

# Rethinking Medical Aid in Dying: What Does It Mean to ‘Do No Harm?’

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Author's disclosure of conflict of interest is found at the end of this article.

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<https://doi.org/10.6004/jadpro.2023.14.4.5>

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## Abstract

Medical aid in dying is the act of prescribing lethal medications to a consenting patient who can self-ingest them with the intent of hastening their death. A majority of patients who utilize medical aid in dying are patients with terminal cancer. As oncology patients continue to choose deaths most suitable to them, it is critical that advanced practitioners in oncology be knowledgeable regarding this end-of-life decision. With 40 states denying patients access to medical aid in dying, the purpose of this end-of-life care review is not to persuade for or against medical aid in dying, active euthanasia, or other forms of dying with dignity, but rather to shed light on patient decisions and available end-of-life options for patients where medical aid in dying is not honored. One author has succinctly named this era as “Dying in the Age of Choice,” and therefore the purpose of this article is to present the current state of medical aid in dying. The article presents case studies for the reader, as well as a comparison of California’s statistics with the national average. Much like other controversial subjects that intersect morality, religion, and Hippocratic medical ethics, practitioners in the healing arts must remain unbiased and honor the wishes of patients even when they differ from their own. In serving the population with the highest utilization of medical aid in dying, advanced practitioners in oncology should be familiar with the legal specifications in their state or be abreast of solutions for guiding patients through end of life in the states where medical aid in dying remains illegal.

**I**n 1999, long-time euthanasia advocate, Dr. Jack Kevorkian, was found guilty of second-degree murder for the death of Thomas Youk, a 52-year-old man suffering through end-stage amyotrophic lateral sclerosis. Kevorkian was an American pathologist who assisted patients with their own “suicides.” Although a man of controver-

sial and taboo opinions surrounding death, he was a pioneer and catalyst for the hospice movement, death literacy, and “right to die” legislation. “Dr. Death” crusaded the latter half of his life for the radical idea that people should, under certain circumstances, be able to choose a death suitable to them. For some, this suitable death was medical aid in dying

(MAID). At the time of this writing, this self-determined right to die is illegal in 40 states in the United States (Britannica ProCon.org, 2022).

### THE HISTORY OF CALIFORNIA'S END OF LIFE OPTION ACT

First, it is vital to make the distinction between euthanasia, physician-assisted suicide (PAS), and MAID. These terms may be used interchangeably, but they are in fact different (J. Treem, personal communication, October 23, 2022). Euthanasia is when a provider takes action to end another's life for the purpose of alleviating suffering (J. Treem, personal communication, October 23, 2022). Physician-assisted suicide involves a physician prescribing a medication, to be self ingested, to help a patient die; this differs from MAID in that the patient is already dying and must be terminal (J. Treem, personal communication, October 23, 2022). The nuance with MAID is defining suffering, terminal, and dying through two lenses: the unique patient experience, and that of a medical professional.

The California End of Life Option Act (EOLOA) was originally passed in 2015 and allows for terminally ill adults to request and ingest medications that hasten their deaths; it is California's form of MAID (Britannica ProCon.org, 2022). Resembling other states' laws, the California EOLOA has a rigorous approval process: two physicians must independently determine that a patient (1) has 6 months or less to live, (2) is making informed voluntary decisions, and (3) is mentally competent (Cain et al., 2019; California Legislative Information, 2015; Harris, 2016; Lesser, 2016). The patient must also reside in California, be able to self-ingest the medication, and have the ability to change their mind at any point during the process (Black & Csikai, 2015; California Legislative Information, 2015).

The California Department of Public Health (CDPH) has reported annual data on the EOLOA since its inception in 2015 (CDPH, 2022). In 2016, 191 patients received the prescription in California, with 58% ( $n = 111$ ) ingesting the medication, and 11% ( $n = 21$ ) dying of their underlying illness (CDPH, 2022). By 2021, these numbers more than quadrupled, with 772 prescriptions and 486 patients ingesting the drugs to pass away (CDPH, 2022). A majority (66%) of these EOLOA deaths

were patients with cancer diagnoses (CDPH, 2022). To date, California's average percentage of EOLOA patients with cancer (66% in 2021) reflects the national average (63%) of patients with cancer receiving MAID (CDPH, 2022; Britannica ProCon.org, 2022).

Kaiser Permanente released the first statistical analysis that characterized the type of individuals exercising the EOLOA in California (Nguyen et al., 2018). Kaiser's 2018 findings paralleled that of the California Department of Public Health and national averages, with 76% of Kaiser patients having terminal cancer, and 74% of those prescribed the drug ingesting it and dying (Nguyen et al., 2018), as compared with California's 2018 statistics of 73% with terminal cancer and 69% ingesting the medication (CDPH, 2022). At the time of inquiry, the end-of-life concerns these Kaiser patients expressed were (in descending order of frequency): suffering, being unable to enjoy daily activities, having inadequate pain control, being a burden to family or friends, losing their dignity, losing their autonomy, and financial concerns (Black & Csikai, 2015; Nguyen, et al., 2018).

### NATIONAL STATISTICS FOR MEDICAL AID IN DYING

At the time of this writing, Washington, DC, and 10 states have MAID legislation: California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Montana (Britannica ProCon.org, 2022). Since 1998, these states have reported their outcomes. In the available national data from 1998 up to 2017, among the states where MAID is legal or became legal, 66.3% of patients who were prescribed life-ending medication (about 2,800 out of a total of 4,249 patients) took the medication to end their lives; nearly two-thirds (63%) of these patients had cancer (Britannica ProCon.org, 2019).

### AN ANALYSIS OF THE ETHICAL DILEMMA: REDEFINING 'FIRST DO NO HARM'

The trend of increasing use and availability of statutes like California's EOLOA supports that there is both patient desire and need for such a policy. However, there are 40 states where MAID is illegal and remains a felony or manslaughter charge

of varying degrees (Britannica ProCon.org, 2019, 2022). In addition, this controversial debate surrounding the ethics of MAID has some ties to religion and the Hippocratic Oath of medicine. A patient's autonomy to choose MAID may be met with the autonomy of a physician, organization, or state that does not agree with or allow MAID. Spiritual leaders continue to reject MAID under their position against active euthanasia (Black & Csikai, 2015). Until 2019, the American Medical Association (AMA) maintained that MAID was incompatible with their code of ethics and a physician's responsibility to heal (AMA, 2022). The new AMA position on MAID affirms both opinions: that "Physicians can provide medical aid in dying according to the dictates of their conscience without violating their professional obligations" (Compassion & Choices, 2022). The AMA Medical Code of Ethics now has two provisions that support both positions on MAID: "Physicians who participate in MAID are adhering to their professional, ethical obligations as are physicians who decline to participate" (AMA, 2019, 2022; Compassion & Choices, 2022). In addition, the AMA continues to promote high-quality end-of-life care through traditional modalities such as advance directives, palliative care, and hospice (AMA, 2022; Black & Csikai, 2015).

The Hippocratic Oath makes for a difficult and ambiguous argument surrounding MAID. Some practitioners within health care believe that actively assisting a patient in ending their life is considered murder or suicide. Yet, other practitioners believe that "doing no harm" is relieving the terminal suffering of the dying. Those who do not support MAID still might support the right to patient choice, with choice trumping opposing opinions. Still more, there are organizations across the country and world that are unabashedly fighting for the humane, autonomous, and self-determining right to declare the end of one's own life.

In an interview with a religious chaplain and grief counselor, the concept of free will was discussed as it relates to MAID (K. Lynch, personal communication, June 14, 2022). Free will plays a vital role in many of the religions that oppose MAID. The discussion raised the questions: "Is society allowing people to exercise their free will?" "Is the ultimate act of free will choosing the time

and place of one's death?" "Is assisting patients such as those presented in the case studies below a supreme act of love rather than murder?" "By disallowing patients to make their own end-of-life decisions, is society, religious or medical, actually doing harm?" (K. Lynch, personal communication, June 14, 2022). Perhaps religion and medicine are at a crossroads where the two can coexist.

In the following section, let us meet a few patients inquiring about MAID. The reader should keep in mind that these circumstances are subject to each state's unique legislation.

## CASE STUDIES

### Patient A

A 33-year-old male with metastatic prostate cancer is nearing the end of his life. He has been told that there are no further treatment options, that his life expectancy is "weeks to months," and that his prognosis is terminal. He has no immediate family in the country and no children, and is therefore destined for a skilled nursing facility on hospice, alone. His cancer pain is difficult to manage, and his new cervical spinal metastasis has paralyzed his bilateral upper extremities. He is physically unable to independently bring pills to his mouth due to his paralysis, and his last wish is to die with dignity via the California EOLOA. Unfortunately, he cannot self-ingest the medication without assistance.

### Patient B

A 53-year-old female with terminal esophageal cancer is no longer able to eat and has no further treatment options. Her Physician Orders for Life-Sustaining Treatment (POLST) and advanced directive both outline her wish to decline a feeding tube. Her affairs are in order, and she has a loving and supportive family who support her wish to take part in MAID. Unable to swallow, she is faced with having a feeding tube inserted strictly for the administration of the MAID medication.

### Patient C

A 50-year-old female has stage 4 colon cancer that has metastasized to her liver and lungs. She lives in a state where MAID is not legal. She understands that clinicians did not go to medical school to kill their patients, but publicly takes the

position that helping her end her own life abides by the Hippocratic Oath, and that forcing her to “drown in bodily fluids is doing more harm than giving her the prescription” (Harris, 2016; Walling et al., 2016).

### Case Study Discussion

These case studies represent examples of patients who may not qualify for MAID or have difficulty accessing it. Perhaps these patients are forced to consider alternative means of death that align with their definitions of dignity and choice. A retrospective study that looked at four decades of data found that the rate of suicide in cancer patients was 28.58 per 100,000 person-years (Zaorsky et al., 2019). From the years 1973 to 2014, 13,311 cancer patients committed suicide (Zaorsky et al., 2019). With 40 states in the US denying MAID or similar legislation, advanced practitioners are encouraged to empathize with the intimate and mortal possibility that one of these stories could be their own.

The purpose of this review is not to persuade for or against MAID, active euthanasia, or other forms of dying with dignity, but rather to shed light on patient suffering, patient decision, and available end-of-life options for patients where MAID is not honored. Much like other controversial subjects (e.g., abortion) that intersect with religious morality and Hippocratic medical ethics, the duty of a practitioner is to remain unbiased and respect the wishes of patients even when they differ from their own. Also critical to the responsibility of oncology advanced practitioners is recognizing that disparities exist in end-of-life education and access to this type of care. In serving the population with the highest utilization of MAID, advanced practitioners in oncology should be familiar with the legal specifications in their state or be aware of solutions for guiding patients through end of life in the 40 states where it is illegal. As cited in Black & Csikai (2015), as society enters an era of “Dying in the Age of Choice,” the purpose of this article is to present the current state of MAID and the role of the advanced practitioner in navigating and honoring that patient-directed choice.

### BARRIERS

Controversies aside, there are tangible barriers to dying in America that can be addressed and im-

proved upon. In addition to the 40 states without MAID legislation, the US as a whole has medicalized the dying process, and consequently there is an underutilization of palliative care and hospice services. Despite hospice eligibility defined as a diagnosis with “6 months or less to live,” over half (53.8%) of Medicare hospice enrollees received only 30 days or less of hospice care (National Hospice and Palliative Care Organization [NHPCO], 2020). Even in states where MAID is permitted, for various reasons, hospitals and practitioners are opting out of this type of care, making it difficult for patients to fulfill their wishes even in areas where MAID is legal. Furthermore, where palliative care and hospice are the only option for patients, disparities exist in accessing it.

### The United States is Largely Death Illiterate

Death literacy, like health literacy, is the ability to understand and make informed decisions regarding death. A death literate society would have a healthy death culture, where respect for, certainty of, and acceptance of mortality would become common knowledge. The lack of death culture in the US is becoming costly. Health-care dollars are finite and the sometimes futile medical care that occurs at the end of life is increasing the overall cost of American health care (Black & Csikai, 2015). Recent literature on health-care spending at the end of life estimates that between 13% to 25% of all US health-care dollars are spent during the last 12 months of life, and nearly 20% of Medicare dollars spent during the last year of life (Duncan et al., 2019).

Medicalized deaths at the hand of technology can prolong the dying process and eventually incapacitate people to where they cannot participate in their own end-of-life decision-making (Black & Csikai, 2015). Despite decades of promoting and improving end-of-life care, a majority of people still experience “extended dying” or do not possess advance directives or POLSTs (Black & Csikai, 2015; Committee on Approaching Death: Addressing Key End of Life Issues & Institute of Medicine, 2015). Advance directives delineate a patient’s medical wishes for treatments such as resuscitation or nutrition in the event that the patient loses capacity to speak for themselves. Unfortunately, even if a patient does have an advance directive,



POLST, or will, they often are not amended as medical conditions worsen, or patient wishes are not followed by designated medical decision makers when the time comes (Black & Csikai, 2015).

### **Underutilization and Decreased Access to Hospice and Palliative Care**

A decreased quality of life and dissatisfaction with the dying experience has been expressed by caregivers, patients, and health-care professionals (Black & Csikai, 2015). This might be explained by the widespread underutilization of hospice and palliative care, a trend that is potentially creating the desire for MAID altogether. According to NHPCO, in 2018, only 14% of hospice users were enrolled for the 6-month benefit period, with 27.9% enrolled for less than one week, and 53.8% enrolled for less than 1 month (NHPCO, 2020). In addition, only about half (54%) of public hospitals offer palliative care services (Black & Csikai, 2015). The literature makes a consistent and unanimous argument that palliative consults occur too late and too close to death (Doyle, 2018; Raphael et al., 2001). Late palliative care consults translate to aggressive treatment near the end of life in the form of increased emergency department visits, intensive care unit admissions, and toxic treatments such as chemotherapy within weeks of death (Blackhall et al., 2016; Doyle, 2018; Duff & Thomas, 2018).

The adverse consequences of a lack of access to palliative care, or underutilization of hospice, include increased health-care costs, increased burden of medical management in hospitals toward the end of life, and undermanaged side effects resulting in inferior quality of life.

### **Religiously Affiliated Health-Care Systems**

In California, no hospital or clinician is required to participate in the California EOLOA (Cain et al., 2019). Some organizations that participate in EOLOA allow individual providers to opt out (Harris, 2016). In a study by Cain and colleagues (2019), 270 California hospitals were surveyed over a 6-month period, showing that 87% of these hospitals had EOLOA policies and 39% permitted physicians to write EOLOA prescriptions. The remaining 61% of hospitals forbade their physicians to write this prescription, with a majority of these

hospitals being religiously affiliated (Cain et al., 2019). Thirteen percent of California hospitals are Catholic-owned or have a Catholic affiliation or doctrine, with 20% of home health visits being provided by Catholic agencies (Harris, 2016). Religious affiliation might be influencing the limitation of Californians' access to EOLOA, as well as the passage of legislation in other states. Religious hospitals and the opt-out option for providers can make it difficult for patients to find organizations or providers that will provide MAID services.

### **Inequitable Access to End-of-Life Care**

Disparities also exist in accessing and utilizing end-of-life care. The literature has revealed that minorities, low-income individuals, and those with lower levels of formal education are underutilizing palliative care and hospice services. This underutilization is due to having less access and possibly less knowledge regarding end-of-life care. There are many more cultures affected by end-of-life disparities than those discussed here, but those summarized in the following sections are well-documented examples.

### **Racial Disparities**

On a national level, of those patients who were prescribed lethal medication in the states where MAID is authorized, 94.2% were White and about half (47.7%) had college degrees (Britannica Pro-Con.org; 2019). California statistics echo this, with 85% of those utilizing EOLOA being White, and 64% having college degrees (CDPH, 2022). It is clear that non-White patients are using MAID at a significantly lower rate.

When evaluating the national hospice benefit, a majority (82%) of Medicare hospice patients were also White (NHPCO, 2020). A recent study by Ornstein and colleagues (2020) retroactively evaluated the end-of-life and hospice records of Black and White decedents. In this study, regardless of cause of death, terminal Black patients were significantly less likely to utilize hospice services and were much more likely to undergo heroic measures or hospitalizations during the last 6 months of life, as compared with terminal White patients (Ornstein et al., 2020).

Other minorities affected by access to care issues are immigrant populations and Indigenous

communities (Wachterman & Sommers, 2021). Because some immigrants cannot access health insurance, they tend to receive intermittent emergency care rather than continuous primary care that would allow for end-of-life care planning (Wachterman & Sommers, 2021). In rural locations such as Alaska, where a higher population of Indigenous communities live, there is an inequity in access to end-of-life care due to geographic location (Wachterman & Sommers, 2021).

Disparities also exist among the states when it comes to utilization of the Medicare hospice benefit. The proportion of Medicare decedents enrolled in hospice at the time of death varied from a low of 22.8% (Alaska) to a high of 60.5% (Utah; NHPCO, 2020). Where Alaska has a 41% minority population, Utah only has a 23% minority population (USA Facts, 2022). According to the most recent statistics from the Department of Health and Human Services, Alaska has the highest population of Indigenous people in America and the lowest utilization rate of hospice (Administration for Native Americans, 2012; NHPCO, 2020).

### **Socioeconomic Disparities**

The hospice care benefit as defined by different states' Medicaid programs also has the potential to detrimentally affect low-income individuals (Wachterman & Sommers, 2021). Medicaid is the state-level program for financial aid in health care across the country. Although Medicare beneficiaries can access hospice, some states choose not to include hospice within their Medicaid programs at all or limit the number of prescriptions a patient can receive, limiting the efficacy of symptom management (Wachterman & Sommers, 2021).

### **Disease Disparities**

Much of the current end-of-life literature places priority on cancer patients (Wachterman & Sommers, 2021). Minorities have a higher rate of other serious advanced illness, like end-stage renal disease (Wachterman & Sommers, 2021). Most notably, this difference in access to end-of-life care translates to adverse end-of-life experiences (financial distress, pain, caregiver burden, overall experience with death; Wachterman & Sommers, 2021). One might infer that these detrimental experiences surrounding end-of-life care, rooted in

inequitable access to care, might be contributing to this statistic: that only 18% of nationwide hospice users are non-White (NHPCO, 2020).

These data may point to differences in belief systems among cultures, but also reveals academic, socioeconomic, and racial disparities in MAID knowledge or access to care, as well as an inequitable distribution of end-of-life care resources. Arguably, death literacy is disproportionately lower in these communities.

### **Negative Terminology**

The term “do not resuscitate” and “allow natural death” mean essentially the same thing, and yet one of them seems more comforting. Similarly, “medical aid in dying” sounds harsher and more technical than “comfortable death” or “dying with dignity.” Medical aid in dying is the practice of allowing physicians to legally prescribe lethal medications to terminally ill individuals, with the intent of these medications to cause patient demise. Some would argue that “relieve suffering” is a more appropriate terminology and might transform the opposing perspective. Despite making a distinction between MAID and active euthanasia, even the AMA uses the term “physician-assisted suicide” in its official opinion statements in their Code of Medical Ethics (AMA, 2019, 2022).

## **THE ROLE OF THE ONCOLOGY/ HEMATOLOGY ADVANCED PRACTITIONER AND PRESCRIBER IN END-OF-LIFE CARE**

Even without MAID authorization, advanced practitioners are equipped to be leaders in health care for dying patients. Advanced practitioners can expand end-of-life care through prescriptive authority, improving the death literacy of communities, initiating hospice and palliative care services early, working to correct end-of-life disparities, notifying attending physician colleagues and advocating for patients who are seeking MAID, and in many states, signing advance directives.

Full practice authority for nurse practitioners exists in 26 US states and territories, and there are 44 states where physician assistants have full prescriptive abilities (American Association of Nurse Practitioners, 2022; Masson, 2021). All MAID-legal states have full practice authority for nurse

practitioners and full prescriptive authority for physician assistants except for New Jersey, which still has nurse practitioner supervision (American Association of Nurse Practitioners, 2022; Masson, 2021). Notably, New Mexico is the only state that allows a “prescribing health-care provider” to carry out its MAID law; all other states specify that it must be an “attending physician” (Britannica ProCon.org, 2022). Expanding access to advanced practitioners improves access to care and decreases cost (American Association of Nurse Practitioners, 2022). In the future, there may be a greater role for advanced practitioners to be involved in the patient evaluation and prescription of MAID.

### **Strategies and Solutions for Advanced Practitioners to Utilize**

The problem of access to MAID is twofold: (1) terminally ill patients, a majority of whom are cancer patients, are suffering under the current health-care infrastructure and have called upon providers for help in dying, and (2) MAID is unavailable to a majority of the country. Organizations such as Compassion & Choices, Death with Dignity, Final Exit Network, and others are fighting for a “right to die” (Black & Csikai, 2015). One solution is to respect patient autonomy and allow MAID in all 50 states, with specific roadmaps to providers who are both highly trained and comfortable with such statutes. However, there are many solutions that may alleviate this problem without the extensive controversy.

Increasing death literacy, expanding palliative care and hospice services, addressing inequity and disparities, and promoting end-of-life care planning are all actionable items that can be taken without approving MAID in all 50 states, regardless of medical ethics and religious morals.

### **Promoting Death Literacy**

Noonan and colleagues (2016) describe death literacy as a “set of skills and knowledge that make it possible to gain access to and act upon end-of-life and death care options.” Death literacy of communities is an empowering tool that has the potential to exponentially grow with every passing generation (Noonan et al., 2016). As more people are empowered to become “death literate” in the form of exploring relationships with mortality, stepping

outside of “institutionalized dying,” and developing the courage and skills it takes to help someone die at home, more and more people will normalize the natural dying process (Noonan et al., 2016). The authors discussed how end-of-life caregiving can sometimes be the catalyst for developing death literacy, as it exposes people to a wide array of topics and skills related to dying (Noonan et al., 2016). After 6 years of research, Noonan’s team (2016) described increased death literacy from exposure to things such as palliative and hospice care, advance care planning, wills, funerals, a deeper appreciation for those involved, and the conversations necessary to plan for one’s own death. Encouraging normalizing end-of-life care planning (e.g., advance directives and POLST) might also be a way to improve death literacy (Black & Csikai, 2015).

### **Hospice and Palliative Care Expansion**

There is a knowledge deficit surrounding what palliative care is in both the public and professional spheres. The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO, 2020). It goes on to describe other specifics included in the specialty: relief of pain, life affirmation, death as a normal process, coping, and the counseling or support needed through this journey (WHO, 2020). In addition, palliative care is not a “type of hospice,” but rather hospice is a type of palliative care (WHO, 2020).

There is a consensus in the literature that early palliative and hospice services result in less burdensome medical interventions at the end of life, increase the quality of life at the end of life, and decrease the likelihood of dying within a hospital (Duff & Thomas, 2018; Mulville et al., 2019). Improvements in the length of life and quality of life are both possible with earlier palliative care referrals (Bauman & Temel, 2014; Doyle, 2018; Mulville et al., 2019; Walling et al., 2016). However, only 59% of hospitals with a National Cancer Institute designation have outpatient palliative care

clinics, proving that even at the level of the gold standard, there is the potential for tremendous growth in this field (Hughes & Smith, 2014). With increased life expectancy, scientific discovery allowing people to live with chronic disease, and a baby boomer generation entering elderhood, the demand for palliative care has the potential to explode (Hughes & Smith, 2014).

There is a possibility that improving the hospice and palliative care delivery system will address the complex needs of dying patients and allow them to have dignified and comfortable deaths, eliminating the need for MAID altogether (Committee on Approaching Death: Addressing Key End of Life Issues & Institute of Medicine, 2015; Petrillo et al., 2016). Maximizing transdisciplinary palliative care should be the goal, with MAID as the last resort (C. Pankratz, personal communication, September 3, 2020; Petrillo et al., 2016).

One palliative care physician describes the best palliative care team as “when you have no need for one,” expressing the idea that palliative care is the quintessential healing art of medicine, and that it can and should be incorporated into every aspect of medical care, no matter the specialty (C. Pankratz, personal communication, September 3, 2020). Palliative care should be incorporated into the clinical practice of clinicians caring for patients with chronic or advanced illness.

### **Correcting Inequitable Access and Other Disparities at End of Life**

Conducting research and breaking barriers for minorities and patients of lower socioeconomic status who, for various reasons, have decreased access to end-of-life care, are critical to the role of the advanced practitioner. One suggestion to alleviate this is to reclassify hospice as an essential benefit required by all state Medicaid programs (Wachterman & Sommers, 2021). In addition, continuing to expand the scope of the advanced practitioner is another way to decrease disparities and increase access to care and end-of-life education or planning. Nurse practitioners, for example, have historically gone into communities of the isolated, poor, and underserved (Hamric et al., 2014; Ralston et al., 2015); the role was initially born out of need and disparity.

### **Supporting Dying With Dignity Legislation**

Even in cases where patients obtain a lethal prescription in states where MAID is authorized, many still die of their terminal illness before ever ingesting the medication (CDPH, 2022). Still others report a sense of comfort and control just by “having the option,” even if they never ingest the medication (Black & Csikai, 2015). In areas where MAID is already legal, the NHPCO recommends that policies and guidelines are developed to guide providers on how to appropriately respond to these prescription requests (Black & Csikai, 2015). A rising elderly population consequently results in an increasing mortality rate, with elder law attorneys coming forward to reveal that more people are asking about options for planning their own deaths.

A systematic review of 23 articles evaluating cancer patients’ preferred place of death found that the home was preferred 69.9% of the time (Nilsson et al., 2017). Despite the fact that individuals desire to die in their own homes, as of 2018, a majority of deaths in the United States still occurred in medical institutions (35% in hospitals and 26% in nursing homes/long-term care; Centers for Disease Control and Prevention, 2020). These statistics reveal that 31% of these deaths occurred at home; therefore, only half of patients who reported that they wanted to die at home (as reported by Nilsson et al., 2017) were actually able to. The latest EOLOA statistics for the state of California show that 93% of patients utilizing this method of ending their lives chose to do so at home (CDPH, 2022).

There is legislation that continues to fight for Americans’ right to MAID. As of May 2023, Vermont became the first MAID-legal state removing its residence requirement, allowing people who reside in other states to seek MAID in Vermont (Vermont General Assembly, 2023). In New Mexico, Medicaid now provides coverage for the cost of MAID prescriptions and provider reimbursement (New Mexico Legislature, 2023). Finally, to take effect in July 2023, Washington has expanded definitions of attending and consulting providers to include advanced practitioners (NPs and PAs), and expands mental health provider evaluations to social workers, counselors, and psychiatric nurse practitioners (LegiScan.com, 2023). The bill further expanded Washington residents’ access to



MAID by allowing electronic sending of prescriptions, and MAID medication delivery by certified mail with signature (LegiScan.com, 2023).

## CONCLUSION AND RECOMMENDATIONS

California holds a unique position as a national trendsetter. The passage of the EOLOA has the potential to influence a national shift in end-of-life care, and therefore the quality of life for millions of Americans (Harris, 2016; Petrillo et al., 2016). It is also one of the most diverse states in the US and may model the way for equitable end-of-life care. In the age of the choice to die with dignity, practitioners must be abreast of state legislation, as well as the official positions of their respective professional organizations. They must also be aware of disparities faced by vulnerable populations, and how these statutes may affect them disproportionately. As the aging population and population with cancer increase, advanced practitioners must have adequate legal, ethical, and medical knowledge for the available end-of-life services and options in order to care for a wide variety of patients' wishes.

"What if not a single part of you wanted to die, but you were dying?" (Black & Csikai, 2015). In addition, what if this death was unbearable and full of both psychological and physiological suffering? This is the lens the author encourages all advanced practitioners to use when objectively considering patients' requests for MAID. There are patients who want to take a more active role in the manner in which they die, and they are seeking out legal ways to reduce their terminal suffering.

In considering both sides of this argument, expanding MAID has ethical risks and raises questions such as whether legalizing and encouraging MAID would endanger vulnerable groups or if there would be financial motivations in the form of health-care cost savings (Britannica ProCon.org, 2019). Nevertheless, terminally ill patients with cancer or other life-limiting diseases may benefit from more end-of-life care options than what is currently available in the US.

It is the advanced practitioner's role to carefully consider patients' wishes at the end of life and provide person-centered care. To meet the

needs of a contemporary society, perhaps the Hippocratic Oath should be considered a living document. Health care is at an uncharted crossroads where ethics have not yet caught up to the technology available. Where there is no cure, there is sometimes extended suffering for patients with terminal illness. In the age of medicalized dying that is oftentimes expensive, burdensome, and even undesirable, is medical aid in dying "doing no harm?" ●

## Disclosure

The author has no conflicts of interest to disclose.

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