Minnesota Medical Association

MMA Board of Trustees Physician-aid-in-dying Task Force

Report and Recommendations

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June 2016

Background

In the nearly 25 years since the MMA last formally considered its policy on physician aid-in-dying, five states have enacted laws allowing for a physician to prescribe terminally ill patients medication to end their lives. Legislation to allow the practice was introduced in the Minnesota House and Senate in 2016. While a hearing on the bill was held in the Senate during the 2016 legislative session, no formal action was taken nor was the bill considered in the House. The bill's authors have indicated their intent to continue to promote the bill and advocate for its passage in future legislative sessions.

Existing MMA policy opposes the participation of physicians in assisted suicide:

> **240.21 Decisions Near End of Life**
> The MMA endorses the AMA Council on Ethical and Judicial Affairs recommendations adopted at the 1991 AMA Annual Meeting as follows:
> 1. The principle of patient autonomy requires that physicians must respect the decision to forego 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.
> 4. Physicians must not perform euthanasia or participate in assisted suicide. The societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide.
> (HD-SR30-1992)

The MMA 2015 Annual Conference included a session regarding issues related to end-of-life, including physician aid-in-dying. The topic was further discussed as part of the 2015 Open Issues Forum. Following the Annual Conference, the MMA Policy Council considered policy development on the issue of physician aid-in-dying, specifically whether the MMA should change or reconsider its position of opposition. The Policy Council referred the issue to the MMA Board of Trustees and urged the board to direct staff to "further analyze the proposal before the Minnesota Legislature in order to understand its intent and implications." In addition, the Policy Council included a recommendation to amend MMA policy on physician aid-in-dying by striking the current language in opposition.

Subsequently, the MMA Board of Trustees considered the Policy Council's recommendations. After discussion, the board voted to table the Policy Council's recommendation to amend MMA policy on physician aid-in-dying. The MMA Board instead approved the creation of a task force to examine MMA policy on physician aid-in-dying, because the policy has not been updated in over two decades and because of the possibility that aid-in-dying legislation will be debated in the 2017 legislative session and beyond.

Charge

The Physician Aid-in-Dying Task Force is charged with considering the complex and controversial issues related to physician aid-in-dying and to make recommendations to the Board of Trustees to maintain or modify existing MMA policy on physician aid-in-dying. The Task Force will review physician aid-in-dying legislation proposed in Minnesota, and proposed and/or passed in other states, in the course of developing its recommendations.

It is anticipated the group will meet three times between July and November of 2016.

Members & Staff

The task force will be comprised of six to eight invited physician members. Invitations to participate on the task force will be extended to members of two existing MMA committees: Ethics and Medical-Legal Affairs Committee and the Health Care Access, Financing & Delivery. Staff will also seek committee members with specialties in hospice/palliative care and medical ethics. The MMA Board Chair will have final approval of task force membership.

Staff will work to find task force members with diverse opinions and expertise on the issue. Non-physician guests will be invited to participate in some meetings if they bring a helpful expertise or perspective.

MMA staff members Teresa Knoedler and Eric Dick will support the task force.

Deliverables

- Develop specific policy recommendations regarding physician aid-in-dying, to be considered by the MMA Board of Trustees at its November 19, 2016, meeting.

- A memorandum explaining task force processes, considerations, rationale and decisions, to accompany its policy recommendations to the MMA Board of Trustees.

- Provide structure and content guidance on the physician aid-in-dying policy forum that will be held on September 23, 2016, at the MMA Annual Conference.

- Identify educational resources that will help physicians understand and examine the clinical, practical, legal, and policy issues associated with physician aid-in-dying.

Task Force Membership

Task force membership was solicited according to the Task Force Charge. Douglas Wood, MD, appointed Benjamin Whitten, MD, chair of the task force. The MMA Ethics and Medical-Legal Affairs and Access, Finance and Delivery committees were invited to express interest in the task force. Staff worked with. Wood and Whitten to identify MMA members with expertise that might inform the conversation about physician aid-in-dying. Members with expertise in ethics and experience with hospital ethics committees were specifically sought out by staff. In addition, as directed, staff took note of potential task force member's viewpoints on physician aid-in-dying, and strove to compile a group with diverse viewpoints. Final task force membership was determined by Whitten and Wood. Task force members represented themselves individually, and did not represent their medical institutions, employers, specialties, or any other organization.

Name	Specialty	Organization/Hospital
Lisa Mattson, MD	Obstetrics	UCARE
David Plimpton, MD	Internal Medicine	Retired
Jennifer Kuyava, MD	Palliative Care	North Memorial
Ken Kephart, MD	Family Medicine	Fairview Geriatric Services
Kathryn Lombardo, MD	Psychiatry	Olmstead Medical Center
Benjamin Whitten, MD	Internal Medicine	Abbott Northwestern
Stuart Bloom, MD	Oncology	Minnesota Oncology
Christopher Burkle, MD[1]	Anesthesiology	Mayo Clinic
John Song, MD	Internal Medicine	University of Minnesota

[1] Dr. Burkle participated in two of the task force meetings. He then declined to continue participating in the task force, because he felt he was unable to fully represent the view of the Mayo Clinic consistent with the task force's timeline.

Task Force Meetings and Process

The task force met four times between July and October. Each meeting lasted approximately two hours. As needed, the task force conducted business via email between meetings. The task force also considered member input from the policy forum. As a part of reaching its policy recommendation, the task force members completed an anonymous survey.

July 26, 2016: Meeting #1

At its first meeting, the task force reviewed its charge and reviewed the state of physician aid-in-dying nationally. Members identified key issues to be discussed and considered what terms to use. After extensive discussion, the group agreed on the following starting principles and terminology:

- The task force should focus on the concept of aid-in-dying as a whole, and should avoid getting bogged down in specific legislative initiatives or language;
- "Suicide" is an emotionally charged word, and while acknowledging that reasonable physicians disagree on the correct terminology, the task force would choose "physician aid-in-dying" over "physician-assisted suicide."
- The task force would consider the experiences of other states and state medical societies, but would not look to international models of physician aid-in-dying.
- Because it would not be possible to capture all faith and spiritual perspectives in the time frame allotted, the task force would not seek specific input from faith communities.
- The operative distinction between aid-in-dying and euthanasia is that the former is self-administered, and the latter is not self-administered.

Oregon Data

To glean information on how a legal physician aid-in-dying statute operates, task force members reviewed data collected by the state of Oregon. Passed in late 1997, Oregon's "Death with Dignity Act" (DWDA) is the US's longest running physician aid-in-dying law, and its law contains many provisions common in the four other states with legal physician aid-in-dying structures, as well as bills introduced in Minnesota. Under the law, the Oregon Public Health Division is required to collect compliance data and provide annual reports.

Since 1998, a total of 1,545 people have had prescriptions for lethal medications issued, and 991 have died from ingesting the medications (64.4percent). In 2015, 218 prescriptions were issued, and 132 patients died from their ingestion (seven of the deaths were from prescriptions issued in 2014). Fifty patients did not use the medication and subsequently died from other causes. The ingestion status of the remaining 43 individuals was unknown at the time of the report's publication. Of the 132 patients who died under the DWDA in 2015, most patients (78 percent) were 65 years or older, and the median age was 73. More than 90 percent of the decedents were white, and a large number were well educated (43 percent had at least a bachelor's degree). The most common condition for those who died under the DWDA in 2015 was cancer (72 percent),

followed by heart disease (6.8 percent) and ALS (6.1 percent). The vast majority (92 percent) was enrolled in hospice care, and more than 90 percent died at home.

August 18, 2016: Policy Forum planning sub-group meeting

One of the task force's deliverables was to provide structure and content guidance for the physician aid-in-dying policy forum at the 2016 MMA Annual Conference. The forum, as with all policy forums, is available to any members or guests who register for the Annual Conference. In order to provide the structure and content guidance, the task force determined that interested task force members would form a sub-group to conduct preliminary forum planning, for final review by the full task force. To that end, several members of the task force participated in a conference call with staff to plan the policy forum. On this call the sub-group considered who should moderate, whether there should be educational speakers, what framework would best facilitate conversation, what questions and prompts would best guide conversation, and what key questions should be asked of the audience during polling. The planning group determined that a brief ground-laying presentation, followed by extensive small-group discussion and finally audience-wide polling, would foster open and robust conversation. It was also deemed important that all forum attendees be given an opportunity to submit written comments that would be reviewed by the task force. This planning call gave rise to a draft policy forum agenda and polling questions, to be reviewed by the larger task force and implemented by staff consistent with task force approval. See below at page 11 for a more complete summary of the forum planning process and considerations.

August 24, 2016: Meeting #2

At this meeting the task force reviewed, revised and approved plans for the policy forum on physician aid-in-dying. The bulk of the meeting was spent considering presentations on the medical ethics and the medical-legal considerations of aid-in-dying.

Ethical Considerations of Physician Aid-in-Dying

Task force member John Song, MD, presented an overview of the ethical and moral considerations attendant to physician aid-in-dying. Song identified and discussed the goals and boundaries of five primary avenues of examination: patient autonomy, informed consent, non-maleficence, beneficence, and justice. He also discussed the role of the physician and the implications on public perception of physician duties, as relates to physician aid-in-dying. Song fielded questions from the task force and guests on issues of unequal access to PAID, feminist and disability community perspectives on physician aid-in-dying, and the moral dilemma associated with the inability of physician aid-in-dying paradigms to treat all dying patients equally. Song facilitated group discussion on the concept of patient "harm" and physician beliefs that death is a "failure." The group also discussed how the Hippocratic Oath and physician aid-in-dying interact.

Legal Considerations of Physician Aid-in-Dying

Thaddeus Pope, JD, PhD, a professor at Hamline-Mitchel Law School, presented an overview of a number of legal issues related to physician aid-in-dying. Pope shared with the group a legal history of the issue, discussing the US Supreme Court's ruling, as well as a discussion of physician aid-in-dying laws that exist in a number of states, including Oregon, Washington, Vermont, Montana and California. Pope also shared information around Gallup polling of the public's opinion on the issue, and also discussed other measures currently used to honor patient autonomy at end of life, such as DNR/DNI/POLST orders, and Voluntary Stopping Eating and Drinking (VSED). He briefly raised some equal protections concerns associated with various disease populations and access to methods of end of life autonomy. He answered questions from the task force about residency requirements, and the comparative utility of legislative versus ballot initiatives. He also fielded questions about the issue of "capacity" versus "competency" and "passive" versus "active" aid in dying.

September 23, 2016: Policy Forum at the MMA Annual Conference

See below at pages 11-13 for a full discussion of the policy forum and attendee polling results.

October 5, 2016: Meeting #3

Anonymous Task Force Member Survey

At this meeting the task force reviewed results from an anonymous task force member survey. The survey was intended to solicit candid answers from the nine task force members about their personal beliefs regarding aid-in-dying, and what they believe the MMA's policy position should be. Task force members agreed at the last meeting that anonymity might help members give candid and nuanced responses. The survey was completed by eight of the nine task force members. The task force members expressed a diversity of personal opinions on aid-in-dying, but all eight who completed the survey concluded that, personal opinions notwithstanding, the proper position for the MMA was neutrality.

Physician aid-in-dying Policy Forum Polling Results

The task force also reviewed the polling results from the physician aid-in-dying policy forum at the MMA Annual Conference. (See below for full polling results.) Task force members considered that 45 MMA members attended the forum and participated in the polling; members noted that this is not a large or necessarily representative sample of MMA membership. Task force members agreed that their responsibility was to consider the issue of aid-in-dying broadly, and that they need not view the polling results as a referendum. The task force members took careful note of written comments provided by forum members, as well as staff and member summaries of the conversations that took place at the forum.

State Medical Societies

The task force was given a summary of state medical societies' positions on and processed in states where physician aid-in-dying is legal or may soon be. Of note were the statements of

both the Vermont[2] and Oregon state medical societies, both of which "neither support nor oppose" aid-in-dying. Within the last two years, California and Colorado's medical societies both withdrew their policies in opposition to aid-in-dying, but did not adopt an affirmative policy of support or neutrality. The group considered the process of Washington State's medical society, which initially opposed but ultimately worked collaboratively with advocacy groups and the legislature on the language that would become Washington law.

Medical Examiner and Death Certificate Concerns

Finally the task force heard from Lindsey Thomas, MD, a medical examiner, regarding the proper cause of death for a patient who had availed themselves of physician aid-in-dying. In general, aid-in-dying statutes direct that death be attributed to the underlying disease process, rather than the agent ingested by the patient or as suicide. Thomas expressed questions and concerns raised by the medical examiner community, and asked the group to consider the ethical implications of compelling a medical examiner to perhaps identify a cause of death she did not agree with. The task force appreciated these concerns and spent considerable time examining the medical, ethical and legal implications of the dilemma. It was concluded that the medical examiners' concerns should be given continued attention in the event of aid-in-dying legislation in Minnesota, and that the MMA should ensure that no physician – including medical examiners – is ever compelled by any aid-in-dying legislation to perform or not perform any duty she is not medically, ethically or legally comfortable performing.

Preliminary Policy Formation

The task force began to synthesize the input and education they received, their extensive internal deliberation, their internal survey, and the policy forum polling, in an attempt to reach consensus around what should be the MMA position on physician aid-in-dying. Despite a diversity of personal opinions on the issue, the task force agreed that the question of one's *personal* views on aid-in-dying must be distinguished from what is the proper *organizational* policy, for a broadly representative state-wide physician organization. There was unanimity that the proper MMA position would reflect and respect that competent, ethical, responsible physicians can and do hold varying and contradictory beliefs on physician aid-in-dying. The task force therefore felt that the MMA should adopt a position of neutrality, contingent on the presences of boundaries and safeguards to protect patient and physician interests. The task force articulated several key boundaries and safeguards, and began to assemble language to capture the nuanced recommendations. It was agreed that, with the basic policy principles intact, a final meeting was necessary to allow time and space for consideration of the proper wording of the policy recommendations.

[2] The task force found the following excerpt from the Vermont Medical Society's policy to be intriguing, primarily because the statement reflected the risks attendant to both supporting and opposing physician aid-in-dying. "The Vermont Medical Society believes that any discussion of physician-assisted suicide must be pursued within a broad societal dialogue about the care of sick and dying patients. VMS does not support the passage of laws for or against physician assisted suicide due to a concern that such laws could stifle this dialogue and hinder the provision of high quality end-of-life care."

October 26, 2016: Meeting #4

Potential Membership Implications

The task force was informed that MMA staff had received a letter from the Minnesota Chapter of the American College of Physicians, asking that the MMA continue to oppose physician aid-in-dying. Additional physician members, as well as one clinic member, had also recently informed staff that they would terminate their membership if the MMA supported physician aid-in-dying. The task force considered that this complex and charged issue could cause members to join or to terminate membership; it was noted that this is likely to happen whether the MMA retains its current policy, or adopts new policy in support of or opposition to physician aid-in-dying. The task force was not unconcerned about potential the impact on membership, and discussed whether it was prudent or necessary to change MMA policy at this time. Ultimately, the task force concluded that it was charged with the consideration of the complex issue of physician aid-in-dying, and it was therefore incumbent on the Task Force to produce their deliverables to the Board of Trustees. The task force acknowledged that membership concerns may well be a part of the Board's consideration of the issue, but also concluded that the task force was not equipped to resolve the potential membership implications.

Policy Review and Finalization

In the time since its October 5 meeting, the task force members had reviewed and commented on initial draft policy language. The language articulated the task force's intent to 1) neither support nor oppose physician aid-in-dying out of respect for the diversity of viewpoints of Minnesota physicians, and 2) establish boundaries and safeguards to guide MMA participation in any physician aid-in-dying initiative. Members also desired to reiterate current MMA policy opposing euthanasia. With painstaking attention to word choice, the task force spent the bulk of this meeting assembling a policy statement to recommend to the Board of Trustees. The task force felt that two separate policy statements were necessary: one to articulate a refined, patient-centric policy statement permitting the MMA to oppose physician aid-in-dying initiatives that do not meet the minimum safeguards and boundaries; and another to affirm the MMA's opposition to euthanasia. The task force was careful to identify several principles it determined were central to their policy recommendation:

- Principled, ethical physicians hold different and inconsistent views on aid-in-dying;
- The physician-patient relationship must be at the core of every physician-patient interaction, including any interactions surrounding aid-in-dying;
- The MMA must oppose a physician aid-in-dying initiative that does not meet minimum safeguards and standards; and

- It is incumbent on all physicians, and particularly those who may elect to participate in aid-in-dying, to ensure their patients truly understand palliative and hospice care options that do not involve aid-in-dying.

The task force agreed that the revised policy recommendation would be circulated by staff via email, for final task force member contemplation and reflection. This gave rise to a few small revisions but no significant changes in recommendation.

The task force was apprised that its report and recommendations would be submitted to the MMA Board of Trustees for consideration. The task force was also advised that a member-wide poll on the task force's recommendations would take place, at a time yet-to-be-determined, to provide another data point for the board to consider.

As the timeline for the poll and board presentation changed, due largely to changing board agenda priorities, the task force was kept apprised of the changes and the final decision to poll MMA members in April 2017, and to present the task force's report and recommendations to the Board of Trustees in May 2017.

Policy Forum on Physician Aid-in-Dying

One of the task force's deliverables was to "provide structure and content guidance on the physician aid-in-dying policy forum that [was] held on September 23, 2016, at the MMA Annual Conference." The task force agreed that a sub-group of members would participate in planning sessions with staff, and then bring a proposed forum agenda and polling questions to the entire task force for approval.

Forum Planning

MMA policy forums are held several times a year, and are a way for MMA members to give input on policy issues. The forums generally provide a brief educational or foundation-setting introduction, followed by small group table discussions. The groups then report out to the entire audience, and a large group discussion ensues. Finally, attendees are given polling devices which permit anonymous voting on a few policy questions related to the topic. The physician aid-in-dying forum planning sub-group was given this background.

The planning sub-group met for approximately an hour on August 18. The group spent considerable time discussing how to best present the issue of physician aid-in-dying to the forum attendees. Their intent was to provide enough information to lay a common groundwork for discussion, but not to saturate the audience. They considered having two presenters – one for and one against physician aid-in-dying. The group also wanted to ensure the conversation was about the *concept* of physician aid-in-dying, not any specific legislative initiative surrounding aid-in-dying.

The group resolved these considerations by appointing Benjamin Whitten, MD, as the moderator who would present a brief slide show setting out key terms and providing a brief context for the conversation. Rather than presenting a "pro/con," the group decided that Whitten's introduction should include a list of why some physicians might support physician aid-in-dying, and why others might oppose it. Additionally, the group determined that the audience should be informed of the basic elements of most physician aid-in-dying laws, as well as current MMA and AMA policy.

The group then spent significant time considering what questions to ask the audience during polling. They agreed that it was important to distinguish between personal beliefs and the position that members believe the MMA should take on the issue. They also wanted to encourage introspection by including a question about whether audience members would like to have physician aid-in-dying available to them at their own death. Additionally, the group wanted to know if the audience felt that the growing public support of physician aid-in-dying was directly related to low and improperly used palliative and hospice care.

The group presented to the task force at its August 24 meeting. The task force gave input and finalized the forum agenda as well as the polling questions. Task force members were encouraged to attend the forum.

Forum and polling results

The policy forum on physician aid-in-dying took place as scheduled on September 23, at the MMA Annual Conference. Approximately 60 people attended. Whitten introduced the topic and set the foundation for discussion. Small group discussion was lively and the broad conversation afterwards was reflective and constructive. Despite this topic's polarizing nature, the tone of conversation remained collegial. As planned, the forum ended with audience polling. The polling is anonymous and results are displayed to the audience in real-time. The chart below details the questions and the polling results.

Attendees were also given the option to provide written input to the task force, and several availed themselves of the option. The polling results, as well as a summary of the written input, were shared with the task force at its October 5 meeting (see page 7).

Minnesota Medical Association 2016 Annual Conference
Physician Aid-in-Dying Policy Forum
Attendee Polling Results

	Choice Text	Response Count	Response Pct
1	**What is your personal belief about PAID?**		
	Strongly support	13	25.5%
	Support	18	35.3%
	I don't know	6	11.8%
	Oppose	5	9.8%
	Strongly oppose	9	17.6%
	N	51	
2	**Would you like to have a PAID option available to you at your death?**		
	Yes	32	68.1%
	No	15	31.9%
	N	47	
3	**If PAID was legal (and you treated qualified patients) would you participate in the process of aiding in the death of a patient?**		
	Yes	17	40.5%
	No	11	26.2%
	Maybe	14	33.3%
	N	42	

4	**Societal interest in PAID is a function of inadequate access to and underutilization of hospice and palliative care services.**		
	Strongly agree	7	15.2%
	Agree	20	43.5%
	Disagree	10	21.7%
	Strongly disagree	9	19.6%
	N	46	
5	**What should be the MMA position on PAID?**		
	Support	9	19.1%
	Oppose	13	27.7%
	Neutral	25	53.2%
	N	47	
6	**Forum Evaluation:** **Process allowed all voices to be heard**		
	Strongly agree	32	64.0%
	Agree	11	22.0%
	Disagree	3	6.0%
	Strongly disagree	4	8.0%
	N	50	
7	**Forum Evaluation:** **Overall Satisfaction**		
	Very satisfied	23	50.0%
	Satisfied	17	37.0%
	Dissatisfied	4	8.7%
	Very dissatisfied	2	4.3%
	N	46	

MMA Physician Aid-in-Dying Task Force Policy Recommendations

The task force recommends the following modifications and additions to MMA policy regarding physician aid-in-dying:

Recommendation #1 (New Policy Language)

Physician Aid-in Dying
Physician aid-in-dying raises significant clinical, ethical, and legal issues. A diversity of opinion exists in society, in medicine, and among members of the Minnesota Medical Association. The MMA acknowledges that principled, ethical physicians hold a broad range of positions on this issue.

The physician-patient relationship is a sacred trust. This relationship must be protected through all stages of life including the dying process. The trust and honesty central to this relationship applies to the difficult decisions made at end-of-life, and encompasses any decision to engage in aid-in-dying.

The MMA will oppose any aid-in-dying legislation that fails to adequately safeguard the interests of patients or physicians. Such safeguards include but are not limited to the following:

- must not compel physicians or patients to participate in aid-in-dying against their will;
- must require patient self-administration;
- must not permit patients lacking decisional capacity to utilize aid-in-dying;
- must require mental health referral of patients with a suspected psychological or psychiatric condition; and
- must provide sufficient legal protection for physicians who choose to participate.

All physicians who provide care to dying patients have a duty to make certain their patients are fully aware of hospice and palliative care services and benefits.

Recommendation #2 (New Policy Language)

Euthanasia
The MMA is opposed to euthanasia.

Recommendation #3 (Edits to existing policy)

240.21 Decisions Near End of Life
~~The MMA endorses the AMA Council on Ethical and Judicial Affairs recommendations adopted at the 1991 AMA Annual Meeting as follows:~~

1. The principle of patient autonomy requires that physicians must respect the decision to to accept or forego any treatment, including life-sustaining treatment. 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.

~~4. Physicians must not perform euthanasia or participate in assisted suicide. The societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide.~~
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