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Medical Aid in Dying, Questions of Ethics and Fairness

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Commentary

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Commentary

Medical Aid in Dying (MAID) has received much exposure in a variety of forums. This has often been in the context of advocacy for or against making it legal in various states. It is currently legal in 11 U.S. jurisdictions [1]. Unfortunately, the advocates don't always have correct conclusions in their materials, leading to some opposing the policy who when they learn the facts actually support the policy [2]. I recently engaged in a discussion with some healthcare providers who have been tracking the debate and are puzzled by the opposition from some in New Yorks debate. The question they led to for me was "is it ethical?"

So, please allow me to begin with the facts and then discuss other implications.

The first formal use of MAID in the US was Oregon, where it has now been legal since 1998. Oregon and subsequent jurisdictions define the process as a medical practice that allows a terminally ill, mentally capable adult with six months or less to live to request a prescription from their physician for medication they can decide to self-ingest to die peacefully in their sleep. The intent of these acts is to offer relief of pain and suffering that predictably will worsen and result in death within six months.

The State of Oregon publishes annual reports and tracks the process closely including how many people use the process, what drugs they are prescribed (and when), when (and if) they choose to use the drug, and related data. People are tracked from year to year (some don't use the drug or die in the calendar year it is prescribed) and data is updated accordingly. In the most recent year reported (2023) - 560 people received prescriptions and 367 people died after ingesting medications (others were reported deceased from other causes and 30 reported uses of medication received in the prior calendar year. Since the law passed in 1997, 4274 people have received prescriptions and 2847 have succumbed from using the medications [3]. I point to these reports to illustrate that public health authorities are tracking the process closely and assuring the process is safe and not abused.

So, to confirm, in each jurisdiction where the process has been legalized the following four criteria are required for every applicant:

1. Adult aged 18 or older.
2. Terminally ill with a prognosis of six months or less.
3. Mentally capable of making their own healthcare decisions.
4. Able to self-ingest medication as directed.

Who thinks this is a good idea? A substantial majority of all groups polled by Gallup in 2020 support MAID. Overall, 74% of those polled support MAID; 77% of whites, 65% of non-whites, 70% of Catholics, 59% of Christians, 53% of Protestants, 70% of other religious groups support MAID.

The evidence in Oregon according to their own reports and those of observers is that the process (under the law) offers a compassionate option that protects patients, but also improves care across the end-of-life spectrum. It also fundamentally protects terminally ill people choosing this option from any form of coercion or abuse. Some of the opposition in jurisdictions where this is not yet available point to other options for serving these people. These include hospice, palliative care generally, palliative sedation, voluntary stopping eating and drinking and others. While some of these addresses the primary goal of MAID, that

being reducing the burden of pain (physical and otherwise) related to the terminal illness the patient is suffering with. Each comes with its own limitations on effectiveness and are typically often utilized in concert with MAID in the jurisdictions where it is available [3].

It is important for engaging in this conversation that we illustrate what MAID is not, so to be clear MAID is not euthanasia, is not physician assisted suicide, and is not suicide. These terms have been discussed at length by others as listed below:

1. Leading Medical organizations reject the term "physician-assisted suicide". These include that The American Academy of Hospice and Palliative Medicine, American Medical Women's Association, American Medical Student Association, American Academy of Family Physicians and American Public Health Association have all adopted policies opposing the use of the terms "suicide" and "assisted suicide" to describe the medical practice of aid in dying.
2. The American College of Legal Medicine filed an amicus brief before the United States Supreme Court in 1996 rejecting the term and adopted a resolution in 2008 in which they "publicly advocat[ed] the elimination of the word 'suicide' from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying."
3. Euthanasia is an intentional act by which another person (not the dying person) administers the medication. By contrast, medical aid in dying requires the patient to be able to take the medication themselves and therefore always remain in control. Euthanasia is illegal throughout the United States [4].

Given these clarifications, back to the question that led me to share these thoughts, is MAID ethical? For this part of the discussion, I'll use the four Principles of Bioethics: Autonomy, Beneficence, Non-Maleficence, and Justice. I will not use values and principles related to religious organizations or other types of values – on purpose. These are appropriate for individuals to use in the exercise of their own personal autonomy (and that of family and loved ones), but not as drivers of public policy for health. One's beliefs should not be imposed on others who don't share those beliefs, rather public policy should reflect professional principles that are widely accepted [5].

Principles of Bioethics and MAID

Autonomy: This principle is embedded in the definition and implementation of MAID. The necessity of a patient making a request after having a full understanding of MAID for them and the implications of that decision. Further, understanding that even after the prescription is provided the process only takes place with the exercise of autonomy when the patient decides to utilize the medication(s).

Beneficence: This principle calls for all actions in healthcare to have good intent. In this case the stated intent is to relieve pain, to offer a patient some power over their pain, and to do so in a respectful, safe, controlled environment. The additional adjunct result of the death (projected in six months or less) of the patient is more controlled and stress is relieved by the patient exercising this control.

Non-Maleficence: Often referred to as "do no harm", this area engenders some debate among healthcare providers, some who define death as "bad" and living in any state as "good". From a policy perspective this could impose someone's beliefs on others, from the principle perspective non-maleficence calls on us to focus on principles of bioethics to address these questions.

Basil Varkey offers this: "Nonmaleficence is the obligation of a physician not to harm the patient. This simply stated principle supports several moral rules - do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life. The practical application of nonmaleficence is for the physician to weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient. This is particularly important and pertinent in difficult end-of-life care decisions on withholding and withdrawing life-sustaining treatment, medically administered nutrition and hydration, and in pain and other symptom control. A physician's obligation and intention to relieve the suffering (e.g., refractory pain or dyspnea) of a patient by the use of appropriate drugs including opioids override the foreseen but unintended harmful effects or outcome (doctrine of double effect)" [6,7].

This doctrine of double effect would seem to offer a focus on the act of merciful care to provide patient control and limit pain and suffering, understanding the "foreseen but unintended harmful effects". In MAID the intended effect is relief from pain and suffering, the outcome of death is foreseen but not the primary intent.

Justice: this principle encompassing fairness is carried out here to a great degree through the implementation of a process respectful of autonomy, beneficence and non-maleficence. Additionally, the implementation incorporates assurances that the patient and their loved ones are educated to understand the implications and process related to the decision and implementation. Further the oversight role of public health entities provides assurance of justice through

quality monitoring in the appropriate jurisdictions. The only question for justice that remains is the prohibition of Maid in adjacent jurisdictions and any impact on availability that ensues.

Given this review using the filter of Principles of Bioethics, I offer my own conclusion that MAID as currently available in some jurisdictions and proposed in others meets the principles of bioethics and is an ethical practice.

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