

# Reconsidering physician aid-in-dying

As public opinion evolves, physicians and lawmakers should take note.

BY DAVID B. PLIMPTON, MD

**Editor's Note:** *Last March, Minnesota Medicine published the commentary "Compassionate care? What are we getting into?" by Cory Ingram, MD, a piece expressing opposition to legalizing physician aid-in-dying. The article was prompted by legislation introduced in Minnesota during the 2015 session. You can read that commentary here: [www.mnmed.org/ingramcommentary](http://www.mnmed.org/ingramcommentary).*

*The following commentary provides a counterpoint. The MMA has long opposed physician aid-in-dying. However, given changing opinion across the county, the MMA convened a nine-physician committee to discuss the topic in 2016. At last year's Annual Conference, the MMA held a policy forum to solicit member feedback. This spring, the MMA will send out a survey on the topic before the May Board of Trustees meeting, where the subject will be discussed further. For additional background information, visit [www.mnmed.org/education-and-events/Annual-Conference/Physician-Aid-in-Dying-Policy-Forum-\(PAID\)](http://www.mnmed.org/education-and-events/Annual-Conference/Physician-Aid-in-Dying-Policy-Forum-(PAID)).*

It is time for the citizens of Minnesota to have access to physician aid-in-dying (self-administration of a lethal dose of medication). According to 10 years of reputable polling data, a majority of American citizens, and presumably of Minnesotans, want this option to be available to them at the end of life.<sup>1</sup> My belief is that decriminalizing physician aid-in-dying is essential if physicians are to fully honor the rights of patients with mental capacity; truly embrace patient-centered and family-focused care; acknowledge our unintended contribution to patient suffer-

ing; and provide a complete range of options to relieve intractable suffering.

I believe physician aid-in-dying reflects ethical principles and values we embrace in the Hippocratic Oath and elsewhere.

- **Autonomy:** Competent, terminally ill people who are suffering should have the right to choose the timing and manner of their death.
- **Justice:** Justice requires that we "treat like cases alike." A competent, suffering, terminally ill person requiring life-sustaining treatment can shorten their dying process by refusing or withdrawing from that support, but a competent, suffering, terminally ill person not requiring life-support has no medical option to shorten their dying process.
- **Beneficence:** Death can be good when it is the only means by which intractable suffering can be relieved.
- **Nonmaleficence:** Accelerating the dying process in a terminally ill, suffering person does not always represent harm.
- **Compassion:** Suffering encompasses more than physical pain; existential suffering cannot always be relieved. Physician aid-in-dying is a compassionate response to such unremitting suffering.
- **Individual liberty:** The state should have minimal interest in prolonging the life of a competent, terminally ill patient for whom continued living has become "a fate worse than death."
- **Honesty and transparency:** Legalization of physician aid-in-dying would promote an open discussion between a trusted physician and a fully informed patient. It would also encourage public discourse so we can identify what gives

meaning to our lives and what aspects of our physical, cognitive and spiritual existence we need to maintain our identity. The availability of physician aid-in-dying appears to increase physician referral to—and utilization of—palliative care and hospice services.<sup>1</sup>

## A look back

History reflects incremental changes in the views of medical professionals about physician aid-in-dying. In 1991, the American Medical Association issued the following opinion: "It is understandable, though tragic, that some patients in extreme distress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would 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."<sup>2</sup> State medical societies promptly followed with their own statements of opposition.

These moves were understandable, given the context. At that time, acts by several individual physicians were viewed as threats to the integrity of medicine. In 1991, Dr. Timothy Quill, an internist/oncologist in Rochester, New York, published a case report in the *New England Journal of Medicine* in which he described helping his 45-year-old-patient, who was terminally ill with acute leukemia and without remaining chemotherapeutic treatment options, and who had declined a bone marrow transplant, to die peacefully

but alone. Dr. Quill provided a lethal dose of self-administered oral barbiturate.<sup>3</sup> A grand jury failed to indict him.

Also during the 1990s, Dr. Jack Kevorkian, a pathologist in Michigan, achieved notoriety as “Doctor Death” by enabling suffering individuals, who were not necessarily terminally ill, to self-administer a combination of lethal drugs intravenously, resulting in, by Kevorkian’s estimation, the deaths of 130 human beings. At around that time, advocates for death with dignity made strong efforts in California and Washington to pass laws allowing physician aid-in-dying, but bills in both states were narrowly defeated.

Much has changed since then. In 1994, the state of Oregon passed its Death with Dignity Act by public referendum, with 51.3 percent in favor and 48.7 percent opposed. The law was not enacted until late 1997, however, because of court challenges and an attempt by the Oregon Legislature, through a second public referendum, to repeal the law. That latter initiative was defeated 60 percent to 40 percent. In 1997, the U.S. Supreme Court judged that while the right to die was not guaranteed by the U.S. Constitution, the Oregon Death with Dignity Act could stand, and that other states had the right to enact similar laws.

The Oregon law states that a competent adult who is terminally ill (estimated to have less than six months to live) and suffering intolerably may legally request from their physician a prescription for a lethal dose of medication (usually a barbiturate), which, when self-administered, would result in a peaceful death. The patient must voluntarily make this request and show no evidence of coercion or of impairment of decision-making ability. The patient cannot request physician aid-in-dying in a health care directive or through a health care agent. There is no mandate for participation, so any physician, hospital, health care system, pharmacist or pharmacy may decline to honor the patient’s request—but medical ethics do not allow abandonment of a patient.

In 2008, the state of Washington, using Oregon’s law as its template, passed its own Death with Dignity Act, also by public referendum, 57.8 percent to 42.2 percent. A 2009 Montana Supreme Court decision confirmed a patient’s right to physician aid-in-dying, but provided no guidelines, and subsequent legislative attempts in that state to pass an act similar to Oregon’s have failed.

In 2013, Vermont became the first state to pass a law through legislation that legalized physician aid-in-dying. In October 2015, California followed with its End of Life Option Act. Both state legislatures based their laws on the Oregon Death with Dignity Act with only minor variations. Unique to California’s effort was a vote by the California Medical Association, prior to the legislative debate, to withdraw its long-standing opposition to physician aid-in-dying. In announcing the change, the association’s president, Luther F. Cobb, MD, stated, “As physicians, we want to provide the best care possible for our patients. However, despite the remarkable medical breakthroughs we have made and world-class hospice or palliative care we can provide, it isn’t always enough. The decision to participate in the End of Life Option Act is a very personal one between the doctor and their patient, which is why the California Medical Association has removed policy that outright objects to physicians aiding terminally ill patients in the End of Life Option Act. We believe it is up to the individual physician and their patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage. Protecting that physician-patient relationship is essential.”

Internationally, physician aid-in-dying has also garnered attention. In 1942, Switzerland decriminalized physician aid-in-dying with a stipulation that there must be no selfish motive for the request. The patient need not be terminally ill or even a Swiss citizen; however, the request must be voluntary, and the lethal dose must be self-administered. In 2002, Belgium and the Netherlands legalized physician aid-in-dying and voluntary euthanasia for patient suffering; both forms had been accepted as common practice, and considered morally

equal, since the 1980s. Luxembourg took a similar action in 2009. Germany, Colombia and Japan have also moved to legalize physician aid-in-dying.

In 2016, the Parliament of Canada passed landmark legislation allowing both physician aid-in-dying and voluntary euthanasia for the competent, terminally ill patient who is suffering. Like those who advocated for physician aid-in-dying laws in several U.S. states, Canadian lawmakers wrote their law using Oregon’s Death with Dignity criteria for patient qualification—and that state’s 18 years of data confirming their safe use.

### Recent U.S. news

On June 9, 2016, when California’s End of Life Option Act went into effect, a sixth of the U.S. population had legal access to physician aid-in-dying. In 2016, according to reports from Compassion & Choices, the largest nonprofit advocating for physician aid-in-dying, 20 states, including Minnesota, and the District of Columbia had proposals before their legislatures supporting physician aid-in-dying. On Nov 8, 2016, Colorado citizens, by public referendum, voted to pass an End of Life Options Act (physician aid-in-dying), with 65 percent voting in favor. Before the 2016 election, the Colorado Medical Society Council on Ethical and Judicial Affairs, charged with reevaluation of the organization’s policy on physician-assisted suicide, recommended that it should be “amended in a manner that neither formally takes a strong position for or against physician-assisted suicide but rather infers a position of thoughtful, studied neutrality that promotes end-of-life care, patient discussions, physician education, promotion of access to appropriate care, and ethical and clinical guidelines/parameters/safeguards that should guide physicians and patients where adults in Colorado could obtain and use prescriptions from their physicians for self-administered, lethal doses of medications should the law be amended to permit this patient option.” The Colorado Medical Society’s Board of Trustees supported this recommendation.

In March 2016, the Minnesota Compassionate Care Act (SF 1880-physician aid-in-dying) was heard by the Minnesota Senate subcommittee on Health, Human Services and Housing, followed by testimony from proponents and opponents. When it became clear that the bill would not pass out of committee, lead author Sen. Chris Eaton (DFL-Brooklyn Center/Brooklyn Park) withdrew it, eliminating a roll-call vote. Her plans to have the bill heard during the 2017 legislative session have been compromised by the DFL losing majority control of the Senate.

### Changing views

Opposition to physician aid-in-dying appears to come from three main sources: religion; organized medicine and individual physicians; and advocates for the disabled. Although each group is composed of people with honest, deeply held beliefs, these groups represent a minority opinion. In August 2016, Compassion & Choices funded a survey of 509 likely Minnesota voters. Responses showed broad and deep support for physician aid-in-dying among all demographic groups sampled, including men, women, Democrats, Independents, Republicans, people under and over age 50, residents of Greater Minnesota and metropolitan areas, Christians, and those with no religious affiliation.

In addition, it should be noted that fears surrounding physician aid-in-dying among those who advocate for the vulnerable (i.e., physically or cognitively disabled, poor, uninsured, frail elderly, or minorities) have not been realized. Disability Rights Oregon, the organization charged with monitoring the Oregon law's compliance with the rights of the disabled, has received no complaints of exploitation or coercion of an individual with disabilities relative to Oregon's Death with Dignity Act. Also, fears that allowing physician aid-in-dying (self-administration of the lethal dose) will create a "slippery slope" which will lead to voluntary or involuntary euthanasia (physician administration of the lethal dose) have not been realized. In the U.S., euthanasia remains illegal in all 50 states, even those that have decriminalized physician aid-in-dying. In

no jurisdiction which has allowed physician aid-in-dying alone has there been progression to include both physician aid-in-dying and euthanasia.

Our thinking about death as it relates to the practice of medicine needs to change. For physicians, that will require that we honestly face our own fears about the dying process and death; that we be aware of our potential for maintaining moral overconfidence; and that we initially reframe and, ultimately, reclassify physician aid-in-dying of a suffering, terminally ill person as something very different from the suicide of a person with a potentially treatable mental illness.

We doctors define ourselves by—and take great pride in—our ability to prevent illness, sustain life while having the patient maintain functional capacity, delay death, and “do no harm.” But we may, in fact, be inappropriately prolonging the dying process, in denial about the harm we are doing, and only superficially aware of what informs our thoughts, motives and behaviors. Although we acknowledge that death is inevitable, it is a deeply held belief that death is bad and represents failure. Ironically, we have established standards in which death is acceptable to us as physicians—for example, the Principle of Double Effect or Palliative Sedation, by which we can accelerate the dying process to relieve intolerable suffering in the terminally ill—but we are unwilling to relinquish that control to the patient. We fail to accept the dying, suffering person as our moral equal who has the right to be empowered with self-determination and choose to seek relief from moral and physical distress.

So often we fail to ask dying patients important questions: “When is death acceptable to you?” “What are your fears and your goals?” “Under what circumstances will you have lost your identity, your sense of self?” “Under what circumstances would life be a fate worse than death?” Instead, we impose our own belief system on them. If the dying human being has mental capacity, and can state without evidence of coercion that they wish to end their suffering by death, we as physicians should be able to legally provide the medi-

cal means to safely accelerate the dying process and allow the patient to achieve comfort.

On October 10, 2015, California Gov. Jerry Brown, a former Jesuit seminarian, signed into law the End of Life Option Act. At that time, he issued a statement outlining the process through which he reached his decision and describing the counsel he sought from proponents and opponents of the bill. He concluded as follows: “In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying and in prolonged and excruciating pain. I am certain, however, it would be a comfort to be able to consider the options afforded by this bill, and I wouldn't want to deny that right to others.”

It is time to recognize that the role of medicine has expanded far beyond “healing.” The Oregon experience has proven that control of physician aid-in-dying is possible with appropriate restrictions, guidelines and monitoring, and that there has been no demonstrable harm to society or the medical profession. We must strengthen the doctor-patient relationship with our commitment to create an environment of trust and communication based on our deep understanding of the patient's beliefs, values and goals. We do so by no longer defining ourselves as healers; we can't focus just on life but on the reality of the individual's life experiences in the context of the human life cycle, which includes death. If the suffering, terminally ill person has mental capacity and finds their life to be no longer meaningful, we physicians should be legally allowed to medically help them achieve a gentle death. **MM**

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