

# **ONLINE MEMBER FORUM SUMMARY REPORT**

**I-18**

**REFERENCE COMMITTEE FOR  
AMENDMENTS TO CONSTITUTION AND  
BYLAWS**

**AS OF 11/6/18 11AM CST**

Fri, 09/14/2018 - 10:39

**BOT 14 - Protection of Physician Freedom of Speech**

The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-17 and the remainder of this report be filed:

1. That our American Medical Association strongly oppose litigation challenging the exercise of a physician's First Amendment right to express opinions regarding medical issues. (New HOD Policy); and
2. That AMA Policy H-460.895, "Free Speech Applies to Scientific Knowledge," be reaffirmed (Reaffirm HOD Policy).

Tue, 10/30/2018 - 21:10 (new)

[Paul Wertsch](#)

**RE: BOT 14 - Protection of Physician Freedom of Speech**

Excellent.

**Opinion Type:**

My post is my personal opinion

Sat, 11/03/2018 - 15:07 (new)

[Robert Block](#)

**RE: BOT 14 - Protection of Physician Freedom of Speech**

It is sad that we need to restate the the American principle of free speech, but with organizations trying to squelch that right, we must stand up

**Opinion Type:**

My post is my personal opinion

Thu, 10/18/2018 - 10:54

**Council on Ethical and Judicial Affairs Report 1 - Competence, Self-Assessment and Self-Awareness**

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

- (a) Cultivate continuous self-awareness and self-observation.
- (b) Recognize that different points of transition in professional life can make different demands on competence.
- (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.
- (d) Seek feedback from peers and others.
- (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.
- (f) Intervene in a timely and appropriate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

Wed, 10/24/2018 - 15:25

[Jim Rohack](#)

**RE: Competence, Self-Assessment and Self-Awareness**

I agree with the concept outlined with particular note of (a) thru (f). My concern is the second paragraph with the words I have undelined & italicised: ,,,, a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

It appears CEJA is assuming that safe care is interchangeable with appropriate care and that effective relationships has to be care done in front of the physician. I am questioning why CEJA is just using one part of the 6 domains of Quality Care noted by IOM: Safe, Timely, Effective, Efficient, Equitable and Patient-Centered. It would seem that Competent Care is Quality Care and all of the Domains should be noted as needed in a patient-physician relationship, regardless if it is being delivered by team-based care, remotely, virtually or in person in front of the patient. I would suggest some revisions would be appreciated to note the 21st century delivery of healthcare is more than just a patient in front of the physician.

thank you.

**Opinion Type:**

My post is my personal opinion

Thu, 10/18/2018 - 10:58

**Council on Ethical and Judicial Affairs Report 2 - Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish “Physician-Assisted Suicide” and “Aid in Dying”**

The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the Code of Medical Ethics in light of ongoing debate and the irreducible differences in moral perspectives identified above. The council recognized that supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but diverge in drawing different moral conclusions from those underlying values in equally good faith. The council further recognized that medicine must learn from experience of physician-assisted suicide, and must ensure that, where the practice is legal, safeguards are improved.

After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the Code offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient-physician relationship.

The Council on Ethical and Judicial Affairs therefore recommends that the Code of Medical Ethics not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted and that the remainder of the report be filed.

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Thu, 10/18/2018 - 13:35 (new)

[Permalink](#)

[Lynn Parry](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

This is no different from the previous decision and lacks the rationale for no change. If there is difficulty in accumulating sufficient data because of the relative recent changes in legislation, then CEJA would be best served by a comment that further data is needed to look at the impact of such legislation: on physicians and on the patients they serve. Challenges in helping physicians and patients navigate an increasingly complex moral pathway must be approached with acknowledgement that those challenges exist. Adhering to rigid absolutes in the Code without better guidance leaves a gap in the ability to properly serve our patients and communities.

It is likely that further discussion will be requested.

**Opinion Type:**

My post is my personal opinion

Sun, 10/28/2018 - 19:45 (new)

[Frederick White](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

The submission of CEJA Report 2-I-18 in a form basically unaltered from that of its prior iteration reflects an act of tremendous moral courage by the Council on Ethical and Judicial Affairs.[1] In so doing, CEJA upholds the ethical standards of the American Medical Association despite increasing

pressure from those who espouse either the radical autonomy or the permissive utilitarianism that undergirds the physician-assisted suicide movement.

Those of us opposing physician-assisted suicide, and supporting the current AMA policy as reaffirmed by this report, stand on rule-based deontological ground. The philosophy of Immanuel Kant defined a categorical imperative as “a moral law that is unconditional or absolute for all agents, the validity or claim of which does not depend on any ulterior motive or end.”[2] Those of us opposed to physician-assisted suicide hold to this categorical imperative – it is never morally acceptable for a physician to hasten the death of or take the life of a patient as a primary end.

We do not countenance an exception to this rule because the patient requests a deadly drug. Indeed, CEJA directly confronted this notion of radical autonomy in its 1993 report, saying that:

Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible. The physician's role is to affirm life, not to hasten its demise.[3]

Autonomy-based support for assisted suicide finds in a Kantian hypothetical imperative which, in contrast to the rule-based ethic, allows both means and ends based on a desired outcome. The autonomy-based argument for physician-assisted suicide runs like this – “I want to relieve the patient's suffering. In order to respect the patient's autonomy and relieve the patient's suffering, I must respect their autonomous request for a deadly drug. Therefore I must supply (or allow someone to supply) the patient with a deadly drug and instructions in its use.”

This hypothetical imperative carves out a situational exception to the categorical imperative. It basically states that if the patient requests death and the doctor agrees that death is more acceptable than life, then physician-assisted suicide is allowed. But as Paterson and many others have pointed out, there is no doubt – either philosophically or legally – that “consent does not validate the killing of the innocent.”[4]

This hypothetical imperative not only universalizes the possibility of other exceptions, but it also binds those who accept the permissive conditions to accept their actual use -- citing Kant, “Whoever wills the end, also wills (insofar as reason has decisive influence on his actions) the means that are indispensably necessary to it that are in his control.”[5] Said another way, if you allow it, then you intend it. There is no neutral position. And if you allow one exception, you have opened yourself to accepting others.

The creation of exceptions opens the utilitarian argument that physician-assisted suicide is justified because it produces a greater good in relief of suffering than is found in the dignity and value of life. As Peter Singer and Helga Kuhse have written:

Human life has no intrinsic value but gives rise to two values: well-being and the value of liberty or self-determining action.... [D]octors should, whenever possible, maximize these values. This may include active euthanasia...”[6]

Citing the descent of members of the medical profession into a program of euthanasia in Germany, Leo Alexander indicted the “rational utility” of Hegel.[7] And lest we think that this has no relevance or danger here, the editors of the New England Journal of Medicine cautioned future generations in an accompanying editorial:

The embracement of the utilitarian philosophy of Hegel, with its corollary of euthanasia, has its counterpart in American society — Dr. Alexander cites chapter and verse in the form of the attitude of a physician and a hospital toward patients with chronic degenerative disease....[8]

And lest we be confounded by a false moral distinction between euthanasia and physician-assisted suicide, or by the notion that the death is an incidental result, we need only turn to the analysis of Chief Justice William Rehnquist — “A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life....”[9]

With deliberate intent, and in full knowledge of the wish of the patient to die, the physician supplies both the means and the instruction to accomplish the death. Both morally and functionally, the doctor is a proximate cause of the death of the patient just as surely as if the doctor had directly injected the lethal drug. Absence from the final event does not exonerate the doctor. The fact that the doctor foresees the result (and in fact typically attests to it on a state form) maintains the culpability of the doctor in the causal chain. As Hart and Honore note in their classic treatise on causation, “intended consequences can never be too remote.”[10]

Again, we stand on this ground — “The physician's role is to affirm life, not to hasten its demise.”[11] The American Medical Association should reject the concept that a life may be disvalued by suffering to the point that a physician feels that it is morally acceptable to provide that patient with a lethal dose of drug and instructions in its use.

CEJA Report 2-I-18 calls for reaffirmation of existing AMA policy rejecting physician-assisted suicide. It holds fast to the bright moral line that physician-assisted suicide is an unethical practice, while dealing as gently as possible with those who choose to perform it where legal. The time for deciding has come — the American Medical Association must accept CEJA Report 2-I-18.

Frederick J. White, MD

[1] Council on Ethical and Judicial Affairs, American Medical Association, CEJA Report 2 – I-18, 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), in American Medical Association, House of Delegates Handbook 2018 Interim Meeting \*70, 70-77 (American Medical Association 2018).

[2] The Editors of Encyclopedia Britannica, Encyclopedia Britannica, s.v. Categorical Imperative, (December 17, 2017), <https://www.britannica.com/topic/categorical-imperative>.

[3] Council on Ethical and Judicial Affairs, American Medical Association, CEJA Report 8 – I-93: Physician-Assisted Suicide, 2 (American Medical Association, 1993) (citation omitted).

[4] Craig Paterson, Assisted Suicide and Euthanasia: A Natural Law Ethics Approach 171 (Aldershot, UK 2008).

[5] Immanuel Kant, Groundwork of the Metaphysic of Morals 34 (Allen W. Wood, trans., Yale Univ. Press, 2002).

[6] Helga Kuhse & Peter Singer, Allocating Health Care Resources and the Value of Life, in Unsantifying Human Life: Essays on Ethics 278 (Helga Kuhse, ed., Oxford Blackwell, 2002).

[7] Leo Alexander, Medical Science Under Dictatorship, 241 New England Journal of Medicine 39, 39-47 (1949).

[8] Killers in White, 241 New England Journal of Medicine 76, 76-77 (1949).

[9] Vacco v. Quill, 521 U.S. 793, 802 (1997).

[10] H. L. A. Hart & Tony Honore, Causation in the Law 170 (Clarendon Press 2nd ed. 1985).

[11] Council on Ethical and Judicial Affairs, supra note 2, at 2.

#### **Opinion Type:**

My post is my personal opinion

Sun, 10/28/2018 - 22:37 (new)

[JOSEPH MARINE](#)

#### **RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I congratulate the CEJA for again affirming the AMA's continuing opposition to physician assisted suicide (PAS). Allowing the euthanasia movement to advance in the United States will only corrupt the medical profession and erode public trust in doctors, hospitals, and all health care professionals. We as physicians have nothing to gain and everything to lose by allowing this to happen. The euthanasia movement understands very well that inducing the AMA to abandon its traditional opposition is a key step to advancing more PAS legislation in the US, and then proceeding down the slippery slope followed in every other country that has adopted PAS into wider use and other forms of euthanasia. The AMA risks being used and undermined by political forces that have no interest in the well-being of the medical profession or our medical societies.

After nearly 3 years, I do not understand how proponents of PAS can persist in the fiction that more "study" is needed. I would urge those proponents to study the case of the District of Columbia, which recently passed a PAS law by a wide margin in its City Council. Yet a year after implementation, only 2 out of 11,000 licensed physicians had registered to prescribe it. And not a single patient had used it.

[https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226\\_story.html?noredirect=on&utm\\_term=.3af725839c31](https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html?noredirect=on&utm_term=.3af725839c31)

If PAS is so greatly needed, and if many physicians support it, why are almost no physicians willing to actually participate in it? Could it be that the vast majority of American physicians understand that PAS is wrong, and that patients will not trust practitioners of PAS with their lives and their health?

The reality is that PAS is dangerous and it is unnecessary. As physicians, we are healers, and our role is to "affirm life, not to hasten its demise." We would be foolish to desire a license to kill. Assisted suicide laws do just that. I urge the AMA House of Delegates to accept the wise and considered judgment expressed in the CEJA report.

[https://www.realclearhealth.com/articles/2018/09/20/assisted\\_suicide\\_is\\_the\\_wrong\\_prescription\\_110827.html](https://www.realclearhealth.com/articles/2018/09/20/assisted_suicide_is_the_wrong_prescription_110827.html)



<https://www.usatoday.com/story/opinion/2018/06/08/physician-assisted-suicide-american-medical-association-column/676533002/>

**Opinion Type:**

My post is my personal opinion

Mon, 11/05/2018 - 07:02 (new)

[\(Reply to #4\)Permalink](#)

[John Chang](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Well said-agree with your statements-THANK YOU

**Opinion Type:**

My post is my personal opinion

Tue, 10/30/2018 - 21:23 (new)

[Paul Wertsch](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I think that this is a very good and timely review of the current situation in America. I agree that accurately calling it physician assisted suicide is less ambiguous than Aid in Dying which is something that we all do in helping a patient when they are dying. Let's be as accurate as possible in terminology so that we understand what we are talking about.

**Opinion Type:**

My post is my personal opinion

Mon, 11/05/2018 - 07:09 (new)

[\(Reply to #6\)](#)

[John Chang](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Well said Paul,

Using Ambiguous Terminology is often a means to achieve their goal of PAS

**Opinion Type:**

My post is my personal opinion

Thu, 11/01/2018 - 07:18 (new)

[THOMAS EPPES](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I once again support with Virginia the CEJA report on PAS. I practice 10 miles from the Eugenics capital of Virginia where the local medical academy knew what was going on but never took a stand. [I read 15 years of minutes to make sure I was accurate in this statement.] Only World War II ended the practice in

Virginia. There was a slippery slope world wide in the 1930's and there is one developing today. At the World Medical Association's most recent meeting one can only see the fierce opposition to change the PAS opposition stance proposed by those that support changing to AID or neutral. Our Canadian Colleagues as well as Netherlands, Belgium and isolated provinces/states around the world want the change. The chair from Israel strongly backed by countries when the past is real [Germany] or presently needs a firm stance like Africa, Asian countries stood their ground against PAS. Canada even withdrew from the WMA.

Recently the Medical Society of Virginia affirmed its opposition even when a legislative commissioned study proposed a potential change. That report was fraught with inaccuracies that made AID seem more palatable. I am sure it will surface in 2019. Our physician governor, a pediatric neurologist, frowned at the thought when I discussed it with him because he knew when the slope once started can end.

PAS moves from patient directed, to family directed, to doctor directed and ultimately to the inclusion of children.

[This is very personal to me. My father died of Lewy Body Dementia with a very rough last 6 months of his life as he was taken care of at home, hospice graciously doing a great job in his rural community where the only doctor did not make house calls and refused to believe in hospice. It fell upon me with the Hospice care team. My mother at 91 has Alzheimers with no ability to weight bear therefore cannot be taken care of at home for it takes two to get her out of bed. She lives over half the time in the 1930's and 1940's. The nursing home costs more than her income. Her mind is gone but the rest of her body could go on forever. Fortunately my dad worked hard, saved a lot but it will not last forever at \$9,000 a month. The incentive for PAS would be strong if I let it.]

I include several comments from the Christian Medical and Dental Society's CEO, Dr David Stevens, in his comment to the membership. He has been a missionary to Kenya before his current role, and has a masters in Bioethics. Minor underlined alterations are made to keep the flow of the comments.

PAS destroys trust, which is the foundation of the doctor-patient relationship. It takes no great skill to kill, but it does take great skill to provide superb end-of-life care.

In an economically challenged healthcare system, the cheapest form of healthcare for any illness is a handful of lethal medications.

PAS opens the door to the worst form of elder abuse by the self-centered, exhausted care providers or greedy relatives.

The "right to die" will become the "duty to die" for senior citizens, as some bioethicists already advocate. Not wanting to be "a burden," the elderly will take their own lives.

The better alternative is to: train more palliative care physicians; modify laws to allow adequate pain/symptom control at the end of life; encourage better identification and treatment of depression; promote hospice; and mobilize faith communities and others to provide emotional and relational end-of-life support to struggling patients and families.

Once you say suicide is an option for subjective suffering, there is no logical place to draw the line. Suffering is subjective, so how can this option be denied to anyone suffering from a physical or psychological condition? Canada, which legalized physician-assisted suicide in 2016, is now

considering letting it being mandated in advanced directives, allowing it for children without their parents consent and letting the mentally ill exercise this new "right." A total of 95 percent of physician-assisted suicide in Canada is done by lethal injection by a physician.

Ultimately, healthcare professionals and organizations will be pressured to participate. It is already happening in Canada. In Ontario, doctors are required to refer or they will lose their licenses. A court appeal on constitutional grounds by the Christian Medical and Dental Society of Canada and other groups was unsuccessful. The court in their ruling stated that if physicians don't want to participate, they should change their specialty to pathology or another specialty that does not require direct patient care. [Vermont tried to legislate a mandatory referral if a physician would not offer the option, but it failed at least so far.]

The definition on who qualifies for physician-assisted suicide has already expanded in the U.S. to include patients with a disease that is terminal within six months without treatment. That includes patients with chronic, but treatable diseases, like those with insulin-dependent diabetes.

The so-called safeguards don't work.

Studies show that physicians only get second opinions from other physicians they know will endorse their decision.

It is impossible to accurately predict a patient will only live six months.

Physicians under existing physician-assisted suicide laws are immune from malpractice.

Proposed laws cloak physician-assisted suicide under a shroud of secrecy. Only positive information is published, and there is no possibility of examining how "well" it is working.

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

THOMAS EPPES

**Delegation section or society:**

Medical Society of Virginia

Mon, 11/05/2018 - 07:13 (new)

[\(Reply to #8\)](#)

[John Chang](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Appreciate your comments-well said THANK YOU

We must Support CEJA Report

**Opinion Type:**

My post is my personal opinion

Thu, 11/01/2018 - 09:52 (new)

[Peter Bernardo](#)

### **Physician aid in dying**

The CEJA report correctly points out the "irreducible differences in moral perspectives on physician assisted suicide" but then takes the position that the individual physician's morality supersedes that of the patient. This ignores the competent patient's right to autonomy and self-determination and disavows the possibility that aid in dying may be the best course of action for that particular patient.

The hyperbole and exaggerated slippery slope arguments belie the experience of Oregon patients and their doctors.

### **Oregon's Death With Dignity Act: 20 Years of Experience to Inform the Debate**

Physician assisted suicide is not euthanasia, it is not state mandated, it is not forced upon vulnerable populations. Physicians do not have the option to treat their dying or demented family members. To suggest otherwise is disingenuous and unethical.

### **Oregon Health Authority: Death With Dignity Act**

### **The Changing Legal Climate for Physician Aid in Dying**

### **The American Public Health Association: Patients' Rights to Self-Determination at the End of Life**

In the end, physician aid in dying is one option for a select few patients as they confront the end of their lives. It is legal in 8 states through a well-defined and regulated process. The AMA's ethical position, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" is outdated and incorrect. In Oregon, Physician participation is approved by public opinion, governed by law, and supervised by the State Medical Board.

The AMA's ethical opinion 5.7 on Physician Assisted Suicide should be updated to reflect the current medical practice.

I would move for referral of the CEJA report back for further consideration.

### **Opinion Type:**

My post reflects the opinion of my delegation or section

### **Signature Name:**

Peter Bernardo

### **Delegation section or society:**

Oregon

Fri, 11/02/2018 - 18:28 (new)

[Pham](#)

### **RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I want to applaud CEJA for reaffirming AMA Code of Ethics and not changing their policy on PAS/euthanasia.

The practice of end of life care should not go away from comfort and use euphemism to justify and open access to suicide and active killing. I am not understanding why "new research or data" is suppose to justify for suicide/killing from their physician. Do you need evidence based medicine to prove that jumping out of a plane without a parachute is a good idea or bad one?

The data from Oregon or similar states may be already bias because those patients that are wanting PAS are of course happy or content with their decision. Why else would they go through with it? Of course there are probably emotional and social turmoil with making such a decision but how does this justify for PAS/euthanasia. If you give access to a burglar/thief to rob a bank, we can postulate that they are going to be happy/content with such legal mandate.

Please, lets move away from this every 20 years and continue focusing on sound and ethical medicine rather than revisiting the legalizing of PAS/euthanasia.

**Opinion Type:**

My post is my personal opinion

Sat, 11/03/2018 - 16:47

[Robert Block](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Vermont has now had physician aid in dying for the passed 7 years, We completely agree with the sentiment of Oregon as per Peter Bernardo above. The population would not consider revoking this right. Review of the patient deaths and famaly members reaction does not show the issues the opponents drag out whenever the topic arises. No children, mentally unstable or not thinking clearly are allowed to participate. All reasonable treatment for pain control , support for depression and all compassionate care must be rendererd prior to a physician participation in the process. There is no sign of "slippery slopes" in Vermont except at our ski areas.

We also appreciate the intensive work that CEJA put in, but their output is identical to the prior output: patients deserve the best of care and that includes any legal treatment in that state which would include Aid in Dying in VT, and then turn around and say there will be no change in the medical code, which does not allow Aid in Dying. Which is it?

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Robert Block

**Delegation section or society:**

Delegate from Vermont

Sat, 11/03/2018 - 20:01

[JOSEPH MARINE](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

**Question: What do we really know about physician-assisted suicide (PAS) as practiced in Oregon, Vermont, and other states?**

**Answer: Almost nothing.**

**The reality of PAS in the US is:**

1. No independent monitoring or safety board oversight.
2. Oregon Dept. of Health has no budget or authority to investigate abuses.
3. The Oregon Dept. of Health has no system for reporting of abuses.
4. Medical and legal documents involved in PAS are protected from discovery, subpoena, or entry into court proceedings.
5. Physicians who perform PAS are immunized from negligence in the practice of PAS, an extraordinary legal protection not given to any physicians practicing lifesaving and life-enhancing medicine.
6. There are no witnesses required for ingestion of PAS drugs. The state of Oregon now openly admits in its annual report that it has no way of knowing whether “complications” occurred during PAS in the 80% of cases where there is no medical witness. There is also no way of knowing if drugs were actually self-administered (as the law requires), or whether any other form of “assistance” to the suicide was given.
7. These extraordinary legal protections for PAS collectively ensure that no cases of PAS will be investigated or exposed to public scrutiny.

**The little that we do know about PAS shows that major abuses and problems in the US are already occurring:**

1. Patients attempting to die by PAS have taken up to 4 days to die after ingesting PAS drugs. <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>
2. At least six patients have awoken after taking PAS drugs with the intent to die.
3. Patients in Washington State prescribed cheaper cocktails of experimental PAS drugs have died prolonged deaths after “screaming in pain”. <https://www.usatoday.com/story/news/2017/02/16/kaiser-docs-northwest-tweak-aid--dying-drugs-prevent-prolonged-deaths/98003110/>
4. At least one patient with a history of major depression and suicide attempts has been prescribed PAS drugs. <https://www.nytimes.com/2004/05/07/us/questions-on-safeguards-in-suicide-law.html>
5. Physicians have been pressured by family members to prescribe PAS drugs for family members with dementia. <https://www.weeklystandard.com/wesley-j-smith/suicide-unlimited-in-oregon>
6. Patients have been denied insurance coverage for cancer treatment deemed “investigational” but offered coverage for PAS drugs, despite the fact that PAS has no basis in medical science whatsoever. <https://www.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/>

PAS is not medical care. It is misguided and dangerous public policy which the AMA should continue to oppose.

Joseph E. Marine, MD

AMA Member, State of Maryland

**Opinion Type:**

My post is my personal opinion

Sat, 11/03/2018 - 23:37

[Shane Macaulay](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I write in support of the CEJA report on physician-assisted suicide and commend CEJA for making the right decision on this fundamental ethical issue.

In a world where an instinct to take life seems to be becoming increasingly common, where the idea of killing seems to be less and less unthinkable by a public becoming inured to frequent societal violence, we must not add the medical profession to the list of those who kill, under whatever circumstances or for whatever justification. We must have the courage to stand firmly for those ideals and ethics that have made medicine a profession of healers, not takers of life.

It is well accepted that the utilitarian argument that "the ends justify the means" is ethically flawed, because it allows every kind of ethical lapse on the way to attempting to achieve a perceived good. For example, the "end" of ridding society of crime is good, but it is ethically flawed to use that to justify any means, such as the execution of all criminals. Getting an A on a test is good, but it does not justify the means of cheating. One of the main arguments offered in support of physician-assisted suicide is that it is justified on the basis of relief of suffering. However, on a moment's reflection it will be apparent that, if relief of suffering justifies physician-assisted suicide, then physician-assisted suicide can be the fix for just about whatever ails you. Indeed, this is what has happened in the Netherlands, where physician-assisted suicide started with terminal patients, then progressed to healthy but depressed people, then lonely people, then people "tired of life", and so on. Europe's longer experience with physician-assisted suicide demonstrates the snowballing downstream effects of making an initial ethical error.

Patient autonomy has been suggested as a justification for physician-assisted suicide. However, it is a specious argument to propose that patient autonomy determines what physicians should do. No physician would amputate a patient's healthy limb just because the patient wishes it done. Why not? Because it is wrong, whether the patient wishes it done or not. We don't give certain drugs or perform certain procedures that are absolutely contraindicated, even if the patient requests it, because we are required to use our knowledge to protect the patient. A physician would very appropriately lose his or her license for performing the above actions. So it is unsupportable to use the "autonomy" argument as a trump card in trying to determine the *ethics* of a particular action; patient autonomy is important, but never the only factor in a decision, and it is *never* used to determine overarching professional ethics.

Regarding the linkage between physician-assisted suicide and euthanasia, most physicians rightfully recoil at the thought of direct euthanasia. However, there is no qualitative difference in a physician's moral or ethical culpability between prescribing physician-assisted suicide and performing euthanasia - in both cases, the physician's will or *intent* is to kill the patient, and in both cases the physician provides

the *means*; the only difference is the specific mechanism, patient-administered vs. physician-administered. In a direct parallel, there is no moral difference between a patient self-administering oral antibiotics prescribed by a physician, and the physician directly administering IV antibiotics to the patient. If euthanasia is wrong, then physician-assisted suicide is also wrong.

The courts also clearly recognize the linkage between physician-assisted suicide and euthanasia. The 2016 New Mexico Supreme Court decision in *Morris v Brandenburg*, while unanimously declaring that physician-assisted suicide is not a right under the U.S. or New Mexico constitutions, stated that, if physician-assisted suicide *were* a right, there would be an automatic right to euthanasia under the due process clause. Here is the relevant quote from p. 31 of *Morris v Brandenburg* (<http://www.nmcompcomm.us/nmcases/nmsc/slips/SC35,478.pdf>), reflecting on the U.S. Supreme Court decision in *Washington v. Glucksberg* (<https://supreme.justia.com/cases/federal/us/521/702/case.pdf>):

"Third and perhaps most important, we agree with the legitimate concern that recognizing a right to physician aid in dying will lead to voluntary or involuntary euthanasia because if it is a right it must be made available to everyone, even when a duly appointed surrogate makes the decision, and even when the patient is unable to self-administer the life-ending medication."

\* \* \* \* \*

The Washington State Medical Association has remained opposed to the practice of physician-assisted suicide despite its legalization here, recognizing that medical ethics are not determined by plebiscite, and that physician-assisted suicide is a maladaptive response to the needs of patients at end of life. We can do so much better, and we must.

I speak for the Washington State AMA delegation in recommending acceptance of the CEJA report.

Shane Macaulay, MD

Alternate Delegate, Washington State Medical Association

Past President, Washington State Medical Association

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Shane Macaulay

**Delegation section or society:**

Washington State Medical Association

Sun, 11/04/2018 - 13:11

[William Toffler](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I write in support of the CEJA report on physician-assisted suicide. I, and most of my fellow physicians in Oregon, are either opposed to or do not participate in assisted suicide. There are over 15,000 licensed physicians actively practicing in Oregon and only about 200 have engaged in this problematic paradigm.



There is much mythology about assisted suicide—ten are listed below:

### **Myth #1: Needed for pain**

- Seldom is the reason for PAS
- In reality, it is the “fear” of pain
- Virtually all pain can be controlled with modern approaches
- Inverse relationship of desire and actual pain itself

Patients in more pain were significantly less likely to find euthanasia and PAS acceptable Lancet 1996;347: 1805-1015

### **Pain is not among the top concerns\* related to requests...**

**Oregon PAS deaths n=1275 (%)\***

- 1. Losing autonomy(“Dignity”) 1,154 (90.9%)**
- 2. Decrease in activities that make life enjoyable 1,137 (89.5%)**
- 3. Loss of dignity 865 (75.7%)**
- 4. Losing bodily functions 579 (45.7%)**
- 5. Burden 554 (43.7%)**
- 6. Inadequate pain control\*\* 327 (25.8%)**
- 7. Financial 47 (3.7%)**

\*OHD, Public Health Division, Center for Health Statistics

February 9, 2018 \*\*Although this issue was discussed with the doctor, these individuals were not necessarily experiencing pain

### **Myth #2 PAS—no problems in Oregon**

- Reporting system inherently flawed
- Doctor **NOT** present **84%** of the time when deadly dose is ingested—even fewer when death occurs\*
- Reports 2<sup>nd</sup> and 3<sup>rd</sup> hand; half 50.4% (638/1264) don't provide ANY information about complications.\*
- **Never** any investigation by OHD or government
- OHD **NOT** authorized or funded to investigate\*\*

\*OHD, Public Health Division, Center for Health Statistics, February 9, 2018; \*\*OHD news release. March 4, 2005

- Is any procedure without problems?
- All reports by the relatively small number of doctors (<1.5%) who have agreed to participate in (or who actively promote) PAS
- Records are actively destroyed by the OHD in the name of “privacy”
- Thus, we really don’t know about complications

\*OHD, Public Health Division, Center for Health Statistics; February 9, 2018

### **Myth #3—PAS only for <6 months to live**

- No “crystal ball” courses in medical school
- Prognosis and even diagnoses can be wrong; some patients have lived over 2 years after a doctor gave deadly overdose to them
- 6 months entirely arbitrary—why not 12 months? Why not 6 years?
- Already a push in Oregon to double eligibility time
- Netherlands—criteria will include having “a completed life”
- Essentially anyone eligible—anytime for any reason

### **Myth #4—there are no abuses**

- Already had nurse-assisted suicide
- A “caretaker” stole \$90,000 and a home after “assisting” the person she was “caring for.”
- There are no witnesses—potential for the ultimate elder abuse
- **Never** any investigation by the state
- There is suicide “tourism” to Oregon—e.g. Brittany Maynard
- Doctor shopping for the “right” answer—death\*

\*Kate Cheney and daughter, Erika, The Oregonian. Oct 17, 1999

### **Myth #5—Death is “Dignified”**

- If suicide by overdose is dignified, are those who die naturally “undignified?”
- Taking a massive overdose of sleeping pills can cause problems
  - Nausea and vomiting occur among PAS patients documented in annual reports by Oregon Health Division
  - Prolonged dying (agonal breathing) potentially over days
  - Death doesn’t always occur—David Pruitt woke 67 hours later
- Suicide parties reflect apathy about the person taking the overdose\*

\*Lovelie Svart, The Oregonian. 9/28/2007

### **Myth #6—PAS improves end of life care**

- Perception of pain control by surviving family members worse after passage of assisted suicide\*
- High usage of opioids before passage of PAS and high usage after\*\*
- Palliative care improved in states that specifically passed laws outlawing assisted suicide\*\*
- In fact, some other states prohibiting PAS have higher per capita usage rates of opioids\*\*

\*E. Fromme et al., "Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002," *Journal of Palliative Medicine* 7 (2004): 431-42 at 437, 439. \*\*On Point. Doerflinger Lozier Institute, <http://lozierinstitute.org/the-effect-of-legalizing-assisted-suicide-on-...>

### Myth #7—Expands patient choice

- Patients have the right to take their life now
- Suicide is not illegal
- >70,000+ **non-assisted** suicide annually in the US
- Oregon is among the highest rates (top ten) AND **increasing**.\*

### Non-assisted suicide rates—Oregon, Washington, & all other

\*Jones A, Paton D. *Southern Med J*;2015 108(10):599-604.

- In truth, empowers doctorsto assist suicides
- Patients already have the right to refuse treatment
- The real problem is **accessing**care
- Patients who desire care have been denied care (while offered 100% coverage for PAS)—Barbara Wagner and others\*\*

\*Jones A, Paton D. *Southern Med J*;2015 108(10):599-604.

\*\**Eugene Register-Guard* June 3, 2008

### Myth #8—PAS—patients are screened for depression/mental illness

- Doctors often don't recognize depression
- Some doctors actually believe "depression" is normal--shouldn't be a barrier to assisted suicide
- Of patients given prescriptions to kill themselves:
  - 25%were depressed
  - 23% had anxiety disorder.
  - **None**were detected by the doctors giving them overdoses.\*
- Overall, only 5% referred for psychiatric evaluation\*\*

\*Ganzini L et al. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562435/>

\*\*OHD, Public Health Division, Center for Health Statistics; 2February 10, 2017

### Myth #9—PAS involves doctors who know the patient well

- One doctor wrote for 25 prescriptions last year alone—clearly not all his/her patients\*
- Average length of time with prescribing doctor—13 weeks (and falling)
- Already a drive-in “death with dignity” clinic in San Francisco California\*\*

\*OHD, Public Health Division, Center for Health Statistics, February 10, 2017

\*\*Dr. Lonny Shavelson <https://www.bioedge.org/bioethics/california-doctor-opens-end-of-life-cl...>

### Myth #10—PAS is the solution to suffering

- Rather...the solution is **Care not Killing**
- If a person ...
  - is in physical pain—**treat the source** of the pain
  - is lonely—**provide companionship**

- doesn't value their lives—**work to reflect their inherent value**—just as we do others who aren't labeled “terminal”
- is fearful—**address their fears**
- 

In summary, I urge each reference committee member and each delegate to support the longstanding AMA (and the recently affirmed position of the American College of Physicians) opposing Physician Assisted Suicide. The solution to suffering should not be to end the life of the sufferer. I am speaking for myself and all of the members of Physicians for Compassionate Care.

William L Toffler MD, National Director, Physicians for Compassionate Care

### Opinion Type:

My post is my personal opinion

Sun, 11/04/2018 - 18:30

[Treptow](#)

### RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti

I am an AMA member and a Board Certified Family Medicine physician in private practice from Great Falls, Montana. I applaud and support the CEJA recommendation. I also represent the vast majority of the physicians from our local medical society and region. Montana has the highest incidence rate of suicide in the nation at 26 suicide events/100,000 people, so this issue is important to us.

First, it clearly and logically explains why “aid-in-dying” should not be used in place of “physician assisted suicide”. I render aid to all of my patients, whether they are dying or not, but helping them

commit suicide is an abandonment of those patients in their greatest need. Just as in medicine we try to use the most specific term, so “physician assisted suicide” is the most clear in its description.

Secondly, movement of a position towards neutrality is to take no position at all. It is an abdication of the ethical and philosophical responsibility that the AMA has to society and the physicians who practice. Neutrality is a way of saying that we don’t care if you commit suicide or not. It also suggests that some forms of suicide are OK, while others are not.

Finally, it elevates the ethical principle of patient autonomy above nonmaleficence, beneficence, and justice. Patient autonomy does not supersede the other 3 principles, and that is why we don’t give antibiotics to patients with a viral URI even though they ask for it, why we don’t automatically give them extra opioids when they are in pain, and why we shouldn’t give them drugs (or any means) to end their own life upon their request.

Craig Treptow MD

**Opinion Type:**

My post is my personal opinion

Sun, 11/04/2018 - 20:45

[M Jasser](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

To the Reference committee:

I am the author of the original resolution regarding “The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in Dying’ “ which was referred to CEJA for report back.

I would first like to thank CEJA, AMA leadership and all of my colleagues here and over the past many meetings for your very thoughtful and patient approach to this very important and potentially divisive subject. As the chair of a medical ethics program for over 20 years i can testify personally to how difficult it can be to get consensus on this subject.

First with regards to my resolution asking for clarity in language with regards to physician assistend suicide (PAS), aid in dying, and a host of other terms enlisted in these national conversations, I would like to highlight the conclusions of CEJA which clearly adopted the intent of my resolution: They stated, *“The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council’s view, despite its negative connotations [5], the term “physician assisted suicide” describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance. ”* While CEJA stopped short of a formal recommendation as my resolution requested regarding the words used officially by the AMA to describe Physical Assisted Suicide (PAS), these specific comments from CEJA essentially do that if any AMA leadership were to seek policy guidance.

Second, i would also like to testify in support of the entire report from CEJA and ask that the reference committee not consider asking CEJA to address it yet again which would essentially put our organization into an infinite irretrievable loop on this conversation.

I hope and pray that our reference committee and HOD look upon these determinations as ones deeply, methodically, and carefully thought out and presented by our CEJA. CEJA has had multiple forums and participated in our multiple reference committee discussions and HOD discussions and so much more over the past two years and more and yet came now twice to the same conclusions. I would ask that we respect the conclusions of CEJA as we would any deliberative higher "court" if you will.

I fear the day that our profession approach rulings on ethics and morality in the way of a majoritocracy or in the way of the winds of populism. As I testified previously, just because PAS is legal in a number of states or even if assisted suicide were legal in a majority of states, that does not mean that the morality and ethics of our profession should mirror the winds of populist change. It can always be possible for the state to license or make legal any other profession or "provider" among health care ancillary care providers to perform assisted suicide for any of the state's citizens who wish if the population deems that to be a "right". That can certainly be done without the deep compromise of the ethical and moral foundations of our profession of medicine. I believe the opinion from CEJA falls within that spirit and respect for those who hold those strongly held beliefs without necessitating the engagement of physicians in that facilitation of prescribing a prescription to terminate life- a deep compromise of our professional doctor-patient covenant. I will add that no one is saying here or anywhere in AMA policy that the CEJA position be used to sanction physicians who do participate in PAS in states where it is legal; but that is a very different question from our national organization representing the "House of Medicine" giving ethical permission and change to mirror those legalities and behaviors.

I would also like to remind you that CEJA also had a two hour session in I-17 in which many of us sitting around many tables spoke to their leadership and selected AMA leadership expressing very disparate views and concerns regarding PAS. And yet, with all of that thoughtful input they maintained their report as originally presented to the HOD.

There is a reason, "higher courts" (to use a loose analogy) do not keep rehearing cases brought before them based upon the winds of populism.

I speak here on my own behalf.

Respectfully submitted,

M. Zuhdi Jasser, MD FACP  
Delegate, Arizona  
Nov. 4, 2018 745PM

**Opinion Type:**

My post is my personal opinion

Sun, 11/04/2018 - 21:16

[Hannah Ficarino](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Hannah Ficarino, Delegate from Alabama, speaking on behalf of the Medical Student Section in respectful OPPOSITION to CEJA Report 2.

The MSS agrees that interpretation of the Code of Ethics may differ greatly about appropriate delivery of compassionate care according to the provider's moral perspective. However, the conversation on

physician aid-in-dying is actively evolving, and the eighth and most recent state passed legislation legalizing physician aid-in-dying that will go into effect on January 1, 2019. Our Section believes that the conversation lacks a voice representing physician consensus, and urges the establishment of a neutral stance on the topic of physician-assisted suicide. This would represent a crucial and timely action by the AMA. Clarity in the options, responsibilities, and ethical understanding around end-of-life care and the ability to study physician aid-in-dying will equip physicians to discuss the best evidence-based end-of-life options with their patients.

Furthermore, our MSS supports the use of the term "aid-in-dying" instead of "physician-assisted suicide" and supports protection for physicians who choose to participate in this process in states where aid-in-dying is legal. We urge standardization of this language because the important distinction between physician aid-in-dying versus physician-assisted suicide is paramount to patient understanding of end-of-life options, as well as creating uniform comprehension in the professional realm surrounding the topic.

Thank you for your consideration.

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Hannah Ficarino

**Delegation section or society:**

Medical Student Section

Mon, 11/05/2018 - 19:07

[Morrow](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I continue to support the, well studied, position CEJA has take and congratulate them for maintaining the AMA's long-standing position against Physician Assisted Suicide. The physician-patient relationship is based on trust, the trust of the patient in the good judgement and good will of the physician. PAS will undermine, if not destroy, that relationship. The medical profession was founded on the imperative to heal and protect life, even when cure is not possible.

**Opinion Type:**

My post is my personal opinion

Mon, 11/05/2018 - 20:00

[Daniel Fischberg](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

I salute the CEJA for producing such a thoughtful report, acknowledging the intelligence, compassion and integrity of people that have come to diverse conclusions on this issue. I personally support the recommendations of the CEJA that physician-assisted suicide is the clearest term for this practice and that the AMA not alter our Code of Medical Ethics.

**Opinion Type:**

My post is my personal opinion

Mon, 11/05/2018 - 22:09

[Gaulke](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

Please vote in favor of the CEJA Report which reaffirms AMA Code of Medical Ethics provisions in opposition to physician-assisted suicide and euthanasia. I am able to help my patients cope in so many wonderful ways near the end of life, hastening it as if they are a waste of time or resources is heartbreaking and a break of trust. It would be devastating to the millions suffering and to suffer from Alzheimer's and other diseases if this changes.

**Opinion Type:**

My post is my personal opinion

Mon, 11/05/2018 - 23:09

[Lisa Gilbert](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

**I congratulate the CEJA for continuing to uphold the Hippocratic tradition that separates caring and killing.** We must care always but kill, never. I am grateful to the AMA for having sought out views across the spectrum for several years, carefully investigating the implications of a rejection of Hippocratic ethics in medicine and coming to the correct conclusion.

We only have to look to Europe and Canada to see the shift that takes place once killing our patients is a matter of personal choice. It becomes accepted and then normalized. We have not yet reached this tipping point in Oregon and Washington, but we certainly will. We are not that different from our European and northern neighbors. Like with Canada, Switzerland, Belgium and the Netherlands, it will turn from a slow linear increase to a sky-rocketing exponential increase once it reaches the tipping point, once physician assisted suicide via the "right to die" becomes the normal way to die.

Patients are being killed now decades before they would otherwise have died of natural causes. Is this what we want to enter into our medical profession? Is this supportive of the sacred trust our patients have in us?

Take a look at the specific cases now in Belgium, with extension to mental disorders and minors. A transgender FtM suffering after botched surgeries, a depressed woman after traumatic rape, increase in prisoners being granted euthanasia, an anorexic who was sexual abused by her psychiatrist, many disabled:

<https://www.alliancevita.org/en/2017/06/belgium-15-years-after-legalizin...>

Indeed, disabled societies are very concerned about physician assisted suicide, starting organizations like Not Dead Yet just to protect themselves from what they know is coming based on Europe's dystopia:

<http://notdeadyet.org/adapt-public-comment-opposing-virginia-assisted-su...>

Take a look at Canada, already sky rocketting in the two years of legalization. Disabled men and women are now being encouraged, subtly and otherwise, to accept euthanasia:



<https://www.youtube.com/watch?v=hB6zt43iCs8&t=69s>

<https://www.youtube.com/watch?v=Ev8jTyliJ3Q>

Canada is also preparing for assisted suicide of minors, explicitly without parental consent.

<https://www.nationalreview.com/2018/11/canada-euthanasia-assisted-suicid...>

Furthermore, a woman in Canada ended her life a few days ago because she was afraid she might have dementia or mental issues from her cancer. She might have lived much longer and advocated to allow assisted suicide and euthanasia of patients with dementia or otherwise incompetent.

<https://alexschadenberg.blogspot.com/2018/11/nova-scotia-womans-death-pa...>

Finally, the Netherlands is considering a Completed Life Bill, wherein you can end your life, with physician help, when you consider your life complete. Originally slated at age 75, it was challenged by a 57 year old man who felt it to be discriminatory against him, as he felt his life was complete. Yet he had no pathology.

**Why would we be any different, once we become accustomed to controlling death by causing it?**

The Lozier Institute published two excellent articles. Oregon, so highly lauded as the prime example, has serious concerns from the data reported:

<https://lozierinstitute.org/wp-content/uploads/2018/03/Oregon-Assisted-S...>

Furthermore, it is clear that the path from physician assisted suicide to euthanasia is strategic:

<https://lozierinstitute.org/physician-assisted-suicide-the-path-to-activ...>

Finally, please read these very good articles:

<https://www.heritage.org/health-care-reform/report/always-care-never-kil...>

<http://annals.org/aim/fullarticle/2654458/ethics-legalization-physician-...>

<https://www.bioedge.org/indepth/view/is-it-possible-for-doctors-to-be-ne...>

**Is it possible for doctors to be neutral on physician assisted suicide, however deceptively it might be named? No, it is not. I strongly urge the AMA delegates to consider this in their decision and make their vote for the good our patients, physicians and society. I thank you for your service to our profesion and the common good.**

**Opinion Type:**

My post is my personal opinion

Tue, 11/06/2018 - 07:34

[Lopez](#)

**RE: Study Aid-in-Dying as End-of-Life Option / The Need to Disti**

The American College of Physicians does not support legalization of PAS. Our policy is consistent with the CEJA Report and the AMA Code of Ethics.

Thank you-

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Lopez

**Delegation section or society:**

American College of Physicians

**Tue, 10/16/2018 - 13:21**

**Council on Ethical and Judicial Affairs Report 3 - Amendment to E-2.2.1, "Pediatric Decision Making"**

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, "Pediatric Decision Making," be amended by substitution as follows in lieu of Resolutions 3-A-16, "Supporting Autonomy for Patients with Differences of Sex Development (DSD)," and 13-A-18, "Opposing Surgical Sex Assignment of Infants with Differences of Sex Development," and the remainder of this report be filed:

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

- (a) Provide compassionate, humane care to all pediatric patients.
- (b) Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- (c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- (d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- (e) Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.

(f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.

(g) When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.

(h) When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource.

Mon, 10/29/2018 - 13:08 (new)

[baratz](#)

**RE: Amendment to E-2.2.1, "Pediatric Decision Making"**

While we appreciate what CEJA writes, it does not address areas of serious concern to advocates, such as the validity of data used in decision-making for genital surgery and how information is presented to parents in the consent process. We will continue to work with our AMA toward more clear guidance on these issues.

**Opinion Type:**

My post is my personal opinion

Tue, 10/30/2018 - 14:10 (new)

[baratz](#)

**RE: Amendment to E-2.2.1, "Pediatric Decision Making"**

I received an email from American Urological Association (AUA) attorney Diane Bieri today stating that I have never been a member of AUA and instructing me to discontinue representing myself as a member. When I registered for the May 2016 meeting of the Societies for Pediatric Urology at which I was presenting, I believed that I was required to join AUA in order to complete registration. My CV should be amended to reflect this correction.

**Opinion Type:**

My post is my personal opinion

Sun, 11/04/2018 - 19:16 (new)

[Usman Aslam](#)

**RE: Amendment to E-2.2.1, "Pediatric Decision Making"**

Usman Aslam, Delegate from New York, speaking on behalf of the Medical Student Section in respectful OPPOSITION of the Council on Ethical & Judicial Affairs' Report 3. While we appreciate the Council's meticulous review of the literature surrounding this issue, our MSS believes that CEJA's recommendations do not address the spirit of our original resolution in maintaining the patient with differences in sex development (DSD) at the heart of the decision-making process, particularly when

decisions are made to have irreversible sex assignment surgeries [1]. Such procedures, especially when made for the purposes of cosmetic appearance and gender definition, have unique implications for issues of sex/gender identity, sexual orientation, procreative potential, and sexual function, each of which we believe intrinsically merits a discussion first and foremost with the patient. While we believe it is essential for physicians to offer optimized multi-disciplinary management for these patients, the Council should support the autonomy of patients with DSD by encouraging physicians to postpone genital-normalizing surgeries. We understand that circumstances may arise when surgical interventions in infants with DSD may be necessary for physical function or viability. When medically unnecessary, permanent alterations of genitalia have the harmful effect of assigning a gender that may be incongruent with the patient's gender identity. As specified in the report, most parents and guardians of infants with DSD are inclined to consent for assignment surgery for fear of negative social implications [2]. We believe that undergoing surgery to prevent presumed psychological issues violates the patient's human rights and is deeply unethical. Many intersex individuals believe that parents are not adequately informed of the implications and complications of sex reassignment in the way they would want to be informed before they are consented. In addition, there is a growing body of evidence concluding that DSD patients who delay or do not undergo surgery do not experience additional psychological or physical harms [3]. The social implications that are outlined as concerns and justification for early surgery can be addressed with delayed surgery; however, genital normalization cannot be reversed [4]. We strongly believe that these surgeries should be deferred to preserve future choice. We thank the Council again for its comprehensive report, and we thank the Reference Committee for its consideration.

1. 245.020MSS Supporting Autonomy for Patients with Differences of Sex Development: AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

2. Meyer-Bahlburg HF, Reyes-Portillo JA, Khuri J, Ehrhardt AA, New MI. Syndrome-related stigma in the general social environment as reported by women with classical congenital adrenal hyperplasia. *Archives of Sexual Behavior*. 2017;46:341–351. doi: 10.1007/s10508-016-0862-8:

3. Callens N, van der Zwan YG, Drop SLS, et al. Do surgical interventions influence psychosexual and cosmetic outcomes in women with disorders of sex development? *ISRN Endocrinology*. 2012:1-8. doi: 10.5402/2012/276742.

4. Bennecke E, Werner-Rosen K, Thyen U, et al. Subjective need for psychological support (PsySupp) in parents of children and adolescents with disorders of sex development (dsd). *European Journal of Pediatrics*. 2015;174(10):1287-97. doi: 10.1007/s00431-015-2530-8.

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Usman Aslam

**Delegation section or society:**

Medical Student Section

**Thu, 10/18/2018 - 10:59**

**Council on Ethical and Judicial Affairs Report 4 - CEJA Role in Implementing H-140.837, "Anti-Harassment Policy"**

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

1. That provision (3) of H-140.837, "Anti-Harassment Policy" be rescinded (Directive to Take Action);  
and
2. That the process for implementing AMA's anti-harassment policy be referred to the Board of Trustees for further study (Directive to Take Action)

Fri, 09/28/2018 - 11:13

**Resolution 001 - Support of a National Registry for Advance Directives**

RESOLVED, That our American Medical Association advocate for the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents.

Wed, 10/24/2018 - 15:32

[Jim Rohack](#)

**RE: Support of a National Registry for Advance Directives**

Until functional interoperability of medical records exist, the concept of a national repository for advanced directives would seem a stop-gap solution. Having the patient have the advance directive on them at all times would work about same way with much less cost. While I support getting the data when needed, creating a "no-charge" method is unclear who bears the cost (the patient or healthcare delivery system/physician). For those reasons, I would not be supportive as written to have AMA advocate for such.

**Opinion Type:**

My post is my personal opinion

Sun, 11/04/2018 - 22:17 (new)

[Usman Aslam](#)

**RE: Support of a National Registry for Advance Directives**

"Hetal Bhatt, medical student from California, speaking on behalf of the Medical Student Section in support of Resolution 001.

It has been shown that Advanced Care Planning (ACP) improves respecting end-of-life wishes for patients while reducing family member anxiety and stress. However, ACP documentation varies by state/region and can be difficult to locate. Resolution 001 hopes to alleviate this barrier in providing proper end-of life care by having the AMA advocate for the establishment and maintenance of a national secure method for storage and retrieval of advance directive documents.

Our MSS affirms the need for advance directives for all patients and encourages our AMA to work with state societies to develop a standardized form of advance directives for use by physicians and other health care providers. Additionally, AMA policy encourages every state medical association and their member physicians to make information about living wills and health care powers of attorney continuously available and advocates for implementation of secure electronic advance health care directives. We believe this resolution logically advances existing policy and furthers important efforts to help patients navigate the end of life with grace and dignity. Thank you for your consideration."

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Hetal Bhatt

**Delegation section or society:**

Medical Student Section

Tue, 10/16/2018 - 14:35

**Resolution 002 - Protecting the Integrity of Public Health Data Collection**

RESOLVED, That our American Medical Association advocate for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and be it further

RESOLVED, That our AMA advocate against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data.

Sun, 11/04/2018 - 16:42 (new)

[Angela Wu](#)

**RE: Protecting the Integrity of Public Health Data Collection**

Angela Wu, medical student from Arizona, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 002. As a Section, we have continually supported measures to improve equity and reduce the health disparities that affect the diverse LGBTQ+ population. Our MSS recognizes that collecting patient data on sexual orientation and gender identity is important for research into patient health. An National Academy of Medicine (formerly Institute of Medicine) report also recommends that this essential demographic data be routinely collected so that it can be used to identify patterns of disparities and need

(<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2011/T...>). In light of recent attempts to limit collection of this necessary information, we agree that the AMA should actively advocate against actions that may hinder future efforts to better serve the LGBTQ+ population. Thank you for your consideration.

**Opinion Type:**

My post reflects the opinion of my delegation or section

**Signature Name:**

Angela Wu

**Delegation section or society:**

Medical Student Section



**Tue, 10/16/2018 - 14:36**

**Resolution 003 - Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children**

RESOLVED, That our American Medical Association officially object to policies separating undocumented immigrant parents and/or guardians from children, as well as allowing unaccompanied undocumented minors access to the U.S.; and be it further

RESOLVED, That our AMA condemn the practice of administering psychotropic drugs to immigrant children without parental or guardian consent or court order except in the case of imminent danger to self or others; and be it further

RESOLVED, That our AMA support a position whereby federal immigration officials would become more aware of the emotional decompensation in this immigrant population, with the establishment of policies designed to decrease stress and emotional trauma.

Thu, 10/25/2018 - 09:40

**Resolution 004 - Opposing the Detention of Migrant Children**

RESOLVED, That our American Medical Association oppose the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care (New HOD Policy) ; and be it further

RESOLVED, That our AMA support the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children (New HOD Policy); and be it further

RESOLVED, That our AMA urge that all children released from such detention be provided with indicated follow-up health care to ensure their welfare following these experiences. (New HOD Policy)

Sat, 10/27/2018 - 19:26 (new)

[Charles Hickey](#)

**RE: Opposing the Detention of Migrant Children**

There is moral hazard in having a policy that in effect states that all migrants who arrive at our border with a child must be admitted and may not be separated from their accompanying child nor confined. This would make our AMA complicit in encouraging children being used as pawns to bypass legal United States immigration requirements. This is a back door way of saying that our AMA is in favor of a completely open border. This resolution ignores the need for sensible immigration reform.

**Opinion Type:**

My post is my personal opinion