

# American Clinicians Academy on Medical Aid in Dying

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## 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 specific evaluations and preparations.

Typically, rectal, feeding tube or ostomy self-administration requires a doctor or nurse to be present to manage the procedure. However, if the attending/prescribing doctor reviews the clinical circumstances and concludes that the case is uncomplicated, and a family member or hired assistant appears competent and willing, then the doctor may guide and direct them to complete the procedure themselves. A loved one or doula may be permitted to manage the procedure *only if the case is straightforward and carries a low risk of complications as assessed by the attending/prescribing doctor.*

We welcome questions at [ACAMAID@ACAMAID.org](mailto:ACAMAID@ACAMAID.org)



- 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 communication.

- NOTE: It is legal for another person (clinician or loved one) to mix and prepare aid-in-dying medications, insert a catheter, and help hold and anchor the syringe. However, *the patient must push the plunger to “self-administer” the medications.*
- 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 non-oral administration, one week before aid in dying day

Check-in with the prescribing doctor before the planned aid-in-dying day to be sure the non-oral procedure can safely proceed. Clinical assessments are crucial to ensure the selected section of the bowel is functional and can absorb the large dose of medication into the bloodstream.

- Be sure the patient has 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.
- Administer a saline enema at least 4 hours **before** planned ingestion to prepare the rectal vault. DO NOT administer an enema after this or within 4 hours of medication administration, as this may alter tolerance and absorption of medications. Also, for the same reasons, do not use oil enemas or suppositories within 4 hours of ingestion.
- All nausea and vomiting must be thoroughly and promptly controlled. The Academy recommends non-sedating anti-nausea drugs (ondansetron, metoclopramide) to avoid medications that can slow the gut and potentially cause sedation, 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.
- Review the procedure and sequence of events, so everyone who is going to be present (family, friends) knows what to expect. Please see
  - Video (8min): [Video Enactment of Aid in Dying at the Bedside](#).  
(NOTE: The mixing instructions on the videos are being updated. Until then, please use the instructions below as well as viewing the videos).
- When using a 60cc catheter-tip syringe: Have the patient practice depressing the plunger to empty the syringe (see below) filled with a slightly thickened liquid (approximately the consistency of “Ensure”) 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 carefully not forcing the plunger with so much pressure that the tubing connections open and medications spray out.
- Medications: The night before the aid in dying day, 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 2-6)
2. PEG tube administration (pg 6-8)
3. Ostomy administration (pgs 8-11)

### Rectal self-administration

- Please see o PDF text (4 pgs): [Preparations and Instruction for the Aid in Dying Day](#)

### Supplies:

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



1. 28-30Fr Foley catheter with a 30mL balloon. (The smallest-bore Foley to use is a 22Fr, but larger is better.)



2. 2 x 60mL catheter-tip syringes (one for medications, one for pre-test water flush).



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



4. Foley clamp, or Kelly clamp.



## 5. Lubricating jelly.



## 6. Gloves.



## 7. 4 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.

The procedure should be delayed if the rectal space is occluded with stool. A saline enema should be administered to open the rectal vault, and ingestion should be delayed until 4 hours after the last saline enema. 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. Use an additional saline enema (NOT a suppository or an oil enema) and/or disimpact the rectal vault if needed. **NOTE:** Ingestion should be delayed until 4 hours after the last saline enema.

2. Essential: Administer a saline enema on the morning of aid in dying, **4 hours before the ingestion**. DO NOT administer an enema after this or within 4 hours of medication administration, as this may alter tolerance and absorption of medications. Also, do not use oil enemas or suppositories for the same reasons.
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 catheter can be accessed at the waistline.



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

5. To use a single syringe and not have to swap in a second syringe mid-procedure, we recommend that you 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. (*Extra credit: Dr. Jessica Kaan recommends that you lubricate the syringe so that the patient can self-administer more easily by adding a drop of olive or other oil to the syringe bore before putting the medications in.*)
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.

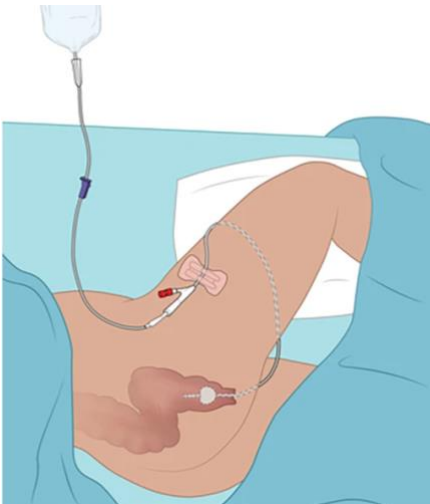


8. Fill the second syringe with 10mLs of water. Flush the catheter just before medication administration, to ensure the tubing is open and ready.

9. *Vigorously and repeatedly* shake the syringe of medications for at least 10 seconds, 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.
12. After the self-administration, you should discretely inspect the perineum and surrounding bedding for signs that medications have leaked out. Placing a gloved hand on the Chux and bedding is a good way to check for significant moisture. *(Extra credit: After mixing the medications, Dr. Robin Plumer adds 1 to 2 drops of blue food coloring so it's easy to see if there is leakage from the rectum.)*
13. Patient Positioning: During rectal infusion, the patient should be **positioned on their left side**, allowing fluid to drain from the rectum into the descending colon by gravity. The right side-lying position should be avoided, as fluid pressure will build in the rectum and fluid cannot flow by gravity into the colon where most of the fluid absorption occurs. The patient may have the head of the bed elevated for comfort or temporarily turn on their back if necessary.



14. 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:

- Please see: ○ PDF text (4 pgs): [Preparations and Instruction for the Aid in Dying Day](#)

## 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. To use a single syringe and not have to swap in a second syringe mid-procedure, we recommend that you 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. (*Extra credit: Dr. Jessica Kaan recommends that you lubricate the syringe so that the patient can self-administer more easily by adding a drop of olive or other oil to the syringe bore before putting the medications in.*)

**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. Then uncap the syringe and attach it to the catheter.
4. 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.



5. After self-administration, disconnect the syringe, flush the line, and clamp the catheter.

Regular post-mortem care can be provided.

### Ostomy administration:

- Please see:
  - PDF text (4 pgs): [Preparations and Instruction for the Aid in Dying Day](#)
  - Video (8min): [Video Enactment of Aid in Dying at the Bedside.](#)

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 ostomy. 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. We recommend using a large foley catheter, 28 to 32Fr, with a 30mL balloon.



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. To use a single syringe and not have to swap in a second syringe mid-procedure, we recommend that you 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. Mix the aid-in-dying medications to the total recommended by the prescriber, typically 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.
4. Uncap the bottle, pour the medications into a small container, and promptly draw the medications into the 60mL catheter-tip syringe. *(Extra credit: Dr. Jessica Kaan recommends that you lubricate the syringe so that the patient can self-administer more easily by adding a drop of olive or other oil to the syringe bore before putting the medications in.)*

**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 removing the syringe cap and attaching 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 the catheter.
10. After 15 minutes, release the pressure and apply the bag, sealing in the 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.