AO 20.03 Death with Dignity (Aid-in-Dying) Role of the Nurse
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Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

Advisory Opinion: Death with Dignity (Aid-in-Dying): Role of the Nurse

Purpose

The advisory opinion clarifies and provides guidance about the roles and scope practice for the nurse in providing palliative and end-of-life care through the Washington Death with Dignity Act (Chapter 70.245 RCW).

Background

The Washington Death with Dignity Act (Chapter 70.245 RCW) allows an eligible individual with a terminal diagnosis and prognosis to legally request and obtain medications to end their life from the a licensed advanced registered nurse practitioner (ARNP), physician (MD), osteopathic physician (DO), or physician assistant (PA). WAC 246-978 Death with Dignity Requirements implement the law. A qualified patient may select the attending or qualified health care provider of the patient's choosing. If the patient selects the ARNP, the patient must also select an MD or DO to serve as the patient's consulting medical provider. The MD or DO and ARNP may not have a direct supervisory relationship with each other. See the Washington State Department of Health Death with Dignity Act webpage for common questions and answers containing general information about the Death with Dignity Act.

This lack of recognition of the direct and intimate role of nurses in the care of patients at the end-of-life leaves nurses in a potential moral quandary regarding their responsibilities to patients. Aid-in-dying is a new area of ethical concern about which public opinion and public policy has evolved quite rapidly such that professional organizations and individual clinicians are still evolving their positions. The situation is exacerbated by the role of most nurses as employees of health care institutions that may have additional policies regarding aid-in-dying. Unlike physicians and ARNPs who often act as independent practitioners outside their association with an institution, most nurses practice solely under the auspices of their employer. Additionally, nurses have their own personal beliefs about the ethical acceptability of aid-in-dying and their own willingness to be involved. Across the profession, there is a wide range of views that need to be accommodated. Nurses are challenged to define their practice while negotiating the space among these personal, professional, institutional, and legal constraints.

The American Nurses Association's (ANA) position statement, The Nurse's Role when a Patient Requests Medical Aid in Dying (2019), clarifies many of the questions nurses are asking. The position of the ANA is that although nurses are strictly prohibited by law from prescribing or administering aid-in-dying medications, they nonetheless have an obligation to provide all other appropriately supportive care to patients at the end-of-life. This care includes providing objective information, managing distressing symptoms, coaching family and care providers in the management of patient care, and remaining engaged, non-judgmental, and attentive to the evolving needs of the dying and their families. They further suggest that nurses have an obligation to not only be knowledgeable about this issue, but also to be engaged in public policy conversations and research to further explore its merits and consequences.

This position is aligned with the ANA's *Code of Ethics for Nurses* (2015) and *Nursing: Scope and Standards of Practice* (2015). For example, the ANA argues that nurses are not "actively participating" in aid-in-dying when providing information, supporting discussion, or being present with a patient. Instead, all these actions are the nurse's ethical "response to the patient's quality-of-life self-assessment" (p. 3) consistent with Interpretive Statement 1.4 of the *Code* that nurses "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and may not act with the sole intent to end life" (ANA, 2015, p. 3). This is a significant departure from the previous ANA position statement aid-in-dying of 2013 that prohibited participation by nurses in aid-in-dying.

This advisory opinion will not reiterate the positions taken in the ANA statement but refers readers to that document for further exploration. Nor does this opinion take a position on the essential question of the acceptability of aid-in-dying itself. Aid-in-dying is legal in Washington State and, as such, nurses need to be prepared to provide care in this context. The context requires consideration of two issues not fully addressed in the ANA statement: employer restrictions on nursing practice and conscientious objection.

Employer Restrictions on Nursing Practice

Washington state law allows employers to establish policy related to the implementation of aid-in-dying within their institutional boundaries (which may include both in-patient, out-patient, and homecare settings). Most in-patient settings restrict patients from ingesting medications that will end their lives; policies for outpatient and homecare settings are more variable and evolving.

A study in the *Journal of Pain and Symptom Management* (JPSM), Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death (2014), summarizes the content of hospice policies in Washington State. Examples of policies include:

- Restricting or allowing staff to be present at the time of patient self-administration of the medication, as well as the duration between ingestion and death.
- Restricting or allowing staff involvement with the process to obtain life-ending medication.
- Restricting or providing information about the law.
- Preventing or allowing a patient from ingesting a lethal dose of medication on the premises of a health care facility.
- Requiring, encouraging, or discouraging the participation of LPNs, RNs, or ARNPs in the process.
- Restricting or allowing initiating communication and notification of the patient's attending physician.
- Restricting or allowing staff to witness necessary legal documents.

Health care institutions may legitimately create policies that are consistent with their philosophy and mission. Health care entities are prohibited, however, from limiting the provision of information about Washington's Death with Dignity Act or information about what relevant resources are available or how to access those resources. RCW 70.03.020.

The most common and ethically defensible limitation is to not allow nurses to be present at the time of medication administration. This restriction has several advantages. Since nurses are legally constrained from administering the life-ending medications, the policy prevents nurses from being pressured by patients or families to assist in administration—an act that in any other circumstance would be well within the nurse's scope of practice. Additionally, it allows nurses who are ethically opposed to aid-in-dying to avoid needing to explicitly opt-out of this most active participation in the process. For nurses who would be comfortable participating at this stage, it also prevents them from providing support to the patient and family at a critical moment in the dying trajectory. Nurses, particularly hospice and home care nurses, often develop significant empathetic relationships with patients and families over the course of their care and absence at this time can potentially be experienced by the patient as professional abandonment. This is a significant departure from the standard hospice commitment to non-abandonment and the promise to witness the patient through the dying process. While

physicians and ARNPs may choose to practice as independent providers at times like this and be present despite institutional policies, nurses choosing to be present outside their nursing role risk violating professional boundaries. Again, nurses need to decide for themselves whether the restrictions on practice imposed by institutional policies are aligned with their vision of professional practice.

Institutional policies that further restrict nursing practice, such as limiting the nurse's ability to provide objective and non-judgmental information about legal options or provide counseling and emotional support as the patient thinks through their end-of-life decisions are ethically problematic in that they significantly impinge on nursing scope of practice and professional standards of care. In 2020, the Washington legislature clarified that a health care entity may not limit a health care provider's provision of information about and regarding Washington's death with dignity act, Chapter RCW 70.245, information about what relevant resources are available in the community, and how to access those resources for obtaining care of the patient's choice. A health care entity may not discharge, demote, suspend, discipline, or otherwise discriminate against a health care provider for providing such information. RCW 70.03.020.

Conscientious Objection

It is broadly accepted that aid-in-dying is a situation in which a nurse may appeal to conscientious objection to avoid acting in a manner that is contrary to their own moral values. While ensuring that patients receive the beneficial care they desire is a fundamental ethical value, it is necessarily balanced by the right of health care providers to maintain their own moral integrity (Magelssen, 2011). "Having moral integrity implies having an internally consistent set of basic moral ideas and principles and being able to live and act in accordance with these" (Magelssen, 2011, p. 18). When a nurse finds that actively participating in aid-in-dying conflicts with deeply held values and judgments, it is reasonable to consider this objection. (Deeply held values are contrasted with those which are capricious, arbitrary, or situationally convenient.)

Although there are multiple formulations of the criteria such objections must meet, Brock (2008) delineates three criteria:

1) The patient is informed of the full range of care options.
2) The patient must be referred to another provider who can provide the services.
3) The refusal must not create an undue burden on the patient.

Interestingly, the Death with Dignity Initiative explicitly does not require physicians to refer patients requesting aid-in-dying to another provider.

Conscientious objection applies to specific actions, not to patients. Such objections cannot be raised to avoid providing general nursing care for a patient, but only to withdraw from participating in a specific action. For example, in the common example of abortion, a nurse may decline to participate in actively implementing a surgical abortion procedure but may not decline to provide post-operative care to that patient. Conscientious objection cannot be used as a claim to refuse to care for a patient based on their social standing, beliefs, or preferences, nor on the bias or prejudice of the nurse.

This suggests that the only activity nurses may request to avoid is being present when patients are ingesting the medications that will end their lives. Given that so many institutions already restrict nurses from being present anyway, this significantly limits the instances in which nurses may reasonably claim conscientious objection to avoid providing care to a patient. However, nurses should be attentive to their own self-presentation and their ability to provide compassionate and non-judgmental care to a patient who is making a decision that is contrary to their deeply held beliefs. If other staff are reasonably available and can substitute for the objecting nurse, it may benefit both the patient and the nurse to make this change. Such an accommodation, however, does not remove the obligation of the nurse to reflect on the opportunity for developing a more empathetic and patient-centered stance.

Statement of Scope

Nurses are accountable and responsible for providing compassionate and comprehensive care to all patients, regardless of their end-of-life choices. Nurses may decline active participation in the implementation of aid-in-dying, but they remain responsible for the full scope of end-of-life care including providing information, symptom management, and other palliative or end-of-life interventions.

The WABON determines that in addition to all standard nursing care the following behaviors are consistent with the standard of care when providing nursing care to patients who have chosen to end their own life:

- Empathetically explore end-of-life options with the patient and family and link them to services, other health care providers or resources to meet their needs;
- Explain the law as it currently exists;
- Maintain confidentiality about the end-of-life decision-making;
- Provide palliative care for the patient, including administration of medications and treatments for pain and symptom management.;
- Follow Portable Orders for Life Sustaining Treatment (POLST)/advanced directives;
- Determine and pronounce death;
- Collaborate and consult with health care team members;
- Understand the ethical and moral dilemmas related to aid-in-dying
- Understand professional organizations' positions related to aid-in-dying;
- Reflect on personal and professional values and request accommodation on the basis of conscientious objection if needed;
- Understand the employer philosophy, policies, and procedures related to end-of-life decisions and aid-in-dying;
- Understand institutional policy regarding the presence of nurse when a patient self-administers a prescribed lethal dose of medication;
- Be involved in policy development within the health care institution and the community.

Nurses who choose not to be involved:

Under the conditions listed above, nurses may decline to be present when patients are ingesting medication to end their lives. In this situation, the nurse should:

- Request to be relieved from providing care on the basis of conscientious objection;
- Continue to provide standard supportive and palliative care to ensure the patient's comfort and safety and avoid abandonment.
- Withdraw only when assured that alternative sources of care are available for the patient and care has been responsibly transferred to another provider;
- Maintain confidentiality;
- Reflect on self-presentation and the development of a non-judgmental stance to ensure patients feel respected despite differences in values
- Be involved in policy development within the health care institution and community.

Nurses shall not:

- Administer the medication that will lead to the end of the patient's life;
- Breach confidentiality of patients exploring or choosing assisted suicide;
- Subject patients or families to disrespectful, judgmental comments or actions because of their decision to choose aid-in-dying
- Subject colleagues to disrespectful comments or actions due to their decision to continue to provide care to a patient who has chosen aid-in-dying;
- Abandon or refuse to provide comfort and safety measures to patients.

Institutional Policy Constraints:

If institutional policies prohibit staff from participating in the aid-in-dying process with interested patients, the WABON recommends that the patient be referred to their attending physician, the Washington State Department of Health and/or the patient rights organization, End of Life Washington, to obtain information and initiate the legal process.

Requirements and Recommendations

Providing care throughout the dying process to patients choosing to end their life through the Death with Dignity Act is within the nursing scope of practice and does not violate any professional norms. However, nurses exploring their obligations to the dying are confronted with a complex set of considerations. Aid-in-dying is legal in the State of Washington. Professional nursing standards require that nurses treat the dying with compassion and avoid abandonment. Individual agencies may have policies that limit nurses' participation in end-of-life care. Individual nurses may have deeply held moral beliefs. All these factors need to be weighed as the nurse decides how to pursue a particular course of action. Nurses must make a choice that is congruent both with their professional obligations and their own moral integrity.

References and Resources

RCW 18.79 Nursing Care

WAC 246-840 Practical and Registered Nursing

Support for Practicing Nurses | WABON
- Practice Guidance | WABON
- Practice Information | WABON

Death with Dignity Act | Washington State Department of Health
- Washington Death with Dignity Act Chapter 70.245 RCW
- Death with Dignity Act Requirements Chapter 246-978 WAC

ANA Position Statement: The Nurse's Role When a Patient Requests Medical Aid in Dying | OJIN: The Online Journal of Issues in Nursing (nursingworld.org)

Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death - Journal of Pain and Symptom Management (jpsmjournal.com)

Death With Dignity National Center | End-Of-Life Advocacy and Policy Reform

End of Life Washington - Your life. Your death. Your choice.

Brock D. W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics, 29,* 187-200.

Magelssen, M. (2012). When should conscientious objection be accepted? Journal of Medical Ethics, 38, 18-21.