

## ► Normalizing Aid-in-Dying within the Practice of Medicine

In “Aid in Dying” in the Courts” (May-June 2015), Stephen Latham expresses the view that where access to aid in dying is established by court decision (as opposed to statute), there is a “pragmatic downside”: “Consider the current situation in Montana: aid-in-dying is legal, but legislative paralysis has left the state with no safeguards or standards in place for its exercise and no formal mechanism for gathering information about the practice.” Having served as counsel in *Baxter v. Montana* and being the former or present counsel in all the other cases Latham discusses (*Morris v. New Mexico*, *Brody v. California*, and *Myers v. New York*), I want to explain that it is incorrect to suggest that there are no safeguards or standards for the practice in Montana. The Montana Supreme Court’s decision clearly limits the practice to mentally competent, terminally ill patients. The physician’s assistance is limited to providing such a patient with a prescription for medication that the patient could ingest to achieve a peaceful death. These are three very substantial safeguards. (All are included in the statutes permitting aid-in-dying that have been enacted in Oregon, Washington, and Vermont). Beyond these bounds set by the court, the practice is governed by best practices, as all medicine is governed. A responsible physician providing aid-in-dying in Montana will learn best practices for this medical treatment, just as she would before providing any treatment. This is how medicine is practiced. Best practice is a preferable way to govern medical practice, as opposed to statute, because it allows for evolution

of practice, responsive to what physicians learn about what best serves the patient. It is time, nearly two decades after the commencement of open practice of aid-in-dying in the United States, for the practice to become normalized within the practice of medicine. There are many other forms of medical conduct that precipitate a patient’s death, including removal of a ventilator or feeding tube, deactivation of a cardiac device, and provision of palliative sedation. None is governed by statute; all are governed by best practices. There is no reason that aid-in-dying ought to be treated differently, at least at this point in time.

### It is time for the practice of aid-in-dying to become normalized within the practice of medicine.

Latham also appears concerned that in jurisdictions where aid-in-dying is practiced subject to court decision rather than statute, there is no “formal mechanism for gathering information about the practice.” Routine gathering of information about provision of medical treatment is not the norm, even for treatment that precipitates death. Delivery of medical treatment is considered private; thus collection and reporting of data regarding provision of medical treatments are not common. Again, comparison of aid-in-dying to other medical treatments that precipitate death is illuminative: data relating to deactivation of a cardiac device or to withdrawal of a ventilator or feeding tube are not collected and reported.

Oregon, the first state to permit the practice of aid-in-dying by statute, served as a highly useful “laboratory”

for a new end-of-life-care option: Oregon’s statute requires the collection and reporting of a vast amount of data. This served a vital function of generating an abundance of data about who chooses aid-in-dying and why. This data, consistent over eighteen years, demonstrated that where aid-in-dying is available, there is no harm to patients or vulnerable populations, and important benefits are realized. Concerns that existed prior to open practice of aid-in-dying have been put to rest. It is not necessary or appropriate to continue to treat this end-of-life choice differently from any of a variety of others. It is time to normalize the practice within the practice of medicine, as is happening in Montana and New Mexico in the wake of court decisions. Clinical practice guidelines, endorsed by major national medical organizations, including the American Medical Women’s Association, began to emerge a few years ago for the practice of aid-in-dying.

While statutory permission for aid-in-dying, subject to a complex regulatory scheme including mandatory data collection and reporting, may have been appropriate when the practice was new, this is no longer the case. It is time to allow the practice to become normalized, governed by best practices, as is happening following court decisions establishing access to this compassionate end-of-life option.

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## the author replies

◀ As one who favors physician aid-in-dying, I must begin by acknowledging my admiration for Kathryn

Tucker's tireless work on behalf of suffering patients. Nonetheless, I disagree with Tucker as to how best to forward the cause. She argues that aid-in-dying should by now be treated as an ordinary part of medical care, governed only by medicine's evolving best practices. I think our gains thus far are considerably more fragile. Court cases like those brought by Tucker and colleagues in Montana and New Mexico can create legal space for unregulated active participation by physicians in their patients' deaths. In such space, disagreement and scandal can thrive, to the detriment of future policy gains.

Tucker is correct that the court decisions limit aid-in-dying to a physician's provision of lethal medication to a terminally ill patient for self-ingestion. Those are real and serious limits on the

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practice. But Oregon (for example) also requires two oral requests for aid-in-dying, made fifteen days apart; a written request, witnessed by two persons, one of whom is not related to the patient; and independent confirmation of the patient's diagnosis, prognosis, and capacity. It provides for psychiatric referral for patients who need it; it requires that information be provided about alternatives to aid-in-dying such as hospice and palliative care; it facilitates notification of next-of-kin; it imposes reporting requirements; and it creates a regime for collecting unused lethal medication after the patient's death.

Tucker thinks that the time for all this elaborate oversight and data-collection is past. I disagree. It is simply not yet true that aid-in-dying enjoys the

acceptance of other kinds of end-of-life care, like hospice care or withdrawal of life-sustaining treatment. Aid-in-dying is still very far from becoming standard of care, with its own professionally generated practice guidelines. Indeed, it is opposed by formal policy statements from the American Medical Association, the American College of Physicians-American Society of Internal Medicine, the American Nursing Association, the Academy of Hospice and Palliative Care, the American Academy of Neurology, the oncology associations of both Northern and Southern California, and the vast majority of state medical societies. In the years since Oregon first adopted the Death with Dignity Act, as many states have acted to strengthen their laws against aid-in-dying as have acted to liberalize them. In short, aid-in-dying is not yet normal medicine. I hope and believe that many of these organizations will alter their positions (as the California Medical Association recently did). But meanwhile I urge that the best way to support aid-in-dying is to enact it responsibly, with safeguards in place, and with data-gathering mechanisms that will provide other states with the kind of data that will give them confidence enough to make similar democratic choices.

Oregon's legally mandated reports of its experience with aid-in-dying make it more likely that, for example, my home state of Connecticut will adopt a similar regime. Neither the ill-defined state constitutional right to aid-in-dying established (pending appeal) in New Mexico nor the absence of applicable criminal law established in Montana, will help anyone here (or elsewhere) frame a rational case for aid-in-dying.

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