

**AMDA- THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE**

**RESOLUTION A24**

**SUBJECT:** UPDATE THE AMDA 1997 POSITION STATEMENT ON CARE AT THE END OF LIFE THAT OPPOSES ANY PHYSICIAN INVOLVEMENT IN MEDICAL AID IN DYING

**INTRODUCED BY:** CMDA THE COLORADO SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE, CALTCM CALIFORNIA ASSOCIATION OF LONG TERM CARE MEDICINE

**INTRODUCED ON:** MARCH 2024

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1 WHEREAS, Medical aid in dying (MAID) “is a practice in which a physician provides a  
2 competent adult with a terminal illness with a prescription for a lethal dose of a drug at the  
3 request of the patient, which the patient intends to use to end his or her life.” Regardless of  
4 personal belief, clinicians should have a patient-centered approach to engage in requests for  
5 MAID. Medical literature proposes that clinicians should be familiar with the legal status of  
6 MAID in the state in which they practice with an understanding of who is eligible and what  
7 resources are available. Patient inquiries regarding MAID should lead to thoughtful discussion  
8 about the motivations for such inquiries and patient values regarding the end of life. (VandeKieft  
9 GK. End-of-Life Care: Medical Aid in Dying. [FP Essent. 2020 Nov;498:32-36](#));

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11 **AND WHEREAS,** The American Medical Association’s Council on Ethical and Judicial Affairs  
12 has published policy statements that include “The social commitment of the physician is to  
13 sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the  
14 preferences of the patient should prevail,” and “For some physicians, the sacredness of  
15 ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude  
16 the possibility of supporting patients in hastening their death. For others, not to provide a  
17 prescription for lethal medication in response to a patient’s sincere request violates that same  
18 commitment and duty.” ([Opinion 2.20](#). *Virtual Mentor*. 2013;13(12):1038-1040. doi:  
19 10.1001/virtualmentor.2013.15.12.coet1-1312. Report of the Council on Ethical and Judicial  
20 Affairs, [CEJA Report 2-A-19](#).);

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22 **AND WHEREAS,** MAID is legal in 11 U.S. states: California (End of Life Option Act; 2016),  
23 Colorado (End of Life Options Act; 2016), District of Columbia (Death with Dignity Act; 2017),  
24 Hawaii (Our Care; Our Choice Act; 2019), Maine (Maine Death With Dignity Act; 2019),  
25 Montana (Supreme Court decision, not statute), New Jersey (Medical Aid in Dying for the  
26 Terminally Ill; 2019), New Mexico (Elizabeth Whitefield End-Of-Life Options Act; 2021),  
27 Oregon (Oregon Death with Dignity Act; 1997), Vermont (Patient Choice and Control at the  
28 End-of-Life Act; 2013), and Washington (Washington Death with Dignity Act; 2008).

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30 MAID legislation has been introduced in 14 states: Arizona, Connecticut, Indiana, Iowa, Kansas,  
31 Kentucky, Minnesota, Pennsylvania, Nevada, New York, North Dakota, Massachusetts, Rhode

32 Island, and Virginia. (Horowitz AC. *Medical Aid in Dying (MAID): Medical, Legal & Ethical*  
33 *Issues*. [CMDA Monthly Meeting Presentation, Dec. 5, 2023](#))

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35 **AND WHEREAS**, AMDA developed a [position statement in February 1997 on Care at the End-](#)  
36 [of-Life](#), or 27 years ago, that takes a position opposing any physician involvement in MAID,  
37 which appears untenable given the changes in legislation and clinical practice in the last quarter  
38 century.

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40 **AND WHEREAS**, In every jurisdiction in the U.S. where MAID is legally permissible, the  
41 manner of death recorded on death certificates is, by law, ruled to be natural causes, not suicide.

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43 **AND WHEREAS**, In all states where medical aid in dying (MAID) is legal, providers and  
44 facilities may choose whether to participate in providing MAID or not, and in many states,  
45 health-care facilities must notify patients and providers in writing of their policy. For example,  
46 Colorado statutes indicate that a health-care provider may choose whether to participate ([C.R.S.](#)  
47 [25-48-117](#)). The health-care facility must notify the physician in writing of its policy with regard  
48 to prescriptions for medical aid-in-dying medication. A health-care facility must notify patients  
49 in writing of its policy with regard to medical aid-in-dying ([C.R.S. 25-48-118](#)).

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51 **AND WHEREAS**, Data on the use of MAID in the U.S. suggests potential educational and  
52 racial and ethnic disparities among patients requesting and utilizing MAID. Ensuring access and  
53 transparency on MAID for all eligible patients is imperative for equity (Kozlov, E., et al. *JAGS*  
54 *2022*, 70: 3040-3044. DOI:10.1111/jgs.179254; AMDA, F22- Resolution and Position  
55 Statements, Apr. 27, 2022). Furthermore, transparent disclosure of facility policies helps to  
56 honor the ethical principle of informed consent.

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58 **THEREFORE BE IT RESOLVED**, That P97, the AMDA-The Society for Post-Acute and  
59 Long-Term Care Medicine Position Statement and Policy on Care at the End-of-Life from 1997,  
60 be revised to remove the language that categorically opposes any physician involvement with  
61 medical aid in dying (MAID).

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63 **AND BE IT FURTHER RESOLVED**, That AMDA-The Society for Post-Acute and Long-  
64 Term Care Medicine advocate among professional organizations involved with post-acute and  
65 long-term care (PALTC) for transparent oral or written disclosure to residents currently residing  
66 in PALTC communities, and before or upon admission to a PALTC community, regarding each  
67 community's policy on MAID in states where MAID is legally available.

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69 **FISCAL NOTE:**

70 If passed by the House of Delegates and adopted as Society policy by the Board of Directors, the  
71 fiscal impact of this would be low, as it would be incorporated into AMDA's existing and  
72 ongoing advocacy and coalition work.



**RESOLUTION RESULTS: <FOR AMDA OFFICE ONLY>**

## Background information:

### [Position Statement on Care at the End of Life](#)

P97

Becomes Policy February 1997

#### Background

Care at the end of life is an important issue to members of the American Medical Directors Association (AMDA). As primary care physicians, we help patients and their families cope with the decisions and emotions surrounding the dying process. As medical directors, we are responsible for ensuring that facility policies regarding end of life issues honor the dignity and autonomy of individual residents and that the staff is educated in providing compassionate and effective care at the end of life.

#### Positions

AMDA fully supports the Patient Self Determination Act and encourages physicians to address advance directives with patients upon admission to the long term care facility. When a patient has no advance directive and is judged by the attending physician to lack decisional capacity on this issue, every effort should be made to identify an appropriate surrogate (in compliance with state law) to address issues of care at the end of life.

AMDA acknowledges that not all available treatments are beneficial in the course of a particular patient's care. After obtaining informed consent, AMDA supports withholding or withdrawing any medical intervention that the physician and patient or appropriate surrogate feel imposes a greater burden than benefit, even if the unintended result of such non-intervention or withdrawal may hasten the patient's death.

AMDA supports aggressive treatment toward relieving the pain, anxiety, depression, emotional isolation, and other physical symptoms that can accompany the dying process even if the unintended result of such treatment may hasten the patient's death. All of the resources available to the medical profession and the care team should be mobilized to provide comfort to dying patients, family members and friends.

AMDA opposes any physician involvement in assisted suicide or active euthanasia of any person regardless of age. AMDA members recognize that we are entrusted with the care of people who are vulnerable in terms of physical frailty and cognitive impairment. Our position recognizes that physician involvement in assisted suicide or active euthanasia would erode the trust vital to the doctor/patient relationship.

AMDA supports professional and public education, policy development and research that enhances the delivery of compassionate and effective care at the end of life.