

Vicki Lachman

Physician-Assisted Suicide: Compassionate Liberation or Murder?

TTrue or False (answers are in the article and at end of the article)

1. Physicians and nurses skilled in palliative care would make assisted suicide unnecessary.
2. Palliative care clinicians see aid in dying as an attempt to sanitize killing.
3. Patients see a *good death* as a right.
4. Oregon health care workers, institutions, and systems have the right to refuse to participate in the Oregon Death with Dignity Act.
5. A 2005 Harris poll revealed a 70%-29% majority of adults are in favor of a law that would "allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended" (Harris Interactive, 2005, ¶ 3).

Fontana (2002) claimed the right-to-die movement is gaining momentum and nurses will care increasingly for terminally ill patients who are considering suicide. She presented a historical perspective on rational suicide dating to ancient Greece in first century B.C. Ancient Rome approved of voluntary suicide and continued to sanction it through the Middle Ages. Fontana suggested it was the influence of the Christian church, which ascribed a sinful nature to suicide, which kept it from being explicitly accepted.

Some say right to die, good death, rational suicide, aid in dying, and merciful release are all euphemisms for the possibility of killing or assisting individuals to kill themselves (Salladay, 2004). Physician-assisted suicide (PAS) can be defined as follows: "When a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the purpose of assisting the patient to end his or her own life" (American Geriatrics Society [AGS], 2007, ¶ 2). AGS also defined voluntary active euthanasia as "when, at the request of the patient, a physician administers a medication or treatment, the intent of which is to end

the patient's life" (¶ 3). Today, the United States supports individual autonomy and honors a patient's right to self-determination (Jamison, 2000). With that in mind, should nurses also respect a patient choosing a good death for himself or herself? If they accept a patient's right to autonomous choice, must they also accept a patient's right to die?

The answer to these questions lies in nurses' moral conscience, as well as the ethical and legal issues surrounding the individual patient. In this article, a brief overview of the three states that have legalized PAS is provided. Information follows regarding who can request PAS and possible nurse responses to these requests. Practical guidelines are provided for nurses who are caring for patients at end of life and receive requests for assistance in dying.

Three States Legalize PAS

In June 1997, the U.S. Supreme Court decided there is no constitutional right to die, but justices did not prohibit states from passing laws that could establish a constitutional right to die (Salladay, 2004). Oregon legalized PAS in 1997, and its action was upheld by the Supreme Court when it removed the obstacle to the state's efforts to authorize physician-assisted suicide, ruling 6-3 that John Ashcroft, the former attorney general, acted without legal authority in 2001 when he threw the federal government's weight against Oregon's Death With Dignity Act (Greenhouse, 2006). The requirements for attending/prescribing or consulting a physician to write the prescription for secobarbital or phenobarbital is clear (see Table 1). However, the hastening of death in Oregon remains uncommon (see Figure 1). In 2008, 30,973 people died in Oregon; only 60 of them died from PAS (Oregon Center for Health Statistics, 2008).

The good news is that this legalization of assisted death was coupled with significant improvements in palliative care training for physicians, the communication of patient wishes regarding life-sustaining treatment, pain management, increased rates of referral to hospice programs, and increased percentage of deaths occurring at home (Quill, 2007). A comprehensive guidebook for clinicians was made available online (The Task Force to Improve the Care of

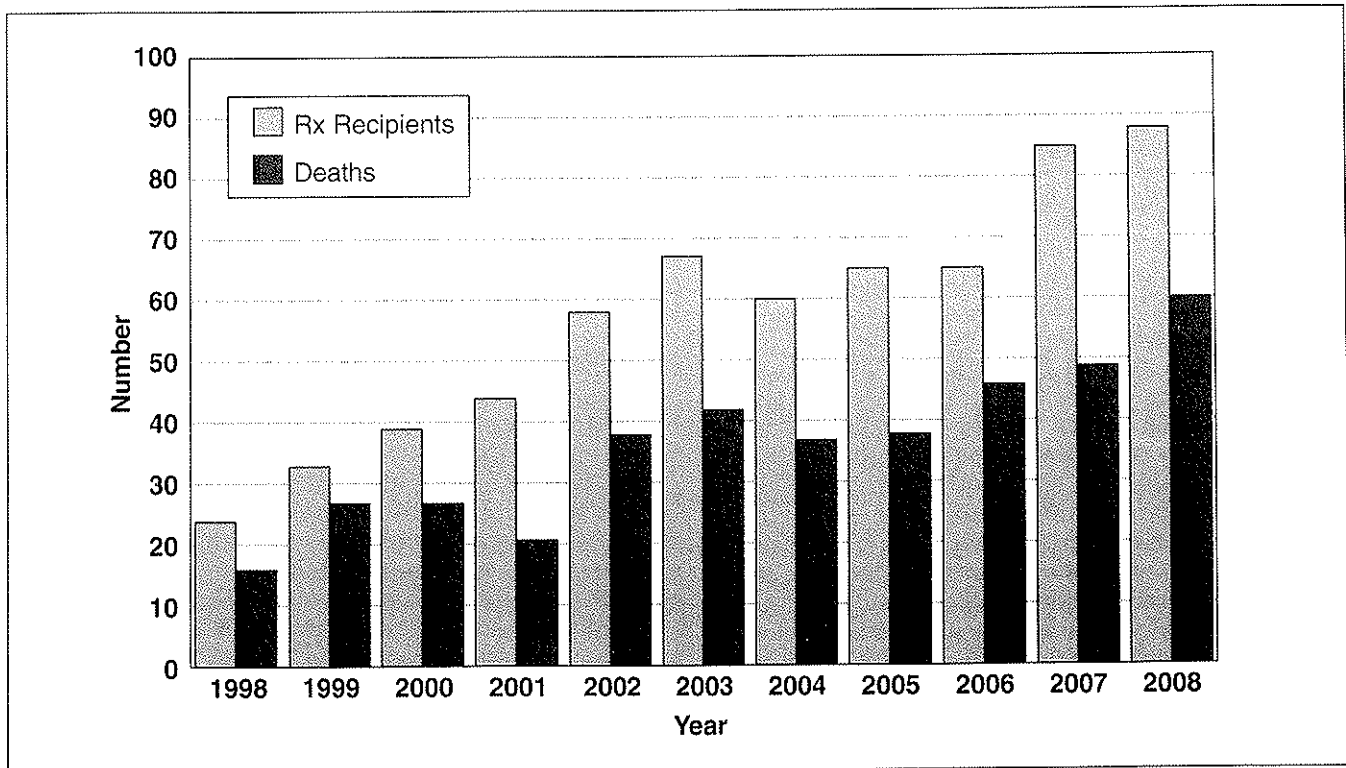
Vicki D. Lachman, PhD, MBE, APRN, is a Clinical Associate Professor, Drexel University, Philadelphia, PA.

Table 1.
Safeguards and Guidelines in the Oregon Act

1. Requires the patient give a fully informed, voluntary decision.
2. Applies only to the last 6 months of the patient's life.
3. Makes it mandatory that a second opinion by a qualified physician be given that the patient has fewer than 6 months to live.
4. Requires two oral requests by the patient.
5. Requires a written request by the patient.
6. Allows cancellation of the request at any time.
7. Makes it mandatory that a 15-day waiting period occurs after the first oral request.
8. Makes it mandatory that 48-hours (2 days) elapse after the patient makes a written request to receive the medication.
9. Punishes anyone who uses coercion on a patient to use the Act.
10. Provides for psychological counseling if either of the patient's physicians thinks the patient needs counseling.
11. Recommends the patient inform his/her next of kin.
12. Excludes nonresidents of Oregon from taking part.
13. Mandates participating physicians are licensed in Oregon.
14. Mandates Health Division Review.
15. Does not authorize mercy killing or active euthanasia.

Source: Compassion & Choices of Oregon, 2009b.

Figure 1.
Number of DWDA Prescription Recipients and Deaths by Year in Oregon, 1998-2008.



Source: Oregon Department of Human Services, 2008.

Terminally-ill Oregonians, 2008). This guidebook will be discussed later as a major resource for addressing clinical and ethical issues surrounding PAS.

Discussion of passage of the Oregon or Washington initiatives must include Compassion & Choices. Compassion & Choices leaders see its primary role in three arenas: (a) supporting dying patients and their families, (b) advocating for legal and legislative initiatives, and (c) educating the public and health care professionals on end-of-life decision making (Compassion & Choices, 2009a). They utilize "client support volunteers" who counsel patients and families on how to gain access to excellent end-of-life care and effective pain and symptom management, while upholding their right to seek aid in dying to avoid intolerable suffering. Compassion & Choices promotes informed end-of-life decision making by educating the public and advising health care professionals. Finally, they devote countless hours to creative legal and legislative initiatives to secure comprehensive and compassionate options at the end of life.

In November 2008, residents of Washington voted 58% to 42% to allow PAS (Steinbrook, 2008). The Washington act took effect in March 2009. Washington had rejected a broader initiative that allowed doctors to administer lethal drugs in 1991. Compassion & Choices created and played a key role in the coalition that passed Washington Initiative 1000 into law (Compassion & Choices of Washington, 2009a). The title of the official ballot measure referred to the measure as "aid in dying." Supporters of the measure called it the Death with Dignity Initiative, and critics referred to it as the Assisted Suicide Initiative (Washington State, n.d.). If Washington's experience is similar to Oregon, more deaths eventually will occur there than in Oregon simply because of the population difference (Washington 6.5 million, Oregon 3.7 million) (Steinbrook, 2008).

Montana became the third state to legalize PAS in December 2009. "Physicians in Montana should not fear criminal prosecution when writing lethal prescriptions for mentally competent patients with terminal illnesses, the state's Supreme Court said in a 4-2 decision issued Dec. 31, 2009" (O'Reilly, 2010, ¶ 1). The court refused to rule terminally ill Montanans have a constitutional right to doctors' assistance in dying, choosing for the restricted position of statutory interpretation. Even though Oregon and Washington used state ballot measures, Montana's efforts may be a precedent for future legal maneuvers. This new way of going through the courts may be better than ballot initiatives that are very expensive (O'Reilly, 2010).

Who Requests PAS?

By 2020, 2.5 million Americans age 65 and older will die each year; 40% of deaths will occur in nursing homes (Valente, 2004). When a patient whose quality of life is limited requests to hasten death, nurses may feel torn between honoring the patient's autonomous right to decide and respecting the sanctity of life. People with cancer, as well as AIDS, amyotrophic lateral sclerosis (ALS), other advanced or terminal illness, poorly managed pain, and other symptoms commonly

make requests for hastened death (Jamison, 2000). A study of patients in Oregon and Washington with ALS found hopelessness was a key factor in making a request under the Oregon Death with Dignity Act (Ganzini, Johnson, McFarland, Tolle, & Lee, 1998). According to the 2007 State Health Division report on Oregon's Death with Dignity Act, the most commonly reported concerns were decreasing ability to participate in activities that make life enjoyable (86%), losing autonomy (100%), and losing dignity (86%) (Oregon Department of Human Services, 2008). The reasons for making a request thus are complex, not simply a matter of symptom control.

How Frequently Do Patients Ask for Assisted Dying?

Approximately 1 of 1,000 dying Oregonians obtain and use a lethal dose of medication; 17% personally considered it as an option (Tolle et al., 2004). Almost two-thirds of surveyed hospice nurses and social workers in Oregon reported having at least one patient ask them about the option during the previous year (Miller et al., 2004). However, these requests are not limited to states where PAS is legal.

A few studies have documented nurses' willingness to engage in assisted suicide or active euthanasia. Kuhse and Singer (1993) found 85% of 218 Australian nurses carried out the requests of physicians for active euthanasia. Asch (1996) found 16% of 1,139 critical care nurses acted on family or patient requests for assistance or active euthanasia. Ferrell, Virani, Grant, Coyne, and Uman (2000) found 3% of nurses had engaged in active euthanasia. In interviews with 10 nurses who were willing to talk about being asked for help in dying, Schwarz (2003) found their decisions about whether to aid patients in dying were not rule-based, but context-driven. Participants did not refer to the code of ethics or their profession's position statement on assistance in dying, but focused on the individual patient's situation.

None of the U.S. laws authorize mercy killing, lethal injection, or active euthanasia (Paris, 2009). Unlike laws in several European countries, the line in the United States is drawn at allowing physician-assisted suicide. Physician-hastening death is legal in Belgium, the Netherlands, and Switzerland (Holt, 2008). In the Netherlands, about two-thirds of the requests for assistance in dying are not granted; the presence of a psychiatric illness was at least one key reason in the government-commissioned studies of 1995 and 2001 (Battin, van der Heide, Ganzini, van der Wal, & Onwuteaka-Philipsen, 2007). In 2002, the Netherlands legalized advance euthanasia directives for patients with dementia. In 2,200 cases, 76% of the time the directive was discussed but euthanasia was seldom performed (Rurup, Onwuteaka-Philipsen, van der Heide, van der Wal, & van der Maas, 2005).

Warnings about potential abuse on vulnerable populations have been voiced by many groups over the years. In a comparison study of physician-assisted dying in Oregon and the Netherlands, Battin and colleagues (2007) found no evidence that patients in the vulnerable groups were more likely to receive PAS.

Vulnerable groups were defined as elders, women, uninsured (Oregon only), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illness, or racial or ethnic minorities. Data came from Oregon Department of Human Services reports (1998-2006) and three independent studies, as well as from four Netherlands' government-commissioned studies (1990, 1995, 2001, 2005). The only heightened risk was found to be with persons with AIDS. These results indicated the argument that vulnerable populations would be disproportionately affected is false.

What Is the Best Response for Nurses to a Request for Aid in Dying?

The American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* (2001) identified the expectation that nurses provide interventions to relieve pain and suffering of the dying patient, even if they may hasten death. However, the same passage states, "...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. 8). The ANA (1994) indicated a belief that nurses should not participate in assisted suicide or active euthanasia because such an act is in direct violation of the *Code of Ethics for Nurses*, the ethical traditions and goals of the profession, and its covenant with society.

The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals (The Task Force to Improve the Care of Terminally-Ill Oregonians, 2008) provides information for health care professionals on an array of issues nurses face in states that allow PAS. The rights of patients and their surrogates to take part in medical decision-making is a firm principle. Because patients have the right to information regarding treatment options, nurses in Oregon may give a patient information about obtaining a prescription if he or she requests it. Nurses should not initiate the discussion, however, because the patient may feel pressured to pursue this option. If nurses do not want to discuss this option, transfer of care should be arranged. However, only rarely would a dying person be a hospital inpatient at the time the prescription is self-administered.

When requests are made, nurses should respond by first examining their own values about assisted dying, listening to the patient's concerns, addressing unmet needs with palliative care options by aggressively managing symptoms, and maintaining a non-judgmental attitude (The Task Force to Improve the Care of Terminally-Ill Oregonians, 2008; Volker, 2003; Wurzbach, 2000). The previously mentioned Oregon guidebook offers effective clinical strategies for end-of-life care to reduce suffering. It also outlines the ethical issues nurses face in the struggle to come to terms with the option of PAS.

Is palliative care always the answer? In secondary analysis of written stories, 36 nurses told their experiences with a request for assisted dying (Volker, 2003). Twelve nurses refused to carry out patients' requests and described symptom management strategies; 24

nurses denied ever having received requests and described practices they believed prevented the requests. Both groups of nurses used similar, established palliative care strategies to lessen suffering in this ethically troubling situation. Some of these nurses questioned whether professional values and mandates should override a patient's request for aid in dying.

After analyzing 100 articles/legal cases, Holt (2008) concluded that because of methodological and design differences, conclusions on nurse attitudes toward euthanasia are limited. No common attitude was found among physicians or nurses in the United States or United Kingdom. However, nurses who frequently care for dying patients did tend to be less supportive of euthanasia. Nurses' support of patient autonomy did not necessarily mean they were supportive of euthanasia.

Conscientious objection begins with the idea that people are not obligated to carry out acts that violate their conscience, even if the acts are legally or professionally legitimate. The Oregon Death with Dignity Act gives support to conscientious practice and respect by stating unequivocally, "No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his/her life in a humane and dignified manner" (Oregon Government, 2007, 127.885 s 4.01[4]).

A legal alternative to PAS is for the patient to stop eating and drinking; this is seen as a choice of stopping life-sustaining treatment (Valente, 2004). If the patient is competent and physical, psychological, and spiritual symptoms have been managed, he or she has a right to exercise this choice. When a person stops eating and drinking, death usually occurs in 1-3 weeks (Valente, 2004). This is consistent with current law in most states, but does require support of caregivers. Professional nurses must honor the patient's wishes and not intervene. Mouth care is needed and palliative care can help caregivers manage the symptoms and the dying process.

Summary

PAS is legal only in Oregon, Washington, and Montana. Studies show nurses receive requests for aid in dying from patients (Asch, 1996; Ferrell et al., 2000; Kuhse & Singer, 1993; Schwarz, 2003; Volker, 2003; Wurzbach, 2000). The simple answer to these requests is that the nurse is prohibited in participating in assisted suicide or euthanasia by the *Code of Ethics for Nurses* and by the ANA position statements (ANA, 1994). In this article, the author attempted to present a balanced view of the ethical issues on both sides of the question of PAS. Honoring the autonomy of a patient does not require participation in PAS. However, nurses who support PAS speak of the patient's autonomous choice and their choice to assist in ending suffering of terminally ill patients. As more states pass ballot initiatives or laws supporting PAS, nurses will be faced with the legal choice to participate in the process of PAS by providing information on the option and attending to the patient who has taken the lethal drug. Nurses need to consider their comfort with the

idea that patients may choose to accelerate dying.
Answers (1. False, 2. True, 3. True, 4. True, 5. True) ■

References

- American Geriatrics Society (AGS). (2007). *Physician-assisted suicide and voluntary active euthanasia*. Retrieved from <http://www.americangeriatrics.org/products/positionpapers/vae94.shtml>
- American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.
- American Nurses Association (ANA). (1994). *Ethics and human rights*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/EthicsandHumanRights.aspx>
- Asch, D. (1996). The role of critical care nurses in euthanasia and assisted suicide. *New England Journal of Medicine*, 334(21), 1374-1379.
- Battin, M.P., van der Heide, A., Ganzini, L., van der Wal, G., & Onwuteaka-Philipsen, B.D. (2007). Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in "vulnerable" groups. *Journal of Medical Ethics*, 33(10), 591-597.
- Compassion & Choices. (2009a). *About Compassion & Choices*. Retrieved from <http://www.compassionandchoices.org/learn>
- Compassion & Choices of Oregon. (2009b). *Compassion & Choices of Oregon - The Oregon law*. Retrieved from <http://www.compassionoforegon.org/index.php?a=law>
- Compassion & Choices of Washington. (2009). *Compassion & Choices of Washington advocates for excellent end-of-life care, patient-centered care, and expanded choice at the end of life*. Retrieved from <http://www.compassionwa.org/>
- 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(3), 445-455.
- Fontana, J. (2002). Rational of the terminally ill. *Journal of Nursing Scholarship*, 34(2), 147-151.
- Ganzini, L., Johnson, W., McFarland, B., Tolle, S.W., & Lee, M.A. (1998). Attitudes of patients with amyotrophic lateral sclerosis and their care givers toward assisted suicide. *New England Journal of Medicine*, 339(14), 67-973.
- Greenhouse, L. (2006, January 17). *Supreme Court removes obstacle to assisted-suicide laws*. Retrieved from <http://www.nytimes.com/2006/01/17/politics/politicsspecial1/18scotuscd.html>
- Harris Interactive. (2005, April 27). *Harris poll: Majorities of U.S. adults favor euthanasia and physician-assisted suicide by more than two-to-one*. Retrieved from http://www.harrisinteractive.com/harris_poll/index.asp?PID=561
- Holt, J. (2008). Nurses' attitudes to euthanasia: The influence of empirical studies and methodological concerns on nursing practice. *Nursing Philosophy*, 9(4), 257-272.
- Jamison, S. (2000). Factors to consider before participating in a hastened death: Issues for medical professionals. *Psychology, Public Policy, and Law*, 6(2), 416-433.
- Kuhse, H., & Singer, P. (1993). Voluntary euthanasia and the nurse: Australian survey. *International Journal of Nursing Studies*, 30(4), 311-322.
- Miller, L.L., Harvath, T.A., Ganzini, L., Goy, E.R., Delorit, M.A., & Jackson, A. (2004). Attitudes and experiences of Oregon hospice nurses and social workers regarding assisted suicide. *Palliative Medicine*, 18(8), 685-91.
- O'Reilly, K.B. (2010). *Physician-assisted suicide legal in Montana, court rules*. Retrieved from <http://www.ama-assn.org/amednews/2010/01/18/prsb0118.htm>
- Oregon Department of Human Services. (2008). *Tenth annual report on the Oregon Death with Dignity Act*. Retrieved from <http://oregon.gov/DHS/ph/pas/docs/year10.pdf>
- Oregon Center for Health Statistics. (2008). *Oregon resident deaths by manner of death and county of residence. 2008 preliminary data*. Retrieved from <http://www.dhs.state.or.us/dhs/ph/chs/data/preabd/deathman.pdf>
- Oregon Government. (2007). *Death with dignity act*. Retrieved from <http://www.oregon.gov/DHS/ph/pas/ors.shtml>
- Paris, J.J. (2009). Why involve physicians in assisted suicide? *The American Journal of Bioethics*, 9(3), 32-34.
- Quill, T.E. (2007). Legal regulation of physician-assisted death—the latest report cards. *The New England Journal of Medicine*, 356(19), 1911-1913.
- Rurup, M.L., Onwuteaka-Philipsen, B.D., van der Heide, A., van der Wal, G., & van der Maas, P.J. (2005). Physicians' experiences with demented patients with advance euthanasia directives in the Netherlands. *Journal of the American Geriatric Society*, 53(7), 1138-1144.
- Salladay, S.A. (2004). Clinician-assisted suicide: Merciful release or unlawful death? *Journal of Christian Nursing*, 21(4), 14-17.
- Schwarz, J.K. (2003). Understanding and responding to patients' requests for assistance in dying. *Journal of Nursing Scholarship*, 35(4), 377-384.
- Steinbrook, R. (2008). Physician-assisted death—From Oregon to Washington State. *The New England Journal of Medicine*, 359(24), 2513-2515.
- The Task Force to Improve the Care of Terminally-Ill Oregonians. (2008). *The Oregon Death with Dignity Act: A guidebook for health care professionals*. Retrieved from <http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>
- Tolle, S.W., Tilden, V.P., Drach, L.L., Fromme, E.K., Perrin, N.A., & Hedberg, K. (2004). Characteristics and proportion of dying Oregonians who personally consider physician-assisted suicide. *Journal Clinical Ethics*, 15(2), 111-118.
- Valente, S.M. (2004). End-of-life challenges: Honoring autonomy. *Cancer Nursing*, 27(4), 314-319.
- Volker, D.L. (2003). Assisted dying and end-of-life symptom management. *Cancer Nursing*, 26(5), 392-399.
- Washington State. (n.d.). *The Washington Death with Dignity Act: Initiative Measure 1000*. Retrieved from <http://wei.secstate.wa.gov/osos/en/Documents/11000-Text%20for%20web.pdf>
- Wurzbach, M.E. (2000). Nursing perspectives on practitioner-suicide. *Nursing Outlook*, 48(3), 116-119.



AHRQ Releases New Health Literacy Tool

The Agency for Healthcare Research and Quality recently released the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Item Set for Addressing Health Literacy in English and Spanish. The primary purpose of the CAHPS Item Set for Addressing Health Literacy is to measure, from the patient's perspective, how well health care professionals communicate with the patient. Only 12% of U.S. adults have proficient health literacy. Over a third of U.S. adults (77 million people) could have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart.

The tool consists of 29 supplemental items designed for use with the CAHPS® Clinician and Group Survey. The items address six areas: communication with doctors, communication about health problems and concerns, communication about medications, communication about tests, communication about forms, and communication about disease self-management. View the health literacy tool at www.cahps.ahrq.gov/content/products/HL/PROD_HL_Intro.asp?p=1021&s=215