

RESOLUTION 12 - 2010

Subject: Death with Dignity
Introduced by: Edith A. McFadden, MD
Referred to: Health Insurance Coverage and Access

1 Whereas, The issue of "death with dignity" has been addressed in Oregon, Washington and
2 Montana with laws which permit physician-assisted suicide; and
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4 Whereas, Oregon has more than 8 years experience with physician-assisted suicide and has not
5 found that this has been abused; and
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7 Whereas, Legislation addressing the issue of "death with dignity" has been in committee in the
8 Wisconsin legislature for a number of years; and
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10 Whereas, There have been a number of news reports regarding "terminal comfort" for patients
11 with terminal diseases whereby the physician orders life-ending doses of medication which keep
12 the patient comfortable in their final hours or days, but which also hasten patient death; and
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14 Whereas, This "physician control" of patient's dying infringes on patient autonomy; therefore be
15 it
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17 RESOLVED, That the Wisconsin Medical Society support Wisconsin legislation, modeled after
18 the Oregon "death with dignity" law, to allow terminal patients to determine the manner and
19 timing of their death when they decide that they no longer want to live.

Fiscal note: Within current budget if replaces an existing legislative priority.

Relevant Policies

Society:

ETH-013

Physician-Assisted Suicide: The Wisconsin Medical Society reaffirms its opposition to any legislation that legalizes physician-assisted suicide in Wisconsin. (BOD, 0709)

ETH-032

Decisions Near the End of Life: The Wisconsin Medical Society believes that:

1. The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision making capacity. Life sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
2. There is no ethical distinction between withdrawing and withholding life sustaining treatment.
3. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

4. Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

5. The Wisconsin Medical Society supports continued research into and education concerning pain management. (BOD, 1109)

(Derived from AMA Policy H-140.966 Decisions Near the End of Life; I-2000)

AMA:

H-140.952 Physician Assisted Suicide

It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. (4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. (CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

H-140.966 Decisions Near the End of Life

Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

(5) Our AMA supports continued research into and education concerning pain management. (CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00)

H-140.987 Voluntary Active Euthanasia

The AMA opposes enactment of any type of federal or state legislation that would require a physician to provide the medicines, techniques, or advice necessary for a patient to pursue a course of suicide, or which would require a physician who is unwilling to participate in suicide to refer the patient to a physician who would be willing to do so. (Res. 79, I-87; Reaffirmed: Sunset Report, I-97)

H-270.965 Physician-Assisted Suicide

Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. (Sub. Res. 5, I-98)

E-2.211 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress--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. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

Relevant Past Resolutions:

RESOLUTION 14 - 2009

Subject: End of Life Choices by Patients
Introduced by: James Allen, MD
Referred to: Quality and Clinical Outcomes

Whereas, Advances in medical treatment are subjecting more patients to a long dehumanizing dying process; and

Whereas, About 25 % of individuals will die of cancer and many will have metastasis; and

Whereas, Some of these patients with metastasis and other diseases are facing long and painful terminal illnesses; and

Whereas, Some physicians have been sued for under-prescription of pain medication and other physicians face the possibility of prosecution for prescribing over usual dosage guidelines for pain; and

Whereas, Patients need compassion and choices when terminally ill, and physicians need legal protection in treating terminally ill patients; therefore be it

RESOLVED, That the Wisconsin Medical Society supports the principle that terminally ill patients should have the right and ability to (a) exercise, without coercion, the choice to receive life-ending medication for self administration, and (b) to use such medication, via self-administration, without the assistance of another, in order to shorten their illnesses through their own actions; and be it further

RESOLVED, That the Wisconsin Medical Society supports state legislation allowing physicians to prescribe life-ending medications for such patients, upon the request of a mentally competent terminally ill patient, after consultation and written confirmation by another physician; and be it further

RESOLVED, That the Wisconsin Medical Society supports inclusion of the safeguards in the Oregon Death with Dignity law in such Wisconsin legislation, to protect both physician and patient rights; and be it further

RESOLVED, That our Wisconsin Medical Society delegation to the American Medical Association submit a resolution to the 2009 AMA House of Delegates Annual Meeting to encourage all the states to introduce such Death with Dignity legislation.

**Board action: Adopt as amended, resulting in ETH-032. Board recommendation to House in 2010
Board Report A:**

H-140.966 Decisions Near the End of Life

The Wisconsin Medical Society ~~Our AMA~~ believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

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(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

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