

Medical Aid in Dying in the United States

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The bioethics, terminology, and definition of medical aid in dying (MAiD) have raised considerable debate in the American medical community for decades. Not historically part of standard medical practice, MAiD has been the subject of controversy internationally since antiquity (Picón-Jaimes et al., 2022). Over time, it has fashioned itself as a distinct practice from palliative care, a community that actually often eschews it. It has already faced and continues to face the legal system, emerging legally sanctioned (with fundamental stipulations) in jurisdictions across the United States and remaining high on the legislative agendas of many others. Despite its recent legal expansion, diversity of positions on MAiD remains, spanning from that it is fundamentally incompatible with the clinician's role as healer to that it is true fulfillment of a clinician's role as an advocate who honors patients' autonomy. Thus, it is imperative to modernly explore the matter, especially in the context of an increasingly aging U.S. population (CDC, 2022). Further, the dynamicity of medicine necessitates that the issue is examined not only as it stands now, but also as what it stands to become. This paper explores the legality of MAiD and its subsequent implications, the arguments for and against MAiD, patient and clinician perspectives on MAiD, and how MAiD reflects the health disparities so prevalent in the American health system. Findings should serve as an overview that can guide recommendations on how to approach terminally ill patients seeking aid in dying during the final stages of life. Although the legal terminology varies by location, as of May 2021, all statutes in the U.S. assert that "actions taken in accord with the respective statutes shall not for any purpose constitute suicide, assisted suicide, mercy killing, or homicide under the law." Additionally, this paper considers only scenarios in which the patient takes the lethal medication themselves and is in control of its administration. For these reasons, 'MAiD', defined as "the practice where a

clinician provides a terminally ill patient, at their explicit request, with a prescription for a lethal medication that they can take on their own,” serves as best fit (Battin & Pope, 2022).

Currently in the U.S., MAiD's legal status exists at the state level. It is currently accessible to 74 million Americans in ten jurisdictions (California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and the District of Columbia) and is on the legal agenda in another 14 states, where another 87 million reside (Kozlov, 2022). In the states where MAiD is permitted, patients qualify for it if they meet the qualifying conditions: 1) the patient must be a mentally competent adult 18 years or older; 2) the patient must have been given six months or less to live because of a terminal illness; 3) two clinicians must confirm the patient's residency, diagnosis, prognosis, mental competence, and voluntariness of the request; 4) the requisite waiting period between requests is fulfilled, which varies between states (World Population Review, 2023). The existence of legislation specifically for MAiD distinguishes it from other end-of-life options such as treatment withdrawal and palliative care and suggests that MAiD has legitimized itself in the medicolegal framework of a society that is - at the very least - open to contending with it. Law allows there to be proxies for the principle that death-hastening actions can be chosen by people who are seriously and irreversibly ill, and state restrictions and criteria directly limit its access to the people for whom it was created. Legal precedent also helps to sort morally justified death from morally unjustified death and avoid the need for case-by-case judgments. However, as MAiD continues to settle itself in legislation, research has shown that its laws are not comprehensive and need refinement. For example, what should be done about a terminally ill, facility-bound patient in Colorado, whose law states that the facility can prevent them from taking the lethal medication on their premises, but that the facility's doctor can prescribe it without issue? What should be done in the case of illness-related issues that can

affect how well a patient can self-administer, ingest, and absorb life-ending medication (e.g. frequent vomiting, patients with ALS)? Further, research on the validity of the legal reporting mechanisms that seek to find whether or not clinicians are acting in accordance with the law is limited (Lynn, 2018).

Perhaps the difficulties with MAiD laws exist in part because they emerged from societal moral principle, and MAiD is a polarizing concept in society. Generally speaking, some people see it as a benefit to patients, while others believe it does more harm than good. A large majority of the arguments in favor of MAiD believe it is justified by respect for patient autonomy and relief of patient suffering. Patient autonomy is the backbone of biomedical ethics, and proponents of MAiD argue that competent patients have the right to make their own decisions about their health at all times, including surrounding their death. If a patient seeks to no longer suffer due to a terminal illness, MAiD upholds their autonomy by acting upon the belief that they should not have to. Giving patients the option to die respects their self-determination, and MAiD is often also referred to as “death with dignity” by the organizations that advocate for it. Those in favor of MAiD generally believe that to oppose it would be paternalistic and autocratic in nature by assuming what is best for the patient and simultaneously denying bodily autonomy to those who are capable of decision-making. Advocates for MAiD also believe that the primary duty of medicine is to relieve suffering and that MAiD is a humane and compassionate medical means of doing so, especially for those whose suffering is refractory or intolerable. Because clinicians have the capabilities of carrying this out, those in support of MAiD believe its practice is paramount to the fundamentals of medicine (Dugdale, 2019).

Arguments against MAiD generally take aim at the supporters’ largest argument: respect for autonomy is not sufficient justification. In this view, patient autonomy is not ultimate because

it cannot be considered in isolation from other ethical principles in medicine. Those against MAiD argue that autonomy must be weighed against other ethical principles including beneficence, non-maleficence, the internal rationality of medicine, justice, and respect for the common good. If MAiD is justified because respect for patient autonomy is viewed in isolation, some argue then there would be no principled way of withholding any requested treatments, for example, antibiotics for the common cold. Additionally, judging whether suffering is sufficient enough to meet the criteria for MAiD may be beyond the comprehension of a clinician. Although the medical aspect of MAiD laws falls well within a clinician's expertise (diagnosis, prognosis), the most important criteria to qualify are subjective, personal, or interpersonal; all of which go beyond a provider's scope of practice. Lastly, opponents feel that medicine's central task is to heal. It cannot be claimed that patients have been "healed" by having assisted them in ending their lives. Unlike symptom relief (which heals) or forgoing treatment (which acknowledges the limits of healing), MAiD subverts healing, and in doing so, undermines the very meaning of medicine.

In considering both sides, it is critical to understand what MAiD means to patients and why they choose it. For patients, cancer is largely the most common diagnosis among patients pursuing MAiD, followed by degenerative neurologic disorders such as ALS and dementia (Kozlov, 2022). A study in Oregon found that the vast majority of patients who elect MAiD are concerned about "losing autonomy" (90.6%) or being "less able to engage in activities making life enjoyable" (89.1%). Other reasons include being a burden on family and loss of dignity. It is also important to note that depression, which is common during the end stages of an illness, may also be a motivating factor (Dugdale, 2019). Moving forward, medicine must consider what role depression, as opposed to terminal illness, plays in patients' decisions to die.

In addition to considering patients' perspectives, it is also critical to consider clinicians' perceptions of MAiD. A 2019 study surveyed physicians' stances on the topics using questions and scenarios that asked: a) whether physicians believed MAiD should be legal/decriminalized in their respective state; b) whether they agreed or disagreed with reasons for patients seeking MAiD; c) implications of MAiD in social, professional, economic, and ethical/moral spheres. The study found that 60% of physicians believed that MAiD should be legal in their home state, with 13% of those physicians expressing their willingness to participate if the practice were legalized. Those who stated that they would not participate cited reasons such as "[inadequate training], legal obstacles, moral dilemmas, religious attitudes, and a belief that it would contradict their Hippocratic oath" (Hetzler et. al, 2019).

While studies have historically focused on physicians' opinions of MAiD, the growth of advanced practice providers (APPs) including physician assistants (PAs) and nurse practitioners (NPs) in the American healthcare system over the last decades certainly warrants evaluating their stances as well. However, there is limited research on the topic. One 2022 survey explored the willingness of Seattle-based oncology APPs to participate in MAiD, finding that 50.6% would be willing to participate in some capacity, 40.3% were unsure if they would participate, and 9.1% would be unwilling. Results showed that participants' education surrounding MAiD was "very influential" in their willingness to participate, with those self-reporting more education on the topic also self-reporting a greater willingness to participate (Singer et al, 2022). Pursuing research similar to this in the near future is important, especially because the legality of MAiD in the United States is projected to expand, and APPs play a crucial role in palliative care. Therefore, it is extremely important that their voices are heard.

The findings of both aforementioned studies on clinician perceptions of MAiD suggest a need for the expansion of comprehensive education and training programs that address the ethical, legal, and practical aspects of MAiD for both physicians and APPs. In addition to the need for open dialogue to discuss how to best navigate these complex end-of-life decisions, there must also be some standardization in education surrounding protocol in how to competently participate. Specifically regarding PAs, as of 2022, the American Academy of Physician Assistants did not advocate for PA participation in MAiD, but does state the “that the ethical, compassionate, well-intentioned provider who discusses voluntary self-termination of life by competent informed terminally ill patients is not subject to prosecution.” The organization also acknowledges that “PAs are front line caregivers for the dying” who “should take a leadership role in educating” (Singer et al., 2022). However, in order to be able to do so, it seems that PAs themselves may require further education about MAiD before being able to develop their personal or professional stances on the subject. Therefore, an initiative to facilitate PAs’ meaningful learning about the subject would be paramount to their beneficent participation in the matter moving forward.

Considering the PA profession's commitment to mitigating healthcare disparities, it is also important to note potential disparities as they relate to MAiD while considering the education and participation of PAs in its practice moving forward. MAiD’s legal status alone affords that its access should be equitable for anyone who chooses to pursue it (within the limitations of state jurisdiction). However, data analysis of every legal MAiD death in the United States since 1998 illustrates some inequitable trends. Non-Hispanic white individuals accounted for a whopping 95.6% of MAiD deaths nationally, and those who died by medical assistance also were very likely to be relatively well-educated. These findings suggest potential socioeconomic

disparities in access to MAiD, as racial minorities and those with limited education are not fairly represented in proportion to the population analyzed. It may be relevant to note that the majority of those who sought MAiD had to pay for its required prescriptions out-of-pocket, as they were federal health insurance program recipients and federal health insurance programs do not cover aid-in-dying costs (Kozlov, 2022). This certainly has the potential to play a role in the aforementioned data trends demonstrated, however, it is unclear at this time whether trends in data are due to socioeconomic inequity in legislation or rather another confounding factor, such as cultural perceptions of MAiD. It is possible that data trends will change significantly as a result of the future expansion, standardization, and de-stigmatization of MAiD over time. If not, they will have to be addressed. Overall, thorough monitoring, research, and education on this topic is required moving forward.

Medical aid in dying (MAiD) and its alternative titles has and continues to be a contested point of discussion in society, and its relevance is only growing as it becomes accessible to more constituents nationwide. MAiD is modernly thought by many to be the ultimate fulfillment of patient autonomy, however, many remain against the practice due to the harm they believe it causes. Recent studies have shown that another demographic may exist: those who are unsure about their stance on MAiD due to a lack of knowledge on its ethics and implementation. Thus, it is important for organizations to prioritize research and educational initiatives on the topic, especially for clinicians who may be legally warranted the scope of practice to participate in it in the current or near future. Furthermore, any obscurities and potential inequities in the legislation surrounding MAiD must be closely monitored and addressed moving forward. Overall, as MAiD becomes an option for millions of Americans to consider, the medicolegal world must make thoughtful preparations and take adequate precautions in the best interest of the greater good.

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