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Advisory Brief: Guidance on Responding to Requests for Physician-Assisted Dying

Background

Suffering near the end of life arises from many sources, including loss of sense of self, loss of control, fear of the future, and/or fear of being a burden upon others, as well as refractory physical and non-physical symptoms. Rarely, patients seek the assistance of a physician to end their life. Physician-Assisted Dying (PAD) is defined as a physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life. Although PAD has historically not been within the domain of standard medical practice, in recent years it has emerged as both an explicit and covert practice across various legal jurisdictions in the United States. PAD has become a legally sanctioned activity, subject to safeguards, first in Oregon in 1997 and, subsequently, in other states including Washington, Vermont, and California. As of the writing of this document, approximately one-sixth of the U.S. population resides in a jurisdiction where PAD is legally permitted, and its legal status continues to evolve at the state level.

Purpose

The emphasis of this guidance statement is to entreat those medical providers who care for patients with terminal disease to understand the complexity of the request for assisted death, to provide an educated systematic response, and to use the best practices of palliative care to alleviate the suffering of patients that triggers a desire to pursue PAD. 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. The ending of suffering by ending life has been held as distinct from palliative care, which relieves suffering without intentionally hastening death.

AAHPM has a separate position statement on PAD that addresses ethical and social policy concerns.

Systematic Approach to Evaluate PAD Requests

Determine the nature of the request.
Is the patient seeking immediate assistance or considering the possibility of hastened death in the future? Is the patient airing thoughts about ending life without a specific intent or plan? Is the patient frustrated with living with illness, but not seriously contemplating ending life?

Clarify the cause(s) of intractable suffering.
Is there a loss of functional autonomy? Does the patient feel he or she is a burden or exhausted from prolonged dying? Is there severe pain or other unrelieved physical symptoms? Is the distress mainly emotional or spiritual?

Evaluate the patient's decision-making capacity.
Is there impairment affecting comprehension and judgment? Does the patient's request seem rational and proportionate to the clinical situation? Is the patient's request consistent with long standing values?

Explore emotional factors.
Do feelings of depression, worthlessness, excessive guilt, or fear substantially interfere with the patient's judgment? Does the patient have untreated or undertreated depression or other mental illness?

Explore situational factors.
Does the patient have a poor social network? Are there coercive influences such as looming bankruptcy? Is the patient subject to emotional, financial or other forms of exploitation or abuse?

Initial Responses to PAD Requests

- Utilize open-ended questions to understand the concerns that led the patient to request PAD
- Respond empathically and strengthen the therapeutic relationship through respectful and non-judgmental dialogue
- Re-evaluate and modify treatment of pain and all physical symptoms
- Identify and address depression, anxiety, and/or spiritual suffering
- Consult with experts in spiritual or psychological suffering when appropriate
- Consult with colleagues experienced in palliative care/hospice as needed
- Commit to the patient the intention of working toward a mutually acceptable solution for the patient's suffering

When unacceptable suffering persists over a timeline often determined by the patient and the clinical course, despite systematic evaluation and standard palliative care intervention as outlined above, search for a mutually acceptable plan is essential. In these situations, consider the benefits and burdens of other alternatives including:

- Discontinuation of potentially life-prolonging treatments such as steroids, insulin, oxygen

supplementation, dialysis, or medically assisted hydration and nutrition
- Voluntary cessation of oral intake if ethically acceptable to the patient and treating practitioners
- Palliative sedation, potentially to unconsciousness, if suffering is intractable and severe

Cautions

Despite consideration of this stepwise response, some patients will persist in a specific request for PAD. AAHPM advises great caution before pursuing PAD where legal, ensuring that:

- The patient continues to receive the best possible palliative care coordinated with an interdisciplinary team and other non-palliative care providers, irrespective of a decision to use PAD
- The patient has decisional capacity commensurate to the request for PAD
- The request is voluntary and not influenced by subtle or explicit coercion from any source
- All reasonable alternatives to PAD acceptable to the patient have been considered
- If the physician responds affirmatively to the request, s/he engages best available practices that limit avoidable suffering through end of life
- If the request conflicts with the physician's values, his/her response should take into account professional obligations of non-abandonment as well as the patient's ongoing clinical needs

Read other Position Statements from AAHPM.

Visit our patient website: PalliativeDoctors.org

8735 West Higgins Road, Suite 300
Chicago, IL 60631
Phone 847-375-4712
Fax 847-375-6475
E-mail info@aahpm.org