Oppose SB0443/HB0403 End-of-Life Option Act
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As a Registered Nurse for 50 years, I have been dedicated to delivering science-based patient care—at the bedside and through state and national guidelines and evidence-based policies for health care professionals. As such I worked closely with physicians, pharmacists, and other health care providers in private, public, VA, and military hospitals, and later in clinical research settings, and on interdisciplinary committees at the National Institutes of Health and the American College of Cardiology/American Heart Association. I have deep concerns about the impact this legislation would have on my physician and pharmacy colleagues, and on professional nursing practice.

In terms of my professional colleagues, medical-aid-in-dying proponents want the terminally ill person to be able to make the decision about when and how to die. But it is far from an autonomous process as physicians and pharmacists would be legally required to be involved irrespective of their professional standard and ethical beliefs. Medical doctors would be asked to provide a prescription for a lethal dose of drugs to patients who want to die, even though there are currently available sanctioned, palliative and hospice care modalities that render compassion, care, and yes, control with their end-of-life journey. The American Medical Association has retained its opposition to assisted suicide reaffirming (November 13, 2023), that the legalization of physician-assisted-suicide is fundamentally incompatible with the physician's role as a healer. Pharmacists would be called upon to mix the lethal dose of poison drugs for these patients. Such drug combinations are not standardized, not FDA tested, and not approved for use to end human life.

And though not specifically called out in SB 443, nurses would inevitably be pulled in to assist the physicians in the Senate Bill's requirements for them, at almost every point in the

process (one of their collaborative roles is to extend physicians' "reach" in many health care settings today). This could include the physician's administrative requirements for documentation (e.g., SB 443, p. 10-B), informing the patient of feasible alternatives and health care treatment options including palliative care and hospice care (SB 443, p. 10-C), facilitating referrals to consulting physicians (SB 443, p. 11-D), or submitting to the pharmacist, "by any means authorized by law" (SB 443 p. 13, 9-II-3), the prescription for the lethal potion, and for the drugs (e.g., anti-nausea drugs), to counter the immediate noxious effects of ingestion of the poison.

Further, hospice is mentioned (SB, p. 3-F-2), which could present a situation for a hospice nurse whose comfort and compassionate care for the patient and the patient's loved ones, intrinsic to hospice, would be interrupted with a medical-aid-in-dying request that would be fraught with professional and ethical conflicts for the hospice nurse, who in most instances would not be permitted to stay while the patient ingests the poison to end their lives. The potential ethical dilemma for hospice nurses is that they would need to abandon their patients, knowing the lethal potion's immediate effects (difficulty swallowing the bitter and intensely burning drink, regurgitation, seizures), and a range of times of death (3 min-68 hours; median 52 min.) Over half of hospices in Oregon in the 25-year analysis (Regnard, Worthington, Finlay, 2023), prevented their staff from being present during the ingestion of the medication.

An American Nurses Association (ANA) position paper on the nurses' role when a patient requests medical aid in dying (ANA 2019) states that the delivery of high-quality, compassionate, holistic, and patient-centered care, including end-of life care is central to nurse practice. It says that the nurse should never abandon or refuse to provide comfort and safety

measures to the patient who has chosen medical-aid-in-dying though the nurse may inform their employer of their "conscience-based objection to being so involved so they can be appropriately assigned." It further says that a patient may request that a nurse be present when the patient ingests the aid in dying drug but if elected to do so, "should understand their boundaries." The Nursing Code of Ethics stresses that nurses "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and *may not act with the sole intent to end life*."

During COVID, nurses were the ones with the early COVID patients who were dying, providing comfort and compassionate care because their loved ones were not allowed to be present. That is the essence of nursing—holding the patients' hand/keeping them comfortable at the point of inevitable death.

However, this law is not needed! Palliative care and hospice care are sanctioned treatment modalities that need to be deployed more, especially in minority communities and the underserved. There are documented racial and ethnic disparities in palliative and hospice care, that should be a clarion call for more inclusive policies (Johnson 2013).

I respectfully urge you to vote against this legislation that would upend the existing science-based, professionally sanctioned, and compassionate end-of-life care that nursing and their health care colleagues--physicians and pharmacists--render to dying patients and their families.

References

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