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

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Conflict between Consulting Physicians regarding Patient Prognosis

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Abstract: A request for an ethics consultation was received from a consulting physician for medical aid in dying asking: "Is there a process when two consulting physicians disagree about the prognosis of a patient requesting medical aid in dying? Can the prescribing physician choose the consulting physician who agrees with his/her prognosis?"

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I. Case Summary: The patient in this case was a 68-year-old female whose recent medical history included dysarthria beginning in the fall of 2020 and initial neurologist's diagnosis of myasthenia gravis. She was treated for more than a year without improvement and with progression of disease. She was treated with antidepressants for her depression without effect and were discontinued by patient.

A different *neurologist* was consulted and in January of 2022 she was diagnosed with amyotrophic lateral sclerosis (ALS) with bulbar symptoms. At this point she was having difficulty swallowing, could not speak intelligibly and used a white board to communicate. She declined further workup, treatment or a feeding tube for nutrition. The patient requested hospice care and medical aid in dying. Despite being unable to speak and having increasing difficulty in swallowing, the patient was living

independently and driving.

The patient had been widowed one year prior to her first diagnosis in 2020 and had one adult daughter who was supportive of her mother's wishes. The patient was evaluated by a hospice/palliative care physician as a consulting physician who, in consultation with the current neurologist, found her eligible for medical aid in dying and also admitted her to hospice.

Before seeing the prescribing physician she was seen by a *second consulting physician* who had concerns that her prognosis did not indicate a life expectancy of less than six months. This consultant also recommended that the patient seek counseling and antidepressant medication treatment. The patient refused any psychological interventions. This second consulting physician, who is the requester for this ethics consultation, spoke with the potential prescribing physician to discuss her concerns and doubts about eligibility of this patient based on uncertain prognosis. She did confirm that the patient had decision-making capacity.

The prescribing physician subsequently evaluated the patient on two visits and relied upon the first consulting physician's findings and her own to prescribe the medications for the patient. The patient subsequently took the medications and died, and the second consulting physician was not notified prior to the prescription and death.

Date of Request: February 26, 2022

Date(s) of Consultation: March 4, 2022

Source of consult request:

____Prescribing Aid-in-Dying Clinician
_x_ One of the consultants for Aid-in-Dying Clinician
____Other Aid-in-Dying Clinician
____Other

II. **Ethics Question(s) as Described by Requester:** Is there a process when two consulting physicians disagree about the prognosis of a patient requesting medical aid in dying? Can the prescribing physician choose the consulting physician who agrees with his/her prognosis?

III. **Ethics Question(s) as Formulated by ACAMAID Ethics Consultant Team:** Is there a process within state Medical Aid in Dying statutes that is required when two consulting physicians disagree about prognosis and therefore eligibility of a patient who is requesting medical aid in dying? Is there an ethical standard that needs to be embedded in this question?

IV **Information Gathering.** The ethics consult team explored the existing statutes to determine if any statutes require a process if two consulting physicians disagree and found no process. The safeguards in the statutes include the requirement of one consulting physician to confirm prognosis, voluntariness and decisional capacity of the patient requesting medical aid in dying.

There are requirements in some state statutes that require the additional evaluation of a psychologist/psychiatrist to evaluate the patient to determine if a mental disorder such as depression may impact the patient's decisional capacity to request medical aid in dying.

The ultimate responsibility to determine prognostic eligibility rests with the prescribing physician and he/she may choose a consulting physician who finds the prognosis ethically supportable for eligibility.

V. **Ethics Consultation Team Analysis:** The ethics consultation team was not asked to evaluate the prognostic information leading to the differing medical opinions and, in fact, would not be qualified to opine on the clinical assessment. However, we were asked to evaluate the question of selection of a consultant under the statutes from an ethical perspective. The question was discussed and reviewed by all team members.

The practice of medical aid in dying and the statutes that govern the practice rely upon the medical judgment of both the prescribing physician and the consulting physician to determine diagnosis and prognosis, along with the decision-making capacity of the patient and the voluntariness of the request. It is recognized that prognostic opinions often differ in medicine but do not constitute an ethical dilemma unless the intent of the clinician violates an ethical principle or violates the rights of the potential patient.

VI. **Ethics Consultation Team Opinion**

It was the unanimous opinion of the ethics consultation team that the behavior of the involved physicians in this case did not violate any ethical principles nor the practice of medical aid in dying. However, we did recognize and support the challenges that differing prognostic opinions can create and the lack of open communications among the physicians in this case that contributed to the concerns raised by this second consulting physician. We recognize that prognostication and estimation of life expectancy in a terminal illness are often difficult to predict, and especially in cases of neurologic degenerative diseases.

VII. **Ethically Supportable Recommendations:**

Our recommendation is that professional courtesy and respect for clinical assessments should include open communications about differing opinions with all parties that are involved in the request of a patient for medical aid in dying. This open communication would avoid the feelings of being disrespected that led to the

request for this consultation. Acting in the best interests of all stakeholders in the practice of medical aid in dying includes listening to the voices of all the clinicians involved.

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.

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Mission Statement: *The mission of the Ethics Consultation Service of the American Clinicians Academy on Medical Aid in Dying (ACAMAID) 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.*