CMS Board of Directors Decision on March 11, 2016

Motion: That any vote on the CEJA report regarding CMS policy 170.994, Euthanasia and Physician-Assisted Suicide be delayed until November of this year; and, that:

a. Circulate the report to the entire membership, including component and specialty societies and urge peer-to-peer discussion and further input to CEJA;
b. Refer the report back to CEJA to incorporate the recommendations into the policy language and to consider additional member input;
c. Ask the Re-engineering the Annual Meeting Work Group to hold an educational session on physician assisted death at the Annual Meeting in September; and,
d. Put the report and recommendations through the virtual policy forum before the November board vote so that the entire membership will have an opportunity to participate in this decision.

Council on Ethical and Judicial Affairs
Reevaluation of CMS Policy on Physician Assisted Suicide

Recommendation: CEJA recommends that current CMS policy on Physician Assisted Suicide (PAS) be amended to:

(1) Stress the need for increasing awareness among physicians and the public around end-of-life issues and the importance of palliative or hospice care;

(2) Ensuring there are adequate protections in state law or in a constitutional amendment for both physicians and patients should such a system be approved by voters or the legislature in the future;

(3) Allow options for patients and physicians to pursue mutually acceptable approaches without violating any party's fundamental values: and,

(4) Substitute PAS with the term Physician Assisted Death (PAD).

CEJA defined (CMS bylaws): CEJA shall serve CMS to interpret the issues of medical ethics that may impact members of CMS by issuance of Opinions; assist in the interpretation of the Constitution, Bylaws and rules of CMS as needed; investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the Board of Directors through the issuance of Reports or Opinions; and perform other duties outlined elsewhere in these Bylaws or assigned by the Board of Directors.

Referral Instructions from the board of directors: CEJA was asked by the board of directors to reevaluate CMS policy on physician-assisted suicide and in doing so to survey CMS members and to consult with physicians specializing in palliative care.

CEJA approach to policy reevaluation: In addition to the guidance from the board of directors, CEJA:

(1) Reviewed the 5 state laws that currently allow physician-assisted end-of-life termination and the experience from these states;
(2) Reviewed AMA ethical guidelines;
(3) Reviewed the most current literature;
(4) Interviewed individual colleagues, attorneys, the clergy and individuals representing patient organizations
(5) Referred to the following four fundamental principles of physician ethical responsibilities: (scroll below to review definitions of each principle):

- The Principle of Respect for autonomy
- The Principle of Beneficence
- The Principle of Nonmaleficence
- The Principle of Distributive Justice

Other State Experiences: (available upon request)

CMS Survey methodology, results and observations:

Methodology: Kupersmit Research (KR) was retained to design and administer an all-member CMS survey. The CMS President invited all-members to participate in focus groups to assist KR in drafting the survey instrument. Four separate focus groups were conducted, three with physicians who responded to the all-member invitation and the 4th with CEJA. The draft survey was presented to CEJA for review, discussion, and comment. The survey was administered February 2 through February 16 2016 to all CMS members with an email address, along with a reminder communication sent on February 8. Six hundred thirty-one physicians completed the survey.

Results: Please review survey results attached.

Observations: See attached summary from Kupersmit Research

CEJA Meetings: CEJA held meetings on January 8, 21, and February 22 dedicated solely to reevaluation of CMS policy. Once CEJA had reviewed current literature, experience from other states, discussed the issue with colleagues and others, and reviewed the CMS member survey results, the following questions were posed and answered:

1. What are the ethical and clinical guidelines/parameters/safeguards that should guide physicians and patients where adults in Colorado could obtain and use prescriptions from their physicians for self-administered, lethal doses of medications?

A. Qualifications of a patient who can participate:

- Adult, age 18 or older
- Has the capacity to make medical decisions: able to understand their own condition, articulate their values, weigh risk and benefits
- Has a confirmed terminal disease that is likely to result in death in 6 months
- Is a resident of Colorado
- Makes a voluntary request for aid in dying
- Has had all feasible end-of-life services, including pain control, palliative care, comfort care and hospice
- Must be able to self-administer lethal medication
- Cannot take medication in a public place

B. Medical Requirements

- Physician must have the qualified patient request aid in dying directly and in writing.
- Waiting period between requests
- Cannot accept a request through an advanced directive, a power of attorney or other proxy.
- Must obtain a confirming second opinion on diagnosis of terminal disease and capacity of patient to make a medical decision
- Refer for counseling if patient is depressed or has mental health issues that may affect judgment (or requirement for mental health evaluation)
- Must discuss and document all options for end-of life care, risks /results of taking lethal medication.
- At the time of prescribing, must document that patient is making an informed decision and that the decision can be rescinded at any time.

Reporting and documentation requirements

- All discussions, consultations and prescriptions must be part of the patient's medical record
- Physician's duty to report to specified agency prescription for aid in dying, patient demographics, disease diagnosis, and insurance.
- Yearly aggregated reports. Individual confidentiality.
- Prescriptions identified as aid-in-dying medication.

C. Other

- Fraud protections: penalties for altering, forging prescriptions or suppressing rescissions
- Penalties for coercion from individuals, facilities or insurers to seek aid in dying medication.
- Civil and other immunity for physicians who write prescriptions or who choose not to participate.
- Requirements for witnesses to written request: must not be the patient's provider; one cannot be related or a beneficiary.
- Safe storage of prescribed medication and requirement of return of unused medication.
- Prohibition of euthanasia
- Encourage family notification

2. Should public policy on physician assisted suicide either through state legislation or a statewide ballot initiative become imminent, i.e., apparent that the issue will become law in the near-term (currently to 3 years), should CMS:

a. Oppose the proposal: Answer: No

b. Support the proposal: Answer: No

c. Be neutral on the proposal and work for patient and physician safeguards that reflect the ethical and clinical guidelines/parameters/safeguards established by CEJA? Answer: Yes, with qualifications

3. How, if at all, should current CMS policy be amended?

Answer: CMS policy should be amended in a manner that neither formally takes a strong position for or against physician-assisted suicide but rather infers a position of thoughtful, studied neutrality that promotes end-of-life care patient discussions, physician education, promotion of access to appropriate care, and the ethical and clinical guidelines/parameters/safeguards that should guide physicians and patients where adults in Colorado could obtain and use prescriptions from their physicians for self-administered, lethal doses of medications should the law be amended to permit this patient option.

Four fundamental ethical principles

- **The Principle of Respect for autonomy** Autonomy is Latin for "self-rule" We have an obligation to respect the autonomy of other persons, which is to respect the decisions made by other people concerning their own lives. This is also called the principle of human dignity. It gives us a negative duty not to interfere with the decisions of competent adults, and a positive duty to empower others for whom we're responsible.Corollary principles:

honesty in our dealings with others & obligation to keep promises.

- **The Principle of Beneficence** We have an obligation to bring about good in all our actions. Corollary principle? We must take positive steps to prevent harm. However, adopting this corollary principle frequently places us in direct conflict with respecting the autonomy of other persons.
- **The Principle of nonmaleficence** (It is not "non-malfeasance," which is a technical legal term, & it is not "nonmalevolence," which means that one did not intend to harm.) We have an obligation not to harm others: "First, do no harm." Corollary principle: Where harm cannot be avoided, we are obligated to minimize the harm we do. Corollary principle: Don't increase the risk of harm to others.Corollary principle: It is wrong to waste resources that could be used for good.Combining beneficence and nonaleficence: Each action must produce more good than harm.
- **The Principle of distributive justice** We have an obligation to provide others with whatever they are owed or deserve. In public life, we have an obligation to treat all people equally, fairly, and impartially.Corollary principle: Impose no unfair burdens. Combining beneficence and justice: We are obligated to work for the benefit of those who are unfairly treated.

Submitted by the Council on Ethical and Judicial Affairs

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