

## Ethics Consultation Service

### What is the appropriate response when a colleague is not following an aid-in-dying law?

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**Posting Party/Consulting Leader (contact person):** Jean Abbott, MD, MH;  
jabbott49@gmail.com

**Consult Members/Authors:** Constance Holden, RN, MSN; Deborah North, MD;  
Yvette Vieira, MMH, HEC-C.

**Outline of Ethics Question:** A resource practitioner for aid-in-dying care has encountered practitioners who have not followed the requirements of the laws in that state, including eligibility, documentation, and other standard legal or medical elements of aid-in-dying care. The resource practitioner wonders what ethical responsibilities should guide their response to these concerns.

*Definition of “resource practitioner”: An experienced prescriber who acts as a source of information or a mentor for others prescribing or consulting for patients considering aid in dying. Their role is to advise the provider on aid-in-dying best medical practices and the process required to comply with the law.*

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#### I. Case Summary

The requester, who is an aid-in-dying resource practitioner, had several encounters where practitioners were participating in aid in dying with patients but not complying with the statutes of the medical-aid-in-dying law in that state. This included not fulfilling all required consultation visits or documentation in the patient record, absence of a formal written request, and prescribing medication for a patient to pick up before all criteria for the process had been met.

*Example 1: “A physician sought out my advice on the dosages of the medications, at which point I became aware that he was about to prescribe without having received the consulting physician’s note and was unaware of the requirement for a written request. I only became aware of these errors because I asked.”*

*Requester’s Response/Action: “I educated him about the process.”*

*Example 2: “A consulting physician called me because the prescribing physician was out of town and the patient called the consulting physician because the patient didn't remember the pharmacy that had her meds. But the consulting physician hadn't submitted their note yet.*

*Requester’s response/Action: “I advised the consulting physician to call the pharmacy and put a hold on the prescriptions until the prescriber returned and then make sure that all of the steps had been properly executed.”*

**Date(s) of Consultation:** November 2023 – February 2024

**Source of Consult Request:**

- Prescribing aid-in-dying practitioner
- Consulting aid-in-dying practitioner
- Other aid-in-dying practitioner
- Other: Resource practitioner for other aid-in-dying clinicians

**II. Ethics Question(s) as Presented by Requester**

*“What do you do when you discover that other physicians [practitioners] are participating in medical aid in dying and prescribing medication without following the law or understanding the important elements under which they should practice? “*

**III. Ethics Question(s) as Formulated by Ethics Consultant Team**

*(a) SPECIFIC TO THE REQUESTER:*

*What is the ethical responsibility of an experienced aid-in-dying practitioner when they encounter other clinicians actively working with patients pursuing aid in dying who are not following best medical practices or complying with the law?*

(b) *BROADER ETHICS QUESTION:*<sup>1</sup>

*What, if any, is the ethical responsibility of expert medical practitioners, specialty organizations, and state medical boards to ensure that practitioners wishing to participate in aid in dying can access training and resources on best aid-in-dying practices and the legal requirements outlined in the jurisdiction in which they practice?*

#### **IV. Information Gathering, Discussion and Analyses**

(a) SPECIFIC TO THE REQUESTER

In the course of our discussions with the requester we were able to glean details of the interactions that gave insight into the intent of these novice practitioners and the requester's responses.

- Medical aid in dying is a very specialized clinical practice. Like other medical practices, it has standards of care and best practices and is bounded by laws where applicable, and should be treated similarly.
- Practitioners are bound by an expectation of medical competency, acting in the best interest of the patient, pursuit of continuing education to improve their skills, and understanding and adhering to the law. (See Appendix 1)
- In discussions with the requester, the practitioners who were not following appropriate measures and processes of aid-in-dying care were deemed to be legitimately unaware of the complexity of the process and the required steps. They were not perceived as being intentionally dismissive of the process or negligent in their behavior.
- The requester also felt that these practitioners were deeply concerned about their patients' wellbeing and were acting in the best interest of the patients despite not following correct processes.
- The practitioners expressed great appreciation for the education and oversight provided by the resource practitioner on how to conduct their aid-in-dying care under the law and utilizing best practices.

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<sup>1</sup> We felt it was prudent to examine the larger scope of the problem presented by the requester. In particular, we wanted to investigate whether there was a systemic or inherent gap in practitioners being able to easily access expert resources or guidance on this special medical practice and what that might mean. Given the complex and variable landscape of medical aid in dying, the ascribed taboo around it and across the country, has this inadvertently created an environment which has failed to provide an opportunity for formal training programs with resources and potential certification requirements for practitioners. Does this gap potentially place patients at risk of harm, jeopardize the medical license of practitioners, or present a case of criminal liability?

- The practitioners immediately corrected their processes and ensured they were complying with the law.
- The requester followed up with these practitioners by providing expert aid-in-dying resources, recommendations for practice workflows, and further education, all of which was received with appreciation.
- We reviewed the recommendations by the various governing bodies of practitioners (Appendix A) to cross-reference recommended actions to be taken.

(b) BROADER ETHICS QUESTIONS:

Since this aspect of the ethical issue is not focused on a specific clinician-patient interaction, but rather several broader concerns, we explored the many and complex issues that have arisen as a result of the adoption of and attitude towards medical aid in dying across the country. Our analysis consisted of research and discussions over several months, reviewing several confounding factors, and balancing those against the increasing demand for aid-in-dying services and the desire to have well-trained practitioners who are willing to participate.

Observations and issues reviewed include:

- A review of professional codes (Appendix A), all of which include:
  - Practitioner responsibilities to provide competent medical care and continue to study and apply the latest knowledge.
  - Guidance on how to responsibly address colleagues who deviate from the law, utilizing peer-to-peer discussion and encouragement, direction to reliable resources, and ultimately reporting to appropriate external authorities if practitioners are not open to learning, improvements in care, and alignment with legal responsibilities.
- There are no current requirements for education, certification, or continuing medical education for providers caring or prescribing for persons considering medical aid in dying. Occasionally, these are required or suggested by a healthcare system. This may discourage participation by a practitioner who would otherwise be motivated to participate in aid in dying.
- There are a variety of optional resources and educational materials dependent on state and institution (see Appendix B). Incomplete or inconsistent resources may decrease the practitioner's sense of confidence and reduce their motivation to participate in aid-in-dying care.

- Jurisdictions have their own laws, some of which may vary quite a bit in process (e.g. 48 hours vs 15-day waits, residency requirements, etc.). This makes understanding the nuances and complexity of the law and process increasingly challenging as there is no one standard or process that practitioners can learn.
- Potential of stigma for the practitioner from their affiliated national and/or state provider organizations like American Medical Association and state medical societies where an official stance of “opposed” or “neutral” can further isolate and discourage practitioners from openly accessing resources, or advocating for professional education and establishing standards of care.
- Within institutions, there can be a lack of transparency about what resources are available for providers or patients wishing to explore and pursue medical aid in dying.
- There are variable quality electronic medical record templates or instructions to guide the clinicians’ aid-in-dying processes and legal requirements for documentation, ensuring that all legal requirements and best standards are met.
- From the patient perspective, finding a provider who participates can be difficult, especially in some areas of the country. Therefore, mentoring and supporting potential practitioners should be encouraged to broaden access.
- Financial issues can be challenging for aid-in-dying clinicians — some do not bill or get reimbursed for these services, and current models of productivity and revenue tracking (RVUs) of providers in organizations can discourage participation because of a practitioner’s need to meet volume and billing metrics.
- The frequency of aid-in-dying services performed by practitioners is variable. Medical aid in dying can be considered a “low frequency – high risk procedure,” but, as with any procedure, it is one that requires education and mentorship or other support.

Examples:

- Colorado: 1,090 prescriptions written in 2018 through 2022, by 219 unique physicians.  
(<https://drive.google.com/file/d/1DLML5hCvII0Udvt0vCalCziN9g9Lhgf9/view>).  
This is a surprising number of different physicians, with an unknown distribution of frequency of writing prescriptions.
- New Jersey: A high concentration of a few physicians. The department of health does not publicly report the number of physicians participating in aid in dying.

- Lack of data on the number of prescribers in several states, due to data collection variability.
- Hawaii: Variations within healthcare systems. One has a high number of different attending/prescribing physicians, while another (Hawaii Kaiser) has one individual as the primary attending/prescribing physician (per Dr. C. Miller of the Academy's Ethics Consult Service).
- Navigators and mentors are not limited to aid-in-dying providers. They can facilitate the process and be effective in assisting clinicians to navigate the legal requirements, directing them to appropriate resources and expert clinical mentors.

## V. Ethics Analysis

1. Stakeholders in this ethical dilemma
  - a) Practitioners: Significant burden, low frequency. Some perspectives we heard: "Why don't hospice and palliative care services offer training in medications and processes?" "If I get good at this, my practice will be distorted." "What if I don't want to embrace this as a physician?" "Respect for the difficulties of staying up to date with this new aspect of practice that has (rapidly) evolving 'best practices.'"
  - b) Resource practitioners: Beneficence for patients, respect for colleagues, sharing of expertise, honoring their code of ethics.
  - c) Institutions: More than half of the 10 largest health systems in the U.S. (based on the number of patient discharges) are Catholic-owned or affiliated. Even when an organization is not religion-based, they may choose not to be involved in medical aid in dying. For healthcare systems, medical aid in dying is a specialized and optional practice.
  - d) Patients/Loved Ones: Would like smooth access at their life's end if they choose aid in dying, and many may want the team that has been caring for their final illness to accompany them at this critical time.
  - e) Society: The provision of high quality, best practices of aid in dying by professionals helps to ensure continued support of legislation and access for patients.
2. Primary values in tension:
  - a. Beneficence for patients/families: Respecting their wishes by providing the best care possible, vs...

- b. Independence for professionals, obligation to practice competently and within legal guidelines, vs...
  - c. Desire to support providers/colleagues who wish to engage aid in dying.
3. Dynamics and sources of distress:
- a. Concern by an aid-in-dying practitioner that another practitioner may not be complying with the law and/or following best practices.
  - b. Concern for the protection/well-being of patients.
  - c. Concern that access for patients wanting to pursue aid in dying is challenging.
  - d. Medical practitioners have an ethical and professional responsibility to address their peers who deviate from the law, or who may not be competent in their practice, or who do not follow standards of care. When incompetent, unethical, illegal, or impaired practices are not corrected and continue to jeopardize patient well-being and safety, the professional should report the problem to appropriate external authorities. (part of professional Codes of Ethics, See Appendix A)

## **VI. Ethics Consultation Service Opinion and Recommendations:**

### **1. Ethically Supportable**

#### (a) SPECIFIC TO THE REQUESTER

It is the opinion of this committee that ethically supportable recommendations for this practitioner, under the disclosed circumstances include:

- o Peer to peer: Encourage conversations when gaps in knowledge are seen and care might not be in the best interest of the patient. Use supportive encouragement.
- o Provide additional sources of education on aid in dying, including organizations, websites, personal experience, etc. to the novice practitioner.
- o Consider a professional reporting response if the provider is not receptive to mentoring and support to improve their knowledge and practice.
- o Support systemic changes that will open education and mentorship access to help educate potential providers in this new aspect of medical care.

**Note:** *The requester had already undertaken the recommendations stated above at the time of the interactions. The apparent issue was resolved in situ with no risk to the patient, practitioner's medical license or criminal liability. It was not felt necessary to formally report the practitioner for what was interpreted as well-intentioned actions that were unfortunately not well informed, since they did not inevitably cause harm to any of the stakeholders.*

(b) BROAD ETHICS ISSUES:

It is the opinion and recommendation of this committee that the systemic gaps in professional support for aid-in-dying care need to be identified. Efforts should be made to ensure broad awareness and access to high-quality education and support for practitioners participating in aid in dying across the country.

National as well as state organizations need to advocate for education and mentorship to help train potential providers in this new aspect of medical care. Transparent, widely available, peer-reviewed publications and communication about the evolving best practices in caring for patients requesting aid-in-dying support are needed.

There should be multiple opportunities for clinicians who wish to provide aid-in-dying services to have access to the most current recommended standards of care including: identification of subject matter experts; access to on-demand clinical training and mentorship; resources provided by state medical boards, clinician support groups, and education sessions.

We propose advocating for the following systemic changes:

- o Education in medical aid in dying should be part of general medical education, not limited to palliative care and hospice specialists. Even if a provider does not prescribe or provide detailed aid-in-dying care, all providers should know the basics of how to respond to and support patients who are considering aid in dying. Many more patients will ask than will actually pursue the process.
- o State and other jurisdictions should have easily accessible websites and mentors to guide prescribers in the legal process as well as the best medical sources of support. Consider quarterly or regular open forums for providers to ask questions and find support.
- o The American Clinicians Academy on Medical Aid in Dying is developing web-based training modules for all aid-in-dying clinicians, including certifications in aid-in-dying medicine. This is to be fully implemented by mid-to-late 2024.
- o Institutions such as hospital systems, hospices and medical groups should develop practice standards based on state law, templates to guide



documentation, and resource staff: navigators, lead providers, etc.

- Licensing bodies in states should offer continuing education units in aid-in-dying care as options that are part of their end-of-life or other continuing medical education requirements.

**Rationale:** Providers need to understand aid-in-dying procedures according to the most recent and comprehensive definition: *Medical aid in dying refers to the legal practice where a clinician cares for a terminally ill patient who considers and potentially follows through with hastening their imminent death through the use of medications prescribed for that purpose.* (UpToDate: *Medical aid in dying: Clinical Issues*. September 2023. <https://tinyurl.com/UTDclinical>)

## 2. **Options found not ethically supportable, and rationale:**

- Failing to intervene when a professional becomes aware of a colleague with gaps in knowledge or process, and not providing conversation and education to correct aspects of care that are not aligned with best practices.
  - This is based on the collective commitment to the Professional Code of Ethics for Physicians (and other professions in states where they can prescribe). See Appendix A
  - Not intervening could be seen as patient abandonment.
- Allowing practices that do not align with state law.
  - We should not treat medical aid in dying differently than any other legitimate medical practice. The same expectation for standards of care and complying with law should apply. Resources to assist in learning this new procedure should be readily available, if not mandated.
  - By having aid-in-dying laws adopted in only specific states, there is a risk of stigma or social censure being applied to the practice. This may inhibit wider exposure to shared discussion, knowledge, and adoption of quality aid-in-dying services on a national level.
  - Each state where aid in dying is permissible may have statutes that contain different requirements and allowances. Therefore, it is imperative that providers are aware and well educated about the particular law under which they are practicing, to protect their professional licensing and the rights/well-being of patients.

- Allowing practices that do not align with standards of care, even as we recognize that standards are evolving and it may be challenging to keep up with best practice recommendations.

### **Summary of the Big Picture Issues highlighted in this consult:**

Medical aid in dying should not be treated differently than any other legitimate medical practice. The same expectation for standards of care and complying with the laws should apply. Resources to assist in learning this new procedure should be readily available, if not mandated. Education in medical aid in dying should be part of general medical education, and not limited to any one specialty, such as palliative care and hospice. If a practitioner chooses to not actively participate in aid in dying in a prescribing or consulting role, they should still be competent in knowing the basics of the process and how to respond and support patients who are considering this service, including referring patients to appropriate expert resources.

### **VII. 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.

### **VIII. 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 Jean Abbott (team leader) and team members: Deborah North, Yvette Vieira, Constance Holden, for the Academy Ethics Consultation Service

Date: March 2, 2024

## **Appendix A:**

American Medical Association, Principles of Medical Ethics (2001)

Source: <https://code-medical-ethics.ama-assn.org/principles>

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- **V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.**
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall, recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

**AMA – Reporting Incompetent or Unethical Behaviors by Colleagues** ([Reporting Incompetent or Unethical Behaviors by Colleagues | AMA-Code \(ama-assn.org\)](#))

Medicine has a long tradition of self-regulation, based on physicians' enduring commitment to safeguard the welfare of patients and the trust of the public. The obligation to report incompetent or unethical conduct that may put patients at risk is recognized in both the ethical standards of the profession and in law and physicians should be able to report such conduct without fear or loss of favor.

Reporting a colleague who is incompetent or who engages in unethical behavior is intended not only to protect patients, but also to help ensure that colleagues receive appropriate assistance from a physician health program or other service to be able to practice safely and ethically. Physicians must not submit false or malicious reports.

### **AMA – Peer Review and Due Process** ([Peer Review & Due Process](#) | [AMA-Code \(ama-assn.org\)](#))

Physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.

### **Statement of Values of the Physician Assistant (PA) Profession**

<https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf>  
(relevant statements)

#### Values:

- PAs hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- PAs assess their personal capabilities and limitations, striving always to improve their medical practice.
- PAs actively seek to expand their knowledge and skills, keeping abreast of advances in medicine.
- PAs respect their professional relationship with physicians.
- PAs share and expand knowledge within the profession.

#### Competency:

- PAs should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic health care providers. PAs should also strive to maintain and increase the quality of their health care knowledge, cultural sensitivity, and cultural competence through individual study and continuing education.

Illegal and Unethical Conduct:

- PAs should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by health care professionals to the appropriate authorities.

**Code of Ethics for Nurses (including Nurse Practitioners):**

<https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/>

(relevant statements)

3.5 When nurses become aware of inappropriate or questionable practice, the concern must be expressed to the person involved, focusing on the patient's best interests as well as on the integrity of nursing practice.....When incompetent, unethical, illegal, or impaired practice is not corrected and continues to jeopardize patient well-being and safety, nurses must report the problem to appropriate external authorities....

4.3 Nurses have a responsibility to define, implement and maintain standards of professional practice.

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**Appendix B:**

**Current Examples of Sources of Provider Education and Support for Participating in Medical Aid in Dying**

National mentors and resources:

- The American Clinicians Academy on Medical Aid in Dying – 8 nationally available on a “clinician’s hotline” through their website, representing most states where it is legal.  
<https://www.acamaid.org/hotline/>
- Compassion and Choices Doc2Doc line. <https://www.compassionandchoices.org/d2d>

State-based – some examples as of February 2024:

State	Resources: State-based	Advocacy, Other Groups
Oregon		<ul style="list-style-type: none"> <li>• <a href="https://www.eolcoregon.org/">Oregon's Death With Dignity Act legal requirements for Physicians (eolcoregon.org)</a></li> </ul>
Washington	<ul style="list-style-type: none"> <li>• <a href="#">Death with Dignity Act   Washington State Department of Health</a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Information for Medical Providers - End of Life Washington</a></li> </ul>
Montana		
Vermont		<ul style="list-style-type: none"> <li>• <a href="#">Clinician's Guide - Patient Choices Vermont</a></li> <li>• <a href="#">Medical Aid in Dying (Act 39) (vtethicsnetwork.org)</a></li> </ul>
California	<ul style="list-style-type: none"> <li>• <a href="#">Medical board of CA</a></li> <li>• <a href="#">CA Department of Public Health</a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">EoLOA for Healthcare Providers 2023 (coalitionccc.org)</a></li> <li>• <a href="#">Welcome to End of Life Choices California - EOLCCA</a></li> </ul>
Colorado	<ul style="list-style-type: none"> <li>• <a href="#">Medical Aid in Dying   Department of Public Health &amp; Environment (colorado.gov)</a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">End of Life Options Colorado – for clinicians</a></li> </ul>
Washington DC	<ul style="list-style-type: none"> <li>• <a href="#">Death with Dignity Act of 2016   doh (dc.gov)</a></li> </ul> <p>(registration required to access physician portal)</p>	
Hawai'i	<ul style="list-style-type: none"> <li>• <a href="#">Office of Planning Policy and Program Development   Health Care Provider Resources (hawaii.gov)</a></li> </ul>	
New Jersey	<ul style="list-style-type: none"> <li>• <a href="#">Department of Health   Advance Directive   Medical Aid in Dying (nj.gov)</a></li> <li>• <a href="#">Pages - Medical Aid in Dying for the Terminally Ill Act (njconsumeraffairs.gov)</a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">NJ Death With Dignity for healthcare providers</a></li> </ul>
Maine		<ul style="list-style-type: none"> <li>• <a href="#">For Providers - Maine Death with Dignity</a></li> <li>• <a href="#">Healthcare Professionals Checklist: Maine Hospital Assn</a></li> </ul>
New Mexico	<ul style="list-style-type: none"> <li>• <a href="#">End-of-Life Options Act (nmhealth.org)</a></li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">End of Life Options Act for Providers – End of Life Options New Mexico (endoflifeoptionsnm.org)</a></li> </ul>

Note: Most state sites include requirements of state laws and checklists only.

Montana: Because it was a court decision and not a law, no provider information is available.