

Will the AMA Heed Its Own Ethics Council Regarding Assisted Suicide?

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COMMENTARY

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It seemed like a major statement on physician-assisted suicide (PAS) by the American Medical Association, and several media websites trumpeted the story in just such terms; for example, "[The AMA Continues to Oppose Physician-Assisted Suicide](#)" and "[AMA Rebuffs Advocates of Physician-Assisted Suicide](#)."^{1,2}

However, more cautious observers quickly pointed out that the Council on Ethical and Judicial Affairs (CEJA) Report 5-A-18 merely put forward the [recommendation](#) of the Council³ and that "...the AMA House of Delegates has not yet taken action on this report [which]...does not represent adopted policy of the AMA at this time" (E.J. Crigger, PhD, American Medical Association, personal communication, May 8, 2018). Indeed, it is far from clear how the delegates will actually vote this June. That said, it will be hard, in my view, for the delegates to repudiate the very clear conclusions of the CEJA report. First, though, a bit of background.

The CEJA report had its genesis in two requests for clarification or revision of the AMA's 1994 "Code of Medical Ethics Opinion 5.7." That opinion stated quite clearly that

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide) . . . Physician-assisted suicide is fundamentally [incompatible](#) with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.⁴

In essence, the two requests (officially known as Resolutions 15-A-16 and 14-A-17) asked the CEJA to consider, respectively, whether the AMA should take a "neutral stance" on physician "aid in dying;" and whether the phrase "physician assisted suicide" ought to be replaced by the phrase, "aid in dying," in official AMA references to this practice. (I am condensing and paraphrasing for the sake of simplicity; the more technical language of the resolutions may be found in the actual [CEJA report](#)³).

The authors of the CEJA report wisely noted the critical role of language in this controversy, stating: "Not surprisingly, the terms stakeholders use to refer [to] the practice of physicians prescribing lethal medication to be self-administered by patients in many ways reflect the different ethical perspectives that inform ongoing societal debate."

Those who favor the practice just described generally prefer the terms "death with dignity" or "medical aid in dying." Those who oppose physician provision of lethal medications generally favor the term "physician-assisted suicide."

After much deliberation, the CEJA report reached two main conclusions:

1. The AMA Code of Ethics should not be amended, effectively sustaining the AMA's position that physician-assisted suicide is fundamentally incompatible with the physician's role as healer.
2. With respect to prescribing lethal medication, the term "physician assisted suicide" describes the practice with the greatest precision.

On the second point, the Council noted that "The terms 'aid in dying' or 'death with dignity' could be used to describe either euthanasia or palliative/hospice care at the end of life; and this degree of ambiguity is unacceptable for providing ethical guidance."

Notably, the Council's analysis and recommendations, if accepted by the AMA House of Delegates, would put the AMA squarely in the camp of the American College of Physicians, whose [2017 position on PAS](#) (and on euphemistic alternative terms, like "death with dignity") is crystal clear:

Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life. On the basis of substantive ethics, clinical practice, policy, and other concerns, the ACP does not support legalization of physician-assisted suicide . . . [Moreover], dictionaries define suicide as intentionally ending one's own life. Despite cultural and historical connotations, the term is neither disparaging nor a judgment. Terms for physician-assisted suicide, such as aid in dying, medical aid in dying, physician-assisted death, and hastened death, lump categories of action together, obscuring the ethics of what is at stake and making meaningful debate difficult; therefore, clarity of language is important.⁵

What about the APA?

The American Psychiatric Association's code of ethics is based on that of the AMA; accordingly, official APA policy is opposed to PAS of any kind. However, in light of the emerging practice in Belgium and the Netherlands of euthanizing non-terminally ill patients—including psychiatric patients—the APA felt it important to craft a position explicitly addressing this population. And so, in December 2016, the APA Board of Trustees passed the following [position statement](#), which originated in the APA Assembly and was unanimously supported by the APA Ethics Committee: "The APA, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death."⁶

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