

Willingness to be present throughout patient death via medical aid in dying in a national sample of interdisciplinary US hospice clinicians: a content analysis of rationales

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Abstract

Background: Although medical aid in dying (MAID) legalization continues to expand across the United States, limited research has elucidated attitudes toward its clinical provision, especially in terms of clinician presence.

Objective: The objective of the current study was to explore attitudes toward presence throughout a patient's death via MAID in hospice physicians, nurses, social workers, and chaplains. Aims included (1) characterizing willingness to be present throughout patient death via MAID and (2) describing rationales for willingness.

Design: We employed a cross-sectional design.

Methods: A national convenience sample of interdisciplinary hospice clinicians in the United States ($N=413$) completed a self-administered, mixed-method survey via Qualtrics. A quantitative item assessing participants' willingness (no, unsure, yes) to be present throughout a patient's death via MAID preceded a qualitative probe inquiring about their rationales behind their previous response. Quantitative responses were characterized through frequencies and percentages. Qualitative responses within each resulting quantitative subsample were content analyzed for surface-level meaning using inductive coding.

Results: Participants who were willing to be present ($n=305$ [74%]) attributed their willingness to personal support, definitions of quality clinical care, and values from their professional training. Some engaged in boundary setting, describing particular conditions under which they would be willing to be present. Those who were unwilling ($n=63$ [15%]) noted personal objections to the concept of MAID, personal objections to MAID participation, and perceptions of MAID's misalignment with healthcare. Those who were unsure ($n=45$ [11%]) premised their responses on ambivalence and a lack of experience, both of which precluded formulating a definitive position.

Conclusion: Although three-quarters of participants were willing to be present during MAID, qualitative responses revealed great nuance within and across quantitative subsamples. Hospice clinicians would benefit from greater professional guidance and support pertaining to MAID.

Keywords: care provision, clinicians, end-of-life care, hospice, medical aid in dying

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Introduction

The United States is one of a growing number of countries across Europe, North America,

Oceania, and South America to have legalized what, domestically, is referred to as *medical aid in dying* (MAID). This practice denotes a qualified

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patient's self-administration of a medication prescribed by an attending provider specifically to hasten their death.¹ Despite the persistence of analogous terms (eg, "physician-assisted death," "physician-assisted suicide"), the United States has increasingly used "MAID" to account for patients' interdisciplinary support needs^{2,3} and to avoid mischaracterizing MAID via stigmatized language describing other forms of self-actualized death.⁴⁻⁹ As of this writing, the United States has legalized MAID via statute in 9 states (California, Colorado, Hawai'i, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington) and the capital (District of Columbia). These jurisdictions collectively account for roughly one-fifth of the country's population.¹⁰ MAID's continued presence on state ballots has led to predictions of legal expansion,¹ and, by extension, increases in MAID pursuit and utilization.

Research on MAID with samples of healthcare professionals largely has prioritized the study of attitudes.¹¹ Many of these studies have conceptualized MAID as a broad and abstract concept. However, increasing experience with MAID in the United States since Oregon's pioneering implementation in 1997¹² has prompted more applied questions about effectuating MAID in clinical practice. Nevertheless, research targeting MAID's clinical provision remains scarce,¹³⁻¹⁵ especially for clinicians outside of physicians¹⁶⁻¹⁸ who serve distinct and complementary purposes in MAID care.³ This dearth has hindered MAID care optimization for patients and families, as well as supportive resources for professionals.¹⁹

Specifically, scholars have called for increased efforts to develop professional roles in MAID provision,^{14,17-23} with particular focus on clinician presence at bedside during MAID utilization.¹⁴ MAID's pronounced relevance to end-of-life care has seen clinician presence raised in specific relation to hospice.²⁴⁻²⁷ Nonetheless, limited research appears to have considered individual hospice clinicians' attitudes toward presence. Review of the literature suggests that only one study to date has prospectively assessed clinician attitudes toward presence, finding that roughly one-third (34%) of a convenience sample of physicians across specialties in Colorado reported either probable or definite willingness to be present during a hypothetical MAID patient's ingestion.²⁸ However, in addition to accounting for neither nonphysician members of the hospice interdisciplinary group nor presence during other critical intervals

throughout MAID death (ie, before ingestion, after ingestion and through death), these results do not detail the rationales for participants' reports. Such exploration is needed because, alongside social and policy considerations, MAID-related attitudes and behavioral intentions are noted determinants of participation.²⁹

Literature review

Qualitative research consistently has shown that MAID patients request clinician presence at death.^{22,30-33} Requests often reflect a desire for psychosocial support during the patient's final moments²² or for the security of knowing that someone of clinical skill would be present should complications (eg, vomiting the MAID medication) occur.^{14,30,34,35}

Available US state utilization report data have demonstrated that clinician presence during MAID is not rare. In the most recent year reported, just under half to over three-quarters (42%–88%) of all known MAID ingestions were attended by a healthcare provider of some kind.^{35,36} After attending physicians (22%–47%), the most populous groups of attendees included "other healthcare providers" (19%–48%) and "volunteers" (41%).^{35,36} These latter groups comprise members of external advocacy organizations that supplement MAID-related care,³⁷ whose reported classification is contingent upon their individual professional licensure (C. New, email, 27 July 2023). These reporting limitations obfuscate the number of deaths attended by patients' hospice team members.

Despite potential benefit, the presence of external personnel may present a suboptimal solution in MAID. For instance, individuals without clinical backgrounds may offer little reassurance to patients concerned about complications. Furthermore, outside clinicians who are unfamiliar to the patient may provide limited emotional comfort. In contrast, US state utilization reports generally indicate that most (78%–95%) of the individuals who use MAID are enrolled in hospice care.^{34-36,38,39} This high overlap may uniquely poise hospice clinicians for MAID presence.²⁵⁻²⁷ Given that hospice teams develop rapport with patients and families, hospice clinicians may be well-suited to address appropriate care needs during MAID.⁴⁰

Nevertheless, many hospice agencies have enacted policies prohibiting or otherwise restricting

clinician presence even in states where MAID is legal, often citing a perceived incongruence between MAID and hospice values.^{25–27,37} Criticized for restricting clinicians' individual autonomy,⁴¹ such policies also may emanate from a desire to avoid situations (or speculations thereof) of errant clinician participation. These concerns have led some hospice agencies to qualify the parameters of permissible clinician presence in accordance with key junctures throughout the utilization process, resulting in stipulations that clinicians present remain outside the patient's room until self-administration is complete.^{24,42,43}

However, complications arising following self-administration may compel clinical intervention. Given that hospice clinicians are charged to provide only "appropriate quality hospice care" by attending solely to "human care" needs,²⁶ using intraprocedural interventions to treat complications may contravene organizational policies and result in clinician termination.²⁴ More extreme interpretations may consider such intervention as exceeding the legal scope for MAID by actively accelerating a patient's death.²⁶ Therefore, hospice agency policies restricting clinician presence reduce the threat of negative consequences for hospice agencies and the clinicians they employ.^{25,26}

Although less common than policies limiting clinician presence, other hospice positions appear more variable, with some allowing clinicians to decide for themselves^{25–27} and others even mandating presence.⁴² Increasingly, research has shown that hospice professionals may want to be present³²—and have been present^{21,22,30,32}—during MAID deaths. This presence has facilitated the extension of support to patients and families^{22,30} that ultimately contributed to higher-quality care via therapeutic presence, arrangement of required equipment and medications, and the initiation of wraparound care for bereaved families and friends.²²

Notwithstanding, understanding of hospice clinicians' attitudes toward their presence during MAID death remains elusive. The available data appear to have emerged from general studies about MAID provision, signaling that presence is a topic of pronounced import to clinicians. Moreover, variation in the breadth and depth of clinician attitudes ultimately warrants further examination. For instance, although some clinicians described presence as consistent with nonabandonment and the provision of quality

end-of-life care,^{31,33,37} MAID presence also has elicited feelings of distress³³ stemming from witnessing a death that does not reflect "the normal process"²² or from the need to navigate arising complications.¹³ Others wrestled with competing emotions,^{32,33} suggesting that MAID attitudes are not necessarily mutually exclusive.

The current study

The expansion of legally viable responses to the historical question of MAID²² has prompted increased interest in developing its clinical provision. Although many state and organizational policies discourage hospice clinician presence,^{25–27} research appears yet to have foregrounded the examination of hospice clinicians' own attitudes. This omission is concerning, due to the competing clinical, ethical, and legal considerations posed by clinician presence.^{41,44} Thus, responding to prior calls to develop clinician roles in MAID provision,^{14,17–20,22,23,32,45} the objective of the current study was to explore attitudes toward presence throughout a patient's death via MAID in hospice physicians, nurses, social workers, and chaplains. Aims included:

1. Characterizing willingness to be present throughout patient death via MAID.
2. Describing the rationales shaping willingness.

Methods

Study design

Our team of interdisciplinary researchers with clinical backgrounds in aging and end-of-life care and varied attitudes toward MAID designed this cross-sectional study using a primarily qualitative descriptive approach.⁴⁶ We recruited a national convenience sample of interdisciplinary hospice clinicians in the United States who were ≥ 18 years old, worked as paid hospice employees, and provided direct patient care. We recruited members of hospice and palliative care professional membership associations (unnamed as per research agreements) representing each discipline defined in the Medicare Hospice Benefit as constituting the hospice interdisciplinary group⁴⁷ (ie, medicine, nursing, social work, spiritual counseling) to complete a self-administered, mixed-method survey via Qualtrics. Some professional membership associations' internal record-keeping prevented excluding nonhospice palliative care members

from their membership lists and, by extension, our composite sampling frame. Dissemination logistics, such as the number of survey invitations (2 vs 5), dissemination mode (email vs newsletter), and dissemination source (professional membership association vs research team) were employed to maximize recruitment. An influx of responses following the second nursing invitation led us to suspect bot infiltration. Thus, we listwise deleted any case recorded in the nursing survey after the second dissemination ($n = 2392$). Implementation of a compensatory round of data collection generated no concerns of fraud.

We defined survey completion as responding to $\geq 50\%$ all items.⁴⁸ Two hundred randomly selected participants received a \$20 egift card as compensation. Surveys remained open for 30 days from November 2022 through January 2023. Reporting of quality criteria for the current study conforms to the Standards for Reporting Qualitative Research (see Supplemental Table 1).⁴⁹

Measures

Willingness. First, participants responded (no, unsure, yes) to an item asking, “Would you be willing to be in the room with a hospice patient using MAID from the time they self-administer a lethal medication until after they die?” We appended the following instructions to offset potential inapplicability⁵⁰: “Please assume that the following conditions are all true:

1. MAID is legal.
2. Your hospice’s policy on MAID permits clinicians to be present.
3. A competent patient voluntarily and explicitly requested your presence.”

Rationale. Then, participants responded to a qualitative probe asking them to “Please explain the rationale behind your previous response,” using a character-unrestricted text entry box.

Data analysis

First, we calculated frequencies and percentages of responses to the quantitative item using Stata (Version 18, College Station, TX: StataCorp; 2023). Then, we performed individual content analyses of responses to the qualitative probe within each of the resulting quantitative subsamples (willing, unwilling, unsure) using NVivo (Release 14, Burlington, MA: Lumivero; 2023).

Content analyses sought surface-level meaning and followed a recursive, four-step method,⁵¹ targeting data decontextualization (Steps 1–3) and recontextualization (Step 4; see Table 1).⁵² In Step 1, TDB read through all responses several times. In Step 2, TDB identified and condensed meaning units within responses. In Step 3, TDB and CLC independently⁵³ coded a randomly selected quarter⁵⁴ of each quantitative subsample’s condensed meaning units. Coding was inductive. Condensed meaning units were labeled with multiple codes, as appropriate. In Step 4, TDB and CLC independently⁵³ abstracted codes into categories. Because differences, identified through discussion, were minimal, TDB coded and categorized all remaining responses, consulting with CLC as needed. After debriefing⁵³ with a leading qualitative MAID researcher to refine prospective findings, TDB presented the refined findings to the full research team who proposed only minor feedback regarding interpretation. Analysis concluded with calculating frequencies and percentages for each code, category, and subcategory.

Results

Data preparation

Professional membership association-provided estimates (range, 853–8500) indicated 20 075 potential participants. We received 1346 total responses. We began specifying our analytic sample via a five-step process of listwise deletion. Specifically, we listwise deleted: 130 cases for not providing informed consent, 683 cases for not meeting inclusion criteria, 26 cases for constituting survey break-off, 11 cases for flagging Qualtrics security measures, and 7 cases for raising concerns about conceptual relevance (ie, pediatric clinicians, non-US clinicians). Then, TDB and CLC conducted a manual review of the remaining 489 cases to screen for sample retention. This process resulted in deleting an additional 50 cases for missingness on the qualitative probe and 26 cases for lacking a substantive response. TDB and CLC identified the latter cases through a screening procedure that concluded after two rounds when perfect interrater reliability was attained (κ [SE], 1.00 [0.00]).

Participant characteristics

The sample ($N = 413$) included hospice physicians (203 [49%]), chaplains (82 [20%]), social

Table 1. Illustration of content analysis process ($N=413$).

Data decontextualization			Data recontextualization	
Meaning unit	Condensed meaning unit	Code	Subcategory	Category
Unwilling				
I would have to think about; I don't agree with physicians prescribing a drug to cause the patient's death	I don't agree with physicians prescribing a drug to cause death	Physicians cause death	Ethics, morals, and values	Personal objections to the concept of MAID
I am ethically opposed to it. Not only that, it is illegal in our state. I would never tell a patient what to do but I don't want to be an active participant in any patient's death. It goes against my training and moral beliefs. I think you will find that most hospice and palliative physicians feel this way	I am ethically opposed. I don't want to be an active participant in any patient's death. It goes against my training and moral beliefs. I think you will find that most hospice and palliative physicians feel this way.	Ethically and morally opposed Goes against training	Ethics, morals, and values —	Personal objections to the concept of MAID Misalignment with healthcare
Unsure				
I and our hospice support MAID, continue to treat the patient, attend after death, etc., but we do not participate by prescribing medication and they cannot take the medications in our IPU. I support this policy, so would support a patient but not participate in MAID. If there was a reason for me to be present, I would consider it, but unsure if ethically I would accept being present	I and our hospice support MAID, continue to treat the patient, attend after death, etc. I support this policy, so would support a patient but not participate in MAID. If there was a reason for me to be present, I would consider it, but unsure if ethically I would accept being present	Support policy versus unsure about ethicality	Explicit ambivalence	Ambivalence
I'm not sure because I have never been directly involved.	I have never been directly involved	Never directly involved	—	Lack of experience
Willing				
Though I do not believe in or support MAID and would not have prescribed the legally obtained lethal medication, I would always support my patient and would be present for his/her death if requested	Though I do not support MAID and would not have prescribed the legally obtained lethal medication, I would support my patient and be present if requested	There despite not supporting	Present despite disagreement	Professional values
Emotional and spiritual support—to feel supported in their decision. Have already done this multiple times	Emotional and spiritual support—to feel supported in their decision	Emotional and spiritual support	Holistic patient and family support	Quality clinical care
IPU, inpatient unit; MAID, medical aid in dying.				

workers (6 [16%]), nurses (58 [14%]), and other clinicians (5 [1%]; see Table 2). Age ranged from 24 through 78 years (median [interquartile range], 52 [42–62] years). Participants were mostly women (267 of 411 [65%]), non-Hispanic or Latino (394 of 407 [97%]), and White (357 of 408 [88%]). The most common religious

identity was Protestantism (117 [29%]). Participants worked in hospice from 0 through 41 years (median [interquartile range], 8 of 412 [4–15] years). Over one-quarter of participants reported contemporaneous professional exposure to working in a state where MAID was legal (115 [28%]).

Table 2. Sample characteristics (N=413).

Characteristic	No. (%)
Age, mean (SD), years	52 (12)
Gender ^{a,b}	
Man	142 (35)
Woman	267 (65)
Other	2 (<1)
Ethnicity ^c	
Hispanic or Latino	13 (3)
Non-Hispanic or Latino	394 (97)
Race ^d	
Asian	18 (4)
Black or African American	18 (4)
White	357 (88)
Multiracial	12 (3)
Other	3 (1)
Religious identity ^d	
Agnostic	38 (9)
Atheist	28 (7)
Buddhist	11 (3)
Catholic	61 (15)
Christian nondenominational	66 (16)
Hindu	6 (1)
Jewish	28 (7)
Protestant	117 (29)
Spiritual	17 (4)
Other	36 (9)
Profession	
Chaplain	82 (20)
Nurse	58 (14)
Physician	203 (49)
Social worker	65 (16)
Other	5 (1)
Years working in hospice, mean (SD) ^{a,e}	11 (9)
Contemporaneous professional exposure to working in a state where medical aid in dying is legal	
Yes	115 (28)
No	298 (72)

^aCategory percentages do not sum to 100%, due to rounding.

^bn = 411.

^cn = 407.

^dn = 408.

^en = 412.

Willingness to be present throughout patient death via MAID

Roughly three-quarters of participants were willing to be present throughout MAID (n = 305 [74%]). The remaining quarter was either unwilling (n = 63 [15%]) or unsure (n = 45 [11%]).

Rationales shaping willingness

The final coding structure contained a total of 644 codes distributed across the three quantitative subsamples (Willing: 506 [79%]; Unwilling: 85 [13%]; Unsure: 54 [8%]; see Table 3).

Willing. Participants willing to be present based their rationales on eight subcategories arrayed across four broader categories. These categories reflected an overwhelmingly positive attitude, albeit one imbued with tension.

Personal Support. Some participants attributed their willingness to broader support for MAID. Bases for this support were moral, professional, and even religious in nature. Participants referenced case examples to illustrate how MAID represents a “legal and sensible action”:

Sometimes, death is a gift to people long suffering. I currently have a 60-year-old patient dying a painfully slow death from [amyotrophic lateral sclerosis] after refusing [percutaneous endoscopic gastronomy] and trilegy. Unlike with dementia, this patient is cognitively intact and aware he cannot swallow. . . . He mentions daily he isn't living; he is just existing. He mentions daily that he is miserable and just wants it to end. I think death would be a welcome gift. —Physician

In some instances, prior experience with MAID prompted support. As one chaplain explained, “when I worked at a hospice in Oregon, I went through this with a couple of patients and families. . . . Going through it with people changed my perspective.” In other instances, MAID unavailability was recognized as predisposing patients, families, and healthcare teams to experiencing the opposite of what end-of-life care strives to accomplish. One physician illuminated how MAID unavailability may lead to dangerous attempts at self-actualized death:

Our hospice has had two patients end their lives violently (self-inflicted gunshot). The hospice team can usually address most physical and spiritual pain. However, when the despair and hopelessness is

Table 3. Content analysis results ($N=413$).

Category	No. (%)	Subcategory	No. (%)	In vivo quote
Willing (506 [79%])				
Personal support	52 (10)	Right to die	16 (30)	No one should die alone. Yes, I could be part of MAID. If it is the patient or medical power of attorney's wish to pass on their terms, well then, OK. I've seen lots of people pass. I have heard lots of people ask us to help them pass. They are just tired and want this to end. I agree with them. I would want a dignified way to nicely end it.
		Personal meaning making	26 (49)	The tasks/functions related to this death would be the same as all others: Provide support to patient, family members, and my peers. I would consider being in a room for this death a greater honor, as I assume timing of dose would be planned in advance, so [the] patient could decide who should be there. So, my presence would have been by request.
Quality clinical care	220 (43)	Psychosocial support	151 (69)	Clinician presence at time of death can be instrumental in normalizing the experience, providing emotional support, and enhancing coping and grief processing.
		Overseeing clinical provision	25 (11)	I think families would be comforted by physician presence and to make sure the cocktail is appropriately administered.
		In case of complications	26 (12)	To make sure that they were able to ingest the medication. Nausea and vomiting can happen. This can cause a prolonged death or the dose may not be effective for the intended cause.
Professional values	221 (44)	Autonomy	54 (24)	It would be an honor to be allowed in such a sacred space. The patient is in charge of their own life, and death, and should be throughout the hospice experience, even if it includes when and how the death happens. Although it might be uncomfortable for me, it is my role to be present to offer support, if requested. As hospice members, we are able to educate, provide resources and medical intervention to provide a "good death," whatever that means for a patient, and provide support, but it is not our role to decide what any of that looks like, even if we would not choose that for ourselves.
		Nonabandonment	28 (13)	The relationship matters. The power rests in me to provide the tool (assuming all legal and ethical guidelines have been followed). If the patient wants me to be present when they use the tool, I should do that (assuming they are willing/able to accommodate my ability to attend). I should be willing to be present when any order I give is implemented. It's a way of acknowledging and owning the gravity of the power of my position.
		Present despite differences	31 (14)	There are so many ways of dying. If someone were pursuing this path, and if I were a part of their care team, and they wanted and needed my support during that tender time, while it would be difficult, I would be honored to be there—just as I would for any of my patients—to provide support and tending during their transition.

(Continued)

Table 3. (Continued)

Category	No. (%)	Subcategory	No. (%)	In vivo quote
Boundary setting	13 (3)	—	—	If no family member were present at the bedside then I would be willing to stay with the patient and assist in monitoring for any symptoms to maximize comfort, as well as providing emotional reassurance so that they were not alone at the end of life.
Unwilling (84 [13%])				
Personal objections to the concept of MAID	35 (42)	Ethics, morals, and values	22 (63)	I believe that no person, regardless of their medical condition, has the right to take their own life. Each patient/person still has value to family/friends, loved ones, etc., no matter their medical condition.
		Spiritual or religious	6 (17)	My spiritual and moral beliefs do not support suicide, which is what MAID is, essentially. I would be very uncomfortable being present for something that I do not support. I believe the soul of a person moves to the afterlife upon their physical death. Suicide is a mortal sin that I believe damns a person's soul to eternal misery and pain. I don't feel I could be present for that act and not feel emotional consequences or turmoil after that act was completed.
Personal objections to MAID participation	26 (31)	Meaning of presence	12 (46)	I cannot condone suicide by my presence, thereby tacitly endorsing the act.
Misalignment with healthcare	23 (27)	Misalignment with hospice care	10 (43)	I think that MAID can be a slippery slope—and that hospice is already perceived as “killing people” at times. Participating in MAID or euthanasia will only strengthen that association in the mind of the public. Finally, while I believe that patients have a right not to prolong their lives artificially or to voluntary stopping of eating and drinking, if they so choose, I do not believe in actively taking a life.
Unsure (54 [8%])				
Contextual ambivalence	49 (91)	Implicit contextual ambivalence	13 (27)	Blurred lines with “first, do no harm” and my position that we can make a patient comfortable without causing their death.
		Explicit contextual ambivalence	21 (43)	I do not believe that healthcare providers should participate or support MAID. At the same time, I believe in support my patients regardless of whether I follow their same principles/beliefs. I would want to them to know that I still care for them and wish them well, so I would be tempted to be in the room. But, I would struggle with whether this would suggest approval/support of the decision, or even make me participatory in the act. As a result of these competing frameworks, I am unsure.
		Conditions for consideration	11 (22)	It depends on my level of comfort of the situation—if I will be safe in the process. “Safe” means as a person and a healthcare professional. If I have a strong relationship with the patient/family and have cared for them for a long time or have a great relationship, I would be more likely.
Lack of experience	5 (9)	—	—	I have not given much thought to this aspect of MAID, mostly because the above conditions are not true for me. Clearly, I have some thinking to do about this issue.

Condensed meaning units were labeled with multiple codes, as appropriate, resulting in a total of 644 codes. Frequencies and percentages provided correspond to those at the next highest level of abstraction. However, values at lower levels of abstraction may not sum to those at higher levels of abstraction, due to interpretive guidelines.⁵⁵
 MAID, medical aid in dying.

overwhelming, I would prefer MAID over a violent death (with horrible consequences for survivors).

Two subcategories of personal support were created.

Right to die. The first subcategory included support for the right to die. Reflecting on the “many patients” who had inquired about MAID in her prohibitive state, one physician concluded that MAID “is an important human rights issue.” Such positions considered the ability to “take back control” and “compassionately end terminal suffering” as fundamental rights. Underpinned by another physician’s assertion that “hospice cannot alleviate all suffering,” participants perceived health systems as natural stewards of this process. As one nurse said, “I think MAID should be a right for all dying or terminally ill people, and they should be able to have support from their care team.” One chaplain sympathized while contemplating his own preferences: “I agree with [MAID patients]. I would want a dignified way to nicely end it.”

Personal meaning making. The second subcategory contained responses highlighting personal meaning derived from companioning patients through death. As one physician explained, “I see this as preserving my humanity.” Another physician agreed: “Being present during the last breath can be very humbling and sacred.” Participants described how the “honor” and “privilege” of being present throughout patient death would be augmented by the choreographed nature of MAID:

I would consider being in a room for this death a greater honor, as I assume timing of dose would be planned in advance, so the patient could decide who should be there. So, my presence would have been by request. —Social worker

Quality of clinical care. Participants viewed presence as “assuring the ‘best’ death possible.” Responses framed presence as an act of professional volition. One physician stated, “I would want to be the one to provide this care if I could.”

Underlying these descriptions was a consensus that MAID constitutes a legitimate medical intervention warranting expert guidance. Put bluntly by one physician, “MAID is a medical procedure.” Resultantly, participants perceived a

double standard in how clinicians uphold their responsibilities to patient care:

Part of what I dislike about MAID is that we do *not* provide monitoring in order to seemingly distance ourselves from the act. Either participate or don’t; but, if you do, you should be present as you would for any other patient. —Physician

Noting the intricacies of providing MAID safely and effectively, one physician articulated, “there is no better qualified person than a physician to help a person end their own life if that is what they choose to do.” Another physician related this sentiment to the implications of conscientious objection: “There is the worry that if I am not there after being asked, they may turn to other sources who may be less equipped to handle the dying process or aftermath.” Participants, therefore, viewed presence as exemplifying high-quality MAID care. Three clinical benefits arose as subcategories.

Psychosocial support. The first subcategory targeted the provision of psychosocial care. Participants viewed presence itself as “an important therapeutic intervention for patients who are dying.” As one physician speculated, “if my presence was requested, I must assume the patient or their family find some benefit or comfort by it.” So strong was this conviction that it drove one social worker to disregard organizational policy: “I have always offered this, even though my employer (of 2 years) has a policy against this, currently.”

Responses supposed substantial distress about dying via MAID. Participants considered the emotional, psychological, and spiritual support conferred through presence to ensure a higher-quality death by “normalizing the experience.” Participants interpreted this support as crucial to ensuring the medical procedure’s success and, ultimately, a higher-quality death:

Death is made bearable by hospice staff who know what is happening and can guide the patient and family through it. . . . If I can support someone through it, I would be comfortable being there. —Physician

A social worker added that presence can assuage distress about postingestion incapacitation: “Patients often find comfort knowing that their family has someone there with them to help guide

them once they are ‘asleep’ and the ‘waiting’ begins.”

Integral in this process was participants’ interpretation of MAID as relational endeavor between patients and families that offered a profound meaning-making opportunity. Presence throughout MAID represented the culmination of a process thereof, throughout which participants helped patients “‘unpack’ all the aspects of utilizing MAID.” Doing so involved facilitating opportunities to reinforce bonds with loved ones:

In the times I’ve been present, my role was to facilitate meaning and support for the patient and their family. I often facilitate ritual and safe space for the family to speak their love and hope for the patient. I can be a safety net for the patient’s last words to their family and chosen friends in the room. It has been a beautiful experience to bring presence to the event. —Social worker

Participants viewed these experiences as setting the stage for contextualizing subsequent grief support for bereaved loved ones.

Overseeing clinical provision. The second subcategory described the responsibility to assist patients and families in preparing for the patient’s self-administration of the medication. Responses reiterated a desire to “ensure things go smoothly” and “ensure that [patients] do not suffer.” Reaching these endpoints entailed counseling patients and families; assuring medication dosing, preparation, and self-administration; and assessing symptom distress.

In case of complications. The final subcategory addressed the need to provide symptom management, should complications arise. Complications identified included the inability to ingest the medication, discomfort, nausea and vomiting, pain, and prolonged death (recounted by a social worker as having lasted between 30 min and 2.5 h). Responses noted current knowledge is too underdeveloped to legitimize clinician absence:

Medical aid in dying is a relatively new procedure for which the complication rate is unknown. Having a skilled clinician at the bedside optimizes the chance of the patient getting the death that they desire. —Physician

Participants asserted that presence with current patients could improve care for future patients,

with one physician explaining, “it adds to clinical knowledge in knowing how the drug works. Every other treatment that we are trained in, as physicians, we learn by administering and following through.” A social worker agreed, stating, “it’s important to have the experience documented.”

Professional values. Intentions to be present were also predicated on professional values prioritizing advancing patients’ medical interests through goal-concordant care. Elaborating on a physician’s complete response of “patient-centered,” one social worker said, “the patient and their family are the center of care. My judgment of their choices is irrelevant as long as all supportive measures and appropriate education has been provided.” Furnishing a “‘good death’, whatever that means for a patient,” informed a “duty to care” discerning no differences between MAID and non-MAID deaths. Reiterated through common refrains to be present “as for any patient,” this equivalence led one physician to contend that presence throughout death is simply “part of the hospice care process.” Three subcategories of professional values emerged.

Autonomy. Responses in this first subcategory showed that the willingness to honor a patient’s wishes cast presence as an expression of support for patient autonomy. As indicated by one social worker, doing so was directly tied to a hospice approach to care: “The patient is in charge of their own life, and death, and should be throughout the hospice experience, even if it includes when and how the death happens.” Supporting autonomy required supporting patients in determining their own limits for suffering. Summarized by one physician, “providing dignity means allowing for personal choice.” For some, the request alone was sufficient to warrant their presence.

Nonabandonment. The second subcategory concerned the desire to adhere to nonabandonment. Premised on a view that “holistic patient care includes care during life and through/beyond death,” participants described nonabandonment as a patient right and hallmark of hospice philosophy that superseded an abstract ideal. In the words of one physician, “we do not desert our patients.”

For these participants, willingness to be present was about more than an abstract ideal:

The relationship matters. The power rests in me to provide the tool. If the patient wants me to be present when they use the tool, I should do that. I should be willing to be present when any order I give is implemented. It's a way of acknowledging and owning the gravity of the power of my position.
—Physician

In this sense, participants attributed the professional value of nonabandonment to a human dynamic. Put simply by one nurse, “I have done this many times and it is a beautiful way to care.”

Present despite disagreement. The final subcategory indicated that arriving at this decision was not without strain. Tensions specifically targeted MAID's implication of clinician participation. Participants clarified that their personal opposition to MAID would render presence challenging. Nevertheless, interpretations of primary clinical responsibility to their patients, as opposed to their own self-interests, yielded refrains concluding that “the process isn't about me.” Thus, commitment to broader values disqualified the available prospect of individual conscientious objection for these participants. One chaplain reflected on this tension:

If someone were pursuing this path, and if I were a part of their care team, and they wanted and needed my support during that tender time, while it would be difficult, I would be honored to be there—just as I would for any of my patients—to provide support and tending during their transition.

Boundary setting. Despite confirming their willingness to companion patients throughout MAID, some participants did so with hesitation. These participants indicated that they would entertain requests for presence only under certain conditions. Circumstances included exhaustion of interdisciplinary medical workup, nonparticipation in MAID-related aspects of care, presence in the house (but not the room) during self-administration, patient older age, and absence of family. By reinforcing the legal ability to determine the extent of their own involvement, these boundaries served, in part, to validate participants' individual conceptualizations of the “limited but valid reasons for MAID” beyond those already codified by law.

Tensions persisted in scenarios meeting participants' increased restrictions. As one physician remarked, “my presence does not equate to acceptance or tolerance. . . . Additionally, I

would actively continue to dissuade the patient from directly causing their death by taking a lethal medication, all the way to the moment of death.” Thus, boundaries conditioned not only the context in which participants would be willing to be present but also the context surrounding how they would engage while there.

Unwilling. Those who were unwilling to be present reflected attitudes that were decidedly negative. Qualitative rationales underpinning this opposition cohered around three categories.

Personal objections to the concept of MAID. These rationales reflected wholesale, personal rejections toward the concept of MAID. As one physician stated, “I don't fundamentally agree with MAID.” Two subcategories targeted the origin of objection.

Religious or spiritual. Speaking to the sacredness of life, this first subcategory concerned objections based on religious or spiritual beliefs:

My spiritual . . . beliefs do not support suicide, which is what MAID is, essentially. . . . Suicide is a mortal sin that I believe damns a person's soul to eternal misery and pain. —Nurse

Ethics, morals, and values. Rationales in this second subcategory, reflecting secular ethics, morals, and values, were more common. One chaplain reported: “I believe that no person, regardless of their medical condition, has the right to take their own life.” Beliefs that MAID would “violate [patients'] human dignity” underlay arguments that presence would inflict “moral injury” and “emotional turmoil” on clinicians.

Personal objections to MAID participation. In contrast, participants focused their objection less on MAID as a concept and more on their specific participation therein. One chaplain explained: “I am comfortable supporting MAID but not being present in the room when it happens.” Participants worried clinician presence could foster a legal “occasion for scandal.” Whereas one physician feared his presence being misconstrued as coercive, another illustrated how a patient's physical decline could jeopardize clinicians present:

In Washington State, the patient must self-administer the Death with Dignity cocktail. I would not want myself or members of the hospice staff to be in a room with a patient to find that the patient

was not able to self-administer, and, then, to be faced with a request from them or their family to administer.

Thus, despite the aforementioned interpretations, these responses clarified that diverging sociolegal considerations governing MAID provision rendered these deaths different from normative hospice deaths. Personal objections contained one subcategory.

Meaning of presence. Participants argued that presence would “condone” or “tacitly endorse” MAID. For one chaplain, doing so would signify “indirect cooperation with a grave moral evil,” which “morally compel” another physician “to stop the individual.” Supporting patients without transmitting support required delineating how participants would engage:

I [would] feel [uncomfortable] being present during ingestion. But, after the medication has been consumed, I am more than happy to return to the bedside to assist the patient and family as necessary.
—Physician

Misalignment with healthcare. Participants perceived a misalignment between MAID and the goals of healthcare. Objections ranged from individual stances to wider professional prescriptions citing contemporaneous professional guidance (viz, American Medical Association’s position statement,⁵⁶ spiritual counselors’ *Code of Ethics*⁵⁷) and interpretations of professional ethics (viz, Hippocratic oath). Responses reflected perceptions of law’s infringement on healthcare by contending that MAID “is not the place of medicine.” One physician added, “if a patient wants to commit suicide, that is done dozens of times a day. If a patient is determined, he or she doesn’t need my help.” Another physician maintained that MAID’s requirement for patient self-administration voided the need for clinician presence. One subcategory was developed.

Misalignment with hospice care. Participants interpreted MAID as particularly misaligned with hospice care. Whereas one physician stated that MAID was “inconsistent with hospice philosophy” altogether, others echoed the narrower tenet that hospice care does not hasten death. Participants hypothesized that MAID participation might exacerbate preexisting misperceptions. As one physician voiced, “hospice is already perceived as ‘killing people’.” Participating in MAID

or euthanasia will only strengthen that association in the mind of the public.” These bases for MAID’s misalignment with healthcare may be synthesized best by one physician’s response:

I believe that patients have the right to self-terminate and have no objection to a competent, mentally well, dying patient doing so. I do not believe that healers should be helping them to do so. We are not trained in this, and it goes against everything we espouse to do with hospice care. There is ample information everywhere for patients to accomplish self-termination safely and painlessly without my involvement. There is no valid reason to involve healthcare in the process.

Unsure. Participants indicating uncertainty about presence described a range of rationales, which we formulated into two categories.

Contextual ambivalence. Participants reported that ambivalence derived from weighing competing frameworks prevented formulating a definitive stance. As one physician expanded, “it’s tough for me to answer with certainty. Legally, clearly OK. But morally/religiously/practically, I struggle.” Participants acknowledged their indecision as likely to obstruct their subsequent patient care. Although the pros and cons described echoed those in the preceding quantitative subsamples, the negotiation of these tensions rose as a central focus to these participants. These negotiations engendered three subcategories.

Implicit contextual ambivalence. Despite selecting “unsure” for the quantitative item, these participants described only objections in their qualitative descriptions, suggesting a more negative attitude toward presence. Rationales included the aforementioned categories of personal opposition to MAID and perceptions of MAID’s misalignment with healthcare. Thus, despite perceiving “blurred lines” between personal and medical principles, the positively appraised aspects prompting participants’ quantitative responses remain unclear.

Explicit contextual ambivalence. More commonly, participants reflected more moderate attitudes, listing pros and cons. Although personal objections and perceptions of MAID’s misalignment with healthcare persisted as sources of opposition, all sources of support converged on patient benefit. Examples included support for autonomy, nonabandonment, and symptom man-

agement. Participants' internal tensions in navigating the divide between their own personal and professional values and their desire to support patients—itsself noted a personal and professional value—was related to prolonged internal struggle. As illustrated by one physician, “I want to respect the patient’s autonomy and yet, also feel like life is precious and would wonder, ‘have I really done everything I could to palliate this patient’s condition? Is this the only option left?’”

Conditions for consideration. Participants indicated willingness to be present “only in select situations.” These conditions concerned mostly patient-related factors, particularly the patient–clinician relationship. As one physician explained, “if I have a strong relationship with the patient/family and have cared for them for a long time or have a great relationship, I would be more likely.” Others' willingness depended on their individual evaluation of the patient's motivation for MAID. Thus, the context surrounding each case appeared to moderate participants' willingness.

Lack of experience. Distinct from a valenced attitude, other participants reported that insufficient MAID experience impeded speculation on their involvement:

I don't know whether I would be comfortable. I'm uncomfortable at the thought but imagine that would be initially. I think I would be OK if they were comfortable through the process of it. I imagine I would have to learn more about the MAID process and what it entails, but would support and be there for the patient and family if that was part of my job. That said, I *fully* support people (if they are competent) being able to make that decision for themselves. It is their life, their choice, and their death. I just want to help make it easier for them, however that occurs. —Nurse

Just as increased exposure to MAID seemed to facilitate nuanced appraisals, MAID illegality precluded consideration of the processes underlying MAID provision. For one physician, this revelation initiated a commitment to deeper consideration about MAID as an applied practice.

Discussion

As MAID legalization continues expanding,¹ hospice clinicians will be increasingly called on to provide MAID-related care. The current study explored attitudes toward presence throughout a

patient's death via MAID in a national sample of hospice physicians, nurses, social workers, and chaplains in the United States. Great nuance in qualitative responses observed within and across quantitative subsamples suggests that attitudes toward presence throughout MAID are multifaceted and may be challenging to accurately quantify.

Regarding Aim 1, 74% of participants indicated willingness to be present throughout MAID in our given scenario. This finding dwarfs the 34% of physicians indicating hypothetical willingness to be present during ingestion in the only other known assessment of clinician attitudes toward MAID presence.²⁸ Differences with our sample of interdisciplinary hospice clinicians and scope of presence from self-administration through death may underlie this discrepancy. For instance, as social workers in our sample discussed facilitating interpersonal meaning making before self-administration, skill sets from more psychosocially oriented professions may have contributed to increased perceptions of professional utility during junctures throughout MAID death outside of ingestion.³ Although MAID-related attitudes may not correspond directly into willingness to participate,⁵⁸ these results suggest high readiness in hospice clinicians for uptake in MAID presence.

Concerning Aim 2, the greatest proportion of codes for participants who were willing to be present pertained to interpretations of professional influences: quality of clinical care and professional values. Participants' view of assistance with MAID as syntonic with their professional duties and values contrasts with the oft-invoked principle that hospice care does not hasten death^{31,32,43,59} endorsed in dominant descriptions of hospice identity.^{59–61} Highlighting a purported “mission creep” in hospice philosophy,⁶² this discrepancy questions the concordance between overseeing hospice organizations and their individual members. This contradictory messaging may exacerbate misconceptions that hospice care hastens death⁶³ and threaten public trust.⁶⁴

Unwillingness was predicated mostly on personal objection. Recent bioethical literature has described MAID as agentially displacing^{30,65–67} in that a patient's agency in using MAID relies on clinician compliance. These considerations raise conscientious objection as a potential barrier to meeting patient end-of-life care preferences⁶⁸ by

counteracting MAID's purported goal to relieve suffering.⁶⁹ Striking here was the difference between wholesale opposition to MAID and opposition that was focused more on one's own presence. Aligning with previous research,³² this distinction suggests a divergence in attitudes toward MAID as a theoretical principle versus an applied practice.

Finally, contextual ambivalence was the most frequent code for those who were unsure. This finding joins a history of research with healthcare professionals regarding MAID^{17,19–23,70} foregrounding the importance of the parameters outlining each patient scenario. Here, context often functioned as a fulcrum, predisposing participants toward presence or absence. Variability observed across individual criteria for presence furthers the aforementioned commentary on conscientious objection by demonstrating that the prospect of conscientious objection manifests in gradations as opposed to the typically inferred all-or-nothing approach. Resultantly, after affirming clinicolegal MAID qualifications to pursue care aligned with their end-of-life preferences, patients must either ascertain and satisfy the contextually variable criteria of individual members of their hospice team^{11,71,72} or identify replacement clinicians,¹ which may be infeasible due to normative clinical decline at the end of life.

Limitations

Although mitigated through analyst triangulation and peer debriefing, our research agreements constrained data collection to one time point, which precluded employing additional trustworthiness procedures, such as member checking,⁵³ that may have strengthened the credibility of our findings. Additionally, some may consider our survey-based, single-item qualitative probe to have limited potential depth in participants' responses. Although founded, we selected this approach to encourage depth by offsetting hospice professionals' noted reticence to discuss aspects of MAID.³⁷ To this end, leading qualitative methodologists have endorsed single-item measures as procuring rich data^{73,74} about sensitive topics⁷³ through the extension of "felt anonymity."^{73,74}

Implications

Policy and practice. Clarity in US state utilization reports is needed to address patient, family, and clinician MAID needs.⁷⁵ Presently, no universal minimum standard in publicly available US state

utilization report data appears to exist. With sensitivity to potential issues of deductive identification, documentation of the end-of-life care professionals present, experience of complications, and course of the procedure could help develop needed guidance on best practices. Additionally, the development and dissemination of concrete clinical guidance on providing MAID is needed to support frontline clinicians in optimizing patient care. Despite high readiness for uptake, responses across all three quantitative subsamples echoed extant research in reporting a lack of training or guidance in MAID provision,^{15,17,19–22,42} which participants related to affecting their provision of patient care. Thus, as professional societies increasingly recognize MAID as a clinical option in legalizing environments, the development and dissemination of such guidance could support the safety and effectiveness of MAID provision. Educational programs may complement these efforts by coordinating training opportunities for interested students to learn about MAID provision,⁷⁶ as legally permissible.⁷⁷

Future research. Future qualitative research should explore clinician presence under more specific circumstances that may facilitate or constrain patient access and clinician participation. Such investigations would inform both a fuller depiction of clinicians' attitudes and experiences and the development of necessary supports. Key foci therein include clinician participation vis-à-vis the presence or absence of loved ones and across settings of MAID death. Future quantitative research should examine how attitudes toward presence translate into intentions to be present and observed presence to elucidate hospice clinicians' behavioral trajectories concerning patient end-of-life care wishes. In addition to other factors, such investigations should account for how state and organizational policies may moderate this process.

Declarations

Ethics approval and consent to participate

The University of Maryland, Baltimore Institutional Review Board approved this study as exempt (HP-00098283). All participants consented to participation via the provision of electronic informed consent.

Consent for publication

All participants consented to the publication of provided data via the provision of electronic informed consent.

Author contributions

Todd D. Becker: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Software; Writing – original draft; Writing – review & editing.

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Joan K. Davitt: Conceptualization; Methodology; Supervision; Writing – review & editing.

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The authors declare that there is no conflict of interest.

Availability of data and materials

Requests for data access directed to the corresponding author may be granted on reasonable request.

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Supplemental material

Supplemental material for this article is available online.

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