AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-23)

Introduced by: Medical Student Section

Subject: Reconsideration of Medical Aid in Dying (MAID)

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, the practice that our AMA calls “physician-assisted suicide” (PAS) is often referred to by many other terms, including “medical aid in dying” (MAID)[1]; and

Whereas, the American Psychological Association and the American Association of Suicidology recognize that “suicide” is distinct from MAID, and the use of “suicide” to describe MAID may misrepresent and stigmatize patients’ rationale and choices[2]; and

Whereas, in jurisdictions where it is legal, MAID allows adults with terminal illness and preserved decision-making capacity to request a prescription for self-administered medications to end their life, while retaining the autonomy to decide if and when to fill the prescription and if and when to self-administer the medication[1]; and

Whereas, medical aid in dying (MAID) is legal by legislation, judicial action, or referendum in eleven US jurisdictions, covering 1 in 4 US adults: California (2015), Colorado (2016), Hawaii (2018), Montana (2009), Maine (2019), New Jersey (2019), New Mexico (2021), Oregon (1994), Vermont (2013), Washington state (2008), and Washington, DC (2016)[3-4]; and

Whereas, our American Medical Association House of Delegates last debated neutrality on MAID at A-18, I-18, and A-19, and after extensive debate ultimately retained our existing Code of Medical Ethics opinion that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”; and

Whereas, in a 2020 Medscape Survey, 55% of physicians (including 51% of primary care and 57% of specialists) supported legalization of MAID[5], indicating that neutrality may more accurately represent the views of the medical profession, rather than opposition; and

Whereas, withholding or withdrawing life-sustaining treatment (including intubation, feeding tubes, medications such as antibiotics or chemotherapy, procedures, and dialysis) is a legal and common end-of-life medical decision in the US and is considered ethical by our AMA[6]; and

Whereas, cancer patients who decide to forgo treatment and accept death may experience considerable pain as they wait for their disease to end their life, and caregivers often report feeling burdened with managing end-of-life pain[7-9]; and

Whereas, death after removal of a feeding tube may take over ten days, resulting in dramatic physical alterations due to starvation and causing anxiety caregivers[10]; and

Whereas, leading ethical scholars have concluded that letting patients die (by waiting to succumb to their disease after withholding or withdrawing treatment) may in many circumstances be less ethical than allowing a patient to actively end their own life[11]; and

Whereas, many medical societies have recently taken variations of neutral positions on MAID, ranging from "studied neutrality" while maintaining concerns over routine use and appropriate safeguards to "engaged neutrality" to "leav[ing] the decision…to the conscientious judgment of its members acting on behalf of their patients"; and

Whereas, despite concerns that MAID may be misused for patients of color, racial inequities in end-of-life care actually indicate that patients of color are less likely to complete advance directives or be asked their end-of-life preferences, that white patients are more likely to use MAID where legal, and that existing safeguards make possible abuse of MAID difficult[8]; and

Whereas, while financial concerns may exist regarding patients choosing MAID over continuation of care, patients already choose between hospice and continuation of care, which may already hold similar financial considerations[16]; and

Whereas, Gideonse v Brown (2022) found that patients can legally travel to Oregon to receive MAID even if they reside in a state where MAID is illegal, so physicians across the US may potentially encounter patients intending to travel for MAID[17]; therefore be it

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions (New HOD Policy); and be it further

RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue (Rescind HOD Policy); and be it further

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:

> Decisions Near the End of Life, H-140.966
> Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
> (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
> (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may

foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~

(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

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RELEVANT AMA POLICY

Code of Medical Ethics Opinion 5.7 Physician-Assisted Suicide
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.
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; Issued: 2016

Code of Medical Ethics Opinion 5.7 Euthanasia
Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.
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 euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.
The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.
Instead of engaging in euthanasia, 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 a 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; Issued: 2016

H-270.965 Physician-Assisted Suicide
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. [Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18]

H-140.952 Physician Assisted Suicide
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. [CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmed: CEJA Rep. 03, A-19]

H-140.966 Decisions Near the End of Life
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.
(5) Our AMA supports continued research into and education concerning pain management.
[CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed in lieu of Res. 211, I-13; Reaffirmed: BOT Rep. 05, I-16]