American Clinicians Academy on Medical Aid in Dying
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Navigating Conflict Between Professional Nursing Commitments to Patients and Institutional "Leave the Room" Policies

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Posted: January 4, 2022

Abstract:

An ethics consultation request was made to the Academy Ethics Consultation Service by a nurse, based on the nurse's ethical discomfort with her institution's policy to "leave the room" at the time of aid-in-dying medication ingestion. The Service addressed the ethics question:
Is it ethically supportable for a hospice organization to require staff to leave the room while a patient ingests the aid-in-dying medications if the staff member's presence is requested by patient/family? Does this requirement violate the nurse's professional commitment of non-abandonment to the patient and family?

The attached analysis reviews some of the origins of this not-uncommon policy across states. We review nursing codes of ethics and professional organizational policy statements. We analyze the ethical commitment to non-maleficence, provision of technical expertise, respect for patient autonomy as well as the risks of conveying a message of stigma and a risk of abandonment associated with such a policy. We believe that, rather than a true ethical dilemma, this case depicts the compromise of a single ethical principle (professional commitment to reducing suffering and non-abandonment of patients) for the sake of risk management concerns. It is our opinion that, even if hospice policies requiring a nurse attending to a patient leave the room during the ingestion of aid-in-dying medications are legally permitted, it is not ethically supportable unless at the patient's or family's request.

We outline several recommendations for members of the Academy, including: encouraging hospices to reconsider these policies; to be transparent with potential patients if they are to continue with those policies; and to seriously consider modifying such policies to drop references to leaving the room altogether.

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I. Case Summary

A nurse left the room when a patient ingested aid-in-dying medications but returned when the patient and family urgently requested her presence. Doing so was in violation of the hospice agency's policy that nurses must leave the room while patients ingest the aid-in-dying medications. Our Consultation Service received a request for our opinion as to whether this hospice policy could be ethically supported.

Consult dates:

- Initial request: October 4, 2021
- Consultation Team meetings: 3 meetings: October – November 2021
- Opinion/Recommendations rendered and posted: January 4, 2022

Requested by: A hospice nurse

II. Ethics Question as Identified by Requestor and Reframed by the Ethics Consultation Team

Is it ethically supportable for a hospice program to require staff to leave the room while a patient ingests the medical-aid-in-dying medications if the staff member's presence is requested by patient/family, and does this requirement violate the nurse's professional commitment of non-abandonment to the patient and family?

III. Information Gathering

A. Information Gathered through Interviews of Hospice Agency Administrators

1. Rationale of hospices that have a policy that prohibits active participation by staff, who are required to leave the room at the moment of ingestion.
    a. The "big stick" of risk from the federal restriction on funding from 1997 [42 U.S. Code § 14402 – Restriction on use of Federal funds under health care programs] has led to "engaged neutrality" for many hospices, but also extreme caution to

avoid any cause for questioning by regional surveyors and fiscal intermediaries appointed by Medicare.

b. Concern that it is a "compromised position" for staff to see the moment of ingestion. There would be a potential "duty to report" illegal activities, if any (for example, if a family member administers the medication or pressures the patient into self-ingesting), for which they could potentially be involved as a witness.
c. Staff is honoring the legal requirement for "self-ingestion."
d. By supporting patients (even if incompletely) who are considering medical aid in dying, the hospice is affirming patient autonomy and non-abandonment. With proper explanation, patients and families can understand that policy is based on their interpretation of federal law and requires that staff not actively participate in medication ingestion.

2. Rationale of hospices that allow full presence of staff at ingestion, death.
    a. Care for patients involves adherence to professional standards for nurses and attendance to all patient/family needs.
    b. There are no known instances of hospice programs having Federal funds withheld because they supported patients who chose medical aid in dying. Medicare, hospices, and other entities participating in aid in dying still are reimbursed through federal funding. Some hospices allow medical staff to serve as attending and consultant physicians and will allow staff to be present for the entire process.
    c. In all eleven U.S. aid-in-dying jurisdictions, hospice programs have the legal option of opting out of offering aid in dying and may decline to accept patients who indicate an intention to participate in aid in dying. In some states, there is a legal requirement for programs to declare whether they will participate in aid in dying. New amendments, SB380, to the California End of Life Option Act require hospices to declare limitations to aid-in-dying support provided to patients.
    d. There is nothing in any of the current state aid-in-dying laws that prohibits a hospice nurse or other staff from being "present" in the room during the ingestion of the aid-in-dying medications.

B. Review of Federal and State Laws Regarding Medical Aid in Dying

1. 42 U.S. Code § 14402 - Restriction on use of Federal funds under health care programs (Effective April 30, 1997) [*emphasis by authors*]
    a. Restriction on Federal funding of health care services Subject to subsection (b), no **funds appropriated by Congress** for the purpose of paying (directly or indirectly) for the provision of health care services may be used—

    (1) to provide any health care item or **service** furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

    (2) to pay (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such an item or **service**, including payment of expenses **relating to** such an item or service; or

(3) to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or **service** or of any expenses **relating to** such an item or service.

Note: statements in law following the above: (a) states should not apply to or affect any limitations relating to – withholding or withdrawing of medical treatment or medical care, withholding or withdrawing of nutrition or hydration, abortion or "the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason."

2. Federal guidance informing hospice policy regarding medical aid in dying:
    a. No direct policy advice from professional hospice organizations.
    b. Heavy supervision of hospices in general, by the fiscal intermediaries with Medicare, with deviations from regulations, documentation, billing resulting in funds withheld.
    c. 1997 federal funding restriction act (see above) is driving much caution with being involved with any "**service** furnished directly or indirectly for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing;"
    d. In the states and jurisdictions that have aid-in-dying-permitting laws, all assert that aid in dying "is not to be construed as suicide, assisted suicide, euthanasia under the law."

C. Review of Position Statements regarding Medical Aid in Dying

1. American Nurses Association (ANA) Position on Medical Aid in Dying (2019)
    a. "Never 'abandon or refuse to provide comfort and safety measures to the patient' who has chosen medical aid in dying (Ersek, 2004, p. 55)."
    b. "Nurses understand that aid in dying legislation consistently requires that the patient — never a health care professional — obtains, prepares, and self-administers the aid in dying medication. It is a strict legal and ethical prohibition that a nurse may not administer the medication that causes the patient's death."
    c. Presence: "A patient may request that a nurse be present when the patient ingests the aid in dying medication. Presence that is consistent with the Code of Ethics for Nurses includes sensitivity to the patient's vulnerability, demonstration of care and compassion, and promotion of comfort to sustain trust in an established nurse-patient relationship (Numminen, et al, 2017). When making the decision on whether to be present, the nurse should consider personal values and organizational policy, as well as the professional relationship that exists with the patient and family. If present during medical aid in dying, the nurse promotes patient dignity as well as provides for symptom relief, comfort, and emotional support to the patient and family. The nurse must maintain patient confidentiality and privacy in the aid in dying

process. The nurse's decision to be present should not be negatively evaluated."

2. Hospice and Palliative Nurses Association (HPNA) Position statement on Medical Aid in Dying
    a. No direct policy regarding bedside attendance.
    b. "The Hospice and Palliative Nurses Association (HPNA) position statement on PAD/PAS states that HPNA does not recognize PAD/PAS as part of palliative care but does emphasize that all patients are entitled to expert and compassionate palliative care."
    c. *"Fidelity*: The ethical imperative to keep promises. For healthcare providers, fidelity includes the promise not to abandon the patient.

D. Review of National Code of Ethics for Nurses

1. American Nurses Association Code of Ethics
    a. Provision 2.1 "The nurse's primary commitment is to the recipient of nursing and health care services – the patient – whether the recipient is an individual, a family, a group, or a community."
    b. Provision 4.2 "…nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of patients."
    c. Provision 5.4 "The nurse is obligated to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient."

E. Review of Other Relevant Data

1. Incidence of complications of ingestion from literature.
    a. According to annual reporting from WA, OR and CA, complications occur during ingestion in 1-2% of patients, most commonly vomiting.

2. No evidence found of Federal financial penalties – by regulation or through legal cases – for abandonment or hospice penalties for participation in medical aid in dying.

IV. Ethics Analysis

A. Ethical Arguments in Favor of Nurse Presence (if the patient and family wishes) During All Aspects of the Aid-in-Dying Process

1. The ethical principle of **non-maleficence** requires us to avoid "doing harm" to our patients. Abandoning a patient and the family during the period of ingestion of aid-in-dying medications has the potential to exact harm on the patient in terms of physical and emotional comfort. Leaving a patient alone at any point in the dying process is

contrary to the philosophy of hospice to provide support and comfort before, during and after the death of a patient.

2. Professional commitment to providing **technical expertise**: leaving the room and the bedside at the moment of ingestion of the medication could result in the patient not swallowing the medication sufficiently quickly or safely to avoid vomiting, choking, or partial sedation and brain damage. This may be more important if medication is being ingested via nasogastric or rectal tube. Nurses are expected to carefully monitor ingestion of any and all medications, even if the patient is self-administering while the nurse is present.

3. The ethical principle of respecting **autonomy** requires the professional commitment to honor and respect a patient's choice and to minimize suffering and to provide emotional support and expertise during the exercise of that choice.

4. Affirmation of **the legitimacy of** medical aid in dying in states where this is legal: it is not considered euthanasia or suicide. Leaving the room at the moment of ingestion may be perceived as stigmatizing the activity, at a time when this is a solemn and, for many, sacred event. It can convey a message to the patient and family that the choice of aid in dying is not appropriate.

5. The meeting of a patient's needs is the primary responsibility of the nurse. When a nurse's obligation to stay with the patient conflicts with organizational policy, the nurse's commitment remains to the identified patient. Never "abandon or refuse to provide comfort and safety measures to the patient" who has chosen medical aid in dying, (Ersek 2004, p. 55)

6. The commitment to truth-telling in documentation is part of a nurse's professional responsibility.

7. If institutions wish not to engage in support for patients considering aid in dying to control the time of their death, processes exist for non-participation. However, if an institution makes a commitment to support patients in medical aid in dying, that commitment should align with the best practices in supporting the patient and family; this raises the issue: is "partial" participation ethical?

8. The scope of restrictions on nursing practice is a matter for state regulation.

9. Use of medical aid in dying is not morally different with respect to outcome from other methods of controlling the time of death, including removal of the ventilator, and the administration of sedatives to control symptoms.

10. A nurse practice act (NPA) exists in every state in which aid in dying is legal, and that NPA is not discretionary:
    a. It is illegal for an institution to force a professional to violate their own professional practice act.

b. Professional practice acts require that you not abandon patients. Sometimes the NPA prohibits this directly and explicitly. Other times, the NPA prohibits "unprofessional practice." But a substantial body of jurisprudence clarifies that this includes non-abandonment.
c. Therefore, it is illegal to require the nurse to abandon patients.
d. In contrast to this, the End of Life Option Act in California (CA Health and Safety Code sections 443.15 to 443.20) specifically permits hospices to do in the case of medical aid in dying what they would otherwise be prohibited from doing.

B. Ethical Arguments Against Nurse Presence During Ingestion of Medications in the Medical-Aid-In-Dying Process

1. Nurses are hired by an institution and commit to honoring that institution's policies as part of their employment. Institutions have varying risk-based policies and professional commitment includes contractual constraints.

2. Hospice organizations could face threats based on the 1997 federal restrictions for involvement or the appearance of involvement in actively hastening death. If hospices lose certification, services are not available to a large number of dying persons beyond those seeking aid in dying.

3. With careful planning, written instruction, and emotional preparation, a patient and family made aware of the "leave the room" requirement of the employer, are less likely to perceive the nurse's action as abandonment.

4. It may jeopardize hospice access and access to medical aid in dying if forced policy changes result in hospices opting out of aid-in-dying support.

V. Ethics Consultation Opinion

Although this dilemma may appear to represent an ethical tension between the nursing profession's legal and ethical duty to not abandon patients and the right of healthcare entities to be able to define and enforce their values, it appears that institutional policies are often shaped and motivated primarily by legal concerns. We believe that this case depicts the compromise of a single ethical principle (professional commitment to reducing suffering and non-abandonment of patients) for the sake of risk management concerns. It is our opinion that even if hospice policies requiring a nurse attending to a patient leave the room during the ingestion of aid-in-dying medications are legally permitted, it is not ethically supportable unless at the patient's or family's request.

VI. Recommendations:

We recommend that the community of the American Clinicians Academy on Medical Aid in Dying:

1. Encourage hospices to review those policies which ask nurses to violate their professional ethics by not being allowed to be present at the time of ingestion. We suggest that these policies be modified to drop references to leaving the room altogether. A patient is of course free to request that the nurse leave, though to prevent difficulties in self-administration and unwanted side effects, that is medically unadvisable.

2. Support nurses through ethical review of nursing codes, position papers, as well as understanding of origins of hospice policies based in perceived legal risk.

3. Recommend transparency for all hospice agencies about policies for aid-in-dying practices and procedures, including restrictions on staff participation at the time of ingestion, so that patients and families can make an informed choice of hospice providers.

4. Engage in continued monitoring for Federal interference with aid-in-dying procedures across country, though such interference does not seem to have occurred to date.

5. Advocate for change in the federal law restricting funding, noting the conflict with state law.

6. Encourage public discussions through professional panel presentations, authoring a white paper and other writings and public discussion formats to highlight the dilemmas faced by professionals, institutions, and patients.

Disclaimer: All consultations are confidential. Complete documentation is recorded and protected internally by the Ethics Consultation Service. Recommendations are by consensus of committee members and do not represent their associated institutions.

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 brought up by clinicians involved with patients considering medical aid in dying, as well as aid-in-dying issues that arise among hospice and palliative care agencies, healthcare organizations, grief and bereavement services and requests from other ethics committees seeking aid from an ethics group with aid-in-dying expertise.

VII. References

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Posted on the Academy Listserve: January 4, 2022