Physician-assisted suicide (PAS) arouses strong feelings on both sides of the debate. There is a strong and vocal lobby aiming to decriminalise assisted death, and vociferous campaigns against changes that might make it easier for healthcare staff, family members or other carers to help people to die.

The subject is regularly debated by the health professions and the RCN abandoned its opposition in July 2009 after a consultation with its members found 49% supported assisted suicide (RCN, 2009). The college now has a neutral stance.

Recently, the House of Lords rejected a proposal to remove the threat of prosecution from those who go abroad to help an assisted suicide. However, also in July 2009 the Law Lords ruled that the Director of Public Prosecutions must clarify the factors taken into account when deciding whether to prosecute relatives who help a loved one to die.

Despite these developments, there is no immediate prospect of UK law permitting PAS, and healthcare professionals face up to 14 years in prison if convicted of assisting suicide.

Few articles in the British nursing literature offer an objective overview of the practical, legal, ethical and educational implications for nurses. One problem with researching PAS is that, since it has never been legal in the UK, discussions on its implications for healthcare staff are often based on hypothetical situations.

Doctors have a reasonably transparent role in PAS, namely the provision of a prescription and, on the surface, the role for nurses may seem insignificant. However, nurses have an extensive role in PAS in countries where it is practised, and face legal and ethical problems that challenge their professional status.

Nurses in the UK have a responsibility to act in patients’ best interests (NMC, 2008), and the profession has a responsibility to ensure the nurse’s role in PAS is researched and that the profession’s views are accurately represented in debates about any change in the law.

He suggested that the majority of people were in favour of assisted dying (House of Lords, 2006) and pointed out that a poll conducted by Nursing Times found that two-thirds of nurses think euthanasia should be legalised (Hemming, 2003).

A House of Lords select committee in 2005 took evidence from expert witnesses and visited Switzerland, Holland and Oregon, where PAS is practised (House of Lords, 2005). A further member’s bill was debated on 12 May 2006 and but was, again, defeated (House of Lords, 2006).

For PAS to be legalised, parliament is required to accept there is a need for change and be satisfied that no one would be harmed by such a change.

Doctors were given a clear role within Lord Joffe’s (2004) bill as they would be required to administer a prescription, and the Royal College of Physicians responded to this with the results of a survey which found that 73% of physicians did not want the law to change (Royal College of Physicians, 2006). In addition, 94% of palliative medicine consultants also oppose legalisation of PAS (Association for Palliative Medicine of Great Britain and Ireland, 2006).
In 2004, the RCN told the Lords select committee that its members were against the proposals in the bill (RCN, 2004). The Palliative Care Nursing Forum was unanimous in supporting the RCN opposition. The RCN maintained its opposition in 2006. It said that, out of more than 1,000 members, 70% were opposed to PAS (RCN, 2006a). However, Dignity in Dying claimed that the RCN had excluded four-fifths of responses. The RCN said it based its position on a serious consultation, and found Dignity in Dying’s slur ‘offensive and inaccurate’ (RCN, 2006b).

As stated above, the college now has a neutral stance after consultation found that 49% of members supported assisted suicide, 40% were against and 9% were neutral (RCN, 2009).

Meanwhile, doctors reaffirmed their opposition to assisted suicide following a debate at the BMA’s conference in July 2009.

**ISSUES AFFECTING NURSES**

The World Health Organization (2005) says that palliative care is not intended to hasten or postpone death and it is possible to suggest that PAS challenges these principles.

Palliative care is seen as the way forward for the relief of suffering, but not all nurses are skilled in palliative care (Coyle, 2004). Nurses occupy an important position in the day-to-day care of the chronically ill and those at the end of life and may have experience of people who want to talk about ending their life.

**Education**

Nurses do not always understand the differences between palliative care and PAS. Coyle (2004) suggested that palliative care nurse specialists had a role in educating colleagues. She said that, until palliative care is more widely available, PAS should not be legalised.

Moody (2003) suggested that law reform was inevitable and that nurses would inevitably be involved in life-terminating acts and would need to understand the legal and ethical implications. Those who educate nurses would need to consider including assisted dying in the curriculum.

**Communication and openness**

The chief executive of Dignity in Dying believes that legalising PAS would increase palliative care resources as patients would need to consult a specialist nurse or doctor before PAS is agreed. It is argued that this could improve communications as PAS becomes a topic open to discussion (Annetts, 2004).

The organisation states on its website that doctors use double effect to help patients die. This is an action that has wanted and unwanted side-effects; for example, medicines given to relieve symptoms may hasten death. Dignity in Dying also expresses concern that patients may not receive adequate pain relief because doctors fear they will be prosecuted for using too high a dose of analgesia and hastening patients’ deaths.

Bissett (2004) suggested that, regardless of experience or background, professionals find it difficult to initiate conversations with patients about dying. She posited that being required to offer PAS would make these discussions much more difficult and the subject of end-of-life may be avoided. She also stated that palliative care nurses should make their work ‘accessible, understood and reproducible’ so they could support colleagues and the public who fear pain and distress at the end of life.

**Nursing vulnerability**

Specialised palliative care services are not available to everyone who needs them or fully funded by the NHS (Help the Hospices, 2006). Nurses may be in a vulnerable position when PAS is requested as they may feel under pressure to break the law to relieve suffering. Conversely, they may also be afraid of using appropriate doses of medication for the relief of symptoms in case their intention to relieve suffering is misunderstood.

**Ethical issues**

Those who support PAS believe that people should have the right to choose how and when they die. Professionals are expected to respect their patients’ autonomy while maintaining the ethical principles of beneficence and non-maleficence (doing good and not harm). Paterson (2003) argued that respecting the principle of autonomy requires professionals to respect patients’ right to choose how they die. Curtis (2003) warned about the distinction that needs to be made between choice and ‘duty’; for example, dependent people may feel that PAS will relieve their family of the burden of caring for them.

Perhaps the main question is why people want PAS. Mak et al (2003) pointed out that a central controversy relates to defining suffering and the biomedical model of care has focused more on disease than on patient experience.

There is little evidence from patients who have requested euthanasia, but research indicates that their reasons relate to a spectrum of life experiences, not just the effects of disease (Mak and Elwyn, 2005).

Wright (2004) suggests that nurses need to challenge the assumption that dependency is ‘bad’. Patients who are chronically sick or dying often state that they do not wish to be a ‘burden’ and it takes great skill on the part of the nurse to change deep-rooted beliefs about self-worth and cultural norms. He states that being with others in their suffering is demanding but rewarding and that patients who request euthanasia may change their minds if their psychological problems are addressed.

While nurses may agree that PAS should be legalised, they may become more circumspect if asked to provide it themselves. The challenge is to have the skill and commitment to provide relief from suffering (Wright, 2004).

**PROFESSIONAL OPINION**

The results of the Nursing Times survey in 2003 found that nurses supported a change in the law to allow PAS (Hemmings, 2003).

However, this was a poll, with no details given about its method or questions. The findings are not based on robust methods and the results have no validity yet it is widely quoted.

Nurses were asked what prevented them ‘from providing dignified deaths’: 54% cited inadequate staffing; 52% blamed inappropriate placement of patients; and 42% blamed time pressures.

It is a concern if nurses feel that euthanasia is an ethical solution to these problems.

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**Box 1. Common values of nursing, palliative care and physician-assisted suicide**

- A focus on the importance of reducing human suffering, with a rejection of suffering as a positive redeeming value.
- A concern that end-of-life care should not reduce human beings to the biological and result in neglect of the patient as a complete person.
- Recognition that a ‘good death’ is possible.

Source: Hurst and Mauron (2006)
DISCUSSION
If PAS is legalised in the UK, nurses would need to ensure that their role is properly recognised within the law. They need to take into account the experience of nurses in countries where PAS is allowed and ensure that their practice occurs within a transparent process and as part of a multidisciplinary team.

Nurses must ensure that they are involved in discussion about possible changes. Systems would be required so that they could check their legal position. Practising outside the law puts wider society at risk and is unethical.

The values of nursing and palliative care appear to conflict with those of PAS. However, Hurst and Mauron (2006) suggested that the two opposing opinions have common ethical values (Box 1). These values may be at the foundation of the nursing dilemma over PAS, and how to progress from them is a challenge.

Difficult questions must not be ignored. Discussions on end-of-life care need to be based on thoughtful discourse not emotive stories.

So far, the opinion of nurses in the UK has been assumed from opinion polls rather than good-quality empirical research. This leads to poor representation and manipulation of these opinions by those holding strong views.

For example, while Lord Joffe quoted the Nursing Times survey result showing that two-thirds of nurses believed euthanasia should be legalised, he did not mention that just over one-third believed nurses should be allowed to assist patients (Hemmings, 2003). The majority of nurses need more information before they can make an informed opinion; qualitative data is required from all professionals who may be involved in PAS, as well as from carers, patients and the public.

Researching such a legally and ethically sensitive subject is challenging. Volker (2004) suggested the design of studies on assisted dying will warrant careful consideration. Participants involved in such research are vulnerable if they discuss illegal practice and values that are personal and sacred. Researchers are at risk from knowing about illegal acts which could oblige them to report participants.

Findings could be misinterpreted and misrepresented by those with agendas that are contrary to the researcher’s scientific aims. However, conducting and disseminating quality research is part of working in a scientifically robust manner (Volker, 2004).

Nurses and patients need to have higher expectations from care and symptom relief and negative connotations around dependency need to be challenged (Bissett, 2004; Wright, 2005). This is particularly important given the reasons above for nurses being unable to provide a ‘dignified death’ (Hemmings, 2003).

End-of-life care is challenging; discussion around the subject of death can be fraught with difficulties and anxieties (Bissett, 2004). Patients request euthanasia for reasons relating to life experiences, not just medical problems (Mak et al, 2003). Unpicking the reasons rather than taking them at face value will require sensitive and skilled communication. Education is therefore vital. Nurses need skills in palliative care and communication; they need to know the limitations in care that lead to suffering.

Until end-of-life care is practised to a high standard, regardless of location and specialty, it must be difficult to support assisted dying as an ethical option.

The nursing profession needs to be educated beyond the emotional representations of PAS and must examine the issues affecting nurses and society. Until they have an understanding of their legal, ethical and educational obligations around PAS, nurses will be unable to make informed decisions and risk being manipulated by those with strong opinions.

If PAS is legalised, nurses will inevitably be involved and nurse educationalists will need to ensure that assisted dying is on the curriculum; the practical, legal and ethical implications will need to be fully understood by nurses regardless of specialty, experience and seniority.

CONCLUSION
Further research is required into the legal, ethical and educational issues around PAS. Nurses need to be aware of how the legalisation of PAS could affect their profession. Open and informed debates around the ethical issues will raise the profile of end-of-life care.

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