Medical Aid in Dying:
A Handbook for Engaging State Medical Associations
Doctors for Dignity, an initiative of Compassion & Choices, is a nationwide network of physicians who support patient autonomy at the end of life. We advocate for the right to choose from a full range of end-of-life options, including aid in dying. We speak out to increase awareness of end-of-life issues and change law and policy. To join Doctors for Dignity or to learn more, visit CompassionAndChoices.org/D4D.

SECTION I: Introduction / 02

SECTION II: Beginning the Conversation / 04

SECTION III: Data / 06

SECTION IV: Answering Concerns / 08

SECTION V: Steps for Engaging Your Medical Association / 10

SECTION VI: Endnotes / 16

SECTION VII: Resources / 17
Thank you for supporting the movement to improve care and expand patient choice at the end of life. This resource is designed to provide step-by-step information on engaging your state, local or specialty medical association toward supporting, or taking a position of neutrality, in the policy discussion over medical aid in dying.

While state and local medical associations do not always represent the majority of physicians, their official stances on health policies influence lawmakers. In fact, medical association opposition to medical aid in dying is one of the major barriers to enacting legislation in states where bills are advancing. That’s why it is so important for physicians who support patient choice at the end of life to speak out — to lawmakers, to the public and to colleagues.

The good news is, there is a reliable body of knowledge, accurate information and research drawing on the more than thirty years of aid-in-dying data and experience from Oregon, Washington, Montana and Vermont. As evidence-based and data-driven professionals, U.S. physicians must revisit medicine’s historic opposition to medical aid in dying, particularly in light of growing public demand for this end-of-life option.

A strong majority of Americans support medical aid in dying. Numerous polls from a variety of sources, both nationally and at the state level, demonstrate that medical aid in dying commands long-term, bipartisan majority support among American voters. In 2014, a Harris Interactive survey put national support for medical aid in dying at 74%, and a 2015 Gallup Poll that put it at 68%.
Among U.S. physicians, support for medical aid in dying is also on the rise. According to a Medscape poll of U.S. physicians in December 2014\(^1\), a majority (54%) of doctors support medical aid in dying under the kinds of circumstances that legislation being considered in more than half the states would allow.

The California Medical Association (CMA) was the first state medical association in the country to withdraw its opposition to medical aid in dying in the midst of an active policy debate. Shortly before successful passage of the End of Life Option Act, California Senator Lois Wolk, a co-author of the bill, called the CMA’s decision a “game-changer.” See a list of national medical and healthcare professional associations that have taken positions of support or neutrality on medical aid in dying on pages 18–20.

Even if you are not a member of your state, local or specialty society, you can influence the discussion. Medical associations are led by your colleagues who want to do what’s right both for doctors and for patients. You are in a position to influence their understanding about medical aid in dying and encourage them to reexamine their attitudes and opinions.

Along with other resources, this handbook offers guidance for talking about medical aid in dying with your colleagues and fellow society members and provides concrete steps you can take to help change your medical association’s policy.

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How each of us spends the end of our lives is a deeply personal decision, and that decision should remain with the individual as a matter of personal freedom and liberty, without criminalizing those who help to honor our wishes and ease our suffering. This law [The CA End of Life Option Act] will honor that freedom with appropriate protections to prevent any abuse.

– Senator Lois Wolk (D-California)
Beginning the Conversation

Medical aid in dying can be a controversial, emotionally charged issue, even as much of the controversy results from misinformation about the practice. You will talk to colleagues on both sides of the issue. Our goal is to emphasize factual information and first-hand experience with medical aid in dying so that your medical association can reach a position of support or neutrality while still respecting individual members’ opinions in the process.

How to Talk About Medical Aid in Dying

Sometimes, the medical community as well as the public still uses language infused with negative connotations when discussing medical aid in dying. Inaccurate or inflammatory terms such as “suicide” are not only factually incorrect, but detract from thoughtful discussion and deliberation.

What Is Medical Aid in Dying?

Medical aid in dying (sometimes called death with dignity) is a safe and trusted medical practice. It allows a terminally ill, mentally capable adult who has a prognosis of six months or less to live to request and obtain from her or his doctor, and self-ingest — if suffering becomes unbearable — medication that brings about a peaceful death. This is the accurate description of the practice, and its words signal the strict eligibility criteria and key safeguards.

Medical Aid in Dying Is Not “Assisted Suicide”

Factually, legally and medically speaking, it is inaccurate to equate medical aid in dying with assisted suicide. The Oregon, Washington, Vermont and California laws emphasize that:

“Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

Suicide is a tragic result of untreated reversible disease such as depression or addiction. Suicidal patients want to end their lives as a result of
impaired cognition and deficiencies of impulse control, and are most often alone and may use violent means. By contrast, patients seeking aid in dying, while sad, are not depressed and do not want to die. But they are dying from an irreversible and untreatable condition. Their goal is to end, rather than prolong, their end-of-life suffering. They are rational and their cognition is intact. They are connected to family and hospice; they are not alone. Suicide is usually traumatic for family members, whereas after a planned death, family members grieve in a normal fashion. In fact, many family members have described witnessing an aid-in-dying death as peaceful or beautiful.

The medical community has long rejected the term “homicide” for withdrawal of life-sustaining treatment. We must also reject the term “suicide” to describe this compassionate medical option at the end of life.

**Medical Aid in Dying Is Not “Euthanasia”**

Medical aid in dying is fundamentally different from euthanasia because in the act of euthanasia the physician — not the dying person — acts to cause the death of the patient. Compassion & Choices does not support euthanasia, which is illegal throughout the United States. With medical aid in dying, the patient must self-administer the medication and therefore always remains in control.

**Doctor/Patient Relationship**

Patient-centered care puts the patient’s priorities and values first. Medical aid in dying is one option at the end of life and exists within the shared decision-making context of the doctor-patient relationship. As advocates for patients, we collaborate, advise and guide patients to make informed decisions by understanding the risks and benefits of any treatment in conjunction with the patient’s goals of care. Patient self-determination includes the freedom to choose from the full range of options at the end of life, including medical aid in dying.

**Ethical Considerations**

Medical aid in dying raises ethical questions for some physicians and opinions can differ. While some physicians have religious objections to a process that intentionally shortens a life, others willingly support their patients’ choices and provide medical aid in dying to shorten the duration of suffering. In every state where medical aid in dying is currently authorized, physicians, pharmacists, other health professionals and healthcare institutions may decline to participate on personal, religious or moral grounds.
Each year, the Oregon Health Authority and the Washington State Department of Health release reports summarizing aggregated, non-identifying data collected on the practice of medical aid in dying in those states as required by statute. You can find annual reports dating back to 1999 for Oregon and 2009 for Washington.

Below are a few highlights from the reports:

**Who Uses Medical Aid in Dying?**

To be eligible for medical aid in dying, an adult must be terminally ill with a prognosis of six months or less to live and mentally capable of making their own informed healthcare decisions. The dying person must also be able to self-administer the medication.

**Oregon Death With Dignity Act 2015 Data Summary:**

- The most common diagnoses for patients using medical aid in dying are cancer (72%), ALS (6%), and heart and lung diseases (7%).
- Most patients who use medical aid in dying are over the age of 65 (78%) insured (99%) and enrolled in hospice (92%).
- The majority involve their families in the process and die at home (90%).
- Approximately 1/3 of patients who obtain a prescription for the medication do not use it.

**How Many Doctors Participate?**

Data show the number of physicians who participate in medical aid in dying continues to increase in both Oregon and Washington. The number of prescriptions written per physician per year ranges from 1 to 10.
Why Do Patients Choose Medical Aid in Dying?

Suffering can take many forms. The reasons most commonly given for choosing medical aid in dying and every year⁹ include:

» Loss of autonomy.
» Less able to engage in activities that make life enjoyable.
» Loss of dignity.
» Loss of control of bodily functions.
» Unrelenting pain.
SECTION IV: Answering Concerns

Fear of Abuse

Medical aid in dying is an accepted practice with well-established protocols for physicians\textsuperscript{10}. Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less to live are able to request and obtain aid-in-dying medication. Significantly, the prestigious, peer-reviewed Journal of Palliative Medicine published clinical criteria in 2016\textsuperscript{11} for medical aid in dying that physicians use to ensure that the practice meets the highest standards of medical care.

Early fears of abuse of the elderly, disabled or other disenfranchised groups have not materialized. In the more than 30 combined years of medical aid in dying in the authorized states, there has not been a single instance of documented abuse. A report published in the Journal of Medical Ethics about the Oregon Death With Dignity Act concluded: “Rates of assisted dying in Oregon showed no evidence of heightened risk for ... the physically disabled or chronically ill\textsuperscript{12}.” Disability Rights Oregon, the nonprofit charged with protecting the rights of citizens with disabilities in that state, has not received a single complaint of exploitation or coercion of a disabled person since the law took effect in 1997.\textsuperscript{13}

Core safeguards ensure people are protected:

» The requesting adult must be terminally ill with a prognosis of six months or less to live.

» The adult must be capable of making their own healthcare decisions and making an informed decision.

» The physician must make sure the patient is fully informed of all other available options.

» A consulting physician must verify both the patient’s prognosis and mental capacity.
In addition:

» The terminally ill adult must be free from undue influence or coercion.
» Two witnesses need to sign the request form attesting to the voluntary nature of the terminally ill adult’s request for aid in dying.
» The terminally ill adult must be able to self-administer the medication.
» The physician must offer their patient multiple opportunities to rescind the request for aid-in-dying medication.
» No guardian, conservator, power of attorney of health care agent or proxy may request medical aid in dying on behalf of the dying person.

The Impact on Hospice Care

In Oregon, end-of-life care has improved overall since implementation of medical aid in dying, in large part due to the dialogue the Death with Dignity Act encourages between people and their doctors. Hospice referrals are up, as is the use of palliative care. Oregon now has the lowest rates of in-hospital deaths and the highest rates of at-home deaths in the nation, and violent suicide among hospice patients has virtually disappeared.

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Until I retired from the Oregon Hospice Association in 2008, I met with frontline hospice workers regularly to discuss their experiences. Whether they supported or opposed medical aid in dying, they unanimously agreed that conversations about death and dying improved significantly after the law’s implementation. It literally put the topic on the table.

– Ann Jackson, former CEO, Oregon Hospice Association
Sacramento Bee op-ed, 12/9/15

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SECTION V:
Steps For Engaging Your Medical Association

STEP 1.

Become a Member of Your State Medical Association

Perhaps more than any other professional or civic group, state medical associations (SMA) have an enormous impact on legislation relating to health and medicine. Their lobbyists work closely with lawmakers and their views are sought, especially on controversial issues. Persuading your medical association to take a supportive or neutral position toward medical aid in dying will significantly improve the chances that your state will be the next to authorize aid in dying. You will have the greatest ability to impact change within your state medical association once you become a member. Like any organization that relies financially on dues, leaders within your SMA respond to the will of their membership in establishing positions and priorities.

Membership rates vary and some associations offer reduced dues for certain groups such as students, residents, or retired physicians. Membership dues are tax deductible. Corollary benefits may include:

» Up-to-date information about regulatory and legislative changes that could affect your practice.
» Educational programs from medical experts, including CME opportunities.
» Discounts on professional products and services.
» Weekly updates on the latest medical news and best practices.
» A network of colleagues for social and professional support.
» Strong representation at your state capitol with the opportunity to have an impact on the policy issues that affect the practice of medicine and public health.
» Opportunities to develop your leadership skills by serving on committees such as medical-legal affairs, ethics, health care access, finance and delivery, quality or public health.

» In most cases, when you join your state medical association you also join your local society which is a component of the state society and represents physicians from a geographic area.

Many of the same principles apply to working with your specialty association.
Find Out Your Association’s Current Position

After you join your SMA, you’ll first need to determine your association’s current policy on medical aid in dying, if one exists. This information may be available on your SMA website or from any officer or staff member. In some cases, SMA’s may defer to the American Medical Association’s (AMA) policy on “assisted suicide,” which has not been updated since 1997.

The California Medical Association and the Oregon Medical Association are the state associations that have taken a position of neutrality; several local societies have, too. In 2016, Colorado, Minnesota, Maryland and other state associations have been reviewing the data in order to update their policies.

Learn Your Association’s Process for Changing or Adopting Policies

Each SMA is run a little differently. Many have a house of delegates where members meet annually to consider policy resolutions introduced by members. A reference committee holds an open discussion about the proposed resolution and a vote is taken that will determine whether the policy is adopted, rejected or referred for more study.

Ultimately, in many cases, the Board of Trustees will decide what course of action is taken on a resolution and the timeline for action. SMA Committees may be asked to study the proposed resolution and may make a recommendation to the Board.

Review the rules and procedures of your SMA which may be available online or from a policy manual. Consider asking a colleague who understands the ins-and-outs to give you an overview. As you reach out to learn about society policy and procedures, you will also build relationships you can leverage in the future.

Assess Current Attitudes About the Issue

A list of your SMA’s Board of Trustees and committee members is usually available on the association’s website. Start with colleagues you know and begin a conversation to determine their position and those of other board members. SMA leaders represent their component societies, so your local society board member should be very willing to talk with you.

If you prefer, you can also draft an email to begin the conversation. If your state legislature has active medical aid-in-dying legislation, determine the SMA’s position and whether individual SMA leaders have specific concerns.
Once you have received a response from each of your correspondents, consider the following as a next step:

» For those who indicate that they oppose medical aid in dying or need more information, send them additional information from authoritative sources listed in the ‘Resources’ section on page 17.

» For those who already support patient choice and medical aid in dying for terminally ill patients who are suffering, consider asking for their support as you try to raise the visibility of the issue within the SMA.

**STEP 5.**

**Attend a Committee Meeting (Better Yet, Join One)**

Because committees have time to explore issues in more detail, consider attending a meeting of your SMA’s ethics or policy committee to introduce the discussion. Committee staff can provide members with data and research to inform the conversation. Winning the support of the ethics or policy committee is a key first step towards revising your SMA’s position on aid in dying.

**STEP 6.**

**Attend Your Local, Component Society Meeting**

Component medical societies, as organizational members of the state organization, can influence policy. Get to know the leaders of your local society and attend a meeting to learn about local priorities. It may be easier to influence your local society before approaching the state society. The steps below will also apply to your local society.

**STEP 7.**

**Suggest an Educational Forum on Medical Aid in Dying**

Now that you understand how some of your colleagues in leadership feel about medical aid in dying, you are likely to find a mix of those in favor, those opposed, and those who want to learn more. One great way to move the conversation forward is to request an educational forum for members. SMAs are turning to policy forums as a way to educate and involve their members in major policy debates. This is especially important in the case of aid in dying because of the lack of accurate information — and the abundance of misinformation.

Compassion & Choices can help you locate experts to present information to your SMA. For example, Dr. David Grube, Compassion & Choices’ National Medical Director, can present “A Physician’s Perspective on Medical Aid in Dying” at no cost to the organization. A family physician with nearly two decades of experience in the medical practice of aid in dying, Dr. Grube will provide your colleagues with current, accurate data as well as insights from clinical experience.
Ask for a Survey of Members

Because medical aid in dying can be a controversial issue, SMAs may be reluctant to take a position. Surveying SMA members can help to reassure leaders to take up the aid-in-dying issue, adopt a policy on it or withdraw opposition. Most SMA engage an outside contractor to conduct and evaluate the survey data, but make sure you can participate in the survey development process, or review the survey before it is distributed.

The language and wording of the survey will have an impact on the outcome, so be sure that the language is neutral and accurate. For example, instead of asking “Do you support physician assisted suicide?” the survey could ask “Should terminally ill, mentally capable patients have the option to receive aid-in-dying medication in cases of intractable pain or suffering?” It is also important to clarify that physician aid in dying is not euthanasia (a doctor injecting a patient with a lethal dose) which is illegal in every state. In addition, aid in dying is distinct from palliative sedation, the double effect and voluntary withdrawal of nutrition and hydration.

A good survey will assess members’ personal level of support and their preferred policy position for the organization. If possible, include the SMA’s current policy position and published articles on aid in dying. The survey should ask explicitly whether members prefer that the SMA officially oppose aid in dying, officially support aid in dying, or neither support nor oppose. If there is a range of opinions on aid in dying, neutrality may be the most diplomatic stance for the SMA to adopt.

Finally, it is also valuable to elicit members’ concerns should legislation be introduced. Again, watch for biased language. Here are a few examples of concerns physicians have expressed: pressure from families or insurers to offer aid in dying instead of treatment; slippery slope to euthanasia; legal protections for physicians; ethical concerns.

In 2016, The Colorado Medical Society (CMS) and the Maryland State Medical Society (MedChi) surveyed their members to determine their attitudes and preferred policy position in response to legislative campaigns in their states. In both instances, a clear majority of respondents supported medical aid in dying as an end-of-life option and neutrality as the preferred medical society position.

**CMS:** 56% support medical aid in dying / 72% prefer neutrality

**MedChi:** 54% support medical aid in dying / 60% prefer neutrality
Two Possible Paths to Success

Based on what you’ve learned about your organization’s process for adopting or changing policy, you can determine which of the next paths to take.

Path A: Introduce a Resolution at the Annual Meeting

Many SMAs meet annually to determine policy priorities and conduct other business. Component societies elect delegates to attend and represent their interests at the annual meeting. Any delegate can introduce a resolution. Volunteer to serve as a delegate or ask your component society delegate to introduce a resolution.

Path B: Launch a Grassroots Campaign for Change

If the SMA Board is empowered to make policy decisions on its own, the next step will be to recruit like-minded colleagues to contact board members individually. A personal conversation, even if by phone, is preferred, but email messages are efficient and also effective.

» Start with the board or committee member who represents your component society; ask them to advocate for the policy change on medical aid in dying.

» Identify colleagues willing to support your effort.

» Draft a sample email message colleagues can send to board members expressing support for the policy change.

» Submit a letter to the editor of your SMA’s monthly publication about why it is time to reconsider this policy.

» Attend other component society meetings to engage in a discussion about the need for policy change.

Other Professional Societies

If you are already active in your specialty society, that can be another avenue for influencing change. For example, the California Academy of Family Physicians adopted a policy of neutrality, then influenced the California Medical Association to do the same.

The steps above apply to your specialty society as well. Start with gathering information by speaking to leaders, learn the process, then determine the best next step.
The California Chapter of the American Academy of Family Physicians

by Catherine Sonquist Forest, M.D., M.P.H., Clinical Assistant Professor of Medicine at Stanford Health Center

I first became aware that there would be legislation to authorize medical aid in dying when I was meeting with the California State Senator representing my district, Senator William Monning. He has been a supporter of family physicians and an advocate for patient rights for years. I asked him how I could best assist – he asked me to find out what the current California Chapter of American Academy of Family Physicians (CAFP) and California Medical Association (CMA) policies were.

When I found out that the only CAFP policy was archaic (referring to Physician Assisted Suicide and Euthanasia) and that public opinion in our state, as well as physician opinion across the nation, had moved to a supportive majority, I began to mobilize to submit a new resolution to the CAFP.

I contacted our CAFP to request that Senator Monning be able to address the all-member all-advocacy (AMAM) directly since this was an issue with important consequences for our practices, should it pass. My relationship with his office led them to hold the speaking time in his schedule and the CAFP graciously created a slot at the AMAM — an honor for our physicians to be directly addressed by the Senate Majority Leader!

Since we had missed the deadline to submit a resolution to the AMAM meetings, it was submitted directly to the board. Ultimately, I contacted members from multiple counties to sign on as co-authors. In addition, a colleague who sits on the Board of the CAFP opted to sign as author (pulling her off the vote but making a point). I stayed in close contact with CAFP staff throughout. Ultimately, the Board opted to go to a neutral position after consulting with Oregon, Washington, and likely, the CMA.

Simultaneously, I sent a copy of the resolution directly to our delegates and the medical students at the CMA. Our resolution and research was used to launch the effort that resulted in the CMA’s decision to withdraw its opposition and take a neutral stance.


9) ibid.

10) Clinical Criteria a for Physician Aid in Dying, David Orentlicher, MD, JD, Thaddeus Mason Pope, JD, PhD, and Ben A. Rich, JD, PhD, JOURNAL OF PALLIATIVE MEDICINE Volume 19, Number 3, 2016. http://online.liebertpub.com/doi/pdf/10.1089/jpm.2015.0092

11) ibid.


13) Correspondence with Compassion & Choices, available on request.

SECTION VII: Resources

Studies, Articles, and More Information

Institute of Medicine:
Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

Oregon Public Health Authority:
Death With Dignity Act Annual Reports and Resources
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct

Journal of Medical Ethics:
www.jme.bmj.com/content/33/10/591

Journal of Palliative Medicine:
Clinical Criteria for Physician Aid in Dying
http://online.liebertpub.com/doi/full/10.1089/jpm.2015.0092

Annals of the New York Academy of Science:
Oregon’s Experience With Aid in Dying: Findings From the Death With Dignity Laboratory

AMA Position on “Physician Assisted-Suicide”

Doctors for Dignity, an initiative of Compassion & Choices, can provide information and the tactical support. Contact DoctorsForDignity@CompassionAndChoices.org
Healthcare Professional Associations Recognize Medical Aid in Dying

A growing number of national and state organizations representing healthcare professionals have endorsed or taken a neutral position on medical aid in dying as an end-of-life option for mentally capable, terminally ill adults. The complete statements also express Compassion & Choices’ view that terminally ill people deserve information about and access to the full range of end-of-life options, including hospice and palliative care, terminal sedation, voluntarily stopping eating and drinking (VSED) and medical aid in dying.

The California Medical Association (CMA)
40k+ members
Promotes the science and art of medicine, the care and well-being of patients, the protection of the public health and the betterment of the medical profession.

“As physicians, we want to provide the best care possible for our patients. However, despite the remarkable medical breakthroughs we’ve made and the world-class hospice or palliative care we can provide, it isn’t always enough. The decision to participate in the [California] End of Life Option Act is a very personal one between a doctor and their patient, which is why CMA has removed policy that outright objects to physicians aiding terminally ill patients in end of life options. 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.”

The American Medical Student Association (AMSA)
30k+ members
Committed to improving healthcare and healthcare delivery; improving medical education; involving its members in the social, moral and ethical obligations of the profession of medicine.

“The American Medical Student Association: 1. SUPPORTS passage of aid-in-dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death. Aid in dying should not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide.”
American Public Health Association (APHA)
50k+ members
Committed to improving health of the public and achieving equity in health status.

“The American Public Health Association (APHA) has long recognized patients’ rights to self-determination at the end of life and that for some terminally ill people, death can sometimes be preferable to any alternative. Accordingly, the American Public Health Association: Supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA are in place. Rejects the use of inaccurate terms such as “suicide” and “assisted suicide” to refer to the choice of a mentally competent, terminally ill patient to seek medications to bring about a peaceful and dignified death.”

American Medical Women’s Association (AMWA)
4k+ members
Physicians, residents, medical students and healthcare professionals dedicated to advancing women in medicine and improving women’s health.

“1. AMWA supports the right of terminally ill patients to hasten what might otherwise be a protracted, undignified or extremely painful death. 2. AMWA believes the physician should have the right to engage in practice wherein they may provide a terminally ill patient with, but not administer, a lethal dose of medication and/or medical knowledge, so that the patient can, without further assistance, hasten his/her death. This practice is known as aid in dying. 11. AMWA supports the passage of aid-in-dying laws that empower mentally competent, terminally ill patients and protect participating physicians, such as that passed in Oregon, the Oregon Death With Dignity Act.”
The American College of Legal Medicine (ACLM)
700 members
Professional society concerned with addressing issues that arise at the interface of law and medicine.

“BE IT RESOLVED: That the ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified or painful death, provided, however, that such person strictly complies with law specifically enacted to regulate and control such a right; and BE IT FURTHER RESOLVED: That the process initiated by a mentally competent, though terminally ill, person who wishes to end his or her suffering and hasten death according to law specifically enacted to regulate and control such a process shall not be described using the word “suicide”, but, rather, as a process intended to hasten the end of life.”

American Academy of Hospice & Palliative Medicine (AAHPM)
5k+ members
Organization for physicians, nurses and others specializing in hospice and palliative medicine.

“Excellent medical care, including state-of-the-art palliative care, can control most symptoms and augment patients’ psychosocial and spiritual resources to relieve most suffering near the end of life. On occasion, however, severe suffering persists; in such a circumstance a patient may ask his physician for assistance in ending his life by providing physician-assisted death (PAD). PAD is defined as a physician providing, at the patient’s request, a lethal medication that the patient can take by his own hand to end otherwise intolerable suffering. The term PAD is utilized in this document with the belief that it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation physician-assisted suicide. AAHPM takes a position of ‘studied neutrality’ on the subject of whether PAD should be legally regulated or prohibited, believing its members should instead continue to strive to find the proper response to those patients whose suffering becomes intolerable despite the best possible palliative care. Whether or not legalization occurs, AAHPM supports intense efforts to alleviate suffering and to reduce any perceived need for PAD.”
Sample Email

Dear colleague [NAME]

As a member of the [NAME OF MEDICAL ASSOCIATION/ACRONYM], I believe it is time to rethink our position with regard to medical aid in dying. As of 2016 five states authorize the practice of medical aid in dying and support for the option is growing. With more than 30 cumulative years of data and first-hand experience from hundreds of physicians in five states, there is now ample information to warrant a full review of the facts.

[ACRONYM] prides itself on being a scientific and evidence-based professional association. In that spirit, I am respectfully requesting a comprehensive study and reexamination of its long-standing opposition to medical aid in dying. Would you be willing to meet or speak with me by phone?

Thank you for considering this request. With your advice and assistance, I look forward to advancing this conversation with our colleagues.

Thanks and warm regards,
[YOUR NAME]

Biography

David Grube, M.D. National Medical Director
Compassion & Choices

Dr. David Grube retired after practicing family medicine for 35 years in Philomath, Oregon. He graduated from the University of Oregon Medical School and has been a leader in the Oregon Academy of Family Physicians (OAFP). He was appointed to the Oregon Board of Medical Examiners in 2001, and served seven years (two years as president). He was chosen OAFP Family Physician of the Year in 1986 and Oregon Medical Association Doctor Citizen of the Year in 2009. He currently serves as the Interim Director for the Oregon Medical Board and Medical Director for Compassion & Choices. Dr. Grube has practiced medicine in Oregon since passage of its Death with Dignity Act. He is an expert on how its implementation has improved care for terminally ill people in Oregon.
Model Resolution

Whereas, five states now authorize medical aid in dying, including Oregon, Washington, Montana, Vermont and California; and

Whereas, “medical aid in dying” describes a medical practice defined by established standards of care, which enables a mentally capable, terminally ill adult to obtain a prescription for medication, which the patient may choose to self-administer, in the face of unbearable suffering, to advance the time of an approaching death[i]; and

Whereas, medical aid in dying has been successfully implemented in Oregon through its 1997 Death with Dignity Act[ii]; and since implementation, the quality of end-of-life care, pain management, and the use of hospice have all greatly improved[iii]; and

Whereas, a body of scholarly research on medical aid-in-dying practice in Oregon[vi] and Washington[vii] demonstrates the utility and safety of the practice in upholding a patient's right to self-determination; and

Whereas, Gallup polls have shown that 7 out of 10 Americans agree that “doctors should be allowed by law to end a patient's life by some painless means if the patient and his or her family request it[viii];” and

Whereas, American Medical Association House of Delegates member organizations and other respected public health organizations have adopted neutrality or positions in support for medical aid in dying, including the American Medical Women’s Association[ix], the American Medical Student Association[x], the American Public Health Association[xi], and the California Medical Association[xii]; and

Whereas, a Medscape survey of physicians in 2014 indicates that 54% of U.S. Physicians agree that “assisted suicide” should be allowed, another 15% percent agree it should be allowed in some cases, reflecting an increase of 8 percentage points since 2010[xiii]; and

Whereas, more than 20 states are currently considering legislation to authorize medical aid in dying[xiv]; therefore be it

RESOLVED, that [organization] withdraw opposition to medical aid in dying pending a full review of 1) data collected from the states that currently authorize aid in dying, and 2) input from physicians who have provided medical aid in dying to qualified patients; and therefore, be it further

RESOLVED, that the [organization] Council of Judicial and Ethical Affairs, provide a report and recommendation at the Annual Meeting in [year].
Footnotes for Model Resolution


[vi] Barbara Coombs Lee, Oregon’s experience with aid in dying: findings from the death with dignity laboratory, Ann NY Acad Sci, ISSN 0077-8923, 2014

[vii] Loggers, et al., Implementing a Death with Dignity Program at a Comprehensive Cancer Center, NEJM, 368;15 April 11, 2013


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