American Clinicians Academy on Medical Aid in Dying
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# Ethics Consultation Service

## Lost Hospice Eligibility with Aid-in-Dying Medications Held by Patient

December 16, 2022

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**Abstract**

An ethics consultation request was made to the Academy Ethics Consultation Service by a hospice agency nurse practitioner. She expressed concern that a patient who qualified for aid in dying and received the aid-in-dying medications is due to be discharged from hospice (for no longer meeting 6-month prognosis requirements), therefore arguably falling out of eligibility for aid in dying, but who declines to relinquish the medication.

**Table of Contents**

### I. Case Summary

Patient in early 70s has heart failure due to several myocardial Infarction.

- Managed by cardiologists and palliative care, eventually opting for hospice.
- Significant anxiety and depression and on multiple medications.
- Accepted by hospice and evaluated for aid in dying by palliative care physician.
- After being given prescription and obtaining the aid-in-dying medications, patient scheduled and cancelled ingestion twice.
- Re-evaluation 5 months into hospice service concluded that the patient’s functional status had improved, symptom burden decreased, and life expectancy exceeded the 6-month hospice parameters. Thus, hospice status was revoked, with referral back to palliative care.

- Care team determined patient no longer eligible for aid in dying as patient no longer with 6-month prognosis (per hospice) and requested return of aid-in-dying medications
- Patient refused to relinquish his aid-in-dying medications because 6-month prognosis was no longer certified, when asked to do so by hospice providers.

**Date of Request**

Initial call: October 19, 2022

**Date(s) of Consultation**

October 25, 2022; October 26, 2022; October 31, 2022; November 21, 2022; presentation to care team: December 16, 2022.

Source of Consult Request:

____Prescribing AID IN DYING Clinician
____Consultant for AID IN DYING Clinician
__x_ Other AID IN DYING Clinician (multiple)
____Other

## II. Ethics Question(s) as Described by Requester

A. How should we respond to the patient's refusal to return aid-in-dying medications when told that he is no longer aid-in-dying eligible?

B. Should this patient be considered "suicidal" if he ingests aid-in-dying medications when no longer qualifying for hospice by their 6-month criteria. And does his retention of aid-in-dying medications put our organization's (hospice and palliative care) at risk legally?

## III. Ethics Question(s) as Formulated by the Academy Ethics Consultation Team

A. Is it ethically supportable for the care team to request the return of the aid-in-dying medications from a patient who is discharged from hospice because he no longer meets hospice prognostic parameters, but who chooses to keep his aid-in-dying medications, which were legally prescribed for him 7 months prior?

B. What is an ethically appropriate response to a patient whose ingestion of aid-in-dying medications might be perceived as suicide if used outside of a 6-month prognosis while still maintaining focus on the patient's best interest?

## IV. Information Gathering

A. Medical

1. 70-year-old with large anterior wall myocardial infarction October 2021, major complications, long hospital stay, ejection fraction 25%; second admit for cardiogenic shock. Accepted for home palliative care. History of anxiety, prostate cancer, on anxiolytic and multiple cardiac medications.
2. January 2022, accepted by hospice on continued cardiac support medications with fatigue, lethargy, shortness of breath; home health aide 6 days/week.

3. Medical aid in dying requested by patient February 2022, accepted and prescribed March 2022.
4. Improved functional status with assessment October 2022 such that no longer eligible for hospice by their metrics: driving, ambulatory independently, not requiring supplemental oxygen, active and living alone.
5. Always assessed to have decisional capacity.
6. Increasing staff recognition of anxiety component of medical condition.

B. Patient Preferences

1. Initially considered hospice-eligible but wanted more aggressive interventions.
2. Unclear goals: Scheduled aid-in-dying medication ingestion twice while in hospice, but declined once staff in house, and even when family gathered, due to family "not treating him well enough."
3. Mistrust of health care system, though trusting of some members.
4. No designated Healthcare Power of Attorney.

C. Quality of Life

1. Currently able to visit prior work site, friends.
2. Lives alone, but has hired caregiver 6 days/week for cooking and cleaning.
3. Articulates to staff intermittently very anxious about course of disease, timing of death.
4. Tension in relationships within family.

D. Contextual Features

1. Refuses to give up aid-in-dying medications.
2. Staff concern that he is depressed, sad, feeling lonely and abandoned by hospice team, though transfer to palliative care within same system has been arranged.
3. See Appendix for legal information received.

E. **Ethics Consultation Team Discussion and Analysis**

A. Patients who have met criteria, undergone the entire process, and have had the aid-in-dying drugs legally prescribed have a right to their medications. There is no provision or expectation in the law that the drugs must be removed from patient *if* for some reason they no longer meet aid-in-dying eligibility in the future.

B. Prognostic evaluations are difficult, particularly in non-cancer trajectories like heart failure or terminal lung or liver disease, which may result in changes in functional status, even if the underlying disease is terminal and "irreversible."

C. Of greatest beneficence to all patients with terminal disease is to provide a platform of respect, transparency, and non-coercion in all care transactions. From this platform the patient may be able to experience a greater sense of self determination, mastery over decision making and more confidence in his/her ability to manage his circumstances and psychological health. This is an act of respect for the autonomy of the patient and will continue to allow than to feel a sense of control or ownership in the process and the decisions they choose to make.

D. Patients may have complex behavioral or social situations which interfere with the usual level of support they would need for assistance in achieving aid in dying. Their teams must continue to support such individuals and document and try to mitigate the psycho-social-spiritual distress they are experiencing.

E. Patients frequently have lethal means of killing themselves (such as guns, other medications, or even the standard hospice "comfort kits"). So, the main concern of a hospice team may be legal liability, which needs to be seen with perspective. It is not the role of ethics to dispense legal advice and therefore individual case concerns should be referred to the organization's legal/risk departments if there are specific issues.

F. Aid-in-dying eligibility is a discrete medical determination based on the evaluation at a point in patient's terminal and irreversible decline of illness. There is no stipulation in law that a patient is required to return aid-in-dying medications while they are still alive.

G. Patients should *not* be evaluated for prognosis by hospice criteria but by an independent aid-in-dying provider for eligibility under the conditions stipulated in the law. Hospice eligibility is based on funding and resource usage, and should not be conflated with aid-in-dying eligibility, which is a onetime discrete medical assessment. There is no limit on how long a patient is eligible for taking the medications. In fact, some providers of aid-in-dying prescriptions have patients who have ingested multiple months or even years after obtaining the medications.

H. Patients should continue to be offered re-evaluations for hospice eligibility should the patient wish to pursue re-admission in the future.

## VI. Ethics Consultation Team Opinion

A. Patients who are being discharged from hospice for no longer meeting the hospice prognosis of less than six months life expectancy, have the right to maintain their previously prescribed aid-in-dying medications for their terminal, irreversible disease, as diagnosed at the time of evaluation for eligibility for aid-in-dying medications. A patient's intent in keeping the medications is ethically supportable as long as it was legally prescribed for their terminal medical condition by a qualified physician. Aid-in-dying eligibility does not expire, nor is it dependent upon hospice status. Prognostication is a difficult task and has great variability among patients. Patients are known to ingest the aid-in-dying medications more than one year after obtaining them.

B. Screening and documentation by authorized professionals for any serious mental health issues that might impact the patient's decision-making capacity or plan of care would be appropriate if there is a concern about capacity. Difficult behaviors will be seen in this as well as other medical contexts, and may require a formal complex care plan, which would serve to provide the best psychological and emotional support to the patient, consistency for the staff and relief of their moral distress. Such patients are challenging, particularly since they most often do not lack decisional capacity.

C. Best practices for prescribing aid-in-dying medications are evolving and currently it is recommended that dispensing only occur just before the planned time of ingestion.

## VII. Ethically Supportable Recommendations

A. Allow patient to continue possession of their previously prescribed aid-in-dying medications based upon their original diagnosis and evaluation for aid-in-dying eligibility, as independent from hospice admission eligibility.
B. Reassure the patient that they can be re-admitted to hospice should they again meet criteria.
C. Maintain a transparent transition and care plan for the patient with the Palliative Care team regarding the goals of care.
D. If there is a concern by the care team that the patient might lack decision-making capacity to appropriately utilize the aid-in-dying medications, a professional evaluation of the patient's mental status should be conducted.
E. Remind the patient of the need to keep the aid-in-medications safe from others, similar to precautions with other medications in their possession.
F. Provide access to psycho-social-spiritual support/resources for this patient as needed.
G. Advise care team to refer to their legal/risk team for any legal concerns.
H. Forceable or coercive removal of aid-in-dying medications from the patient or dismissal from palliative care services in the face of refusal to relinquish medications would not be ethically supportable.

## VIII. Confidentiality

All consultations are confidential. Complete documentation is recorded and protected internally by the Academy Ethics Consultation Service. Opinions and options presented are by consensus of consultation service members and do not represent their associated institutions.

## IX. Disclaimers

**Legal:** The Academy Ethics Consultation Service does not provide legal advice. Moreover, information in this consultation summary is provided for informational purposes only and is not legal advice. Transmission or receipt of information on the Academy website or listserv does not create an attorney-client relationship and is not a substitute for obtaining legal advice from an attorney licensed to practice in your location.

**Medical**: Information in this consultation summary is not intended to substitute for professional medical advice, diagnosis, or treatment from treating, prescribing, and consulting clinicians or from mental health professionals.

**Submitted by** __________________
Jeanne Kerwin, DMH, HEC-C, Team Lead for the
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Team

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**Appendix 1:**

1. In jurisdictions where aid in dying is legal, there are no provisions requiring the return or expectation of returning the aid-in-dying medication if the patient is found to no longer meet eligibility requirements for aid in dying.

2. Intent for Medical aid in Dying versus Suicide

American Public Health Association
Profound psychological differences distinguish suicide from actions under Developmental Disabilities Administration. The American Psychological Association has recognized, "It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide." Patients' Rights to Self-Determination at the End of Life (www.apha.org)

American Association of Suicidology

The American Association of Suicidology recognizes that the practice of physician aid in dying, also called physician assisted suicide, death with dignity, and medical aid in dying, is distinct from the behavior that has been traditionally and ordinarily described as "suicide," the tragic event our organization works so hard to prevent. Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS. AAS PAD Statement Approved 10.30.17 ed 10-30-17 (www.suicidology.org)

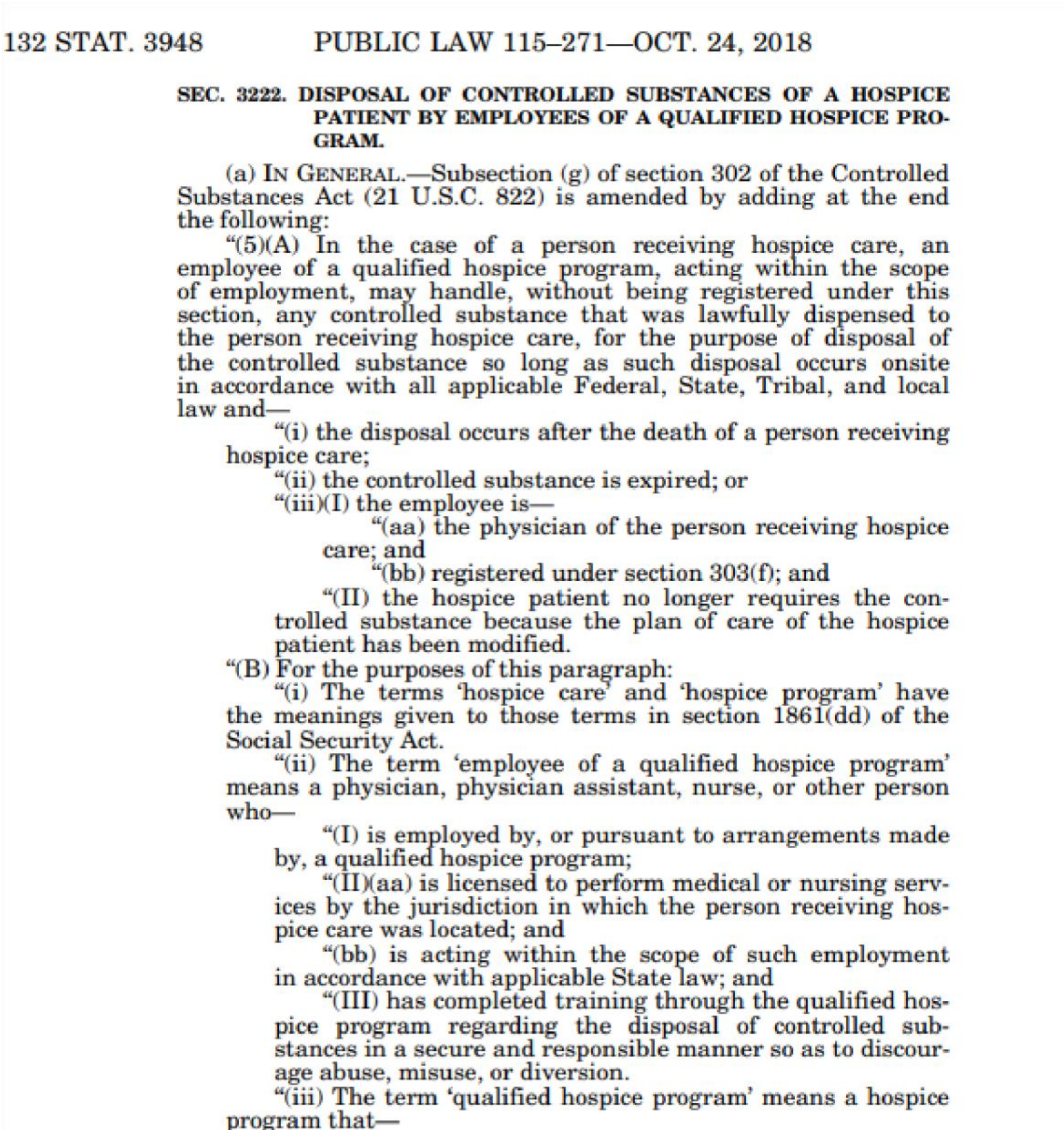
Involuntary psychiatric hospitalization or involuntary treatment of rational, terminally ill patients who want to hasten death, may also be unnecessarily harmful and not in the patient's best interest. Clinicians may find further assurance in an official position statement published on October 31, 2017 by the American Association of Suicidology (AAS), "Suicide" is not the same as "Physician aid in dying." This statement recognizes that "Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS." Medical Aid in Dying: Ethical and Practical Issues for Psychiatrists (www.psychiatrictimes.com)

American Psychological Association

Health care professionals working with individuals with advanced illness need to compassionately ascertain the reasons, meanings, emotions, functions, and the context of the request for assisted dying. They must explore contributing factors in the context of the individuals' lives and provide a compassionate, competent, and professional response. Providers need to facilitate conversations with these individuals, their health care providers, and their care partners (families of origin or families of choice) regarding these wishes and associated reasoning (Branigan, 2015). Psychologists are well-positioned to address these issues.

Psychologists in health care settings serving individuals with advanced illness and their care partners may find themselves encountering expressions of desire for hastened death and requests for assisted dying. Psychologists have the legal right to decline to participate in assisted dying activities; however when it is an established patient requiring continued care, the psychologist must meet the ethical code of non-abandonment and make appropriate referrals. Psychologists have theory-driven, evidence-based bodies of knowledge and skills relevant to responding to these requests, addressing the underlying contributing factors, and providing support to care partners. Nevertheless, psychologists may be in need of additional guidance and support in working with individuals near the end-of-life (Canetto, 2011; Werth, 1999).

Reasons most commonly given for requesting assisted dying are related to desire for control and autonomy (Emanuel et al., 2016; Steck, Egger, Maessen, Reisch, & Zwahien, 2013; Gamondi, Pott, & Payne, 2013). Requests for assisted dying also are frequently motivated by depression and inability to engage in enjoyable activities (Smith, Harvath, Goy, & Ganzini, 2015). Terminally ill patients with depressive symptoms are more likely to consider assisted dying (Blank, Robison, Prigerson, & Schwartz, 2001; Emanuel et al., 2000). These findings suggest psychological evaluation is important, as demoralization, dyspnea (shortness of breath) and clinical depression may lead to suffering that results in requests for assisted dying (Chambaere, Cohen, Robijn, Bailey, & Deliens, 2015; Berghmans, & Lossignol, 2012; Gamondi, Pott, & Payne, 2013; Emanuel et al., 2000; Ohnsorge, Gudat, & RehmannSutter, 2014; O'Mahony et al., 2005). Resolution on Assisted Dying and Justification (apa.org)



132 STAT. 3948 PUBLIC LAW 115–271—OCT. 24, 2018

**SEC. 3222. DISPOSAL OF CONTROLLED SUBSTANCES OF A HOSPICE PATIENT BY EMPLOYEES OF A QUALIFIED HOSPICE PROGRAM.**

(a) IN GENERAL.—Subsection (g) of section 302 of the Controlled Substances Act (21 U.S.C. 822) is amended by adding at the end the following:

"(5)(A) In the case of a person receiving hospice care, an employee of a qualified hospice program, acting within the scope of employment, may handle, without being registered under this section, any controlled substance that was lawfully dispensed to the person receiving hospice care, for the purpose of disposal of the controlled substance so long as such disposal occurs onsite in accordance with all applicable Federal, State, Tribal, and local law and—

"(i) the disposal occurs after the death of a person receiving hospice care;

"(ii) the controlled substance is expired; or

"(iii)(I) the employee is—

"(aa) the physician of the person receiving hospice care; and

"(bb) registered under section 303(f); and

"(II) the hospice patient no longer requires the controlled substance because the plan of care of the hospice patient has been modified.

"(B) For the purposes of this paragraph:

"(i) The terms 'hospice care' and 'hospice program' have the meanings given to those terms in section 1861(dd) of the Social Security Act.

"(ii) The term 'employee of a qualified hospice program' means a physician, physician assistant, nurse, or other person who—

"(I) is employed by, or pursuant to arrangements made by, a qualified hospice program;

"(II)(aa) is licensed to perform medical or nursing services by the jurisdiction in which the person receiving hospice care was located; and

"(bb) is acting within the scope of such employment in accordance with applicable State law; and

"(III) has completed training through the qualified hospice program regarding the disposal of controlled substances in a secure and responsible manner so as to discourage abuse, misuse, or diversion.

"(iii) The term 'qualified hospice program' means a hospice program that—

**Appendix 2: Legal issues in medication dispensing.**

## References:

Battin MP. Development of the AAS Statement on "Suicide" and "Physician Aid in Dying". Suicide Life Threat Behav. 2019 Jun;49(3):774-776. doi: 10.1111/sltb.12453. Epub 2018 Mar 26. PMID: 29578238.

Lieberman EJ. Letters to the editor, Death with dignity. Psychiatr News. 2006;41:29.

Brief of Amicus Curiae Coalition of Mental Health Professionals at 17, Gonzales v. Oregon, 126 S. Ct. 904 (2006) (No. 04-623)

Medically Assisted Dying and Suicide: How Are They Different, and How Are They Similar? - PubMed (nih.gov)

Assisted dying: The motivations, benefits and pitfalls of hastening death (apa.org)

AAS PAD Statement Approved 10.30.17 ed 10-30-17 (suicidology.org)

Resolution on Assisted Dying and Justification (apa.org)

Medical Aid in Dying: Ethical and Practical Issues for Psychiatrists (psychiatrictimes.com)

## Mission Statement

The mission of the Ethics Consultation Service of the American Clinicians Academy on Medical Aid in Dying is to provide support for clinicians involved in the practice of medical aid in dying. This support is primarily directed at addressing clinical ethics questions raised by clinicians involved with patients considering medical aid in dying, as well as ethics questions concerning medical aid in dying that may arise within hospice and palliative care agencies, healthcare organizations or grief and bereavement services. The Ethics Consultation Service may also take requests from other ethics committees seeking help from our specialized ethics service for aid-in-dying dilemmas.