Disclosures

- No financial disclosures or conflict of interest

Objectives

- Describe the process of organizational review of PAD/PAS
- Discuss challenges of hospice and palliative care where PAD/PAS is legal

Note - This session will not discuss whether PAD/PAS is right or wrong. Rather the goal is to move the conversation to supporting clinicians in states where it is legal.
Historical Experience with PAS/PAD

- Clinical and administrative role in hospices in Oregon when Death with Dignity legislation first went to vote
  - As Vice president for the Oregon Hospice Association had to make a statement re organization position on law
  - As a hospice coordinator for a community hospital and a Catholic hospital exposed to different perspectives and organizational responses
- Worked with AAHPM, NHPCO on 2016 a forum on aid in dying
- Revised the HPNA Position Statement on PAD/PAS, 2017

Quick Review States where PAD/PAS is Legal

- 1994 - Ballot Measure 16 Death with Dignity Act voted by Oregonians
  - Injunction until 1997
- 2008 - On the Ballot in Washington and passed
  - The original ground zero as legislation was introduced in 1991
- 2009 - Montana Supreme Court decision “nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy.
- 2013 - Vermont Legislature passed the Act 39 Patient Choice and Control at End of Life Act.
  - First state to pass through legislature
- 2014 - New Mexico initially allowed PAD/PAS but decision was overturned in 2015.
- 2016 - Colorado voters passed Proposition 106 making assisted death legal among patients with terminal illness
- 2017 - District of Columbia passed Death with Dignity Act

Opposing Organizations

- American Medical Association
- American Nurses Association
- National Hospice and Palliative Care Organization
ANA Code of Ethics for Nurses

The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

The nurse respects the patient’s right to self-determination. Nurses assist patients with decisions about resuscitation status, withholding and withdrawing life-sustaining therapies, forgoing nutrition and hydration, palliative care, and advanced directives.

The nurse should provide interventions to relieve pain and symptoms in the dying patient with respect to evidence-based palliative care practice standards and may not act with the sole intent to end life.

ANA 2015, p.3

ANA on Euthanasia, Assisted Suicide, and Aid in Dying

The American Nurses Association prohibits nurses’ participation in assisted suicide and euthanasia because these acts are in direct violation of Code of Ethics for Nurses with Interpretive Statements, 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.

ANA Position Statement Euthanasia, Assisted Suicide, and Aid in Dying. 2013.

American Medical Association Code of Ethics for Physicians

5.7 Physician-Assisted Suicide

- Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

- It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

- Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

  - (a) Should not abandon a patient once it is determined that cure is impossible. (b) Must respect patient autonomy.
  - (c) Must provide adequate comfort care and appropriate pain control.

AMA Principles of Medical Ethics: 1LV 2016.
National Association of Social Workers (NASW)

POLICY STATEMENT
- NASW promotes respect for dignity, quality of life, and self-determination, as defined by each person approaching the end of life. Accordingly, NASW supports legislation, policies, practices, programs, regulations, and research that promote the following principles and goals related to clients’ end-of-life decision making and care:
- Consumer education and health care provider communication about the full range of options for end-of-life care and the potential benefits and risks associated with each option
- Clients' ability to exercise the full range of legally available options as the end of life approaches

Opposing Organizations
- American Medical Association
- American Nurses Association

Supportive Organizations
- Compassion & Choices in Dying
- Death with Dignity
- American College of Legal Medicine
- American Medical Student Association
- American Public Health Association
- National Association of Social Workers
Neutral Organizations

- American Academy of Hospice and Palliative Medicine
- Hospice and Palliative Nurses Association
- American Psychological Association
- American Pharmacists Association

Language Matters

Medical Aid in Dying v. Assisted Death v. Assisted Suicide v. Self Determined Death

- Suicide is a stigmatized term that refers to someone taking their own lives after struggling with mental illness.
- The role of the health care professional – RN vs. APRN, MD/DO vs. PA, SW, Pharmacist, Chaplain
- Conscientious objection versus abandonment
- Education about palliative care versus participation
- Support of professionals in states where it is legal

Ethics

- Patient autonomy
- Nonabandonment
- Integrity
- Beneficence
- Nonmaleficence
Terms and definitions

To discuss the issue – need clarity of the issues
■ Physician-assisted suicide
■ Physician aid in dying
■ Physician-assisted death
■ Hastened Death

Be clear about not focusing on-
■ Voluntary active euthanasia or mercy killing
■ Involuntary active euthanasia or murder
■ Palliative or Terminal sedation
■ Withdrawal or Withholding of technology
■ Voluntary Cessation of Eating and Drinking
■ The vast spectrum of palliative care services
■ International practices and religious organizations

What is an organization to do?
■ Members of the organization
  – Who are they?
■ What is the mission?
■ No matter what – essential to address moral distress
■ Challenge is to keep the conversation neutral and non-blaming

Considerations for professionals
❖ Education about hastening death
❖ Ethical principles;
❖ Legislation around assisted death and its implication;
❖ Code of Ethics for various disciplines
❖ Practice:
  ❖ Assessment and understanding the difference between actual desire for hastened death versus unmanageable symptoms
  ❖ Moral Distress,
❖ Policy – Participation in policy about assisted death as it affects
❖ State Laws vs. Federal Law vs. Professional Standards
❖ Nursing
❖ Social work
❖ Chaplaincy
❖ Pharmacist
Thank you--

- Thoughts and Comments
- Reference and Resource List Available online
Physician Assisted Death Resources

Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN

Practical Aspects of Palliative Care
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Boston, MA

References and Resources

Professional Organizations

American Medical Association.

American Nurses Association.

American Society of Healthsystem Pharmacists. 2103.

Professional Hospice and Palliative Care Organizations

American Academy of Hospice and Palliative Medicine.

Hospice and Palliative Nurses Association.

National Hospice and Palliative Care Organization.

Organizations Promoting Aid in Dying

Compassion & Choices in Dying

Death with Dignity

State Legislation


California. *End of Life Option Act.*
