

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-A-18

Subject: Study Aid-in-Dying as End-of-Life Option
(Resolution 15-A-16)
The Need to Distinguish “Physician-Assisted Suicide” and “Aid in Dying”
(Resolution 14-A-17)

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

1 At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, “Study Aid-in-
2 Dying as End-of-Life Option,” presented by the Oregon Delegation, which asked:

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4 That our American Medical Association and its Council on Judicial and Ethical Affairs, study
5 the issue of medical aid-in-dying with consideration of (1) data collected from the states that
6 currently authorize aid-in-dying, and (2) input from some of the physicians who have provided
7 medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual
8 Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-
9 in-dying.”

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11 At the following Annual Meeting in June 2017, the House similarly referred Resolution 14-A-17,
12 The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in Dying’” (presented by
13 M. Zuhdi Jasser, MD), which asked that our AMA:

14
15 (1) as a matter of organizational policy, when referring to what it currently defines as
16 ‘*Physician Assisted Suicide*’ avoid any replacement with the phrase ‘*Aid in Dying*’ when
17 describing what has long been understood by the AMA to specifically be ‘*Physician Assisted*
18 *Suicide*’; (2) develop definitions and a clear distinction between what is meant when the AMA
19 uses the phrase ‘*Physician Assisted Suicide*’ and the phrase ‘*Aid in Dying*’; and (3) fully utilize
20 these definitions and distinctions in organizational policy, discussions, and position statements
21 regarding both ‘*Physician Assisted Suicide*’ and ‘*Aid in Dying*.’

22
23 This report by the Council on Ethical and Judicial Affairs (CEJA) addresses the concerns expressed
24 in Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA
25 reviewed the philosophical and empirical literature, sought input from the House of Delegates
26 through an I-16 educational program on physician-assisted suicide, an informal “open house” at A-
27 17, and its I-17 Open Forum. The council wishes to express its sincere appreciation for
28 participants’ contributions during these sessions and for additional written communications
29 received from multiple stakeholders, which have enhanced its deliberations.

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1 The council observes that the ethical arguments advanced today supporting and opposing
2 “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined
3 in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again
4 as such. Rather, it considers the implications of the legalization of assisted suicide in the United
5 States since the adoption of Opinion E-5.7, “Physician-Assisted Suicide,” in 1994.

6
7 “ASSISTED SUICIDE,” “AID IN DYING,” OR “DEATH WITH DIGNITY”?

8
9 Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal
10 medication to be self-administered by patients in many ways reflect the different ethical
11 perspectives that inform ongoing societal debate. Proponents of physician participation often use
12 language that casts the practice in a positive light. “Death with dignity” foregrounds patients’
13 values and goals, while “aid in dying” invokes physicians’ commitment to succor and support.
14 Such connotations are visible in the titles of relevant legislation in states that have legalized the
15 practice: “Death with Dignity” (Oregon, Washington, District of Columbia), “Patient Choice and
16 Control at the End of Life” (Vermont), “End of Life Options” (California, Colorado), and in
17 Canada’s “Medical Aid in Dying.”

18
19 Correspondingly, those who oppose physician provision of lethal medications refer to the practice
20 as “physician-assisted suicide,” with its negative connotations regarding patients’ psychological
21 state and its suggestion that physicians are complicit in something that, in other contexts, they
22 would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their
23 use obscures or sanitizes the activity. In their view such language characterizes physicians’ role in
24 a way that risks construing an act that is ethically unacceptable as good medical practice [3].

25
26 The council recognizes that choosing one term of art over others can carry multiple, and not always
27 intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation
28 and debate is best served by using plainly descriptive language. In the council’s view, despite its
29 negative connotations [4], the term “physician assisted suicide” describes the practice with the
30 greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The
31 terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or
32 palliative/ hospice care at the end of life and this degree of ambiguity is unacceptable for providing
33 ethical guidance.

34 35 COMMON GROUND

36
37 Beneath the seemingly incommensurate perspectives that feature prominently in public and
38 professional debate about writing a prescription to provide patients with the means to end life if
39 they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of
40 life. A vision that is characterized by hope for a death that preserves dignity, a sense of the
41 sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the
42 deepest aim of medicine, and fully voluntary participation on the part of both patient and physician
43 in decisions about how to approach the end of life.

44
45 Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA
46 believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and
47 well-considered perspectives about physician-assisted suicide that govern how these shared
48 commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting
49 the end of life however it comes as gracefully as one can; for another, it may mean being able to
50 exercise some measure of control over the circumstances in which death occurs. For some
51 physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to

1 abandon the patient preclude the possibility of supporting patients in hastening their death. For
 2 others, not to provide a prescription for lethal medication in response to a patient’s sincere request
 3 violates that same commitment and duty. Both groups of physicians base their view of ethical
 4 practice on the guidance of Principle I of the AMA *Principles of Medical Ethics*: “A physician
 5 shall be dedicated to providing competent medical care, with compassion and respect for human
 6 dignity and rights.”

7
 8 So too, how physicians understand and act on the goals of relieving suffering, respecting
 9 autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and
 10 values that may not be commensurate. Where one physician understands providing the means to
 11 hasten death to be an abrogation of the physician’s fundamental role as healer that forecloses any
 12 possibility of offering care that respects dignity, another in equally good faith understands
 13 supporting a patient’s request for aid in hastening a foreseen death to be an expression of care and
 14 compassion.

15 16 IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED 17 SUICIDE

18
 19 How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different
 20 judgments about what is an ethically permissible course of action is profoundly challenging. With
 21 respect to physician-assisted suicide, some professional organizations—for example, the American
 22 Academy of Hospice and Palliative Medicine [5]—have adopted a position of “studied neutrality.”
 23 Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are
 24 intended to respect that there are irreducible differences among the deeply held beliefs and values
 25 that inform public and professional perspectives [5,6], and to leave space open for ongoing
 26 discussion. Nonetheless, as a policy position, studied neutrality has been criticized as being open to
 27 unintended consequences, including stifling the very debate it purports to encourage or being read
 28 as little more than acquiescence with the contested practice [7].

29
 30 CEJA approaches the condition of irreducible difference from a different direction. In its 2014
 31 report on exercise of conscience, the Council noted that “health care professionals may hold very
 32 different core beliefs and thus reach very different decisions based on those core beliefs, yet
 33 equally act according to the dictates of conscience. For example, a physician who chooses to
 34 provide abortions on the basis of a deeply held belief in protecting women’s autonomy makes the
 35 same kind of moral claim to conscience as does a physician who refuses to provide abortion on the
 36 basis of respect for the sanctity of life of the fetus” [8].

37
 38 Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on
 39 intuition or emotion. Rather, such decisions are based on “substantive, coherent, and reasonably
 40 stable” values and principles [8]. Physicians must be able to articulate how those values and
 41 principles justify the action in question.

42
 43 The ethical arguments offered for more than two decades by those who support and those who
 44 oppose physician participation in assisted suicide reflect the diverging “substantive, coherent, and
 45 reasonably stable” values and principles within the profession and the wider moral community.
 46 While supporters and opponents of physician-assisted suicide share a common commitment to
 47 “compassion and respect for human dignity and rights” (AMA Principles of Medical Ethics, I),
 48 they draw different moral conclusions from the underlying principle they share. As psychiatrist
 49 Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme
 50 Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor
 51 those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of

1 people contemplating end of life. Equally true: neither side is immune from impulses shaped more
2 by ideology than a deep and nuanced understanding of how to best honor and address the needs of
3 people who are suffering” [9].

4 5 THE RISK OF UNINTENDED CONSEQUENCES

6
7 From the earliest days of the debate, a prominent argument raised against permitting physician-
8 assisted suicide has been that doing so will have adverse consequences for individual patients, the
9 medical profession, and society at large. Scholars have cited the prospect that boundaries will be
10 eroded and practice will be extended beyond competent, terminally ill adult patients; to patients
11 with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to
12 encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients
13 will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting
14 the practice will compromise the integrity of the profession, undermine trust, and harm the
15 physicians and other health care professionals who participate; and that forces outside medicine
16 will unduly influence decisions.

17
18 The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide,
19 restrict the practice to terminally ill adult patients who have decision-making capacity and who
20 voluntarily request assisted suicide, along with procedural and reporting requirements—can
21 actually protect patients and sustain the integrity of medicine remains deeply contested. Some
22 studies have “found no evidence to justify the grave and important concern often expressed about
23 the potential for abuse—namely, the fear that legalized physician-assisted dying will target the
24 vulnerable or pose the greatest risk to people in vulnerable groups” [10], others question whether
25 the available data can in fact support any such conclusions, finding the evidence cited variously
26 flawed [11], inadequate [12], or distorted [13].

27
28 Although cross-cultural comparisons are problematic [14], current evidence from Europe does tell
29 a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that
30 permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others
31 [15]. For example, research in the Netherlands has found that “requests characterized by
32 psychological as opposed to physical suffering were more likely to be rejected, as were requests by
33 individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially
34 reversible conditions might successfully end their lives.” At the same time, however, among
35 patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological
36 suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited
37 widespread concern about the emergence of a “slippery slope” [16].

38
39 Studies have also raised questions about how effective retrospective review of decisions to provide
40 euthanasia/assisted suicide is in policing practice [17,18]. A qualitative analysis of cases that Dutch
41 regional euthanasia committees determined had not met legal “due care criteria” found that such
42 reviews focus on procedural considerations and do not “directly assess the actual eligibility” of the
43 patients who obtained euthanasia [17]. A separate study of cases in which psychiatric patients
44 obtained euthanasia found that physicians’ reports “stated that psychosis or depression did or did
45 not affect capacity but provided little explanation regarding their judgments” and that review
46 committees “generally accepted the judgment of the physician performing EAS [euthanasia or
47 physician-assisted suicide]” [18]. It remains an open question whether reviews that are not able to
48 assess physicians’ reasoning truly offer the protection they are intended to provide. To the extent
49 that reporting and data collection in states that permit physician-assisted suicide have similar
50 limitations, oversight of practice may not be adequate.

1 Medicine must learn from this experience. Where physician-assisted suicide is legalized,
 2 safeguards can and should be improved—e.g., “[t]o increase safeguards, states could consider
 3 introducing multidisciplinary panels to support patients through the entire process, including
 4 verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all
 5 palliative and end-of-life options” [19]. Both the state and the medical profession have a
 6 responsibility to monitor ongoing practice in a meaningful way and to address promptly
 7 compromises in safeguards should any be discovered. It is equally important that strong practices
 8 be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health
 9 care organizations in California and Canada, for example, have shared richly descriptive reports of
 10 practices adopted in response to the recent legalization of “aid in dying” in those jurisdictions that
 11 seek to address concerns about quality of practice and data collection [20,21].
 12

13 Medicine must also acknowledge, however, that evidence (no matter how robust) that there have
 14 not yet been adverse consequences cannot guarantee that such consequences would not occur in the
 15 future. As a recent commentary noted, “[p]art of the problem with the slippery slope is you never
 16 know when you are on it” [15].
 17

18 SAFEGUARDING DECISIONS AT THE END OF LIFE

19
 20 CEJA has found that just as there are shared commitments behind deep differences regarding
 21 physician-assisted suicide, there are also shared concerns about how to understand the available
 22 evidence. For example, in the council’s recent Open Forum, both proponents and opponents of
 23 physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health
 24 care system in which patients have uneven access to care, including access to high quality end-of-
 25 life care. They also noted that patients and physicians too often still do not have the conversations
 26 they should about death and dying, and that too few patients are aware of the range of options for
 27 end-of-life care, raising concern that many patients may be led to request assisted suicide because
 28 they don’t understand the degree of relief of suffering state-of-the-art palliative care can offer.
 29 Participants who in other respects held very different views concurred as well that patients may be
 30 vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed
 31 concern in common that forces external to medicine could adversely influence practice.
 32

33 These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in*
 34 *America* [22]. They are concerns echoed in a February 2018 workshop on physician-assisted death
 35 convened by the National Academies of Science, Engineering and Medicine [23]. They underscore
 36 how important it is to understand *why* a patient requests assisted suicide as a starting point for care.
 37

38 Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that
 39 are too often avoided. They open opportunities to explore the patient’s goals and concerns, to learn
 40 what about the situation the individual finds intolerable and to respond creatively to the patient’s
 41 needs other than providing the means to end life—by such means as better managing symptoms,
 42 arranging for psychosocial or spiritual support, treating depression, and helping the patient to
 43 understand more clearly how the future is likely to unfold [4,24]. Medicine as a profession must
 44 ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable
 45 about the options available to terminally ill patients [25]. The profession also has a responsibility to
 46 advocate for adequate resources for end-of-life care [14,25], particularly for patients from
 47 disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to
 48 interfere with excellent care at the end of life.

1 CONCLUSION

2

3 At the core of public and professional debate, the council believes, is the aspiration that every
4 patient come to the end of life as free as possible from suffering that does not serve the patient's
5 deepest self-defining beliefs and in the presence of trusted companions, including where feasible
6 and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more
7 than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey,
8 or of separating their person from their disease" [24]. Decisions about how to approach the end of
9 life are among the most intimate that patients, families, and their physicians make. Respecting the
10 intimacy and the authenticity of those relationships is essential if our common ideal is to be
11 achieved.

12

13 RECOMMENDATION

14

15 Over the past two years, the Council on Ethical and Judicial Affairs has reviewed the literature and
16 received thoughtful input from numerous individuals and organizations to inform its deliberations,
17 and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate
18 discussion about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the
19 irreducible differences in moral perspectives identified above. After careful consideration, CEJA
20 concludes that in its current form the *Code* offers guidance to support physicians and the patients
21 they serve in making well-considered, mutually respectful decisions about legally available options
22 for care at the end of life in the intimacy of a patient-physician relationship. The Council on Ethical
23 and Judicial Affairs therefore recommends that the *Code of Medical Ethics* not be amended, that
24 Resolutions 15-A-16 and 14-A-17 not be adopted and that the remainder of the report be filed.

Fiscal Note: None.

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