EDITORIAL

Developing Humane and Intelligent Guidelines for Professional Nursing Practice

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What can we say based on the recent literature, and in particular, some of the survey research that has been conducted on these sensitive topics? Can one say that the way a nurse answers a survey is the way she will act in a private moment with a very gravely ill person? Getting individuals to clarify a position on how they would act under circumstances when patients request help in dying is a goal. We are very far from understanding what, in fact, the trends are.

Perrin’s article reviews the complex question of “competency” and the way in which it influences our approach to terminating life supports and interventions to the elderly. Probably the center of the debate in this arena is around the fact that individuals with cognitive impairment can still demonstrate the ability to make sound decisions and that the previous belief that incompetency immediately removes the elder’s ability to make decisions has now reopened the whole question about how we approach elders who suffer from cognitive impairment. With the relative paucity of living wills or any advance

euthanasia into the realm of psychiatry. It is generally believed that individuals who would wish to take their own life cannot be of sound mind. It is only in this past decade that this very point has been opened up for reinterpretation.

The changing structure of care delivery from the home to organizations has also induced a profound change on the way that people view and are able to think about dying. The discomfort felt among nurses and health care professionals, in general, centers around the troubling dichotomy between the goals of our professions, that is saving lives, and the notions set forth by assisted suicide and euthanasia, that is helping people to die. Maybe nurses look at the dying process in a different way from physicians given the proximity and nature of their work. However, given the paucity of dialogue, we really cannot say that we know the differences across professions with regard to this subject.

It is certainly disturbing to think that as we grow more comfortable with the notion of assisted suicide, that euthanasia will also gain widespread acceptance. What might the next step be? Suggesting to elders that they have a responsibility to die as has been suggested by Governor Lam of Colorado? And under what circumstances are we supposed to die? When we are costing too much money? When our pain and suffering is too disturbing to other people?

When we have no one to care about us and we are wards of the state? The very fundamental questions that follow once the topics of assisted suicide and euthanasia ensue create enormous debate which is not readily resolved.

This important special issue of the Journal of Gerontological Nursing will generate more questions than it is able to answer given the controversial nature of the topic. Matzo leads with a discussion of the historical references we have been able to glean related to the issues of suicide and euthanasia. In reading her article, one is left with the question, “What is old and who is old?” Can we really learn from ancient history given that an average life span then was only between 35 and 40 years of age? And from a society that had no technology and relatively few medicines to counteract human suffering?

Matzo does an excellent job in pointing out the religious reasons that came to bear upon the decisions at the end of life. This point cannot be overstated. The Ten Commandments, broadly interpreted, clarify that murder or taking one’s own life are not permissible for individuals who consider themselves religious. The profound influence of the Middle Ages on end of life is with us even today. The relatively brief history from the industrial age on has shifted the issue of assisted suicide and
directives still in this country, the literature is fraught with contradictions which make it difficult for nurses to develop consensus and gain some insight into reasonable approaches in these difficult situations.

Mezey, Mitty, and Ramsey look beyond the discussion related to decision-making capacity, and discuss in specific terms the assessment of decision-making capacity for older patients. The important differentiation between competency and capacity is made which then serves as a base for the authors to describe the nurse’s critical role in determining capacity. These authors further differentiate into “decision-specific capacity” which has heretofore been an uncommon approach in the clinical arena. Most of us can think of clinical experiences where, in caring for an older person, their inability to decide about a ventilator was readily interpreted as difficulty in deciding about any life-sustaining intervention such as a feeding tube, medication, etc. These authors pushed that question and provide a cogent discussion related to how a practice is limited when we try to label elders globally instead of trying to understand the decision-specific content. They review the essential features of informing patients, the use of mental status instruments, and the very important discussion related to the variability of illness and recovery. Their article should be a very empowering document to any nurse who reads it and has previously referred this discussion to the physician team.

Suffering is a subjective element that few of us can define in a textbook way. Goetschius reminds us of the variability in practice and in human responses to pain and suffering. The case provided by her and the way in which the family responds to a loved one in pain, reminds all of us “patients do not die on time.” Stories abound regarding patients who lingered far beyond what was expected with painful anecdotes about how family and professionals reacted in that same situation. The reality is that we do not yet know how to support a family who is trying to cope with the death of a loved one any better than we know how to do it ourselves when we are in their same situation.

The approach to pain management for elders who are dying reflects our society’s lack of consensus on how best to manage pain in the context of a dying process. No one wants to be the individual who provided the fatal dose of medication but by the same token, they are equally unhappy to be the individual who provided less than comfort for persons soon to die.

Kazanowski’s article is essential reading.

In summary, this special issue of the Journal of Gerontological Nursing is once again reminding us that pushing such difficult topics to the back of our consciousness will not help as we try to develop humane and intelligent guidelines for our professional nursing practice around assisted suicide and euthanasia. This issue once again opens the critical issues and goes beyond what we thought of before as a basis for what we need to consider next.

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