AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

March 29, 2021

The Honorable Andy Billig
Majority Leader
Washington State Senate
307 Legislative Building
Olympia, WA 98504

The Honorable John Braun
Minority Leader
Washington State Senate
314 Legislative Building
Olympia, WA 98504

Re: AMA Opposition to House Bill 1141

Dear Majority Leader Billig and Minority Leader Braun:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to express our opposition to House Bill (H.B.) 1141. This legislation would dramatically expand Washington's Death with Dignity Act, which enables a patient at the end of his or her life to self-administer a lethal medication with the explicit intention of ending life.

As a threshold matter, it is the policy of the AMA to oppose physician-assisted suicide. Physicians are uniquely bound by the Hippocratic Oath to uphold specific ethical standards, among them that a physician "shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."[1] The AMA Code of Medical Ethics further instructs that, "the practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering."[2] As physicians, we recognize that patients suffering from a terminal illness may experience loss of a sense of self-control and independence, a sense of futility, and the fear of dying. It is understandable, though tragic, that some patients in extreme duress may come to decide that death is preferable to life. We believe that the appropriate approach is to work aggressively to meet patients' needs for compassionate care, comfort, and support, not to hasten death. It is our position that physician-assisted suicide is fundamentally inconsistent with the physician's role as a healer.[3] This position is shared across professional medical associations.

However, we understand and accept that many individuals hold different, yet equally well-considered perspectives about assisted suicide. Despite our divergent views, at the core, we all share a fundamental commitment to values of care, compassion, respect, and dignity and the aspiration that every patient come to

[1] AMA Principles of Medical Ethics I
[2] AMA Code of Medical Ethics Opinion 1.1 Patient-physician Relationships
[3] AMA Code of Medical Ethics Opinion 5.7 Physician-Assisted Suicide; AMA Policy H-140.952 Physician Assisted Suicide

the end of life as free as possible from suffering. Further, we all agree that where assisted suicide is legalized, safeguards can and should be improved. Both the state and the medical profession have a responsibility to monitor ongoing practice in a meaningful way and to promptly address compromises in safeguards. While we appreciate that the Washington legislature is reassessing and seeking to improve upon Washington's Death with Dignity Act, we believe the proposed changes to the law, in H.B. 1141, are misguided and would compromise the quality of care for patients.

First, we are deeply concerned that H.B. 1141 would authorize physician assistants and advanced registered nurse practitioners to act as the authorizing or consulting provider for individuals who request to end their lives, making solemn decisions about patients at the end of life without physician involvement. The AMA has long valued the commitment of nonphysicians to the team-based model of care, and greatly respects the contributions our colleagues make to the health care team. It is our long-held belief that health care professionals' scope of practice should be based on standardized, adequate training, and demonstrated competence in patient care. This is imperative in protecting the health and safety of our patients. While all health care professionals share an important role in providing care to patients, their skillsets are not interchangeable with those of a fully trained physician.

The extensive education and training of physicians is a necessary prerequisite to make the complex clinical judgments necessary about a patient's physical and psychological condition at the end of life. Conditions at the end of life are often medically complex, and the physical suffering is often intertwined with a patient's psychological or emotional suffering from a loss of a sense of self-control, a sense of futility or guilt, and fear of the future. Fulfilling the clinical requirements currently mandated by Washington's Death with Dignity Act—that a physician determine if the patient's condition is terminal; assess the patient's competency; rule out the presence of mental health conditions that may impair the patient's judgment; and explain the patient's diagnosis, prognosis, and range of treatment and palliative care options available—are often not straightforward and utilize the full scale of a physician's training on all aspects of the human condition.

We also fear that many patients may be led to request assisted suicide because they do not understand the degree of relief of suffering state-of-the-art palliative care can offer. The use of more aggressive comfort care measures and treatment for the psychological aspects of terminal illness can often alleviate the physical and emotional suffering that dying patients experience. Physicians are the best equipped health care professionals to make such clinical treatment determinations, convey the full range of options available, and lead multidisciplinary intervention when clinically indicated. We believe patients at the end of life deserve such care led by physicians—the most highly educated, trained, and skilled health care professionals. We cannot and should not allow anything less.

Second, we are also concerned that H.B. 1141 would decrease the amount of time—from 15 days to 72 hours—between when a patient may request a prescription for medication to end his or her life and when the prescription may be written. The ultimate choice of death over life is often taken under duress of painful and debilitating illness and this most intimate decision deserves appropriate space to ensure it is not reached emotionally or impulsively. The waiting period in the existing law is a judicious safeguard to ensure a patient's choice of death has been fully considered and is reasonably stable. The voters of Washington understood and approved of this safeguard when they ratified the 15-day waiting period. We urge the members of the legislature to respect the wisdom of the voters and reject shortening the statutory waiting period.

Finally, we must emphasize that the availability of assisted suicide must not be allowed to interfere with excellent care at the end of life. In particular, we must be cognizant that assisted suicide occurs against the backdrop of a health care system in which patients have uneven access to care, including access to high quality end-of-life care. Too few patients may be aware of the range of options available to alleviate their suffering. The use of advanced pain management techniques, greater reliance on hospice care, and treatment by a health professional with expertise in the psychiatric challenges experienced by terminal patients can alleviate the physical and emotional suffering that may lead a dying patient to prefer death over life. We view requests for assisted suicide as a signal that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. We strongly urge the legislature to take a similar approach. We encourage Washington to redouble its efforts to improve access to high-quality end-of-life care options so that all dying patients are provided optimal treatment for their pain and discomfort.

The AMA believes in end-of-life care characterized by dignity, compassion, respect, and relief from suffering, and we appreciate the legislature's intention to improve Washington's Death with Dignity Act. However, we caution that the expansive changes proposed in H.B. 1141 are not improvements. These changes would instead loosen important safeguards and put patients at risk of receiving suboptimal care at a time when they are most vulnerable. The AMA stands in opposition to H.B. 1141 and we urge you to do the same.

Thank you for your consideration. If the AMA may be of assistance, please contact Annalia Michelman, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org.

Sincerely,

James L. Madara, MD

cc: Washington State Medical Association
Members of the Washington State Senate