REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-19)
Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The House of Delegates asked the Council on Ethical and Judicial Affairs (CEJA) to "study the issue of aid in dying with consideration of data collected from the states that currently authorize aid-in-dying, and input from some of the physicians who have provided medical aid-in-dying to qualified patients. CEJA was further asked to consider the need to distinguish between "physician-assisted suicide" and "aid in dying."

In response to these requests, CEJA carried out an extensive review of relevant philosophical and empirical literature. Its deliberations have further been informed by an educational session at the 2016 Interim Meeting and consultations with stakeholders at the 2017 Annual and Interim meetings, as well as extensive correspondence from stakeholders within the medical community and the public at large. In addition, the council heard passionate testimony from both opponents and supporters of physician participation in assisted suicide at the 2018 Annual and Interim meetings.

Reflecting on this input, CEJA recognized that thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Importantly, the council found that despite deep differences, supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

CEJA interprets existing guidance in the AMA *Code of Medical Ethics* as encompassing the irreducible moral tension at stake for physicians with respect to participating in assisted suicide.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, CEJA recommends that the *Code of Medical Ethics* not be amended.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-19

Subject:	Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
Presented by:	James E. Sabin, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William C. Reha, MD, Chair)

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

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

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

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

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

The council observes that the ethical arguments advanced today supporting and opposing "physician-assisted suicide" or "aid in dying" are fundamentally unchanged from those examined

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in CEJA's 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of Opinion E-5.7, "Physician-Assisted Suicide," in 1994.

"ASSISTED SUICIDE," "AID IN DYING," OR "DEATH WITH DIGNITY"?

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

Correspondingly, those who oppose physician provision of lethal medications refer to the practice as "physician-assisted suicide," with its negative connotations regarding patients' psychological state and its suggestion that physicians are complicit in something that, in other contexts, they would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their use obscures or sanitizes the activity. In their view such language characterizes physicians' role in a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still others, meanwhile, argue that the choice by terminally ill patients to take action to end their own lives with the assistance of their physician is distinct from what is traditionally understood as "suicide" [4].

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.

COMMON GROUND

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

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying "with dignity" may mean accepting the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some

physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of Principle I of the AMA *Principles of Medical Ethics*: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."

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

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different judgments about what is an ethically permissible course of action is profoundly challenging. With respect to physician-assisted suicide, some professional organizations—for example, the American Academy of Hospice and Palliative Medicine [6]—have adopted a position of "studied neutrality." Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are intended to respect that there are irreducible differences among the deeply held beliefs and values that inform public and professional perspectives [6,7], and to leave space open for ongoing discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither neutral or appropriate for organized medicine [8], and as being open to unintended consequences, including stifling the very debate it purports to encourage or being read as little more than acquiescence with the contested practice [9].

CEJA approaches the condition of irreducible difference from a different direction. In its 2014 report on exercise of conscience, the Council noted that "health care professionals may hold very different core beliefs and thus reach very different decisions based on those core beliefs, yet equally act according to the dictates of conscience. For example, a physician who chooses to provide abortions on the basis of a deeply held belief in protecting women's autonomy makes the same kind of moral claim to conscience as does a physician who refuses to provide abortion on the basis of respect for the sanctity of life of the fetus" [10].

Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on intuition or emotion. Rather, such decisions are based on "substantive, coherent, and reasonably stable" values and principles [10]. Physicians must be able to articulate how those values and principles justify the action in question.

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging "substantive, coherent, and reasonably stable" values and principles within the profession and the wider moral community. While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme

Court's advisory panel on physician-assisted death, "neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and nuanced understanding of how to best honor and address the needs of people who are suffering" [11].

THE RISK OF UNINTENDED CONSEQUENCES

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

The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide, along with procedural and reporting requirements—can actually protect patients and sustain the integrity of medicine remains deeply contested. Some studies have "found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups" [12], others question whether the available data can in fact support any such conclusions, finding the evidence cited variously flawed [13], inadequate [14], or distorted [15].

Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [17]. For example, research in the Netherlands has found that "requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone," mitigating fears that "solitary, depressed individuals with potentially reversible conditions might successfully end their lives." At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent "reported only psychological suffering." At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a "slippery slope" [18].

Studies have also raised questions about how effective retrospective review of decisions to provide euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch regional euthanasia committees determined had not met legal "due care criteria" found that such reviews focus on procedural considerations and do not "directly assess the actual eligibility" of the patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients obtained euthanasia found that physicians' reports "stated that psychosis or depression did or did not affect capacity but provided little explanation regarding their judgments" and that review committees "generally accepted the judgment of the physician performing EAS [euthanasia or physician-assisted suicide]" [20]. It remains an open question whether reviews that are not able to assess physicians' reasoning truly offer the protection they are intended to provide. To the extent

that reporting and data collection in states that permit physician-assisted suicide have similar limitations, oversight of practice may not be adequate.

Medicine must learn from this experience. Where physician-assisted suicide is legalized, safeguards can and should be improved—e.g., "[t]o increase safeguards, states could consider introducing multidisciplinary panels to support patients through the entire process, including verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all palliative and end-of-life options" [21]. Both the state and the medical profession have a responsibility to monitor ongoing practice in a meaningful way and to address promptly compromises in safeguards should any be discovered. It is equally important that strong practices be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health care organizations in California and Canada, for example, have shared richly descriptive reports of practices adopted in response to the recent legalization of "aid in dying" in those jurisdictions that seek to address concerns about quality of practice and data collection [22,23].

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

SAFEGUARDING DECISIONS AT THE END OF LIFE

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

These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in America* [24]. They are concerns echoed in a February 2018 workshop on physician-assisted death convened by the National Academies of Science, Engineering and Medicine [25]. They underscore how important it is to understand *why* a patient requests assisted suicide as a starting point for care [26].

Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that are too often avoided. They open opportunities to explore the patient's goals and concerns, to learn what about the situation the individual finds intolerable and to respond creatively to the patient's needs other than providing the means to end life—by such means as better managing symptoms, arranging for psychosocial or spiritual support, treating depression, and helping the patient to understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients [28]. The profession also has a responsibility to advocate for adequate resources for end-of-life care [16,28], particularly for patients from

disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.

CONCLUSION

At the core of public and professional debate, the council believes, is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease" [27]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

RECOMMENDATION

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.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, the Council on Ethical and Judicial Affairs 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.[1]

Fiscal Note: None.

[1] CEJA plans to present E-5.7 and E-1.1.7 in online and print versions of the *Code of Medical Ethics* as suggested in the Appendix.

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APPENDIX

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics *encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.*

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

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.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and

committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX