

## Position Statements

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# Euthanasia, Assisted Suicide, and Aid in Dying

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**Status:** Revised, Combined Position Statement

**Originated by:** ANA Center for Ethics and Human Rights

**Adopted by:** ANA Board of Directors

**Purpose:** Historically, nurses have played a key role in caring for patients at end-of-life across healthcare settings. Nurses provide expert care throughout life's continuum and at end-of-life in managing the bio-psychosocial and spiritual needs of patients and families both independently and in collaboration with other members of the interprofessional healthcare team. While resources do exist to educate and support nurses in this role, there are limited resources to assist nurses in understanding and responding to patient and family questions related to euthanasia and assisted suicide.

The purpose of this position statement is to provide information that will describe the nurse's ethical obligations in responding to requests for euthanasia and assisted suicide, define these terms, support the application of palliative care nursing guidelines in clinical practice, and identify recommendations for nursing practice, education, administration, and research.

**Statement of ANA Position:** The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001; herein referred to as *The Code*), the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.

**History/previous position statements:** ANA adopted position statements on Euthanasia and Assisted Suicide originated by the Task Force on the Nurse's Role in End-of-Life Decisions, Center for Ethics and Human Rights on December 8, 1994.

**Supersedes:** Position Statements: Assisted Suicide (12/08/94); Active Euthanasia (12/08/94).

## Supportive Materials

### ***ANA's Foundational Documents***

#### *Code of Ethics for Nurses with Interpretive Statements*

Provision 1, Interpretive Statement 1.3 of *The Code* (2001) speaks to the nurse's commitment to the inherent:

"... worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by death, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying" (p. 12).

In a succeeding paragraph, the statement goes on to say that:

"... nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care. This is particularly vital in the care of patients and families at the end-of-life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying...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" (p. 12).

#### *Nursing's Social Policy Statement: The Essence of the Profession*

In the section entitled, "Knowledge Base for Nursing Practice" of this document, it states that "Nurses are concerned with human experiences and responses across the life span. Nurses partner with individuals, families, communities, and populations to address issues such as....physical, emotional, and spiritual comfort, discomfort, and pain...emotions related to the experience of birth, growth and development, health, illness, disease, and death....decision-making and the ability to make choices" (2010b, pp.13-14). In its discussion of the Code of Ethics for Nurses, the section entitled, "Standards of Professional Nursing Practice", *Social Policy Statement* clearly states that "although the Code of Ethics for Nurses is intended to be a living document for nurses, and health care is becoming more complex, the basic tenets found within this particular code of ethics remains unchanged" (2010b, p. 24).

#### *Nursing: Scope and Standards of Practice, 2<sup>nd</sup> Edition*

Standard 7, under the heading "Standards of Professional Performance," reiterates the moral obligation of the nurse to practice ethically and to provide care "in a manner that preserves and protects healthcare consumer autonomy, dignity, rights, values, and beliefs" and "assists healthcare consumers in self determination and informed decision-making" (2010a, p. 47).

## ***Other Supporting Material***

Palliative and hospice care provide individualized, comprehensive, holistic care to meet patient and family needs predicated on goals of care from the time of diagnosis, through death, and into the bereavement period. The following excerpt from this document emphasizes the role of palliative nursing care in the nurse's recognition and relief of symptoms within his or her professional boundaries and in a manner consistent with safe, competent, ethical nursing practice:

"...Palliative care recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Palliative care affirms life and neither hastens nor postpones death. Palliative care exists in the hope and belief that through appropriate care and the promotion of a caring community, sensitive to their needs, patients and families may be free to attain a degree of mental, emotional, and spiritual preparation for death that is satisfactory to them" (ANA & HPNA, 2007, p. ix-x).

### ***World Health Organization on Palliative Care***

The World Health Organization (WHO) defines palliative care as:

"... an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (National Consensus Project for Quality Palliative Care, 2009, p. 8). Palliative care "affirms life and regards dying as a normal process" and "intends neither to hasten nor postpone death" (National Consensus Project for Quality Palliative Care, 2009, p. 8).

## **Terminology**

***Assisted suicide:*** Suicide is the act of taking one's own life. In assisted suicide, the means to end a patient's life is provided to the patient (i.e. medication or a weapon) with knowledge of the patient's intention. Unlike euthanasia, in assisted suicide, someone makes the means of death available, but does not act as the direct agent of death. Nurses have an opportunity to create environments where patients feel comfortable to express thoughts, feelings, conflict, and despair. The issues that surround a request for assisted suicide should be explored with the patient, and as appropriate with family and team members. It is crucial to listen to and acknowledge the patient's expressions of suffering, hopelessness, and sadness. Factors that contribute to such a request should be further assessed and a plan of care initiated to address the patient's physical and emotional needs. Discussion of suicidal thoughts does not increase the risk of suicide and may actually be therapeutic in decreasing the likelihood. The relationship and communication between the nurse and patient can diminish feelings of isolation and provide needed support.

**Aid in dying:** Aid in dying is an end-of-life care option in which mentally competent, terminally ill adults request their physician provide a prescription for medication that the patients can, if they choose, self-administer to bring about a peaceful death (Compassion & Choices, 2012).

**Euthanasia:** Euthanasia, often called "mercy killing", is the act of putting to death someone suffering from a painful and prolonged illness or injury. Euthanasia means that someone other than the patient commits an action with the intent to end the patient's life, for example injecting a patient with a lethal dose of medication. Patients may consent to euthanasia (voluntary), refuse euthanasia (involuntary), or be unable to consent to euthanasia (non-voluntary). In euthanasia someone not only makes the means of death available, but serves as the direct agent of death.

For the purpose of this position statement, the term *euthanasia* refers to those actions that are inconsistent with the *The Code* and are ethically unacceptable, whether the euthanasia is voluntary, involuntary, or non-voluntary. The nursing profession's opposition to nurse participation in euthanasia does not negate the obligation of the nurse to provide compassionate, ethically justified end-of-life care which includes the promotion of comfort and the alleviation of suffering, adequate pain control, and at times, foregoing life-sustaining treatments. Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it (2010c).

**Hospice care:** Hospice care is the care of patients and families at end-of-life during the last few weeks or months of life and, as such, builds on the palliative care model to minimize suffering by providing appropriate symptom management and emotional support. In a study conducted by Herman and Looney (2011), symptom distress was the variable that most significantly correlated with quality of life following by symptom frequency, severity, and depression. The higher the symptom distress (inclusive of depression), frequency, and severity, the lower the quality of life. As noted by Sherman and Cheon (2012):

"In short, palliative care/hospice partnership creates a common sense allocation of health care resources as patients move across the illness trajectory and approach the end-of-life. With palliative and hospice care, the wishes and preferences of patients and families are respected, often with a desire to withdraw life-prolonging treatments and insure their comfort and dignity as death approaches." (p. 156)

**Palliative sedation:** The primary intent of palliative and hospice care is to relieve or minimize suffering through effective symptom management in order to enhance the patient's quality of life and support patients and families in the dying process. There are times, however, when the patient's symptoms may become intractable and refractory to treatment. Both the definition and terminology associated with palliative sedation have been widely debated. In its 2011 position statement entitled "Palliative Sedation", the Hospice and Palliative Nurses Association (HPNA) states that:

"While there is no universally accepted definition, palliative sedation can be understood as the controlled and monitored use of non-opioid medications intended to lower the patient's level of consciousness to the extent necessary, for relief of awareness of refractory and unendurable symptoms. Previously, palliative sedation was termed terminal sedation; however, the term palliative sedation more accurately describes the intent and application to palliate the patient's experience of symptoms rather than to cause or hasten the patient's death" (p. 1).

Interdisciplinary assessment and collaboration is essential to determining the appropriateness of palliative sedation and assure effective communication between the patient, family, significant other, surrogate, and/or other healthcare providers. (HPNA, 2011, p. 2). As patient advocate, the nurse plays a pivotal role in maintaining the human dignity of persons by providing highly competent, compassionate nursing care that is ethically appropriate and consistent with acceptable standards of nursing practice. HPNA describes:

"... the ethical justification that supports palliative sedation is based in precepts of dignity, respect for autonomy, beneficence, fidelity, nonmaleficence, and the principle of double effect, which evaluates an action based on intended outcome and the proportionality of benefit and harm" (p. 1).

**Withholding, withdrawing, and refusal of treatment:** The withholding or withdrawal of life-sustaining treatment (WWLST), such as mechanical ventilation, cardiopulmonary resuscitation, chemotherapy, dialysis, antibiotics, and artificially provided nutrition and hydration, is ethically acceptable. Studies indicate that most patients who die in a hospital, particularly in intensive care, do so following the withdrawing or the withholding of life-prolonging therapies (Ersek, 2005). WWLST is allowing the patient to die from their underlying medical condition and does not involve an action to end the patient's life.

Patients have the right to exercise their decisional authority relative to health care decisions, including foregoing life-sustaining treatments. The provision of medications with the intent to promote comfort and relieve suffering is not to be confused with the administration of medication with the intent to end the patient's life. In palliative sedation, medications are used to create varying degrees of unconsciousness for the relief of severe, refractory symptoms at end-of-life, when all other palliative interventions have failed. Some clinicians and ethicists consider this an alternative to assisted suicide, as the intention of the physician is not to cause death, but to relieve suffering (Quill, Lee, & Nunn, 2000). Some have argued that patients have a right to the autonomous choice of assisted suicide and that ending suffering quickly is an act of beneficence (Ersek, 2004, 2005).

**Legislative and community initiatives:** Fontana (2002) asserts that nurses caring for terminally-ill patients who are considering assisted suicide will increase as the aid-in-dying movement continues to achieve momentum. Three states have legalized assisted suicide, beginning with Oregon in 1997, followed by Washington in 2008, and Montana in 2009 (Lachman, 2010). The mission of the organization, Compassion & Choices, is to "improve care and expand choice at the end of life" ([www.compassionandchoices.org](http://www.compassionandchoices.org)). Compassion & Choices provides education, support, and advocacy to patients and families related to accessing excellent end-of-life care, promotes healthcare policy initiatives to expand the option of assisted suicide, and upholds an individual's right to seek assisted suicide to avoid intolerable suffering. Nurses will likely be increasingly exposed to requests from patients or families and encounter ethical dilemmas surrounding the legal option of assisted suicide. Nurses need to be aware of their own sense of suffering, discomfort, confusion, and inadequacy that could be caused by aid-in-dying. Nurses should seek the expertise and resources of others including nurse colleagues, other interprofessional healthcare team members, pastoral services, hospice specialists, and ethics consultants/committees when confronting the complexity of these issues. Acknowledgement of the struggle of those loved ones caring for the patient and the patient's vulnerability can connect nurses deeply with the experience of the patient and family.

Despite changes in a few states regarding the legalization of assisted suicide, the public, as well as professional nursing, remains uneasy. Seventy percent of the Ferrell et al (2002) sample of oncology nurses opposed legalization of assisted suicide. Carroll (2007) found a public divided, but an increasing acceptance toward support of both assisted suicide and euthanasia. Nursing needs to be prepared for political and public moral discourse on these issues and to understand how *The Code* responds to these questions. Nurses must examine assisted suicide and euthanasia not only from the perspective of the individual patient, but from the societal and professional community perspectives as well. Involvement in community dialogue and deliberation on these issues will allow nurses to recommend, uphold initiatives, and provide leadership in promoting optimal symptom management and end-of-life care.

The Oregon Nurses Association (ONA) has developed resources to guide nurses in their practice around patient or family requests for assistance in dying (ONA, 1997). Nurses can choose to be involved in providing care to a patient who has made the choice to end his/her life or may decline to

participate based on personal moral values and beliefs. In this latter case the nurse can “conscientiously object to being involved in delivering care. ONA states that the nurse is obliged to provide for the patient’s safety, to avoid abandonment, and withdraw only when assured that alternative sources of care are available to the patient” (Task Force, 2008, p. 2).

If the nurse chooses to stay involved with the patient, the nurse may do all of the following:

- Explain the law as it currently exists.
- Discuss and explore patient options with regard to end-of-life decisions and provide resource information or link the patient and family to access the services or resources they are requesting.
- Explore reasons for the patient’s request to end his or her life and make a determination as to whether the patient is depressed and, if so, whether the depression is influencing his or her decision, or whether the patient has made a rational decision based on personal values and beliefs (ONA, 1997, p. 2).

***Professional organization perspectives on participation:*** Both the American Medical Association and the ANA (2010b) state that clinician’s participation in assisted suicide is incompatible with professional role integrity and violates the social contract the professions have with society. Physician-assisted suicide is essentially discordant with the physician’s role as healer, would be problematic to control, and would pose grave societal risks. Instead of joining in assisted suicide, physicians must aggressively answer to the necessities of patients at the end of life (AMA, 1996). Both have vowed to honor the sanctity of life and their duty not to inflict harm (nonmaleficence). The American Psychological Association (2009) takes a position that neither endorses nor opposes assisted suicide at this time. The American Public Health Association (2008):

“Supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA [Death with Dignity Act] are in place. A “terminal condition” is defined in state statutes. Some states specify a life expectancy of 1 year or 6 months; other states refer to expectation of death within a “reasonable period of time”. .

Acknowledging the prohibition against participation in assisted suicide does not necessarily lessen the distress and conflict a nurse may feel when confronted with a patient's request. Nurses may encounter agonizing clinical situations and experience the personal and professional tension and ambiguity surrounding these decisions. The reality that all forms of human suffering and pain cannot necessarily be removed except through death is not adequate justification for professional sanctioning of assisted suicide.

Nurses receiving requests for assistance in dying is not new. Many studies have documented such requests (Asch, 1996, 1997) Ferrell, Virani, Grant, Coyne, & Uman 2000; Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002; Matzo & Emanuel, 1997; Volker, 2003). The number of requests and the nurse's subsequent illegal action was initially startling to some, especially in the Asch (1996) study, where 17% of the critical care nurses received requests and 16% engaged in assisted suicide or euthanasia. The validity of the study was questioned because the definitions were vague. In Matzo and Emanuel (1997) only 1% of respondents stated that they provided or prescribed drugs they knew would be used for assisted suicide. Ferrell, et al. (2000) found 3% had assisted in helping patients obtain medication and 2% had administered a lethal injection at the patient's request.

The nurse may not administer the medication that will lead to the end of the patient's life. Also the nurse may not subject patients, families, or colleagues to judgmental comments about the patient's choice. If the nurse believes that assisted suicide is morally justified, but works in a jurisdiction where assisted suicide is illegal, then participating puts the nurse at risk for civil and criminal prosecution, loss of license, and imprisonment (Ersek, 2005). Relative to ANA's position, participation in assisted suicide would be in direct violation of *The Code*.

Several questions are still relevant to assess the patient's request for dying. All of the questions are directed to understanding the meaning of the request to the patient. For example, questions such as: What reason does the patient give for the request? Does the patient view suicide as the only option? What is the social, cultural, and religious context? These questions assist nurses in better understanding the meaning of these requests and help patients deal with the emotional suffering that may accompany this burden.

## Recommendations

- Increase education for undergraduate, graduate, and doctorally-prepared nurses in developing effective communication skills in caring for patients with life threatening illnesses who request assisted suicide or euthanasia.
- Increase education for nurses in values clarification to promote nurses' understanding and clarify attitudes towards euthanasia and assisted suicide while at the same time supporting a patients' autonomous decision-making.
- Develop and/or coordinate efforts with other nursing organizations to help nurses reframe end-of-life care communication to avoid inflammatory language (i.e. "pull the plug") that undermines improvements in palliative care and to continue the dialogue regarding nursing's role when patients request assistance in dying.
- Collaborate with local nursing organizations in states where assisted suicide is legal to educate nurses regarding what professional obligations do and do not exist when nurses in those states are present at such requests.



- Increase ANA outreach to the media to assist the public in acquiring a better understanding of palliative care and hospice and dispel potential misunderstandings.
- Promote frank and open discussions within nursing at the highest levels of leadership in an effort to discourage secrecy and misunderstanding as to the realities of daily nursing practice for those nurses who work in practice settings where these issues are not unusual, given the population being served.
- Provide resources to help nurses manage their own distress and the distress of their patients when assisted suicide or euthanasia is requested.
- Encourage nurses to seek the expertise and resources of others including nurse colleagues, other interprofessional healthcare team members, pastoral services, hospice specialists, and ethics consultants/committees when confronting the complexity of these issues.
- Increase nursing's voice in the assisted suicide and euthanasia debates in practice and legislative arenas to articulate the reasons for ANA's opposition to nursing's participation, based upon its ethical position as reflected in *The Code*.

## Summary

The American Nurses Association recognizes that assisted suicide and euthanasia continue to be debated. Despite philosophical and legal arguments in favor of assisted suicide, it is the position of the ANA as specified in *The Code* that nurses' participation in assisted suicide and euthanasia is strictly prohibited.

Nurses must acquire the competencies required to become experts in providing palliative care and manage the patient's symptoms compassionately and effectively in collaboration with other members of the interprofessional healthcare team. Nurses must remain informed and be cognizant of shifting moral landscapes, legislative activity, and ongoing debate related to assisted suicide and euthanasia. More education is needed to assist nurses in responding in an ethical and compassionate manner that is consistent with the provisions and interpretive statements outlined in *The Code* when patients present with such requests.

ANA acknowledges that there are nurses working in states where assisted suicide is legal. The ANA Center for Ethics and Human Rights is available to provide consultation to nurses who are confronted with these ethical dilemmas to assist them in upholding their professional responsibilities, despite the moral distress they may encounter when confronted with these situations.

## References

American Academy of Hospice and Palliative Medicine. (2007). Physician-assisted death. Retrieved from <http://www.aahpm.org/positions/default/suicide.html>

- American Medical Association. (1996). Opinion 2.211: Physician-Assisted Suicide. (June.) Retrieved from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>
- American Nurses Association. (2001). *Code of Ethics for Nurses with interpretive statements*. Silver Spring, MD: American Nurses Publishing.
- American Nurses Association. (2010a). *Nursing: Scope and standards of practice*. (2<sup>nd</sup> ed.) Silver Spring, MD: Nursesbooks.com.
- American Nurses Association. (2010b). *Nursing's social policy statement: The essence of the profession*. Silver Spring, MD: Nursesbooks.com.
- American Nurses Association. (2010c). Registered nurse's role and responsibilities in providing expert care and counseling at end-of-life. Silver Spring, MD: Author.
- American Nurses Association and Hospice and Palliative Nurses Association. (2007). *Hospice and palliative nursing: Scope and standards of practice*. Silver Spring, MD: Nursesbooks.com.
- American Psychological Association. (2009). APA policies on end of life issues and care: APA resolution on assisted suicide. (January). Retrieved from <http://www.apa.org/about/policy/assisted-suicide.aspx>
- American Public Health Association. (2008). Patients' rights to self-determination at the end of life. (October 28. Policy # 20086). Retrieved from <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372>
- Asch, D.A. (1996). The role of critical care nurses in euthanasia and assisted suicide. *New England Journal of Medicine*, 334, 1374–1379.
- Asch, D.A. (1997). Euthanasia among U.S. critical care nurses: Practices, attitudes, and social and professional correlates. *Medical Care*, 35, 890–900.
- Carroll, J. (2007). Public divided over moral acceptability of doctor-assisted suicide Retrieved from <http://www.gallup.com/poll/27727/public-divided-over-moral-acceptability-doctorassisted-suicide.aspx>
- Compassion & Choices. (2012). Nurses' talking points. Retrieved from <http://www.compassionandchoices.org/what-you-can-do/get-involved/nurses-talking-points/>
- Ersek, M. (2004) The continuing challenge of assisted death. *Journal of Hospice and Palliative Nursing*, 6(1). Retrieved from [http://www.medscape.com/viewarticle/468566\\_5](http://www.medscape.com/viewarticle/468566_5)
- Ersek, M. (2005). Assisted suicide: Unraveling a complex issue. *Nursing 2005*, 35(4) 48–52.

- Ferrell, B, Virani, R., Grant, M., Coyne, P., & Uman, G. (2000). Beyond the Supreme Court decision: Nursing perspectives on end-of-life care. *Oncology Nursing Forum*, 27, 445–455.
- Fontana, J. (2002). Rational of the terminally ill. *Journal of Nursing Scholarship*, 34(2), 147–151.
- Ganzini, L., Harvath, T.A., Jackson, A., Goy, E.R., Miller, L.L., & Delorit, M.A. (2002). Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *New England Journal of Medicine*, 347, 582–588.
- Hermann, C.P., & Looney, S.W. (2011). Determinants of quality of life in patients near the end of life: A longitudinal perspective. *Oncology Nursing Forum*, 38(1), 23–31. doi:10.1188/11.ONF.23–31
- Hospice and Palliative Nurses Association. (2011). Palliative sedation. Pittsburg, PA: Author. Retrieved from <http://www.hpna.org/DisplayPage.aspx?Title1=Position%20Statements>
- Lachman, V.D. (2010). Physician-assisted suicide: Compassionate liberation or murder? *MedSurg Journal*, 19(2), 121–125.
- Matzo, M.L. & Emanuel, E.J. (1997). Oncology nurses' practices of assisted suicide and patient-requested euthanasia. *Oncology Nursing Forum*, 24, 1725–1732.
- National Consensus Project for Quality Palliative Care. (2009). *Clinical practice guidelines for quality palliative care*, (2<sup>nd</sup> ed.). Pittsburgh, PA: Author.
- Oregon Nurses Association. (1997). Assisted suicide: The debate continues. *The Oregon Nurse*, 62(2). Retrieved from <http://www.oregonrn.org/associations/10509/files/Assisted%20Suicide%20Adjusted.pdf>
- Quill, T.E., Lee, B.C., & Nunn, S. (2000). Palliative treatments of last resort: Choosing the least harmful alternative. University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel. *Archives of Internal Medicine*, 132, 29–37.
- Sherman, D.W., & Cheon, J. (2012). Palliative care: A paradigm of care responsive to the demands for health care reform in America. *Nursing Economics*, 30(3), 153–162, 166.
- Smith, K.A., Goy, E.R., Harvath, T.A., & Ganzini, L. (2011). Quality of death and dying in patients who request physician-assisted suicide. *Journal of Palliative Medicine*, 14(4), 445–450.
- Task Force to Improve the Care of Terminally-Ill Oregonians. (2008). *The Oregon Death with Dignity Act: A guidebook for health care professionals*. (Convened by the Center for Ethics in Health Care, Oregon Health and Science University.) Retrieved from <http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>
- Volker, D.L. (2003). Assisted dying and end-of-life symptom management. *Cancer Nursing*, 26(5), 392–399.

