Ethical Reflections on Medical Aid in Dying: A Thoughtful Conversation

Karen G. Gervais, Ph.D.
Don C. Postema, Ph.D.
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Presenter

Karen G. Gervais, Ph.D.

• Director, Minnesota Center for Health Care Ethics
• Visiting Professor of Philosophy, St. Olaf College
• Dr. Gervais has no relevant conflict of financial interests to disclose

Presenter

Don C. Postema, Ph.D.

• Program Director of Medical Bioethics, HealthPartners
• Ethicist-in-Residence, Gillette Children’s Specialty Healthcare
• Emeritus Professor of Philosophy, College of Arts and Sciences, Bethel University
• Dr. Postema has no relevant conflict of financial interests to disclose, unless you think “paid ethicist” is a contradiction.
Overview

1. What motivates current changes in attitudes, law, and moral argument regarding medical end-of-life practices?
2. Recent developments in MAiD in the US and Canada
3. The moral arguments for and against PAD
4. Reflections on law, morality, and healthcare practices related to medical aid in dying

How We Die: Why the Discussion Now?

1. Aging of the population.
2. What are the limits of “Medical Aid in Living”? The harms of overtreatment.
4. Substantial health care costs at end-of-life (60% of Medicare spending during the last 6 months of life occurs in the final month; personal financial stressors).
5. Resurgence of political libertarianism.

The Silver Tsunami

It is estimated that by 2050, people over 65 will represent more than 20 percent of the population, up from 15 percent today...about 40 million additional Medicare-age patients flooding the already beleaguered U.S. healthcare system.

When older persons are asked “What’s your number one priority?”, they almost always respond that it’s to maintain their independence.

The “Culture of Medical Progress”

“Interest in assisted death comes, in part, from a culture of medical progress that does not know how to stop extending our lives. Medicine is particularly good in extending our dying—and much of that extension is in old age. I believe that the care of the elderly is rapidly coming to be a crisis for many countries, rich and poor. Inevitably, this crisis has also meant a growing attraction to assisted death.”


Growing Awareness of Overtreatment

But what do older patients really think about overuse? The University of Michigan’s National Poll on Healthy Aging (NPHA) recently surveyed 2,007 US adults age 50 to 80 years. Only 14 percent of poll respondents agreed that more medical treatment is usually better. In contrast, more than half (54 percent) felt health care providers often order medications, tests, or procedures that patients don’t really need. One in six (17 percent) reported that in the last year a health care provider had recommended a medication, test, or procedure that they felt they did not need.

• https://www.healthaffairs.org/do/10.1377/hblog20180308.855164/full

Health Care Advance Directives: The Prospects of Choice

In lives marked by diminishing cognitive capacities, what is the role of advance healthcare directives? What can others do for and to us to carry out our wishes when we’re no longer capable of expressing those wishes?

...dying is no longer something that happens to you, but something you do.

• Margaret Pabst Battin, 1998.
Initial Distinctions

- Euthanasia
  - Voluntary
  - Passive and active
- Physician-Assisted Dying (PAD)
- Physician-Assisted Suicide (PAS)
- Medical Aid in Dying (MAiD)
  - A continuum from palliative to hospice care
  - A variety of agents and their roles

Legal and Political Discourse

- “Death with Dignity” (Oregon, 1997 and Washington, 2009)
- “Patient Choice and Control at the End of Life Act” (Vermont, 2013)
- “Compassionate Care Act” (2016 Minnesota bill)
- “End-of-Life Option Act” (California, 2016, Colorado, 2016 and 2017 Minnesota bill)

In U.S., Support Up for Legal Doctor-Assisted Suicide (Gallup Poll, May 7, 2017)
Conventional medical ethics and the law draw a bright line distinguishing the permitted practice of withdrawing life-sustaining treatment from the forbidden practice of active euthanasia by means of a lethal injection. When clinicians justifiably withdraw life-sustaining treatment, they allow patients to die but do not cause, intend, or have moral responsibility for, the patient’s death. In contrast, physicians unjustifiably kill patients whenever they intentionally administer a lethal dose of medication.
We argue that the differential moral assessment of these two practices is based on a series of moral fictions—motivated false beliefs that erroneously characterize withdrawing life-sustaining treatment in order to bring accepted end-of-life practices in line with the prevailing moral norm that doctors must never kill patients. When these moral fictions are exposed, it becomes apparent that conventional medical ethics relating to end-of-life decisions is radically mistaken.

Miller, Truog, and Brock, “Moral Fictions and Medical Ethics,” *Bioethics* 24:9 (2010)

The Law of the Land: PAS is a State Matter, Not a Federal Constitutional Right

“I agree that there is no generalized right to ‘commit suicide.’ There is no dispute that dying patients...can obtain palliative care, even when doing so would hasten their deaths...The difficulty in defining terminal illness and the risk that a dying patient’s request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.”


The “Laboratory of the States”

“the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States.”

O’Connor, Cruzan v Missouri, 1990

“There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure.”

O’Connor, Vacco v. Quill, 1997
What Hath the States Wrought?

PAS is now legal in 6 states
- Oregon (1997)
- Vermont (2013)
- Colorado (2016)
- Montana (2009, Court ruling)
- Washington, DC (2017)
- California (2016)
- Washington (2009)

More than 1 in 6 Americans (18%) now have a legal PAS option

PAS History: Oregon
Oregon: End-of-Life Concerns

Preliminary Conclusions (Oregon and Washington)

1. A relatively small percentage of deaths occur under the provisions of PAS, and there has been no dramatic increase in this number.

2. The demographics of those using PAS:
   - Relatively well-educated (2/3 have some college)
   - Mainly white patients with health insurance
   - Accompanied by palliative and hospice care
   - Cancer, neuro-degenerative diagnoses primary
Preliminary Conclusions (Oregon and Washington)

3. The most often cited reasons for seeking PAS:
   - Fear of loss of control (autonomy)
   - Loss of meaning and dignity
   - Not intractable pain or suffering

4. Extrapolations to other states and populations are possible yet challenging

The Canadian Supreme Court Steps In

• In February, 2015, the Court ruled that “the prohibition on physician-assisted dying infringes on the right to life, liberty, and security of the person in a manner that is not in accordance with the principles of fundamental justice.”
  • Carter v. Canada, 2015
• A patient “may have a grievous and irremediable condition that causes unendurable suffering that is intolerable to the individual in the circumstances of his or her condition.”

The Canadian Government Responds

“...permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other;
Whereas it is desirable to have a consistent approach to medical assistance in dying across Canada....”
• Statutes of Canada 2016, Bill C-14, Preamble
Provisions of the Bill

The bill passed on June 17, 2016 legalizes physician-assisted death and requires that a patient must:
• Be a Canadian citizen or permanent resident
• Be a mentally competent adult 18 or older
• Have a serious and incurable disease, illness or disability
• Be in an advanced state of irreversible decline, with enduring and intolerable suffering.


Additional Provisions of Note

• Includes both physicians and nurse practitioners.
• Includes both administering a substance to cause death and prescribing a self-administered substance to cause death.
• A “grievous and irremediable medical condition” which causes unendurable physical or psychological suffering is a prerequisite.
• The patient’s “natural death has become reasonably foreseeable...without a prognosis necessarily having been made as to the specific length of time they have remaining.”

(Statutes of Canada 2016, Bill C-14)

What’s Next in Canada?

• Developing common reporting requirements for all provinces
• Mandated all provinces, in the next two years, to review issues related to PAD requests:
  1. Made by mature minors
  2. Made in advance of loss of capacity
  3. Made by individuals with mental illness as their sole underlying condition.
PAS: Alternative Moral Arguments

- Focal point of debate: compelling “hard case” (tightly defined, suffering requirement)
- Recent pt eligibility criteria include terminal illness, adult, decisional capacity AND physician eval of capacity and reasons for, voluntariness of, pt request; exclusion of depression, coercion; informed understanding of alternatives to PAS —“Clinical Criteria for Physician Aid in Dying” (Orentlicher, Pope, Rich, et al), 2012

How we will proceed

- PAS can be evaluated ethically
  - On an individual case-by-case basis
  - As an element of EOL societal policy
- Format:
  - Individual case: Arguments Con and Pro
  - Social policy inclusion of PAS option: Pro and Con
Individual Case: PRO (1)

• Assume: Hard case and our established ethical principles
• AUTONOMY: PAS is a justifiable extension of pt’s choice to control manner and timing of death
• JUSTICE: pt in hard case should have same option to choose death as, e.g., pt who refuses life-prolonging ventilator

Individual Case: PRO (2)

• BENEFICENCE and NONMALEFICENCE:
  – Physician has duty “to comfort always” – a duty of MERCY to prevent a worse death for those overmastered by disease
  – Physicians’ knowledge, skills, and authority to dispense means for merciful death uniquely qualify them to assess, evaluate, inform, prescribe and guide pts who request PAS
  – Physician expertise protects against unjustified exceptions to societal rules

Individual Case: PRO (3)

• Extensions of ethical principles of patient autonomy and physician beneficence/nonmaleficence are ethically justifiable
• Hard cases are morally exceptional and require moral courage:
  – Physicians may make morally justified exceptions to standing moral rules against assisting suicide
• Hard cases should be managed in privacy of physician/patient relationship
Individual Case: CON (1)

- Sanctity of life principle: every human life has inherent value and right to protection
- Therefore, the deliberate taking of a human life (by suicide or killing) cannot be morally justified (except, e.g., in self-defence)
- Prohibiting physician assistance in suicide is required in order to minimize suicides

Individual Case: CON (2)

- Sanctity of life and opposition to suicide
  - Philosophical roots (Kant: suicide a moral contradiction)
  - Religious roots (God’s gift and decision)
  - Pragmatic perspective: Absolute rule strengthens presumption against suicide/killing and maximizes chances of only highly exceptional, compelling violations

Individual Case: CON (3)

- “PAS is fundamentally inconsistent with the physician’s professional role” (AMA)
- Physician as healer, trusted for commitment to restore health or provide comfort without the express intent to help pt end life, is core to physician professionalism
- Integrity of physician/patient relationship rests on this concept of professionalism
Individual Case: CON (4)

- PAS as practiced is now driven by pts wanting to choose the time and manner of death as an extension of right of self-determination
- Physician professionalism is undermined by being service providers accommodating pts self-determining choices to end life
- “The physician’s role is to maintain solidarity with those whose health is diminished.”
  
  Yang and Curlin, JAMA, 2016

Social Policy Alternatives: PRO and CON (1)

- EOL Policy Options: we have a choice
  - Policy 1: Status Quo EOL Options (in MN)
    - Excludes (by prohibiting) PAD (PAS and AE)
  - Policy 2: Expansion of EOL Options
    - Includes (by legalizing) PAS

- What do these policy options include?

Societal EOL Policy Options (2)

- Policy 1: Status Quo EOL Options
  - Allowing to die (passive euthanasia)
    - foregoing or discontinuing life-prolonging treatments (e.g., implanted cardiac device, vent, dialysis, ANH)
  - Aggressive pain and/or symptom management
  - Hospice and palliative care
  - Palliative sedation (when deemed appropriate)
  - Voluntarily stopping eating and drinking (VSED)

  "Clinical Criteria for Physician Aid in Dying" (Orentlicher, Pope, Rich, et al), 2012
Societal EOL Policy Options (3)

- Policy 2: Expansion of EOL Options (+ PAS)
  - Allowing to die (passive euthanasia)
    - foregoing or discontinuing life-prolonging treatments (e.g., implanted cardiac device, vent, dialysis, ANH)
  - Aggressive pain and/or symptom management
  - Hospice and palliative care
  - Palliative sedation (when deemed appropriate)
  - Physician assisted suicide
  - Voluntarily stopping eating and drinking (VSED)

Societal EOL Policy Options (4)

- For ethical reasons, should we stick with Policy 1, or adopt Policy 2, legalizing PAS?
- The ethical considerations relevant to a policy decision vary dramatically from those relevant in the compelling hard case.
- What are ethical implications of adding PAS (for the hard cases only) to our societally approved “cafeteria” of EOL options?

PRO Policy 2 (1)

- PRO Policy 2: Legalization of PAS
  - Secures essential clarifications of scope of patient autonomy and physician authority/mercy
  - Protects patients’ right to choose in hard cases, and physicians’ freedom from liability in rendering merciful assistance
  - Offers the only humane way out in hard cases
  - Permits full exercise of pt’s right to choose among EOL options, countering medicalization of EOL experience
CON Policy 2 (1)

• CON Policy 2: Slippery Slope Arguments
  – Our existing EOL options (Policy 1) are sufficient as they stand
  – Legalization of PAS portends bad consequences for us as a society, including erosion of professionalism

• 2 Types of SS of Concern
  – #1: Conceptual Slippery Slope
  – #2: Empirical Slippery Slope

CON Policy 2: Conceptual SS (1)

• Autonomy and mercy principles are inherently open to extension to other compelling cases
• Autonomy and justice principles require expanding eligibility for pts unable to self-administer lethal prescription
• Mercy principle: limiting PAS to pts who can currently request, consent, and self-administer is ethically indefensible and unjust

CON Policy 2: Conceptual SS (4)

• ADs, agents, and recognized surrogates should be allowed to represent the advance statements, current interests, and values of terminally suffering, decisionally incapacitated pts
• Autonomy, nonmaleficence, justice
CON Policy 2: Conceptual SS (5)

• Conceptually, autonomy/mercy as principled basis for PAS, suggest extension to active euthanasia, a further type of PAD, for terminally suffering, decisionally and physically incapacitated patients.
• Legalization permits gradual, principled extension of criteria for compelling cases, and enlargement of physician role.

CON Policy 2: Empirical SS (1)

• Prohibitions against suicide and physician assistance in patient’s death play essential social roles.
• Principled individual exceptions in hard case may be justified, but Policy 2 removes deterrents against harms to vulnerable persons and groups.
• Conceptual SS exacerbates this concern.

CON Policy 2: Empirical SS (2)

• Vulnerable persons/groups include elderly, poor, decisionally compromised, disabled.
• Demographic changes underway are substantial, so harm potential great.
• Mental health infrastructure and reimbursement inadequate and flawed.
• Coverage arrangements are compromised, at risk, unclear.
CON Policy 2: Empirical SS (3)

• Physician expertise needed: determining eligibility, decisional capacity, screening for untreated depression, assessing and validating pt’s reasons for request, assuring voluntariness, exploring pt’s circumstances for coercion or undue influence of social/economic factors, informing and assessing pt understanding of alternatives, prescribing lethal meds, and guiding pt in use

CON Policy 2: Empirical SS (4)

• Physicians are not sufficiently trained in decisional capacity evaluation, communication, palliative care options, geriatric care, mental health, depression to field PAS requests
• Our work force is not ready.
• We cannot assure that PAS requests will be managed responsibly, so we should not legalize.

CON Policy 2: Empirical SS (5)

• Solution for hard cases (narrowly defined or more broadly defined based on autonomy/mercy/justice principles) is ongoing reform of healthcare delivery and reimbursement for serious illness and EOL
• Post-Oregon PAS legalization literature suggests vulnerable have not been affected
• Nonetheless, an example concern ...
CON Policy 2: Empirical SS (6)

- Recent NEJM: pressure in Belgium, Netherlands, Canada to add to PAD (PAS and AE) psychiatric PAS for non-terminal patients
- Response: Vulnerability of mentally ill in US - fragmented MH services, millions without health insurance, fragile public funding - suggests where policy change is concerned, policy must consider societal context.

Implications for Healthcare Professionals

These developments prompt reflection by physicians and providers as to their professional role and their obligations to their patients and society.

- Will there be fundamental changes in the health care professions, or an expansion of existing professional practices?
- How can patients best be cared for at the ends of their lives?

Are There Intractable Moral Issues?

1. Are there patients for whom death is beneficial?
2. Is physician-assisted suicide/euthanasia morally equivalent to withholding/withdrawing life support?
3. Is it morally acceptable for physicians to cause death intentionally?

Whither Society?

Underlying social and moral questions surface and need to be addressed.
• How should recognition of autonomy at the end of life mesh with the common good?
• What are the limits of autonomy relative to the rights and duties of professionals?
• Can the vulnerable be protected at the end of their lives while maximizing the autonomy of the rest?

Whither Biomedical Ethics?

• Will debates about medical assistance in dying turn primarily on the autonomy rights of persons, the duty to address suffering, or the professional ethics of caregivers?
• To what degree are these debates a reflection of social and economic privilege?
• Has death been medicalized such that it has lost its primary existential meaning and implications? Is how we die now more important than why we live and die?

Medical Assistance in Dying Today