

## Non-Oral Self-Administration of Aid-in-Dying Medications

*A guide for clinicians at the bedside managing the procedure*

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### Introduction and Resources

The Academy has gathered [data](#) showing that rectal, feeding tube, or ostomy administration of aid-in-dying medications is safe and effective when patients are carefully screened, prepared, and supported. Clinicians can minimize potential complications by performing thorough evaluations and preparations.

Typically, rectal, feeding tube, or ostomy self-administration requires a doctor or nurse to be present to manage the procedure. We welcome clinical questions — please first review the information below, and if you have further non-urgent questions, email [ACAMAID@ACAMAID.org](mailto:ACAMAID@ACAMAID.org). For urgent clinical questions, call the Academy Clinicians Hotline, 510 298 1135.



- The Academy highly recommends that all patients considering aid in dying are enrolled in hospice care, especially those who may need non-oral self-administration of medications. Terminally ill patients' conditions can change rapidly and having good palliative care and realistic contingency plans are essential.
- Monitoring and preparing patients for non-oral routes of administration requires vigilant clinical attention and solid communication between clinicians involved. Nurses should receive a physician's, NP's, or PA's order for the placement of any catheter for the self-administration of aid-in-dying medications.
- The prescribing doctor should perform a careful review of the patient's medical records, including surgical and oncological notes, as well as [the red flags checklist for potential complications](#), before considering non-oral

routes. Physical assessments, such as rectal exams, are also essential. Review these early during care and repeat closer to the planned aid-in-dying day, or anytime the patient has a significant change in condition.

- Patients should be informed early in their course of care that aid in dying may become too risky. Patients and their families should be prepared, with their hospice providers, with detailed contingency plans such as assertive palliation of symptoms to the point of comfortable sedation.
- NOTE: It is legal for another person (clinician or other) to mix and prepare aid-in-dying medications, insert a catheter, and help hold and anchor the syringe. But *the patient must push the plunger to “self-administer” the medications.*
  - There is a common misperception that hospice nurses are legally prohibited from mixing aid-in-dying medications. This is not correct — each hospice makes their own decision, but mixing the medications is not prohibited by any aid-in-dying law.
- Supplies are generally available from hospices or online medical supply stores. We recommend having two complete sets of supplies on hand, in case the first clogs or otherwise malfunctions.

### **General pre-care for all non-oral administration, one week before aid-in-dying day**

The prescribing doctor will need to check in with the patient at least a week before the planned aid-in-dying day to be sure the non-oral procedure can safely proceed. The nurse will need an order to place any catheter. Clinical assessments are crucial, to be certain the section of bowel to be utilized is functional and can absorb the large dose of medication into the bloodstream. *Clinical vigilance is essential, including hospice care.*

- Since patients’ conditions often change, a careful re-review of the patient’s medical records, especially surgical and oncologic notes is essential. An additional review of the Academy’s [Red Flags Checklist](#), and repeated physical assessments, are also important.
- Clinicians from different healthcare organizations may need to share information and assessments and collaborate smoothly. Safety requires that communication between providers, such as hospice nurses and prescribers, be well established.
- Be sure the patient has essential bowel care in the 72 hours before aid in dying. If needed, gently increase laxatives to ensure a daily bowel movement, even if intake is minimal.
- All nausea and vomiting must be thoroughly and promptly controlled, even in patients using non-oral routes. This helps ensure absorption. The Academy recommends non-sedating anti-nausea drugs (ondansetron, metoclopramide) to avoid medications that can slow the gut and potentially cause agitation and other neurological side effects (Compazine, Haldol). Dexamethasone, 4 to 8mg/day, is very effective for nausea and vomiting, and has additional positive effects such as improved mood, energy and appetite.
- The clinician who plans to be present should review the procedure and sequence of events, and contingencies, so everyone who is going to be present (including family and friends) knows what to expect.

- Use a 60cc catheter-tip syringe: Have the patient practice depressing the plunger to empty the syringe into a bowl, so they feel prepared and are confident they can manage the procedure. They will need to apply sufficient pressure to smoothly release the medications, while being careful not to force the plunger with so much pressure that the medications spray out.
- Medications: The night before the aid-in-dying day, patients should follow the prescriber's instructions regarding what medications to continue or stop, and when to stop taking food or fluids.

## Detailed instructions

1. Rectal administration (pgs 3-6)
2. PEG tube administration (pgs 6-8)
3. Ostomy administration (pgs 8-10)

### Rectal self-administration

Please see the video(15min): [Rectal Self-Administration of Aid-in-Dying Medications](#)

### Supplies:

**Warning: We do not recommend using Macy catheters for this procedure.** Aid-in-dying medications are a thick easily clumped suspension of powders, which may clog the narrow 14Fr lumen of a Macy Catheter.

1. 28-30Fr Foley catheter with a 30mL balloon. Anything above a 22Fr is acceptable, but not preferred.



2. 2 x 60mL catheter-tip syringe. (one for test flush before procedure)



3. 30mL Luer-lock syringe (to inflate balloon).



4. Foley clamp, or Kelly clamp.



5. Lubricating jelly.



6. Gloves.



7. 2 oz of (regular) clear filtered apple juice.



8. Chux and paper towels.



### Within 72 hours of the procedure:

A digital rectal exam, using a gloved, lubricated finger should be performed to ascertain that:

- The anal opening is intact, can accept the catheter, and sufficiently toned to hold the medications in.
- The rectal vault is not filled with stool.
- Tumor has not invaded the rectum.
- The rectum is warm, moist, and well-perfused.

If the rectal space is occluded with stool, the procedure should be delayed. Laxatives or enemas should be administered to open the rectal vault. Blockage by internal tumors, external constrictions, or scarring, warrants calling off the rectal self-administration of medications. *This is why clinical vigilance is essential, including hospice care.*

### On the day of aid in dying:

1. Repeat the rectal exam (see above). A small amount of firm stool, high in the rectal vault, will not significantly interfere with the absorption of medications. But large amounts, especially of thick, pasty stool, may bind the

medications and interfere with absorption, or clog the catheter. If needed, use an additional enema or disimpact the rectal vault.

2. Essential: Administer an enema on the morning of aid in dying.
3. Lubricate and then insert the catheter 3 to 4 inches into the rectum. Inflate the balloon to 30mLs, and then gently tug the balloon back against the internal sphincter to seal the rectal outlet. (NOTE: Do not insert the catheter deeply or it may run into stool high in the rectal vault and clog.)
4. Thread the protruding end of the catheter up between the legs, along the perineum, up through to the waist (not along the outside of the thigh as this may pinch the catheter closed). Pants or undergarments can then be pulled up over this, so the catheter can be accessed at the waistline.



After the catheter is inserted, the patient will be able to comfortably sit up in bed.

5. [Mix the aid-in-dying medications](#) to a *total* of 2 ounces (60mL) with clear filtered apple juice (or water, but apple juice is preferred). For safety reasons, add the liquid to the powders in the bottle. Do not attempt to pour the dry powders out of the bottle. Cap and shake the bottled medications vigorously.
6. Uncap the bottle, pour the mixed medications into a small container, and promptly draw the medications into the 60mL catheter-tip syringe.
7. Important: The suspended medications settle out *very quickly* and can become a firm plug, which may clog the tip of the syringe. If medications must be transported or stored for a few moments before use, put the syringe cap on and keep it tip-side up in a container, or lay it flat (on a plate or tray). *Do not* store the filled syringe with the catheter tip facing down, because the medications may settle into the narrow end and create a plug.



8. Fill the second syringe with 10mLs of water. Flush the catheter just before medication administration, to ensure the tubing is open and ready.
9. *Vigorously and repeatedly* shake the syringe of medications for at least 10 seconds before use, then remove the cap, and attach it to the catheter.

10. Allow the patient to self-administer: The patient should apply enough firm pressure to smoothly depress the plunger and empty the syringe without causing explosive force. You may need to hold and anchor the attached catheter and syringe while the patient depresses the plunger.



11. After self-administration, clamp the catheter and disconnect the syringe. Another flush is not required.

Do not remove the catheter post-mortem, so any remaining medications do not leak out. Regular post-mortem care can be provided.

### PEG (or other feeding tube) administration:

#### Supplies:

1. We recommend using a 60mL catheter-tip syringe, if at all possible, even if the patient is accustomed to using a pump or gravity bag. Bag or pump tubing is typically very narrow and more easily clogged than a catheter-tip syringe attached directly to the feeding tube.



2. 2X 60mL catheter-tip syringes (one for medications, and one for water flush)
  - If the patient is too weak to depress the plunger on a 60mL catheter-tip syringe, there may be alternative means to self-administer. Patients commonly understand their own strengths and may be able to strategize with their prescribing doctor. One method is to use a gravity bag with a slightly kinked tube to block the flow of medications, which can then be released by the patient's hand or even mouth. Please discuss these issues with the prescriber.



3. *Clear* filtered apple juice.



## Within 72 hours of the procedure:

The prescribing physician will need to assess the patient, especially in the days before aid in dying is planned, to be sure it safe to proceed. It is important to alert the prescriber about any issues involving the digestive tract, such as low appetite, nausea, vomiting, constipation, diarrhea or reflux. If the prescriber finds any unresolvable issues that could cause complications, the procedure may need to be cancelled. *This is why clinical vigilance is essential, including hospice care.*

## Procedure:

1. Mix the aid-in-dying medications to a *total* of 2 ounces (60mL) with clear filtered apple juice (or water, but apple juice is preferred). For safety reasons, add the liquid to the powders in the bottle. Do not attempt to pour the dry powders out of the bottle. Cap and shake the bottled medications vigorously.
2. Uncap the bottle, pour the mixed medications into a small container, and promptly draw them into the 60mL catheter-tip syringe.
12. Important: The suspended medications settle out *very quickly* and can become a firm plug, which may clog the tip of the syringe. If medications must be transported or stored for a few moments before use, put the syringe cap on and keep it tip-side up in a container, or lay it flat (on a plate or tray). *Do not* store the filled syringe with the catheter tip facing down, because the medications may settle into the narrow end and create a plug.



3. *Vigorously and repeatedly* shake the syringe of medications for at least 10 seconds before use, then uncap the syringe and attach it to PEG tube.
4. Allow the patient to promptly self-administer: You may need to hold and anchor the PEG tube and syringe while the patient depresses the plunger. The patient should apply enough firm pressure to smoothly depress the plunger and empty the syringe without causing explosive force.



5. After self-administration, disconnect the syringe, flush the line with 10mLs of water, and clamp the catheter.

Regular post-mortem care can be provided.

## Ostomy administration:

The ostomy route requires more clinical information and medical support than other non-oral routes. The prescriber should review all pertinent surgery notes and scans to better understand the placement, utility, mechanics, and potential absorptive function of the part of the GI tract that will be used. To ensure the procedure can be safely carried out, the clinician should perform a test run a few days in advance, accessing and flushing the ostomy with a small amount water, so any issues can be identified and hopefully resolved before the actual procedure.

### Supplies:

1. Foley catheter, 28 to 32Fr, with a 30mL balloon. Anything above a 22Fr is acceptable, but not preferred.



2. 30mL Luer-lock syringe (to inflate the balloon)



3. Narrow-orifice procedure wafer — with a small hole that will cover the stoma and tightly fit the catheter, to prevent the aid-in-dying medications from refluxing into the bag. *Do not cut smaller.*



4. Two 60mL catheter tipped syringes, one for medication and one for a water test.



5. Foley clamp, or Kelly clamp.



6. Lubricating jelly.



7. Clear filtered apple juice.



8. Gloves.





## 9. Chux and paper towels.



Within 72 hours of the procedure:

The prescribing physician should review the patient's clinical situation to be sure it is safe to proceed. If the prescriber finds any unresolvable issues that could cause complications, the procedure may need to be canceled. *This is why clinical vigilance is essential, including hospice care.*

## Procedure:

1. Follow the prescriber's suggestion about medications and intake the day before aid in dying, as well as choosing the best time of day to proceed. Many patients know the time of day that their stool is least likely to flow, which may be a good time for the procedure.
2. Mix the aid-in-dying medications to a total of 2 ounces (60mL) with clear filtered apple juice (or water, but apple juice is preferred). For safety reasons, add the liquid to the powders in the bottle. Do not attempt to pour the dry powders out of the bottle. Cap and shake the bottled medications vigorously.
3. Uncap the bottle, pour the medications into a small container, and promptly draw the medications into the 60mL catheter-tip syringe.
13. Important: The suspended medications settle out *very quickly* and can become a firm plug, which may clog the tip of the syringe. If medications must be transported or stored for a few moments before use, put the syringe cap on and keep it tip-side up in a container, or lay it flat (on a plate or tray). *Do not* store the filled syringe with the catheter tip facing down, because the medications may settle into the narrow end and create a plug.



4. Remove the existing wafer (and bag), and clean around the stoma. Apply skin prep all around peri-stoma, and allow to dry as much as possible, so entire area including the stoma is sticky with adhesive.
5. Apply the narrow-orifice procedure wafer, *covering as much of the stoma as possible*. Leave just enough room to pass the catheter. Use the warmth and gentle pressure of your palm to mold and stick the wafer in place.
6. Lubricate and then insert the tip of the catheter through the narrow-orifice procedure wafer, past the stoma, and into the intestine as far in as it will comfortably go, *at least 4-6 inches*. Inflate the balloon fully to 30mLs. *Do not pull back against the wafer.*

7. Flush the catheter using 10-15 mL of plain water in a catheter-tip syringe to ensure the line is patent, then clamp.

*Important: The suspended medications settle out very quickly and can become a firm plug, which may clog the tip of the syringe.*

6. *Vigorously and repeatedly* shake the 60mL catheter-tip syringe of medications for at least 10 seconds before use. Removing the syringe cap and attach it to the protruding end of the Foley catheter.
7. Unclamp the catheter and allow the patient to promptly self-administer: You may need to hold and anchor the attached catheter and syringe while the patient depresses the plunger. The patient should apply enough firm pressure to smoothly depress the plunger and empty the syringe without causing explosive force.



8. After self-administration, clamp the catheter as close to the ostomy as possible, and remove the syringe.
9. Using your gloved palm, occlude the exit as much as possible by gently but firmly pressing down on the opening in the wafer, covering the clamp and protruding end of catheter.
10. After 15 minutes, release the pressure and apply the bag, sealing in clamp and the protruding end of the catheter.

Do not remove the catheter post-mortem, so any remaining medications do not leak out. Regular post-mortem care can be provided.