Committee News

The Ethics of Ending: Anesthesiologists and the Complexities of Physician-Assisted Dying

William J. Shearon, BS
Lara R. India, MD
Peter A. Goldstein, MD
Ike I. Eriator, MD, MPH, MBA
Rachel A. Hadler, MD
Michael Souter, MBChB, DA, FRCA, FNCS

Controversy surrounding a physician's role in lethal prescriptions has existed for millennia (asamonitor.pub/3ZjISdJ). Today, some form of medical assistance in dying is a legal end-of-life option for roughly 200 million patients worldwide (*Ann Palliat Med* 2021;10:3540-53). Anesthesiologists are unfortunately associated with the world of lethal prescriptions, as evidenced by a 2006 U.S. District Court ruling that ordered California to "have a physician, specifically an anesthesiologist, personally supervise" the administration of a lethal injection for capital punishment (*N Engl J Med* 2006;354:1221-9). An anesthesiologist's decision to participate in physician-assisted dying requires evaluation of one's personal moral principles, which vary greatly on this issue. Opioids and benzodiazepines, medications that are routinely administered during anesthesia, are commonly prescribed at the end of life. As a result, even if an anesthesiologist does not participate in physician-assisted death as part of their individual practice, the discussion remains germane because of the specialty's perceived connection to the practice (*Can J Anaesth* 2016;63:326-9; asamonitor.pub/3XlpnyX).

> **"It is nearly impossible to separate physician-assisted dying from legal, moral, or ethical controversy. An individual physician's moral boundaries remain even when the practice is legal. The ethical concepts of autonomy, beneficence, justice, and nonmaleficence each apply, while equal, valid consideration must be given to the physician's own moral agency."**

Academic and legislative definitions

The terminology surrounding medical assistance in dying is not consistently applied in academic literature nor in state or national legislation (*Ann Palliat Med* 2021;10:3540-53; *Yale J Biol Med* 2019;92:747-50). Here, we will use "medical assistance in dying" as an umbrella term that includes "euthanasia" and "physician-assisted death," among others (see Table for definitions of the terms used in this article) (*Ann Palliat Med* 2021;10:3540-53). We realize that any term may produce some opposition, so we seek primarily to align the definitions with the established terms in ethical literature. Some terms that are more common in academic use have alternate meanings in legislation, even though each seeks to define the same phenomenon. "Euthanasia," as defined in the Table, is illegal throughout the United States and is therefore beyond the scope of this article.

In contrast, physician-assisted death is now legal in 11 U.S. jurisdictions. The legal term used is often "medical assistance in dying," but the process is the same as what this article refers to as "physician-assisted death" (*Ann Palliat Med* 2021;10:3540-53; asamonitor.pub/3TnFIlA).

Predominant Term in Ethics	Definition
Medical assistance in dying	Umbrella term that includes "euthanasia" and "physician-assisted death," among others
Euthanasia	When a person (generally a physician) administers a medication, such as a sedative and neuromuscular relaxant, to intentionally end a patient's life with the mentally competent patient's explicit request
Physician-assisted death	When the physician provides medication or a prescription to a patient at his or her explicit request with the understanding that the patient intends to use the medications to end his or her life

Table: Predominant terms and definitions used in ethical literature, adapted from Emanuel et al. (*JAMA* 2016;316:79-90).

Physician-assisted death in the U.S. and Canada

Ten states (California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington) and the District of Columbia have legalized the practice of physician-assisted death for terminally ill patients. Oregon was the first to do so in 1994; most recently, New Mexico legalized it in 2021. Montana is unique because the legalization comes through a State Supreme Court ruling, not an act of the state legislature. New bills like those described above are routinely introduced in statehouses nationally, though none since New Mexico's have been enacted.

For a patient's request for physician-assisted death to be considered, most state laws stipulate that a patient's life expectancy must be six months or less. Other requirements vary and may include ensuring that the individual is an adult with decision-making capacity, the request has been made voluntarily, and the individual making the request is physically able to self-administer the prescribed medication(s). Importantly, these laws require that each patient must self-administer their prescription. State laws further emphasize several aspects of patient education, including the choice to opt out at any time during the process.

Medical assistance in dying is growing more popular abroad. Canada's law, originally passed in 2015, recently came under renewed scrutiny as Ottawa considered the extension of federally funded physician-assisted death for physically healthy patients suffering from mental illnesses. The proposal, scheduled to take effect in March 2024, was delayed until 2027 after a strong and negative public response (asamonitor.pub/3zgNXJo).

Ethical considerations

It is nearly impossible to separate physician-assisted dying from legal, moral, or ethical controversy. An individual physician's moral boundaries remain even when the practice is legal. The ethical concepts of autonomy, beneficence, justice, and nonmaleficence each apply, while equal, valid consideration

Continued on next page

William J. Shearon, BS
ASA Committee on Ethics, and Medical Student, University of Missouri School of Medicine, Columbia, Missouri.
X: @WillieShearon

Peter A. Goldstein, MD
ASA Committee on Ethics, ASA Committee on Research, Professor of Anesthesiology, Professor of Anesthesiology in Neuroscience, and Professor of Medical Ethics in Medicine, Weill Cornell Medicine, New York, New York.

Rachel A. Hadler, MD
Vice Chair, ASA Committee on Palliative Care, Member, ASA Committee on Ethics, Assistant Professor of Anesthesiology, Division of Critical Care, Emory University School of Medicine, Atlanta, Georgia, and Attending Physician, Palliative Care Service, Division of Geriatrics and Extended Care, Atlanta VA Medical Center, Atlanta, Georgia.

Lara R. India, MD
ASA Committee on Ethics, ASA Committee on Palliative Care, and Assistant Professor of Anesthesiology, Medical College of Wisconsin, Milwaukee, Wisconsin.

Ike I. Eriator, MD, MPH, MBA
ASA Committee on Ethics, ASA Committee on Membership, and Professor of Anesthesiology, University of Mississippi Medical Center, Jackson, Mississippi.

Michael Souter, MBChB, DA, FRCA, FNCS
Chair, ASA Committee on Ethics, Member, ASA Committee on Trauma and Emergency Preparedness, and Professor of Anesthesiology and Pain Medicine, and Neurological Surgery, University of Washington, Seattle, Washington.

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ACE Anesthesiology Continuing Education

ACE Question

Which of the following mechanisms is MOST likely responsible for the analgesic effects of gabapentin?

(A) Acting as an agonist at the γ-aminobutyric acid (GABA) receptor

(B) Blocking *N*-methyl-D-aspartate (NMDA) receptors

(C) Blocking voltage-gated calcium channels

Though gabapentin and pregabalin are structural analogs of GABA, they are not active at the GABA receptor. Gabapentin is extensively used for the treatment of neuropathic pain conditions. Its mechanism of action is thought to be mediated by blocking voltage-gated calcium channels and reducing calcium influx. By blocking calcium influx, gabapentin reduces the release of excitatory neurotransmitters like glutamate, substance P, norepinephrine, and calcitonin gene-related peptide from primary nociceptive afferents, thereby modulating nociceptive transmission. Gabapentin has been used to treat neuropathic pain conditions associated with diabetic neuropathy, postherpetic neuralgia, trigeminal neuralgia, complex regional pain syndrome, and painful peripheral neuropathies associated with cancer.

Gabapentin was initially approved by the U.S. Food and Drug Administration as an anticonvulsant, but it is now widely used off-label in conjunction with other medications for the management of pain. The use of gabapentin in enhanced recovery protocols has become more controversial given recent data suggesting that the opioid-sparing effect is minimal, while the risk for postoperative respiratory depression may be increased.

Gabapentin does not block the NMDA receptor. ■

References:

1. Gropper MA, Cohen NH, Eriksson LI, Fleisher LA, Leslie K, Wiener-Kronish JP, eds. Miller's Anesthesia. 9th ed, 2020:742-6.
2. Hardman JG, Hopkins PM, Struys MMRF, eds. Oxford Textbook of Anaesthesia. 2017:318-9.

Answer: C

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Complexities of Physician-Assisted Dying

Continued from previous page

must be given to the physician's own moral agency. (asamonitor.pub/3TnFIlA; *Surg Endosc* 2021;35:2217-22). The question of whether a patient's autonomy outweighs a physician's obligation to nonmaleficence is central to such discussions.

Some readers may remember an anonymous physician's experience of providing medical assistance in dying titled "It's Over, Debbie," which was published in *JAMA* in 1988 (*JAMA* 1988;259:272). The case described an exhausted resident cross-covering on the gynecology-oncology service at a private hospital. The resident was called to the bedside overnight for a young woman with intractable vomiting and end-stage ovarian cancer. In response, the resident personally administered 20 milligrams of intravenous morphine with the intention to "give her rest." The patient became apneic shortly thereafter. The essay, and the decision to publish the essay in the journal, engendered an enormous response (*JAMA* 1988;259:2142-3). Then, as now, this conversation is reasonable; more broadly, the conversation needs to encompass how patient-centered care can be best provided at the end of life, which is our aim in the present essay. Debbie's case exposed the lack of patient-oriented safeguards when medical assistance in dying was done without a strong patient-physician relationship, patient education, or psychological evaluation.

The ethical doctrine of double effect can be used to evaluate treatments for patients at the end of their life. The principle describes how an unintended negative consequence can be permissible if an action is the means to a separate, intended outcome (*Philos Ethics Humanit Med* 2023;18:7; St. Thomas Aquinas Summa Theologica: Complete English Edition in Five Volumes. 2000). It is classically applied in the administration of opioids, either to provide analgesia or relieve air hunger, in perimortem patients. By considering the character of the positive effect (comfort), a clinician may be able to tolerate a negative side effect (apnea) so long as the intention is not euthanasia. The doctrine includes four criteria to justify a negative, unintended effect:

1. The act itself (in this case, prescription) must be a moral good, or at least indifferent
2. The decision-maker must not *intend* the negative effect but may *allow* it
3. The negative effect must not be the means to achieving the positive effect
4. The intended effect must be proportionally desirable to accept the negative effect's severity.

In considering the clinical status of moribund patients, maybe with widespread metastases or other incurable symptoms, physicians will approach each patient individually. Strong respect for colleagues' moral boundaries in this area can minimize disruptions to care and ensure the patient's wishes remain the focus of management discussions. Regardless of one's subspecialty or the legal status of physician-assisted dying locally, anesthesiologists may need to discuss these end-of-life scenarios with patients, colleagues, and families. ■

Disclaimer:

The opinions expressed in this article are those of the authors alone and should not be construed as ASA policy or legal advice.

Roadmap to Become an Anesthesiologist

Anesthesiologists are detail-oriented, vigilant, hands-on, skillful with procedures, calm in stressful scenarios, and communicate well with patients, surgeons, nurses, and multidisciplinary health care teams. Becoming an anesthesiologist is challenging but rewarding. See how you can build a successful career in this exciting field. Learn more at **asahq.org/education-and-career/roadmap-to-anesthesiologist**.