MONMOUTH UNIVERSITY

SCHOLARSHIP WEEK

Death with Dignity: An Ethical Review of Medical Aid in Dying

Christina Gulotta, Emily Herbst, Dominick Milano, Tahreem Nisa, Isabella Pecoraro, Maddie Stein

Faculty Advisor: Pauline Papapietro, PA-C, M.S.

MONMOUTH UNIVERSITY

PHYSICIAN ASSISTANT PROGRAM

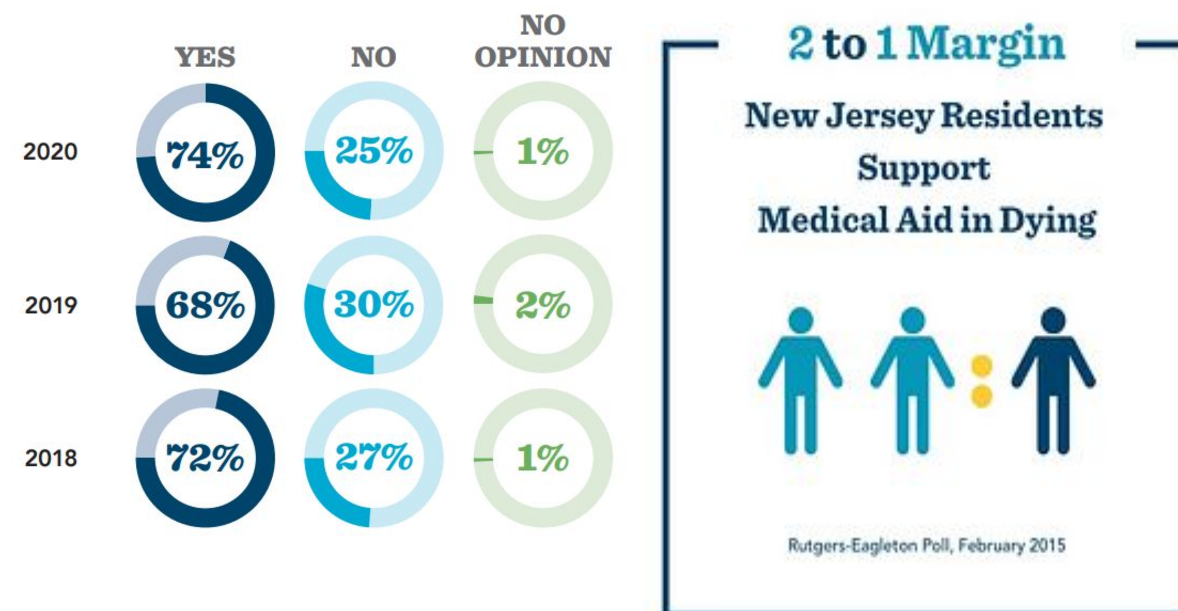
Introduction

Medical aid in dying (MAiD) is defined as the legal practice of prescribing medications to assist terminally ill patients who have decided to hasten their impending death as a means of easing their own suffering. [1]

Aid in dying, physician aid in dying, medically assisted deaths, physician-assisted deaths, and hastened deaths are other commonly used phrases referring to medical aid in dying. "Assisted-suicide" has been deemed as misleading as legal physician assisted deaths should not be considered as cases of suicide, but it is still a term commonly used.[1]

The practice was first legalized in 1994 with the enactment of the Death with Dignity Act in Oregon. This law permits physicians to prescribe life-ending medications without facing criminal charges. It also ensures that individuals who choose to end their own lives are protected from legal consequences typically associated with suicide. PAS provides a legal pathway for physicians to facilitate the deaths of individuals who meet specific criteria, though it is not guaranteed.[2]

Critics of this practice cite the concept of euthanasia, which is defined as a physician or third party making the decision to end someone else's life and playing an active role in carrying out that act. In the case of medical aid in dying, the patient themselves makes the decision to end their own life and self administers the prescribed medications alone in order to end their life.[2]



Ethical Principles

- **Autonomy**
  - Patient centered care involves patients having the decision to end their suffering if they chose to do so. [3]
  - Respects a patient's decision-making process based on their individual beliefs, circumstances and values.[3]
- **Beneficence**
  - Providing assistance in ending an individual's suffering can be considered a merciful act.[2]
  - Alleviating significant psychological and physical suffering of terminally ill patients can be seen as an act of compassion, reducing their suffering.[3]
- **Nonmaleficence**
  - Life prolonging care while the patient is suffering is doing harm to some patients. [4]
  - Reduced quality of life without the possibility of a cure. [4]

Case Studies

- *Carter vs Canada* [5]: 2016 Supreme Court ruling in Canada that overturned prior legislation and ruled in favor of physician-assisted deaths of terminally ill patients
  - Canadian Charter of Rights and Freedom (right to life, liberty and security of the person, which was the result of *Rodriguez v British Columbia in 1993*) in conflict with The Criminal Code (everyone who aids or abets a person in committing suicide commits an indictable offense). The ruling aligned with the *Rodriguez* case that prohibiting assistance in dying interfered with the terminally ill patient's liberty and security.
- In 2014, Brittany Maynard was a 29 year old living in California, US with a terminally diagnosed brain tumor. California at the time did not allow terminally ill patients to seek aid in dying, so her entire family moved to Oregon where she was able to pass peacefully of her own volition under Oregon's Death with Dignity Act. While battling her terminal illness, she had to pack, move, and search for new physicians in Oregon. She shared her experience and story with the public to try and incite a change in legislation in California so other residents with terminal illnesses wouldn't have to go through what she had to. After passing in 2014, her mother continued to try and enact this change until California passed its End of Life Option Act in 2015. [6]

Literature Review

- Termination of Life on Request and Assisted Suicide Procedure: legalization of euthanasia-assisted suicide (EAS) in 2002 in the Netherlands, which is less strict on who can qualify than the US. Out of 1,456 Dutch physicians surveyed, 85% answered they understand and support EAS in patients with cancer or physical diseases, but less than 40% supported its use for psychiatric diseases, early-stage and advanced dementia, or patients who are tired of living.[7]
- State-Dependent Legal Requirements for MAiD in the United States as of 2023[1]:
  - 18 years of age + and reside in a state where it is legal
  - Terminally ill with prognosis < 6 months, determination made by 2 independent physicians, or an APN or PA with confirmation by a physician in New Mexico and Washington.
  - 2 physicians determining eligibility: prescribing physician responsible for aid-in-dying care and a consulting/second opinion physician
  - Mentally capable of making their own medical decision (mental health evaluation mandatory in Hawaii)
  - Physical ability to self-administer medications without assistance (except in New Mexico)
  - Makes 2 verbal requests and signs a written request expressing consideration of medical aid in dying (waiting periods between requests varies by state)
  - Provider must educate patient on other options, palliative and hospice care, and how their request can be withdrawn at any time for any reason
  - If depression or mental illness is suspected from a provider that has misrepresented their decision making capability, they are to be referred for psychological or psychiatric evaluation
  - Within 30 days of writing the prescription the provider must file with the designated state health agency. Information to be filed includes; patient's written request, clinical checklist and compliance form, and consulting clinician compliance form
- Medications Prescribed:[8]
  - Preparation [in Oregon]: do not consume fatty foods 4-6 hours before planning to initiate the 2-step procedure of taking the prescribed medications. First, the patient is prescribed and will take an antiemetic. 45 to 60 minutes later, the patient will have to drink a 9g dose of a powdered, short-acting barbiturate, such as secobarbital, mixed into half a cup of water in under 2 minutes.
- In 2018, the leading cause death in US was heart disease. However, the main illness for MAiD in NJ was cancer, then ALS.

Pros

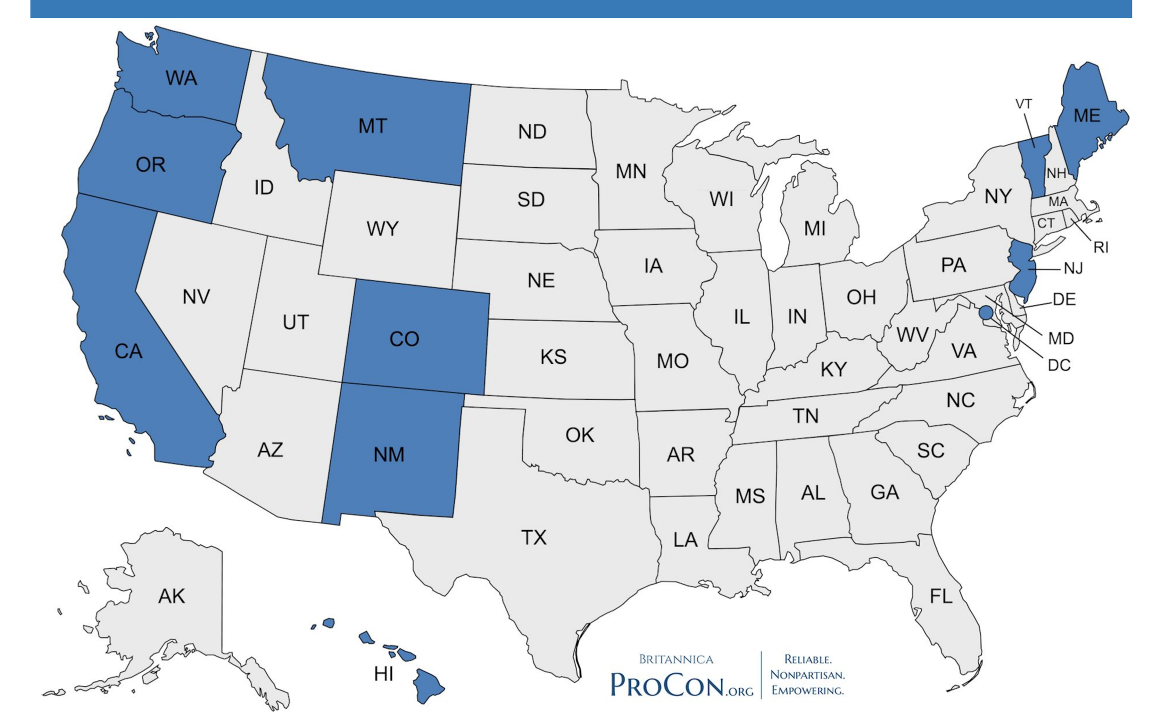
- Autonomy: Patients can make their own healthcare decisions and could control the circumstances of their death. [9]
- Ease the pain and discomfort of patients suffering from terminal illness and disease. [9]
- Safeguards in place to ensure only terminally ill patients can choose to end their suffering. [9]

Cons

- Goes against the Hippocratic Oath 'Neither will I administer a poison to anybody when asked to do so'.[9]
- Risk of an incorrect terminal diagnosis or a change in the patient's prognosis.[10]
- Can be a harmful example/ misinterpreted by youth who may be considered ending their life. [10]
- The patient must follow the medication instructions carefully or risk surviving.[11]

Discussion and Future Implications

- Insurance coverage [1]
  - There is currently no ICD-10 code for billing
  - Federal agencies (Medicare and VA insurance) cannot cover MAiD
  - Medicaid: it is up to individual state
  - Private health insurers claim to cover, but rarely do
- Laws [12]
  - States that it is currently legal in
    - California, Colorado, DC, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington
  - States considering it this year
    - Michigan and New York
  - New Jersey
    - First passed in 2019
    - 2022- amendment introduced that would eliminate the 15 day waiting period under some circumstances



Contact: Monmouth University
Physician Assistant Program

185 NJ-36 Building C, West Long Branch, NJ 07764

References

1. Shavelson L, Battin MP, Pope TM. Medical aid in dying: Clinical considerations. UpToDate. Accessed November 26, 2024.
2. Shibata B. An Ethical Analysis of Euthanasia and Physician-Assisted Suicide: Rejecting Euthanasia and Accepting Physician Assisted Suicide with Palliative Care. Journal of Legal Medicine. 2017;37(1/2):155-166. doi:10.1080/01947648.2017.1303354
3. Ahmad N, Masum A, Ali AW. Conceptual, legal, and ethical considerations in physician-assisted suicide: An overview. UUM Journal of Legal Studies. 2024;15(2):707-744. doi:10.32890/uumjls2024.15.2.12
4. Spina B. Ethical justifications for voluntary active euthanasia. Richmond Journal of Law & Public Interest. 1998;3:71.
5. Government of Canada D of J. Legislative background: Medical assistance in dying (Bill C-14). Introduction - Brief Summary of Carter v. Canada. February 2, 2023. Accessed November 26, 2024. https://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/p1.html.
6. Lawatsch E. Reflecting on Brittany Maynard's legacy, five years later. Death With Dignity. January 31, 2024. Accessed November 26, 2024. https://deathwithdignity.org/news/2019/11/brittany-maynards-legacy-five-years-on/.
7. Bolt EE, Snijdewind MC, Willems DL, van der Heide A, Onwuteaka-Philipsen BD. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living? *Journal of medical ethics*. 2015;41:592-598
8. Orentlicher D, Pope TM, Rich BA. Clinical Criteria for Physician Aid in Dying. *J Palliat Med*. 2016;19(3):259-262. doi:10.1089/jpm.2015.0092
9. Dugdale LS, Lerner BH, Callahan D. Pros and Cons of Physician Aid in Dying. *Yale J Biol Med*. 2019;92(4):747-750. Published 2019 Dec 20.
10. Rosenberg L, Butler J, Caprio A. Results From a Survey of American Geriatrics Society Members' Views on Physician-Assisted Suicide. Journal of American Geriatrics Society. December 2, 2019. Accessed November 26, 2024. https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.17755
11. The Office of the Chief State Medical Examiner. Medical aid in dying for the terminally ill act - nj.gov. nj.gov. 2019. Accessed November 26, 2024. https://www.nj.gov/health/advancedirective/documents/maid/2019_MAID_DataSummary.pdf.
12. Paine D. Death with dignity U.S. legislative status state map. Death With Dignity. November 13, 2024. Accessed November 26, 2024. https://deathwithdignity.org/states/.