forth are similar to the criteria established for physician aid in dying in Oregon. A major difference between practice in Oregon and the Netherlands is the requirement of Dutch medical professionals to report their care to a review committee. If the doctor fails to comply with criteria or to report the case they are prosecuted for their actions. Overall, the healthcare system and the legal system in the United States and in the Netherlands differ vastly, making the comparison of the two countries inaccurate. Pressure to widen end of life care practices could occur if physician aid in dying was legal in the United States. However pressure does not mean inevitability, “are we to be deterred from giving a right to one group of persons who are entitled to it for fear that another group will claim it” (Levy, 2008, p. 13)? If physician aid in dying is determined to be ethical, but fear of the ‘slippery slope’ prevents it from becoming legal then terminally ill persons are suffering without cause.

Legal precedent

The ethical argument in support of physician aid in dying does not change the fact that the practice is not legal everywhere in the United States. Patients have the right to make decisions in all aspects of their care, but the right to request aid in dying in the United States is only legal in Oregon, Washington, Vermont, Montana, and California. In 1997 the Supreme Court determined that there is no federal constitutional right to death in the cases of *Washington v. Glucksberg* and *Vacco v. Quill*. However, this practice is also not prohibited by the constitution, each state can determine if and under what conditions aid in dying is allowed.

The XIVth amendment states, “no state shall deprive any person of life, liberty, or property without due process of the law” (U.S Constitutional amendment XIV). Due process of the law ensures that the government cannot deprive a citizen of any of the aforementioned rights without reason. According to this amendment, the state has the right to interfere in matters of person’s liberty when the state’s interest in protecting its residents is greater than the claimed liberty interest of the resident. Aid in dying cases have mentioned legislation such as *Planned Parenthood v. Casey* (1992), which sustained a woman’s right to abortion, and *Cruzan v. Director, Missouri Department of Health* (1990), which established the right to terminate unwanted medical treatment. Both of these cases established that a patient’s liberty interest regarding some aspects of healthcare treatment is greater than the state’s right to interfere. In addition, these cases represent the Supreme Court’s belief that some moments and decisions in individuals’ lives are “placed out of the prohibitory authority of the state as they are decisions regarding matters that are highly personal, intimate and are of great importance to the individual” (*Compassion in Dying v. Washington State*, 1996).

Proponents of aid in dying claim that the liberty interest protected by the XIVth amendment includes a person's right to die and to request aid in dying. Aid in dying legislation states "the decision to end one's own life is one of the most intimate choices a person can make in a life-time, a choice central to personal dignity and autonomy" (*Compassion in Dying v. Washington State*, 1996). As previously mentioned, the court has recognized a person's right to make medical decisions regarding care of a highly personal matter in *Casey* and *Cruzan*. Therefore, if the right to make healthcare decisions is based on the tenant that these decisions are highly personal, proponents state the right to die should also be legal.

Physician Aid in Dying and Medical Associations

The 2015 Gallup poll found that "nearly 7 in 10 Americans (68%) say doctors should be legally allowed to assist terminally ill patients in committing suicide" (Dugan, 2015, para. 1). The poll shows that support for physician aid in dying has risen over the past 18 years when the issue was first surveyed. Despite increasing public support the American Nurses Association (ANA), the American Medical Association (AMA), and the National Hospice and Palliative Care Organization (NHPCO) continue to oppose the practice of physician aid in dying (AMA, 1996; ANA, 2013; NHPCO, 2005). These organizations view the practice as incompatible with the professional role of nurses and physicians and encourage the support of patient's use of other end of life options.

However, there is national support for this issue from the American Medical Women's Association (AMWA), the American Medical Student Association (AMSA), the American Public Health Association (APHA), and American College of Legal Medicine (ACLM) (ACLM, 2008; AMSA, 2008; AMWA, 2007; APHA, 2008). The organizations that support the practice of physician aid in dying emphasize the patient's right to autonomy as well as the intimate

experience of dying. The American Psychological Association (APA), California Medical Association (CMA), and the American Academy of Hospice and Palliative Medicine (AAHPM) take a position of neutrality neither opposing nor supporting the issue (AAHPM, 2007; APA, 2009; CMA 2015). Organizations that take a stance of neutrality acknowledge the importance of patient choice regarding end of life care, but also recognize that the issue is complex and ever evolving. All organizations, regardless of stance, emphasize the importance of supporting the patient and not abandoning them when they are terminally ill. In addition, they contend that improving upon end of life care quality and availability is necessary.

Recommended Alternatives

The stance of the American Nurses Association and the American Medical Association is to oppose physician aid in dying. Instead, they recommend other end of life care options such as hospice and palliative care, as well as the use of practices such as withdrawing life sustaining treatment, palliative sedation, and voluntary stopping of eating and drinking. A patient has a right to using any of these aforementioned end of life care options. These end of life options can indirectly hasten a patient's death, but according to the rule of double effect these practices are ethically acceptable.

Hospice and Palliative Care

Hospice and palliative care are treatment options that are used with the intention of reducing a patient's symptoms of pain and suffering. Palliative care is provided to anyone at any stage of disease while hospice is a function of palliative care that is specific to people with terminal illness. The ANA and AMA both recommend intervening with hospice care and improving the understanding of hospice care options rather than providing physician aid in dying. Whether or not physician aid in dying represents a failure of palliative care or if it can be

a function of palliative care is discussed when considering the issue. The majority of physician aid in dying patients residing in Oregon are enrolled in hospice. Therefore the practice of aid in dying is already in some way incorporated with hospice care. However, failure of hospice or palliative care is not a reason for requesting aid in dying, only 25.2% of all aid in dying patient's in Oregon report inadequate pain control as a reason for requesting aid in dying (OHA, 2016, p. 6). Rather, "requests to hasten death are complex personal wishes that reflect patients' values and perceptions of what makes a good life and a good death" (al-Awamer, 2015, p. 1039). Fear of decreased availability of palliative care in states where the practice is legal is often conveyed. In Oregon, Washington and Vermont, states where aid in dying is legal under death with dignity acts palliative care is the reported to be the best in the nation. In 2015, all three states received an 'A' from National Palliative Care Research Center (NPCRC) regarding the states' access and availability of palliative care. The level of palliative care in these states exceeds the level of care of the nation, which received a 'B' on the 2015 report card.

Withdrawing Life Sustaining Treatment

The right of a patient to withdraw life-sustaining treatment (WLST) demonstrates that the healthcare community respects a patient's autonomy. These organizations contend that the difference between death from WLST and physician aid in dying is that "WLST is allowing a patient to die from their underlying medical condition and does not involve an action to end the patient's life" (ANA, 2013, p. 6). Therefore WSLT is considered an ethically acceptable practice. The patient is not given means to end their life, but by stopping treatment they are no longer prolonging their life, therefore they are given some control of the timing of their death. The support of this medical practice indicates these organizations respect the patient's ability to know when they have endured enough.

Palliative Sedation

Palliative sedation is the practice of administering sedatives to reduce a patient to a semiconscious state in order to eliminate suffering. “The ethical justification that supports palliative sedation is based on precepts of dignity, respect for autonomy, and beneficence” (ANA, 2013, p. 5). The ethical reasoning for this practice is evidently similar to the argument in support of physician aid in dying, despite the AMA and ANA not supporting practice of the latter. When a patient is receiving palliative sedation they often elect to withdrawing nutrition and hydration a practice referred to as voluntary stopping of eating and drinking (VSED). Withdrawing these life-sustaining measures occurs because they prolong the life of the patient, but do not improve their quality of life. A perceived benefit of voluntary stopping of eating and drinking is that it does not involve any order action by the physician or nurse making it ethically accepted.

Rule of Double Effect

“The Rule of Double Effect is a bioethical doctrine that provides justification for clinical actions that have two foreseeable effects, one beneficial and one detrimental” (Rose, 2007, p. 149). The justification for such clinical actions is that the intended action is beneficial for the patient and the detrimental action is an unintended side effect. When a nurse is administering pain medication to a hospice patient there are the side effects of sedation and reduced respiratory function, which can hasten death. According to the rule of double effect, this action is ethically justifiable because the intention of medication administration is not first to hasten death and second to provide pain relief. Rather potentially hastening death is an unavoidable side effect of an ethically justifiable action of reducing pain and suffering. The ANA’s Code of Ethics with Interpretative Statements (2015) shows this organization’s support of this rule stating, “the nurse

must act to prevent unwarranted, unwanted or unnecessary medical treatment and patient suffering” (p. 8).

By the rule of double effect aforementioned practices of withdrawing treatment, palliative sedation, and voluntary stopping of eating and drinking are ethically justified because any action done by healthcare providers is intended to end suffering first although death is an unpreventable side effect. Physician aid in dying is not justified because the action is done with the knowledge that the patient intends to their life and by ending their life a side effect so to speak is ending their suffering. Why couldn't we frame aid in dying the same way as WLST, palliative sedation, and VSED; arguing that aid in dying is provided to end suffering and death is a foreseeable but unpreventable side effect. The distinction preventing this framework from being applied to aid in dying is; the former options are letting the patient die and aid in dying is giving the patient the means to die. But in either scenario the fact remains that the patient is dying.

Impact on Nursing

The American Nurses Association position statement on euthanasia, assisted suicide, and aid in dying “prohibits nurses’ participation in assisted suicide and euthanasia because these acts are in direct violation of the Code of Ethics for Nurses with Interpretive Statements” (ANA, 2013, p. 1). This ethical objection stems from the concept of nonmaleficence. The International Council of Nurses’ (ICN) takes a neutral stance regarding the practice. The “ICN views access to pain and other symptom relief medication and interventions as a basic human right and as part of the right to die with dignity” (2012, para. 1). The ICN’s stance encompasses the duty of nurses to end patient suffering by any reasonable means available. The varied stances of these major organizations are representative of the varying beliefs of nurses regarding the practice.

The relationship of nurses to their patients places the nurse in a vital position to address

end of life concerns. As a member of an interdisciplinary healthcare team the nurse must advocate for a patient when these concerns are expressed. Irrespective of personal beliefs, nurses still encounter patients who have questions about, or wish to participate in, aid in dying. This is not a concern singular to nurses who practice in states where the practice is legal. The widely publicized case of Brittany Maynard a terminally ill California resident who moved to Oregon to obtain aid in dying, showed us that terminally ill people are willing to move in order to obtain physician aid in dying.

Death with dignity acts have not changed the scope of nursing practice for registered nurses or advanced practiced registered nurses. It is illegal for all nurses to administer the lethal medication prescribed for an aid in dying patient. Although nurse practitioners may be able to prescribe medication, they are not legally allowed to write a prescription for the purpose of physician aid in dying. A nurse is not obligated to care for a patient who wishes to request or requests aid in dying. However a nurse is responsible for transferring care of their patient to another competent nurse if are unable to provide care themselves. The foremost role of the nurse in aid in dying is to “explore the meaning of the request, alleviate symptoms that may be contributing to the patient’s distress, and facilitate communication between the patient, family, and healthcare team” (Miller, 2008, para. 4). Physician aid in dying adds new dimension to previous roles in nursing as a patient advocate and educator. Nurses need to explore their personal beliefs about the practice to understand if they are able to advocate for a patient who wishes to request aid in dying and continue to support them if they follow through with their request. They must also feel comfortable providing education about the process, the medications prescribed, and medication administration. The American Nurse’s Association recommends the increased education of nurses regarding aid in dying, values clarification to illuminate nurses’

attitudes to aid in dying, and patient education regarding palliative care and hospice care options (ANA, 2013)

My Stance

I believe that physician aid in dying should be an option for terminally ill patients. Medicine has changed the nature of death for the terminally ill and with it our treatment of death must also change. Physician aid in dying does not cause death. It allows terminally ill patients to control the timing of an inevitable death. No, I do not believe that it should be the first line of treatment for these patients, but rather an option for those whose suffering is unbearable even with extensive treatment provided by palliative care and hospice. Most importantly, I believe it is the patient who should be allowed to determine when their suffering has reached this point based on the principle of autonomy. In my opinion, physician aid in dying is not a question of life or death; it is a question of a drawn out painful death or a quick merciful one. When considering the argument against physician aid in dying based on the principle of nonmaleficence, I fail to see how allowing a patient to end their suffering is harming them. Rather, I believe forcing a person to live in untreatable and irretraceable pain and suffering is greater cause of harm. Allowing a patient to end their suffering is an act of beneficence. I agree that physician aid in dying alters the integrity of the nursing profession to promote and protect human life, but I do not think it comprises this professional integrity. It is also part of the nursing role to aid a patient's suffering and value their opinions and beliefs. With the multifaceted role of nursing it is unfair to say physician aid in dying compromises the integrity of profession in its entirety because it comprises one aspect of the profession. Terminally ill patients should be able to approach nurses with end of life concerns knowing that our profession is built on the belief of respect for persons and a duty to help cure ailments and promote their life. However they should also know that we

have no wishes to prolong their suffering or prolong their life without considering their quality of life. Physician aid in dying is incorrectly viewed as abandonment of our patients. Impending death because of terminal illness does not stop our nursing process or alter our level of compassion for our patients. Therefore impending death because of terminal illness but the choice to control the timing of this death via physician aid in dying should also have no impact on our nursing process or level of compassion. In both cases our patient is dying, they deserve our utmost respect, compassion, and exceptional nursing care. While treatment of a patient can stop, we never stop our care.

Conclusion

The intimate relationship between a nurse and their patient is one built on trust and empathy. Therefore, when a nurse is caring for a terminally ill patient they see firsthand the torment and pain their patient experiences. They stand by this patient's side through the highs and the lows of terminal illness and are there to discuss the patient's wishes for end of life care. With the various advancements in medicine, illnesses that previously took a patient's life quickly can now be treated, extending the life of the individual. However, for some individuals, the treatment is just as distressing as the illness and the increased life expectancy is not a blessing, but a curse.

Physician aid in dying is a legal end of life care option for residents of Oregon, Washington, Vermont, California and Montana. This practice allows a terminally ill competent person to request lethal medication that will give them control over the timing of their death. This practice presents an ethical dilemma concerning a person's right to die. Support for the practice is based on the principles of autonomy, mercy, and the idea that healthcare providers cannot abandon patients in their time of need. Ethical opposition stems from the principles of

nonmaleficence and professional integrity as well as the concept of the 'slippery slope'. Medical associations have varying stances regarding the use of the practice. The American Nurses Association (ANA) does not support physician aid in dying. Rather, the ANA suggests the use of palliative care and hospice to end suffering. Based on the rule of double effect the ANA supports the practices of withdrawing life sustaining treatment, palliative sedation, voluntary stopping of eating and drinking. Nurses are not obligated to participate in physician aid in dying, but should reflect on their personal and professional beliefs regarding the practice. The foremost role of the nurse in aid in dying is to "explore the meaning of the request, alleviate symptoms that may be contributing to the patient's distress, and facilitate communication between the patient, family, and healthcare team" (Miller, 2008, para. 4). As a future nurse, I have reflected and believe that physician aid in dying should be an option for the terminally ill. The practice of aid in dying is not assisting suicide; it is allowing a person to have a death with dignity.

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