American Academy of Hospice and Palliative Medicine Adopts Position of "Studied Neutrality" on Physician-Assisted Death

By Daniel S. Goldberg, J.D., Ph.D Student
dgoldbe2@central.uh.edu

On February 14, 2007, the American Academy of Hospice and Palliative Medicine ("AAHPM") released a new Position Statement on physician-assisted death ("PAD").[1] The AAHPM's prior official Position on PAD was one of opposition, but the new Statement endorses "studied neutrality" on whether PAD should be "legally regulated or prohibited."[2]

Though the new Statement does not detail the reasons for the change in Position, it does acknowledge that "deep disagreement persists regarding the morality of PAD. Sincere, compassionate, morally conscientious individuals stand on either side of this debate."[3] Of course, both of these propositions seemed sound during the period in which the AAHPM was officially opposed to PAD, so these two facts alone do little to illuminate the reasons for the changed position. Moreover, it seems unlikely that the AAHPM endorses neutrality of any kind on whether PAD should be "legally regulated" insofar as arguing that PAD should be permitted without any regulation at all seems an extreme position. Rather, the fighting issue, so to speak, is whether PAD should be prohibited outright, or permitted and managed with legislative, executive, and judicial oversight, as is done in Oregon.[4]

The human problem that animates the debate over PAD is that of intractable suffering. Typically, many requests for PAD attend cases where, despite the best palliative care, the patient continues to suffer (hence the adjective "intractable" to modify "pain"). Thus, the AAHPM Statement recommends, as a starting point, that practitioners "carefully scrutinize the sources of fear and suffering leading to the request with the goal of addressing these sources without hastening death."[5] If it is the suffering that is prompting the patient to request PAD, then an analysis of the causes of that suffering, as well as possible means of ameliorating those causes, is paramount. To that end, the AAHPM offers a "systematic" method of assessment, suggesting that the provider (1) determine the nature of the request; (2) clarify the cause of intractable suffering; (3) evaluate the patient's decision-making capacity; and (4) explore emotional factors.[6]

The Statement recommends a number of initial responses to a request for PAD, including expression of empathy, intensified treatment of pain, consultation with clinical, spiritual,

---

[1] American Academy of Hospice and Palliative Medicine, *Position Statement: Physician-Assisted Death*, Feb. 14, 2007, *available at* http://www.aahpm.org/positions/suicide.html (hereafter referred to as "Statement").
[2] *Id*.
[3] *Id*.
[4] *See* Oregon Death with Dignity Act, OR. REV. STAT. § 127.800 *et seq.* (Supp. 2007).
[5] Statement, *supra* note 1.
[6] *Id*.

and psychological specialists, etc.[7] Of course, the most difficult legal and ethical issues surrounding PAD factor in once the initial responses – both clinical and non-clinical – have not sufficiently diminished the patient's suffering. The Statement, however, recommends other arguably less standard palliative techniques short of PAD, including:

- Discontinuation of potentially life-prolonging treatments, including corticosteroids, insulin, dialysis, oxygen, or artificial hydration or nutrition;
- Voluntary cessation of eating and drinking as an acceptable strategy for the patient, family, and treating practitioners; and
- Palliative sedation, even potentially to unconsciousness, if suffering is intractable and of sufficient severity.[8]

There are several legal and ethical issues worth unpacking in these recommendations. The first is that despite the strong consensus in the bioethics literature maintaining the lack of any meaningful distinction between different kinds of life-sustaining treatment, U.S. practices with regard to withdrawal of artificial nutrition and hydration have not reflected the consensus among commentators. For example, Pope John Paul II issued a controversial allocution in 2003 where he argued that nutrition and hydration never constituted extraordinary means, and consequently, their use "is to be morally evaluated as ordinary and obligatory."[9] This matters because, in the Catholic tradition of medical ethics, there is no obligation to assent to the use of extraordinary means to prolong life.[10] The Pope was essentially stating that food and water are not life-sustaining treatments as compared with, for example, ventilators, with the implication being that the former, as distinguished from the latter, may not ethically be refused.

The allocution created more than a little consternation, and the ensuing discussion in the Catholic theological community prompted the Pope to issue a later encyclical affirming that all interventions are subject to the traditional proportionality (i.e., risk-benefit) analysis.[11] Similarly, in spite of the fact that the famous cases of *In re Quinlan* and *Cruzan* are often lumped together as "right-to-die" cases, there is reason to believe that the fact pattern in the *Cruzan* case presented a more difficult case than that in *Quinlan*.[12] This is because in *Quinlan*, Karen Quinlan's surrogate was only seeking judicial sanction to remove Ms. Quinlan from the ventilator.[13] In contrast, in *Cruzan*, the plaintiffs sought removal of all life-sustaining treatment, including nutrition and hydration.[14] And, of course, Terri Schiavo died by having her nutrition and hydration tubes removed, which

---

[7] *Id.*
[8] *Id.*
[9] Thomas A. Shannon & James J. Walter, *Implications of the Papal Allocution on Feeding Tubes*, 34 HASTINGS CTR. REP. 18, 18 (2004).
[10] *See id.*
[11] *See id.*; *see also* Albert R. Jonsen, Mark Siegler, & William J. Winslade, CLINICAL ETHICS 139 (6th ed. 2006) (noting that the Pope subsequently "reaffirmed" the use of the proportionality/benefits-to-burdens balancing test generally accepted among Catholic theologians).
[12] *See* William J. Winslade & Daniel S. Goldberg, *Dying in America: Legal Decisions, Ethical Conflicts, and the Kinetics of Cultural Change*, 13(2) ANNUAL REV. L. ETHICS 1 (2007) (forthcoming).
[13] *Id.*
[14] *Id.*

led to charges that the proponents of withdrawing life-sustaining treatment were trying to starve Ms. Schiavo to death.[15]

In short, withdrawal of nutrition and hydration remains ethically controversial, and is so even where withdrawal of artificial respiration, for example, would elicit no such controversy. There are some reasons why food and water are often regarded differently than other forms of life-sustaining treatment:

> Many people believe that nutrition must always be offered, just as pain management, shelter, and basic personal care must be . . . . Beliefs about food and the associations concerning food are deep-seated, and in some cohorts and communities they are linked to historical or personal experiences with starvation (e.g. during the Holocaust or the Great Depression.[16]

These same considerations affect the AAHPM's second recommended "less palliative" technique, in which patients voluntarily cease eating and drinking as an acceptable treatment. Though it is generally agreed that adult, competent patients have a right to refuse life-sustaining treatment including nutrition and hydration, the notion that these procedures are deemed different from other forms of life-sustaining treatment complicates the scenario where the capacitated patient voluntarily refuses nutrition and hydration. For example, Jansen and Sulmasy argue that some cases of a capacitated patient's request to cease artificial nutrition and hydration are ethically unjustified.[17]

Finally, when discussing physician-assisted death, the disability rights perspective ought not be ignored. Particularly with regard to incapacitated patients, if it is true that the able-bodied dramatically underestimate the quality of life even of those who might be viewed as severely disabled,[18] then the use of palliative sedation if such techniques are designed to produce unconsciousness, let alone physician-assisted death, seem problematic. This is not to assert that such practices are unethical or illegal, though the latter remains legally prohibited in every state but Oregon. Nevertheless, addressing end-of-life scenarios, including palliative sedation and physician-assisted death, seems to require engaging the disability rights critique.

In short, the issues surrounding physician-assisted death remain unsettled. This itself is unsurprising, as a survey of U.S. attitudes and practices towards death and dying over the last half-century demonstrates precisely such uncertainty and debate. The discourse over physician-assisted death is part and parcel of the larger social dialogue on death, dying, autonomy, and the state's interest in preserving life. The AAHPM's changed position with regard to physician-assisted death reflects the difficulties and tensions involved;

---

[15] *Id*.
[16] David Casarett et al., *Appropriate Use of Nutrition and Hydration*, 353 N. ENG. J. MED. 2607, 2608 (2005).
[17] Lynn A. Jansen & Daniel P. Sulmasy, *Sedation, Alimentation, Hydration, and Equivocation: Careful Conversation About Care at the End of Life*, 136 ANNALS INT. MED. 845, 846 (2002).
[18] *See* Winslade & Goldberg, *supra* note 12, at nn. 69-72 (citing sources).

even the change itself is merely a move to an official position of indecision (read: neutrality). As the oft-heated public discourse on physician-assisted death continues, the AAHPM's perspective bears watching.

April 2007