**Statement on Physician-Assisted Death**

**Approved by the AAHPM Board of Directors on February 14, 2007**

**Background**

Suffering near the end of life arises from many sources, including relentless pain, depression, loss of sense of self, loss of control and dignity, fear of the future, and/or fear of being a burden upon others. A primary goal of the American Academy of Hospice and Palliative Medicine (AAHPM) is to promote the development, use, and availability of palliative care to relieve patient suffering and to enhance quality of life while upholding respect for patients' and families' values and goals.

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. Subject to safeguards, PAD has been legal and carefully studied in Oregon since 1997. In all other states, PAD remains prohibited by law, although there is an underground practice that remains largely unstudied.

Situations in which PAD is requested are particularly challenging for physicians and other healthcare practitioners because they raise significant clinical, ethical, and legal issues.

**Statement**

When a request for assistance in hastening death is made by a patient, AAHPM strongly recommends that medical practitioners carefully scrutinize the sources of fear and suffering leading to the request with the goal of addressing these sources without hastening death. A systematic approach is essential.

**Evaluation of Requests**

*Determine the nature of the request.*  
Is the patient seeking assistance right now? Is he seriously exploring the clinician's openness to the possibility of a hastened death in the future? Is he simply airing vague thoughts about ending life?

*Clarify the cause(s) of intractable suffering.*  
Is there severe pain or another unrelieved physical symptom? Is the distress mainly emotional or spiritual? Does the patient feel he is a burden? Has he grown tired of a prolonged dying?

*Evaluate the patient's decision-making capacity.*  
Does the patient have cognitive impairment that would affect his judgment? Does the patient's request seem rational and proportionate to the clinical situation? Is his request consistent with his past values?

*Explore emotional factors.*  
Do feelings of depression, worthlessness, excessive guilt, or fear substantially interfere with the patient's judgment?

Initial responses to requests for hastened death:

* Respond empathically to the patient's emotions.
* Intensify treatment of pain and other physical symptoms.
* Identify and treat depression, anxiety, and/or spiritual suffering when present.
* Consult with specialists in palliative care and/or hospice.
* Consult with experts in spiritual or psychological suffering, or other specialty areas depending on the patient's circumstances.
* Utilize a caring and understanding approach to encourage dialogue and trust and to assure the best chance of relieving distress.
* Commit to the patient to work toward a mutually acceptable solution for his suffering.

When unacceptable suffering persists, despite thorough evaluation, exploration, and provision of standard palliative care interventions as outlined above, a search for common ground is essential. In these situations, the benefits and burdens of the following alternatives should be considered:

* Discontinuation of potentially life-prolonging treatments, including corticosteroids, insulin, dialysis, oxygen, or artificial hydration or nutrition.
* Voluntary cessation of eating and drinking as an acceptable strategy for the patient, family, and treating practitioners.
* Palliative sedation, even potentially to unconsciousness, if suffering is intractable and of sufficient severity. (See [AAHPM Statement on Palliative Sedation](http://aahpm.org/positions/palliative-sedation)).

Despite all potential alternatives, some patients may persist in their request specifically for PAD. AAHPM recognizes that deep disagreement persists regarding the morality of PAD. Sincere, compassionate, morally conscientious individuals stand on either side of this debate. 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.

For physicians practicing in regions where PAD is legal, AAHPM advises great caution before instituting PAD including assurance that

* The patient has received the best possible palliative care. The permissibility of PAD is dependent upon access to excellent palliative care. No patient should be indirectly coerced to hasten his death because he lacks the best possible medical and palliative care.
* Requests for PAD emanate from a patient with full decision-making capacity.
* All reasonable alternatives to PAD have been considered and implemented if acceptable to the patient
* The request is voluntary. Safeguards should focus in particular on protection of vulnerable groups including the elderly, frail, poor, or physically and/or mentally handicapped. Coercive influences from family or financial pressure from payors cannot be allowed to play any role.
* The practitioner is willing to participate in PAD, never being pressured to act against his own conscience if asked to assist a patient in dying.

Whenever PAD is being considered by a patient with his or her physician, patients should continue to receive the best possible palliative care. Although many hospice and palliative care practitioners find it morally unacceptable to participate in PAD even where legal, neither a person requesting PAD nor his family should be deprived of any other measure of ongoing palliative care during the dying process and period of bereavement. The most essential response to the request for PAD in the practice of palliative care is to attempt to clearly understand the request, to intensify palliative care treatments with the intent to relieve suffering, and to search with the patient for mutually acceptable approaches without violating any party's fundamental values.

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