“If assisted suicide is legalised, are nurses best placed to do it?”

We have a strange relationship with death. It pervades our games, books and movies to the point that we’re desensitised to it but factual depictions often heighten sensitivities to the levels of censorship. Choosing to Die, Terry Pratchett’s documentary on assisted suicide, is an example – despite depicting a legal reality and dealing sensitively with participants, it produced 900 complaints and claims that it was “repugnant” and “disgraceful”.

I watched it with morbid curiosity and professional interest. The “escorts” – staff coordinating the assisted suicide – particularly caught my attention. Their role was clear, but we had no sense of how their experience and training led them to be considered the most appropriate people to carry it out. This begs the question: if a service that administers merciful death becomes a reality, who is best placed to deliver it?

Assisted suicide is legal in several jurisdictions, including Belgium, Luxembourg, the Netherlands, Switzerland, Oregon, Washington and Montana. Generally, the barbiturates used have to be prescribed by a medic and patients have to take them themselves; nurses are involved in every other part of the process.

The Oregon Nurses Association produced guidelines of acceptable actions for nurses who choose to participate. These include: assessing decisional capacity and discussing alternatives; dealing with spiritual and practical matters during the preparation time; providing care and support during the dying process; and all the administration and coordination connected with the act – everything, in fact, other than prescribing and administering the drug.

But there has been a new development: in the US three physicians contended that nurses are best suited to carry out all roles central to assisted suicide including, where legal, prescribing and administering the lethal dose. Is this as shocking as it seems?

Practically, nurses are best placed to coordinate and administer holistic care for the dying. Prescribing and administering medication is not beyond us and our duty of care, arguably, puts us in a better philosophical position than a physician’s Hippocratic oath (“I will not give a lethal drug to anyone if I am asked”). Practically and philosophically there is no reason for us not to take up a central role on this issue.

But do we want to? Would our responsibilities include assisted death because we are better placed to do it or because of a shortage of willing doctors? Could nurses agreeing to assist be addressing their own pain in seeing suffering rather than thinking of the patient’s best interests?

Perhaps this poisoned chalice should be shared to create a multidisciplinary process including social workers and religious leaders. It may seem like simply moving from hangman to firing squad but, if assisted suicide does become a reality, surely anything that helps make it more humane, effective and confined to appropriate cases is welcome? Either way, we must take an active role in any policy development so we direct it, rather than allow others to define it for us. NT

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