Academy of Aid-in-Dying Medicine
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Instructions for medical staff managing rectal administration of medical aid in dying:

Attending/prescribing provider name and contact information:

Back-up/alternate provider name and contact information:

3 -7 days before the planned procedure:

1. Instruct the patient and family on planning and preparing:
    - The catheter is a small, flexible tube inserted 2 inches into the rectum, anchored internally by a small water-filled balloon. The tubing is threaded up between the legs to the waistband. Patients can be fully dressed for the procedure and usually do not feel the catheter or experience discomfort once it is inserted. Patients self-administer 2-4 oz of medication by depressing the plunger and emptying a syringe into the tubing, which is roughly half the volume of a typical saline enema. (Consider bringing these supplies to demonstrate to the patient and family.)
    - Constipation or loose stools should be carefully managed using medications if needed, with the goal of a soft but formed, easily passed bowel movement every 3-5 days to ensure the aid-in-dying medications are easily absorbed.
    - Bisacodyl (stimulant) suppositories should not be used in the 48 hrs. before the rectal procedure to minimize the risk of rectal stimulation expelling the aid-in-dying medications from the rectum.
    - Continue all medications, including comfort medications, unless otherwise ordered by the attending provider.
    - The patient should practice depressing the plunger and fully emptying a 60-100mL syringe filled with water into a bowl to ensure they can easily do so on the day.
    - Remind the patient that to proceed, they must be sufficiently oriented to communicate to staff an understanding of their terminal disease, prognosis, and their end-of-life options, including aid-in-dying.
    - Remind the patient that they can change their mind at any point and choose not to proceed with the procedure, and that it is perfectly normal to adjust plans.
    - The patient should stop eating after midnight the night before the procedure and consume only clear liquids thereafter.
    - Patients may feel more comfortable wearing an incontinence brief in case of urination but are unlikely to pass stool.
    - Ideally, the procedure should be initiated in the morning to allow time for attendance.
    - The patient must be able to self-administer by depressing the plunger and emptying the 60mL syringe filled with aid-in-dying medications, without assistance. However, staff or family can help prepare the medications and anchor the catheter if needed.
    - The 2-4 oz of liquid medication can cause a slight burning sensation, which will pass quickly once sedation begins.
    - Explain what to expect: Once the sedation takes effect, the patient can be gently laid on their left side (to enhance absorption), and the family can come close for comfort. Typically, the time to sleep and enter a deep coma is 5-10 minutes, and the time to death is around 2 hours, but may range from 1 day to 10 minutes.
    - Normalized the dying process: The patient's lips may become blue, their face may become pale, and their jaw may relax. There may be slight stiffening and relaxation of the body, followed by sudden deep breathing, which can then stabilize and become shallow for several hours. Reassure patients and families that once in a deep coma, the patient will not experience any discomfort.
    - Staff should plan to stay at least until the patient is deeply comatose and the family is sufficiently comfortable and knows whom to call if concerns arise or reassurance is needed.

- The patient's heart and lungs will slow down and stop. Death can be determined once there is no detectable neck pulse and no breath for over 10 minutes.
- Typically, a hospice nurse visit can be provided whenever needed, including once the patient has died, for post-mortem care.

2. Prepare and update contingency plans with patients and their families in case the patient loses capacity or aid in dying is not clinically advisable. These plans should outline who will provide bedside attendant care, the typical signs and symptoms to expect, the care that may be needed, and which medications might be beneficial.
3. Ensure that facility staff or caregivers are informed and prepared; SNFs can legally prohibit aid in dying on their premises, but other facilities may have different requirements. If the patient intends to use a short-term rental, the owner/operators should be notified and made aware that this individual is ill and likely to die very soon, on the premises. (A friend's or family member's home may be a viable alternative if needed)
4. Inspect the medications, confirm the Rx (DDMAPH, patient's name, and DOB), and ideally put them in the lockbox until needed, for safety.
5. Bring supplies, in duplicate, to the home: 4x saline enemas, 2x 26-30fr foley w/30mL balloon, 2 x 60-100mL catheter-tipped syringes (with cap), 2x 30mL leur syringe for balloon, 2x small foley clamp, graduated cylinder (to hold filled syringe upright), chux, gloves, mask, lubricant, 8 oz clear filtered apple juice.
    a. Avoid using a Macy catheter; its lumen is too narrow (14fr), and the one-way valve is prone to clogging with aid-in-dying medications, which tend to clump easily.
6. Assess GI function: intake, output, symptoms (N/V, bowel sounds, constipation, diarrhea, ascites), and medications.
7. Assess cognition: orientation, use of comfort or other sedating medications, ability to understand and communicate terminal disease, prognosis, and end-of-life options, including aid-in-dying.
8. Assess the patient's ability to fully depress and empty a 60mL catheter-tipped syringe filled with water.
9. Perform a rectal exam, assessing for stool quality and quantity, obstructions, sphincter tone, and general tissue condition (warm, moist, non-friable).
10. Administer a saline enema. Assess for leakage during administration and the ability to retain the enema for at least 10 minutes. May repeat as needed.
11. Call the attending provider to review the assessment findings, and (ideally) to receive a verbal order. Discuss:
    a. The patient's plans for ingestion (if any)
    b. Assessment findings and Clinical factors associated with prolonged or complicated aid-in-dying,
    c. Any changes to the prescription dose or route of administration.
    d. Review the instructions, especially the amount of volume to add to the medications.
    e. medications to continue or discontinue before the procedure
    f. Promptly notify the prescriber and do not proceed with aid in dying if the patient has
        i. Palpable rectal obstructions (stool or tumor) or very thin, friable rectal tissue.
        ii. Very weak rectal sphincter tone such that an enema cannot be easily retained for 10 min.
        iii. The patient appears not to have capacity, such that they cannot communicate an understanding of their terminal disease, prognosis, and end-of-life options, including aid-in-dying.
        iv. The patient appears not to have sufficient strength to self-administer by depressing the syringe plunger.

1 day before the planned procedure:

1. Verbally confirm that the patient wishes to proceed with plans to take the medications to die, and that they understand they can change plans at any time.
2. Ensure all necessary supplies are on hand. (see above)
3. Review what to expect on the day of the procedure. (see above)
4. Review contingency plans.

5. Assess GI and cognitive function (see above), as well as the patient's ability to depress the plunger and fully empty the catheter-tipped syringe.
6. Perform a rectal exam, assessing for stool (quality and quantity), obstructions, sphincter tone, and general tissue condition (warm, moist, non-friable).
7. Administer a saline enema. Assess for leakage during administration and the ability to retain for 10 minutes. May repeat as needed to empty the rectal vault fully.
8. Report assessment findings and clinical factors (see above), and review medication to continue or discontinue the day before the procedure with the attending provider.
    a. Promptly notify the prescriber and do not proceed with aid in dying if the patient has
        i. Palpable rectal obstructions (stool or tumor) or very thin, friable rectal tissue.
        ii. Very weak sphincter tone such that an enema cannot be easily retained for 10 min.
        iii. The patient appears not to have capacity, such that they cannot communicate an understanding of their terminal disease, prognosis, and end-of-life options, including aid-in-dying.
        iv. The patient appears not to have sufficient strength to self-administer by depressing the syringe plunger.

The day of the planned death, upon arrival:

1. Verbally confirm that the patient wishes to proceed with plans to take the medications to die, and that they understand they can change plans at any time.
2. Also verbally confirm that they have the strength to self-administer, are sufficiently oriented, and have maintained NPO/clear liquids only after midnight.
3. Review what to expect during the procedure (see above).
4. Perform a rectal exam to ensure the rectum is empty; administer an enema if necessary.
    a. NOTE: Wait at least one hour after the last enema before proceeding to minimize the risk of expelling medications.
5. Insert a 26-30fr catheter with a 30mL balloon into the rectum. Then, inflate the 30 mL balloon fully and tug it back against the internal sphincter to create a seal. Thread the catheter between the legs along the peritoneum, tuck it into the waistband of the clothing, secure it, and clamp it.
6. Prepare medications:
    a. Place a barrier, put on masks, and gloves.
    b. Pour roughly ½ the ordered volume of clear, filtered apple juice directly into the medication bottle, cap it, and shake it for at least 30 seconds.
    c. Then, decant this suspension into a cup and draw it up into the catheter-tipped syringe.
    d. Next, pour an additional amount of filtered apple juice into the cup and draw it into the syringe, filling it to the **total volume ordered, being very careful not to overfill the syringe.**
    e. **Cap the syringe and place it tip/cap-side up** into the graduated cylinder, **keeping the tip upright** to prevent blockage, as medications tend to clump in the tip.
7. Clean up and dispose of any contaminated materials in a plastic bag and store it out of easy reach for later cleanup.
8. Bring capped tip-up medications in the graduated cylinder, along with an additional water-filled catheter-tipped syringe (for flush), to the bedside.

During self-administration

1. Have the Patient sit upright or lie on their left side.
2. Just before self-administration, flush the catheter with 10- 15 mL of water (using a second syringe) to check the catheter for clogs and discreetly check for any anal leakage. If any are observed, remove the catheter and insert the second/spare catheter, then flush to reassess.

3. Hold the filled capped syringe tip up and shake vigorously for 30 seconds.
4. Uncap the syringe and insert it into the catheter.
5. Unclamp the catheter and anchor for the patient if needed.
6. Instruct the patient that they may proceed and depress the plunger.
7. Once the patient has depressed the plunger, clamp the line, remove the syringe, and place it in a safe location.
8. No further flush is required. If any concerns, check discreetly for any leakage of medications.
9. Note the time of ingestion and the time of full sedation to report later to the attending provider.
10. Once sedation has begun, lie the patient down on their left side (to improve absorption).
11. Support the family by encouraging them to gather close for comfort and to normalize signs of the dying process, while reassuring them that the patient is deeply in a coma and is comfortable.
12. Once the patient has been unconscious for 15 minutes and the family is settled, consider leaving the bedside to clean up. Gather the syringes, rinse any contaminated containers, including the medication bottle, and remove any labels. Dispose of the bottle, syringes, graduated cylinder, and other contaminated materials in a plastic bag, then place it in the outdoor bin (not in the kitchen trash).
13. If staff must depart, family should be notified who to call if they have any questions or concerns, or once the patient has died.
14. Death can be confirmed once neck pulses and breathing have stopped for at least 10 minutes.
15. Leave the catheter in the rectum post-mortem to contain residual medications and ensure staff safety.

~reviewed and updated 10/2025