AMERICAN MEDICAL STUDENT ASSOCIATION

HOUSE OF DELEGATES 2008

RESOLUTION: D 01

INTRODUCED BY: **Jason Cheng**, Coordinator, Interest Group on Death and Dying; **Taylor Mac Black**

SCHOOL: University of Michigan Medical School, University of Washington School of Medicine

SUBJECT: Principles Regarding Physician-Assisted Suicide

TYPE: Resolution of Principles

WHEREAS there is increasing use of neutral terms like “physician-assisted dying”, “physician-assisted death”, or “physician aid in dying” to avoid the more emotionally-charged “physician-assisted suicide”[i,ii,iii,iv];

WHEREAS a nationwide poll has shown a majority of Americans to favor laws allowing physician aid in dying[v];

WHEREAS the well-respected organization AMWA has adopted an official position that “supports the passage of aid in dying laws, which empower mentally competent, terminally ill patients and protect participating physicians, such as that passed in Oregon, the Oregon Death with Dignity Act”[vi];

WHEREAS there is a precedent to this resolution in that AMSA filed a 1996 amicus brief stating that “in certain limited and carefully-regulated circumstances, physician-assisted suicide should be a lawful option available to competent, terminally ill patients,” in other words, that “mentally competent terminally ill patients should have the option of a safe, legal and state-regulated means of hastening death with the assistance of a physician”[vii];

WHEREAS the Oregon Death with Dignity Act[viii] was passed in 1997 with many of the guidelines proposed in AMSA’s current Principles Regarding Physician-Assisted Suicide, eg, two physicians must verify the patient’s decisional capacity and the terminal status of the illness; request must be verified by two witnesses; process must be thoroughly documented; the offer of comfort care, hospice care, and pain control must be made; and there must be a 15-day waiting period after first oral request and 48-hour waiting period after written request before writing of a prescription[ix];

WHEREAS the practice of physician aid in dying already exists in unregulated form[x], sometimes without adherence to criteria in the Oregon law and the present AMSA policy such as verification of the patient’s decisional capacity or consultation of a second physician[xi];

WHEREAS a small minority of the Oregon patients who request a prescription for lethal oral medication actually receive and use it, demonstrating the effect of the screening process[xii];

WHEREAS the Oregon data shows a large majority of those who used physician aid in dying were also enrolled in hospice care at the time[xiii]; and most hospice nurses and social workers believe that such patients should remain in hospice[xiv]; demonstrating that some patients seek physician aid in dying despite intensive symptom management and that the two are not mutually exclusive;

WHEREAS after the passage of the Oregon Death with Dignity Act, there has been an associated improvement in quality of palliative care, as evidenced by some Oregon physicians’ increased hospice referrals and improved knowledge of pain control[xv], as well as other Oregon physicians’ increased confidence in interacting with terminal patients[xvi];

WHEREAS the Oregon data showed “no evidence of heightened risk for the elderly, women, the uninsured, … people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities”[xvii];

THEREFORE BE IT RESOLVED THAT the Principles Regarding Physician-Assisted Suicide, Number 1 (pg 150-151) be AMENDED to read:

Principles Regarding Physician ~~Assisted Suicide~~ **Aid in Dying**

The American Medical Student Association:

1. ~~Should the practice of physician assisted suicide become legalized,~~ **SUPPORTS passage of aid in dying laws that empower mentally competent, terminally ill patients to hasten what might otherwise be a protracted, undignified, or extremely painful death. Aid in Dying** ~~SUPPORTS this practice only as~~ should be a last resort option in patient care if the following criteria are met. **It should not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide.** The criteria include, but may not be limited to: (1998)
   a. There must be a request from the patient that is voluntary and free of coercion of any type, including financial. If the patient is an inpatient or a nursing home resident, the voluntary nature of the request must be verified by a patient advocate, i.e., ombudsperson. (1998)
   b. The explicit nature of the patient's request must be documented and persist throughout a specified waiting period. (1998)
   c. The patient must be determined ~~competent~~ **to have capacity**, based on current standards of ~~competency~~ **capacity**. (1998)
   d. The patient must be terminally ill, as defined by current standards. (1998)
   e. The patient must have unbearable physical, mental and/or emotional suffering, as defined by the patient, whereby the patient feels that his/her quality of life is such that life is no longer worth living. (1998)
   f. Physician-aid-in-dying must be considered only as a last resort, after the following issues have been thoroughly explored ~~and exhausted or rejected~~ by the patient:
      1. All appropriate standard and experimental allopathic and osteopathic therapies.
      2. All relevant culturally sensitive alternative therapies.
      3. All palliative care options, such as hospice.
      4. Comprehensive pain management.
      5. Comprehensive psychiatric, psychosocial and spiritual support.
   g. Assistance in death must be carried out only by a physician, through the prescription of a lethal dose of medication, as determined jointly by the patient and physician.
   h. No health care provider who is morally or otherwise opposed to the participation in physician-aid-in-dying will be obliged to assist.
   i. The physician to whom the request is made should be familiar not only with the patient's medical condition, but also the patient's experience of his/her illness and present state of mind. The patient and physician must enjoy a lasting, mutually trusting and open relationship, including but not restricted to ongoing discussion about issues of death and dying.
   j. A thorough psychiatric consultation must be included in evaluating the patient's request. This must include, but not be restricted to, ruling out treatable affective conditions, such as clinical depression.
   k. Hospital ethics committees and ethicists may be consulted to address specific ethical concerns and areas of conflict resolution.
   l. An independent physician must be consulted to review the entire case to determine that the above criteria have been met and that the request is a reasonable option.
   m. All cases of physician-aid-in-dying must be documented on an aid-in-dying report form. This form should include, but not be restricted to, information pertaining to the nature of the request, patient demographics, the patient's medical and psychosocial history, and surrounding circumstances, and documentation of how the criteria have been met.
   n. A system of safeguard review must be established at both institutional and state levels. Data on practices and patient characteristics must be made available to the public, while maintaining individual patient privacy. (1993)

FURTHER BE IT RESOLVED THAT the Principles Regarding Physician-Assisted Suicide (pg 150-151) be AMENDED BY ADDITION to read:

7. SUPPORTS open and complete communication, free from coercion, between physician and patient regarding all possible end-of-life care options for the terminally ill patient

FISCAL NOTE: None

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[i] Quill TE and Battin MP. Introduction. Physician-Assisted Dying: The Case for Palliative Care and Patient Choice. The Johns Hopkins University Press: 2004. pp. 1-2.

[ii] American Academy of Hospice and Palliative Medicine Position. Statement on Physician-Assisted Death. http://www.aahpm.org/positions/suicide.html. Accessed January 10, 2008.

[iii] American Public Health Association. Interim Policy on End-of-Life Choices. http://www.apha.org/about/news/pressreleases/2006/06policiesnewsrelease.htm. Accessed January 10, 2008.

[iv] Tucker KL, Steele FB. Patient choice at the end of life: getting the language right. J Leg Med. 2007 Jul-Sep;28(3):305-25.

[v] Taylor, Humphrey. 2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide. From THE HARRIS POLL #2, January 9, 2002. http://www.harrisinteractive.com/harris_poll/index.asp?PID=278. Accessed January 10, 2008.

[vi] American Medical Women's Association. AMWA Position Statement on Aid in Dying. http://www.amwa-doc.org/index.cfm?objectId=242FFEF5-D567-0B25-585DC5662AB71DF9. Accessed January 10, 2008.

[vii] Brief Amici Curiae of the American Medical Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents. 1996 WL 709332. (U.S.) For Vacco vs. Quill and Washington vs. Glucksberg cases.

[viii] Oregon Death with Dignity Act. http://www.oregon.gov/DHS/ph/pas/docs/statute.pdf. Accessed January 10, 2008.

[ix] AMSA Principles Regarding Physician-Assisted Suicide. http://www.amsa.org/about/ppp/pas.cfm. Accessed January 10, 2008.

[x] Meier DE et al. A national survey of physician-assisted suicide and euthanasia in the United States. N Engl J Med. 1998 Apr 23;338(17):1193-201.

[xi] Emanuel EJ et al. The practice of euthanasia and physician-assisted suicide in the United States: adherence to proposed safeguards and effects on physicians. JAMA. 1998 Aug 12;280(6):507-13.

[xii] Ganzini L et al. Physicians' experiences with the Oregon Death with Dignity Act. N Engl J Med. 2000 Feb 24;342(8):557-63.

[xiii] Oregon Department of Human Services. Death with Dignity Act Year 9 Report. Tables 1 and 2. http://www.oregon.gov/DHS/ph/pas/ar-index.shtml. Accessed January 10, 2008.

[xiv] Miller LL et al. Attitudes and experiences of Oregon hospice nurses and social workers regarding assisted suicide. Palliat Med. 2004 Dec;18(8):685-91.

[xv] Ganzini L et al. Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act. JAMA. 2001 May 9;285(18):2363-9.

[xvi] Dobscha S et al. Oregon physicians' responses to requests for assisted suicide: a qualitative study.J Palliative Med. 2004 Jun;7(3):469-71.

[xvii] Battin MP et al. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups. J Med Ethics. 2007 Oct;33(10):591-7.