HPNA Position Statement: Medical Aid in Dying (MAiD)

The Hospice and Palliative Nurses Association (HPNA) promotes high-quality palliative nursing care that addresses the physical, emotional, social, and spiritual needs of patients, their families, and communities.[1–4] HPNA acknowledges that some patients with terminal illnesses may seek medical aid in dying (MAiD) as an end-of-life care option where legally available. Although suffering is not a requirement in order to qualify for MAiD in the United States, some patients may utilize this option to relieve their suffering, which is consistent with the ethical principles of palliative nursing care.[5] Suffering at the end of life may be caused by loss of control; death anxiety; feeling like a burden; and refractory physical, social, emotional, spiritual, and existential symptoms.[3,4] MAiD is consistent with the fundamental ethical principles of patient autonomy and beneficence.[6]

The term "medical aid in dying" has evolved from other terms, including "physician assistance in dying (PAiD)" or "physician-assisted death/physician-assisted suicide (PAD/PAS)".[7] MAiD is now the most common and inclusive term to describe the practice where a qualified healthcare professional prescribes a life-ending medication to an eligible patient for self-administration.[8] MAiD is intended to provide control over the dying process.[9] Using incorrect or unclear terminology risks stigmatizing patients and families, which can cause mistrust and a breakdown in communication. MAiD legislation requires strict legal and medical protocols to ensure that the process is carried out ethically, with careful consideration of the patient's autonomy and well-being.[7] The evolution in terminology reflects a shift to a more compassionate and patient-centered approach to the concept of end-of-life choices. Laws and regulations vary geographically, contributing to the complexity and controversy of discussions about MAiD and end-of-life choices.[10–12]

In the United States, MAiD is regulated through a legislative approach, with individual state MAiD laws that govern which patients qualify for this option and the procedural requirements for MAiD.[13] Generally, in states where MAiD is legal, to be eligible for MAiD, patients must: 1) be 18 years of age, 2) have a terminal illness with a less than six-month prognosis, 3) have the capacity to make their own medical decisions, 4) have the ability to self-ingest prescribed medications for MAiD, and 5) make two verbal requests (as of 2024, New Mexico is the only state which requires only one verbal request) and sign a written request for MAiD (usually a waiting period between statements based on state law).[14] Additional requirements are that healthcare providers: 1) advise the patient about other options, including palliative and hospice care; 2) make the patient aware that the request for MAiD can be withdrawn at any time; 3) ensure the patient receives appropriate psychiatric evaluation if depression or mental illness may be affecting decisional capacity, and 4) file the patient's request, a checklist and compliance form, and consulting clinician compliance form (if applicable) with the state health agency.[14] As of 2024, only two states, Washington and Hawaii, allow advanced practice registered nurses to certify patients who are eligible for MAiD and to prescribe MAiD medications.

MAiD legislation is expanding, which has critical practice implications for nurses, particularly palliative and hospice nurses, who support patients and their families during end-of-life decision making and transitions in care.[6] As of 2024, at least 22% of the U.S. population live in a jurisdiction with legal access to MAiD,[15] with more states considering legalization. Consequently, more palliative and hospice nurses will be caring for patients who may consider MAiD.[16]

HPNA acknowledges that, in the United States, patients who are facing terminal illness and reside in a jurisdiction where MAiD is legal have a right to this option. Furthermore, patients from any state may choose to travel to other states that have no residency requirements (for example, Oregon and Vermont) or to places outside the United States to seek MAiD.[6,8] Therefore, given variations in where this option is available, consideration of MAiD carries unique complexities for hospice and palliative nursing practice.[17] This makes it imperative that all nurses have the skills to talk with patients who are considering MAiD.

HPNA adopts a stance of engaged neutrality regarding whether MAiD should be legally permitted or prohibited. All hospice and palliative nurses should develop competence and mastery regarding MAiD in the domains of education, clinical practice, research, advocacy, and leadership. Nurses willing to participate in providing care to patients as they consider and/or complete aid in dying should have the educational and organizational support they need to provide attentive care to these dying patients, as they would any other dying patient. Nurses who are morally conflicted because the states where they practice do not offer MAiD may wish to actively participate in creating MAiD-related policies and guidelines at the organizational, local, state, and national levels. Hospice and palliative nurses should have the option of non-participation in MAiD practice if it is not consistent with their personal ethics/conscience.

Hospice and palliative nurses must have the support and knowledge required to meet the legal and institutional practice requirements of MAiD.[12] In a survey of 2,043 nurses in the United States, more than 50% of nurses were willing to provide direct care to patients considering and/or completing MAiD and would feel comfortable caring for a patient during the final stages of MAiD.[16] However, only 16.4% had experience caring for someone considering MAiD. These results indicate that most nurses in the United States have limited experience with MAiD and need support and evidence-based education in caring for patients and their families as they consider this option.

Considering or Requesting MAiD

Nursing care for patients considering MAiD (and their families) is crucial to ensure that patients and families are not overtly or inadvertently disenfranchised or stigmatized as they proceed with MAiD and that they experience a safe and comfortable death, free from complications.

Key nursing responsibilities include:[7,8]

- Provide compassionate, nonjudgmental, patient- and family-centered palliative care as patients consider and utilize the option of MAiD.[18–20]
- Participate in the development of MAiD policies, including neutral or supportive policies about caring for patients who choose MAiD and for their families, as well as advocacy for conscientious objection, at the organizations where they practice.
- Identify resources to support patients who choose MAiD and their families to ensure that they receive education on hospice and palliative care and MAiD, particularly if no organizational policies or resources for MAiD discussions are available in their settings of care or communities.
- Reinforce with patients and their families that a patient must make the request for MAiD to the provider and must meet eligibility criteria.
- Collaborate closely with the provider who is assessing the request for MAiD.
- Coordinate care with the prescriber, local MAiD support organizations, and end-of-life doulas who may provide this support.
- Ensure interprofessional support and communication for the entire care team during the process.
- Coordinate care and involve interdisciplinary services for patients and families choosing MAiD.

Attentive, informed nursing care is crucial to:

- Support patients as they make their way through the required steps for establishing eligibility.
- Monitor and prepare patients and families for the MAiD procedure and prevention of complications.
- Prepare for contingencies and other trajectories should MAiD become an unsuitable option, such as loss of capacity or the ability to self-ingest.
- Facilitate patient and family well-being through the day of MAiD.
- Ensure families have appropriate grief counseling that addresses their unique needs.

Conscience-Based Refusals

It is of critical importance that MAiD is offered in conjunction with high-quality hospice and palliative care. Palliative care should be initiated before MAiD is offered and continue during and after the MAiD decision-making process for patients and their families. A nurse may experience moral distress when a patient requests MAiD.[5,8,12] If a nurse is practicing in a jurisdiction where MAiD is legal and feels morally unable to provide care for a patient requesting MAiD, they may practice conscientious objection and not take part in care that compromises their moral integrity.[8] However, the nurse is obligated to make certain that the patient and family are not abandoned and that they continue to receive high-quality palliative care.[6,8,17]

HPNA recommends that hospice and palliative nurses develop competencies and mastery in the following domains to support their understanding and implementation of MAiD.

Education:

- Increase knowledge as MAiD evolves and expands. Nurses should participate in webinars and other educational offerings to become knowledgeable about MAiD.
- Examine through self-reflection their beliefs and values regarding MAiD as a care option and share these beliefs with their supervisors to ensure they receive support and that patient care is protected.
- Understand the laws specific to MAiD in the state(s) where they practice.
- Understand the need to educate the patient and the family about MAiD.
- Advocate for high-quality palliative care to those considering MAiD as a care option.

Clinical practice:

- Provide supportive listening to patients and families as they deliberate their end-of-life options.
- Seek additional knowledge and resources to gain experience in pain and symptom management, as well as spiritual and psychosocial distress, to ensure that all patients have access to high-quality palliative care and that untreated suffering is not the basis for requests for MAiD.
- Know that all MAiD laws require the patient to ingest medications without assistance; a nurse may not administer MAiD medications.[8]
- Follow evidence-based guidelines, as well as state and institutional policies, when providing palliative care to patients who choose MAiD.
- Protect the confidentiality of all those involved in MAiD.

Research:

- Expand research to examine the impact on patients as access to MAiD expands.[21]
- Examine the impact of MAiD specifically among people facing barriers and those disadvantaged by the healthcare system.
- Explore the potential impact of MAiD on healthcare professionals, healthcare systems, and communities.
- Examine the quality of palliative care, hospice care, and end-of-life care and their relationship to the frequency of MAiD use.
- Examine healthcare professionals' attitudes toward MAiD and their confidence in their ability to provide high-quality palliative care before, during, and after a MAiD decision and throughout the process.
- Conduct longitudinal studies of the experiences of families and communities after the death of a patient who elected MAiD and their bereavement care needs.[21]
- Explore factors related to MAiD decision making and ways to support patients and families throughout the decision-making process.

Policy/advocacy:

- Advocate for the development, use, and availability of hospice and palliative care to alleviate patient suffering and enhance quality of life while valuing patient and family goals of care.[22]
- Advocate for policies that support high-quality palliative care for all terminally ill patients regardless of a request for MAiD.
- Adhere to the nursing code of ethics, policies, and procedures concerning non-abandonment.
- Participate actively in creating MAiD-related policies and guidelines at the organizational, local, state, and national levels.
- Ensure that policies address the needs of people and communities facing barriers.
- Promote end-of-life decision-making autonomy.

Leadership:

- Engage in public education regarding the differentiation among end-of-life care options, including hospice and palliative care, withholding or withdrawing life-sustaining therapies, palliative sedation, voluntary stopping of eating and drinking, and MAiD.[22]
- Lead efforts to create MAiD supports and resources targeted to patients, families, and healthcare professionals.
- Advocate for prioritization of culturally sensitive treatment and care for all patients, colleagues, and populations.
- Promote nurses' reputation as a trusted source of information.

Consider engaging with the following entities at your organizations regarding MAiD organizations:

- Committees dedicated to risk, legal matters, or corporate compliance
- Ethics consultants
- Ethics committees
- State protocols

Resources for clinicians*

- American Clinicians Academy on Medical Aid in Dying
- Medical Aid-in-Dying (The Hastings Center)
- Medical Aid in Dying: Ethical and Practical Issues (*Journal of the Advanced Practitioner in Oncology*)
- Medical Aid in Dying: Clinical Considerations (UpToDate)
- Rethinking Medical Aid in Dying: What Does it Mean to 'Do No Harm?' (*Journal of the Advanced Practitioner in Oncology*)

Advocacy and policy resources*

- American Clinicians Academy on Medical Aid in Dying
- Department of Health and Human Services Nondiscrimination Final Rule to Protect Conscience Rights
- Federal statute on MAiD
- Medical Aid in Dying Resources (National Hospice and Palliative Care Organization)
- Resources-Considering Medical Aid in Dying – Consortium on Law and Values (University of Minnesota)
- States that have legalized or introduced legislation on MAiD (Death with Dignity)

*These resources are provided for informational purposes only and should not be taken as an endorsement by HPNA of any outside organization. Any views expressed do not necessarily reflect those of HPNA or its Board of Directors.

References

1. World Health Organization. *Palliative care*. Accessed February 8, 2024. Available at: https://www.who.int/health-topics/palliative-care
2. Radbruch L, De Lima L, Knaul F, et al. Redefining palliative care—a new consensus-based definition. *Journal of Pain and Symptom Management*. 2020;60(4):754-64. doi: 10.1016/j.jpainsymman.2020.04.027
3. Rattner M. Increasing our understanding of nonphysical suffering within palliative care: a scoping review. *Palliative and Supportive Care*. 2022;20(3):417-32. doi: 10.1017/S1478951521001127
4. Wachholtz AB, Fitch CE, Makowski S, Tjia J. A comprehensive approach to the patient at end of life: assessment of multidimensional suffering. *Southern Medical Journal*. 2016;109(4):200-6. doi: 10.14423/SMJ.0000000000000439
5. Lehto RH, Olsen DP, Chan RR. When a patient discusses assisted dying: nursing practice implications. *Journal of Hospice and Palliative Nursing*. 2016;18(3):184-91. doi: 10.1097/NJH.0000000000000246
6. Pesut B, Thorne S, Greig M, Fulton A, Janke R, Vis-Dunbar M. Ethical, policy, and practice implications of nurses' experiences with assisted death: a synthesis. *Advances in Nursing Science*. 2019;42(3):216-30. doi: 10.1097/ANS.0000000000000276
7. Roy K. Medical aid in dying: what every nurse needs to know. *American Journal of Nursing*. 2022;122(3):30-7. doi: 10.1097/01.NAJ.0000822660.87763.45
8. ANA. *The Nurse's Role When a Patient Requests Medical Aid in Dying* [Position statement]. 2019. Available at: https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf
9. Hannig A. "Assisted suicide" deserves a different name. Here's why. *BrandeisNOW*. Accessed April 28, 2024. Available at: https://www.brandeis.edu/now/2022/july/assisted-dying-hannig.html
10. Dige M. Assisted death, dignity, and respect for humanity. *Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*. 2022;47(6):701-10. doi: 10.1093/jmp/jhac024
11. Gallagher R, Coelho R, Violette PD, Gaind KS, Chochinov HM, on behalf of an International Community of Palliative Care Professionals. Response to "Medical assistance in dying, palliative care, safety, and structural vulnerability." *Journal of Palliative Medicine*. 2023;26(12):1610-7. doi: 10.1089/jpm.2023.0581
12. Lamb C, Pesut B. Conscience and conscientious objection in nursing: a personalist bioethics approach. *Nursing Ethics*. 2021;28(7-8):1319-28. doi: 10.1177/0969733021996037
13. Pope TM. Medical aid in dying: key variations among U.S. state laws. *SSRN Journal*. 2020;14(1):25-59. doi: 10.2139/ssrn.3743855

14. Shavelson L, Battin MP, Pope TM. *Medical Aid in Dying: Clinical Considerations*. UpToDate. Available at: https://www.uptodate.com/contents/medical-aid-in-dying-clinical-considerations/print?search=aid%20in%20dying&usage_type=default&source=search_result&selectedTitle=1%7E150&display_rank=1
15. Compassion and Choices. *Medical Aid-in-Dying Utilization Report*. Accessed April 26, 2024. Available at: https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report
16. Davidson JE, Bojorquez G, Upvall M, et al. Nurses' values and perspectives on medical aid in dying: a survey of nurses in the United States. *Journal of Hospice and Palliative Nursing*. 2022;24(1):5-14. doi: 10.1097/NJH.0000000000000820
17. Pesut B, Thorne S, Schiller CJ, Greig M, Roussel J. The rocks and hard places of MAiD: a qualitative study of nursing practice in the context of legislated assisted death. *BMC Nursing*. 2020;19(1):12. doi: 10.1186/s12912-020-0404-5
18. American Nurses Association. *Nursing Scope and Standards of Practice* (4th ed.). American Nurses Association; 2021.
19. Dahlin C. Palliative Nursing: *Scope and Standards of Practice* (6th ed.). Hospice and Palliative Nurses Association; 2021.
20. Ferrell BR, Paice JA. *Oxford Textbook of Palliative Nursing* (5th ed.). Oxford University Press; 2019.
21. Dierickx S, Cohen J. Medical assistance in dying: research directions. *BMJ Supportive and Palliative Care*. 2019;9(4):370-2. doi: 10.1136/bmjspcare-2018-001727
22. American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. American Nurses Association; 2015.

HPNA thanks the following individuals for their contributions to this statement:
Natalie S. McAndrew, PhD, RN, ACNS-BC, CCRN-K, Christine A. Fortney, PhD, RN, FPCN, Sarah Rossmassler, DNP, ANP-BC, AGPCNP-BC, ACHPN, Kaveri M. Roy, DNP, RN, CNE, Betty Ferrell, PhD, CHPN, FAAN, FPCN, Daniel Cogan, APRN, ACHPN, Thalia DeWolf, RN, CHPN, Constance Holden, RN, MSN, Rebekah Malloy, RN, BSN, CCRN, CHPN, and Sarah Potter.

This statement reflects the best available evidence at the time of writing or revisions.

Approved by the HPNA Board of Directors TBD