American Clinicians Academy on Medical Aid in Dying
www.ACAMAID.org

Ethics Consultation Service

Complex Social Situations as Confounders to Prescribing Aid-In-Dying Medications

December 8, 2023

Posting Party/Consulting Leader (contact person): Lynette Cederquist, MD

Team Members/Authors: Lynette Cederquist, MD; Deborah North, MD; Jean Abbott, MD, MH, HEC-C.

Abstract:
An ethics consultation request was made to the American Clinicians Academy on Medical Aid in Dying Ethics Consultation Service by a primary care physician who is also a medical-aid-in-dying prescriber, expressing concern that a patient who qualified for aid in dying from a medical standpoint has an unstable living situation and previous interactions with healthcare system and family that has impeded prior plans for medical aid in dying. The potential prescriber is concerned that these social and living complexities make them question if they should again prescribe, given prior behaviors that are difficult to evaluate.

Table of Contents:

I. Case Summary
II. Ethics Questions as Presented
III. Ethics Questions as Formulated by Ethics Consultation Service
IV. Information Gathering
V. Ethics Consultation Service Discussion and Analysis
VI. Ethics Consultation Service Opinion
VII. Ethically Supportable Recommendations
VIII. Confidentiality
IX. Disclaimers

I. Case Summary:

The case concerns a middle-aged male with terminal cystic fibrosis who has qualified for medical aid in dying twice in past 3 years but has never ingested the medications. He lives with

a family member with whom he has a contentious relationship. He is now asking again for another prescription. Unstable living situation, with conflicting messages from the patient regarding his wishes.

II. Ethics Question(s) as Described by Requester: Should a patient's complex social/living situation be factored into deciding if he is a candidate for medical aid in dying?

III. Ethics Question(s) as Formulated by the Academy Ethics Consultant Team: *May a patient who meets legal requirements for medical aid in dying but poses significant psychosocial barriers to care be refused medical aid in dying?*

IV. Information Gathering

A. Medical
   1. Middle-aged patient with end-stage cystic fibrosis and recurrent infections, resulting in chronic hypoxic respiratory disease.
   2. Medical co-diseases: insulin dependent diabetes mellitus; recurrent bowel obstructions with malnutrition; severe chronic pain from steroid-induced avascular necrosis and osteoarthritis of the hip and spine.
   3. Chronic opioids for long-standing pain, without evidence of opioid use disorder.
   4. Hospitalized with increasing frequency in the past year for treatment of pneumonia or for uncontrolled pain.
   5. Poor prognosis, declines lung transplant or other novel therapies, but has sought treatment for recurrent lung infections during this time.
   6. On disability for years.

B. Patient Preferences
   1. Hard to discern due to mixed verbal messaging and actions, changing wishes.
   2. Referred previously to hospice but not currently enrolled – disenrolled in past due to disagreements with them.
   3. Was provided an aid-in-dying prescription twice in past 3 years, initially in 2020, again in 2022. He verbalized a plan to ingest but has not followed through and no decrease in anxiety when patient possessed the aid-in-dying medications.
   4. Refuses to name an agent to serve as his Durable Power of Attorney for Healthcare.
   5. Has refused independent housing to avoid family conflict.
   6. Has been provided aid-in-dying prescriptions in the past, but primary care provider feels patient "didn't know what to do or how to proceed."
   7. Has asked for provider's help in finding solutions but has refused multiple options/proposed solutions, like hospice, conversations/arrangements with family at home.
   8. He does not want to ingest at home because he believes his family member is not supportive and would call 911.
   9. He wanted to ingest in the hospital, but hospital policy did not allow that.

C. Quality of Life
    1. States he is suffering and wants help ending his suffering.
    2. Significant anxiety about his deteriorating quality of life; wishes to have control at the end, though not relieved with prior prescriptions for aid-in-dying medications.

D. Contextual Features:
    1. Lives with family but physician forbidden from talking to that close relative. (Prior hospice has found them very reasonable.)
    2. Only "friend" is patient's dog.
    3. Felt to be intelligent but emotionally immature.
    4. Accuses family member with whom he lives of stealing his pain medications in the past. He reports being estranged from the rest of his family.
    5. Provider interactions: Patient calls/texts his primary care physician at all hours. Provider has tried to facilitate alternative living options, committed to helping patient "end suffering" but unable to discern how to do this. While provider has "befriended" patient, feels difficulty setting boundaries.

V. Ethics Consultation Team Discussion and Analysis — highlights

A. Multiple stakeholders wishing to benefit this patient but unclear how or what are patient's wishes (i.e. patient autonomous wishes are unclear and changing).
B. Suspected personality disorder, making goals and motivations unclear.
C. Concern as to whether this patient's request for medical aid in dying is motivated more as manipulative behavior rather than an authentic wish to be able to end his own life.
D. There was some concern regarding prior threats and attempts of self-harm including two benzodiazepine overdoses entwined in request.
E. Physician is experiencing significant moral distress with no support to set boundaries, which are particularly difficult to set if the patient does indeed have an Axis II disorder.
F. Recognition of institutional and societal desire to use medical aid in dying within legal parameters and in a manner in which access by others would not be jeopardized.

VI. Ethics Consultation Team Opinion

1. While this patient is presumed to have decision making capacity, he may lack the emotional capacity to choose aid in dying.
2. It is difficult for providers to say "no" to medically terminal patients because they want to facilitate autonomous patient wishes and not provide barriers, particularly with medical aid in dying, where access to providers willing to honor this end-of-life wish may be limited.
3. It is particularly difficult to set boundaries with patients who give changing and conflicting messages and may have an Axis II disorder, even if they meet criteria for decisional capacity.
4. Lack of a situation for safe ingestion can be a barrier to use of aid in dying.
5. Access to this end-of-life option for a patient with a terminal disease may provide peace of mind, even if the patient does not have concrete intent or timetable.

6. Support of physicians prescribing aid-in-dying medications is particularly important when patients have co-existing psychiatric disease. Such patients can cause significant interpersonal challenges if they have decisional capacity but have psychiatric conditions such as a personality disorder.
7. Patients are allowed to qualify for medical aid in dying if their prognosis is 6 months or less, even if they are declining life-extending treatments, as this patient appears to wish to do.

VII. Ethically Supportable Recommendations

1. We recommend strong consideration for asking the patient to agree to a psychological consult to better assess the patient's motivations and emotional capacity to proceed with his request for medical aid in dying, as well as ongoing psychology involvement if possible.
2. It would be ethically acceptable for this clinician to decline to renew this prescription if he is not agreeable to stipulations and if the prescriber's concerns about safety, motivation and intent cannot be resolved.
3. While there is no legal means to take the patient's aid-in-dying meds away, it is acceptable to ask him if they can be held by a trusted individual (particularly as his physician had held is meds for a time for this individual in the past).
4. The consult team all agreed that this patient is among the most challenging for any kind of medical treatments, and particularly for consideration of aid in dying, and we recognize the very understandable moral distress the physician is feeling.
5. Given the level of distress the physician is experiencing as a result of this case, they may well benefit from general support and/or education in boundary-setting from a psychiatric colleague.

VIII. Confidentiality

All consultations are confidential. Complete documentation is recorded and protected internally by the American Clinicians Academy on Medical Aid in Dying 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 American Clinicians Academy on Medical Aid in Dying 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 ___Lynette Cederquist_____ (team leader)

for the American Clinicians Academy on Medical Aid in Dying Ethics Consultation Service Team

Team members: Jean Abbott, Deborah North

Date: 12/7/2023