



The Medical Society
of the State of New York

**Testimony of
The Medical Society of the State of New York
before the
Assembly Committee on Health
“Medical Aid In Dying”
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Submitted by

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Good morning: My name is Dr. Thomas J. Madejski, President of the Medical Society of the State of New York. I am an Internist who specializes in geriatric medicine and palliative care. One of my other professional hats is that of medical director for Orleans Hospice.

In my experience, there are great disparities in access to and the quality of care at the end of life. It is a complex issue with large variations in the wishes of patients and the application of care when patients approach the end of their natural lifespan or are faced with a terminal illness. First and foremost, I believe that we need to create an environment that eliminates the desire for a patient to contemplate ending their life, due to fear of inadequate care at the end of life. As the recently elected president of MSSNY, I have asked a number of our committees to examine how MSSNY can help to improve the care of our patients at end of life.

Assembly Bill 2383A would permit a terminally ill patient to request medication from physicians to be self-administered for the purpose of hastening the patient's death. Until such time as the law changes, aid in dying or assisted suicide by a physician is still illegal in New York State. The New York Court of Appeals September 7, 2017 Myers v Schneiderman decision reaffirms this.

In 2017, the MSSNY House of Delegates passed a resolution calling upon MSSNY to conduct a membership survey to determine our members' attitudes on death and dying. This resolution also called upon the Medical Society's Bioethics Committee to develop the survey instrument. The MSSNY Bioethics Committee, under the tutelage of its Chair Dr. Jeffrey M. Berger, Chief of the Division of Palliative Medicine and Director of Clinical Ethics at NYU Winthrop Hospital, began work immediately following the 2017 House of Delegates. The committee members took great care in the development of the survey questions so as to be sure they would not bias the results. The survey questions revolved around individual physician experience with death and dying and patient requests for assistance. The questions also included whether physicians would prescribe a lethal dose if it were legal to do so under NYS law; whether or not the activity was within or without the appropriate scope of physicians' medical practice; whether the activity, if legally permitted, would have any effect on trust of physicians within racial and ethnic minorities and the disabled community. This work has recently been completed and on March 5, 2018, the survey was sent by email to MSSNY members. The survey period closed on Monday, March 19, 2018.

Most physicians who responded to the survey did not support issuing a prescription for a lethal dose of medication for a terminally ill patient. A large majority indicated that such a measure could have a negative impact on healthcare among racial/ethnic minorities and the physically disabled patient. Equally troubling, were physicians concerns that such a measure would have a negative impact on trust between the physician and patients.

MSSNY Bioethics Committee is currently analyzing the data related to the survey with anticipated report to the MSSNY Council in the near future. Our surveys are helpful in giving our leaders a general sense of the perspective of our membership with regard to how best to approach an issue.

This is a very complicated and controversial issue within our membership. There are passionate physicians on both sides making well-reasoned arguments. MSSNY long-standing position against “aid in dying” is based upon the sacred principle that physicians are dedicated to healing and preserving life, not ending it.

However, based on the very preliminary survey results, MSSNY does NOT anticipate changing its position on this matter any time soon.

In 2015, MSSNY’s Bioethics Committee recognized that there was a need to update its policy on this issue and brought a resolution to the MSSNY HOD asking for a revision of the statement regarding physician assisted suicide as a means of trying to balance the evolving views of the MSSNY membership. Members of the 2015 MSSNY HOD agreed with the revision to this statement, but definitively wanted the statement: *Physicians should not perform euthanasia or participate in assisted suicide* included in the MSSNY policy 95.989. At this point, this remains MSSNY position and the policy in whole states:

95.989 Physician-Assisted Suicide and Euthanasia:

Patients, with terminal illness, uncommonly approach their physicians for assistance in dying including assisted suicide and euthanasia. Their motivations are most often concerns of loss of autonomy, concerns of loss of dignity, and physical symptoms which are refractory and distressing. Despite shifts in favor of physician-assisted suicide as evidenced by its legality in an increasing number of states, physician-assisted suicide and euthanasia have not been part of the normative practice of modern medicine. Compelling arguments have not been made for medicine to change its footing and to incorporate the active shortening of life into the norms of medical practice. Although relief of suffering has always been a

fundamental duty in medical practice, relief of suffering through shortening of life has not. Moreover, the social and societal implications of such a fundamental change cannot be fully contemplated. MSSNY supports all appropriate efforts to promote patient autonomy, promote patient dignity, and to relieve suffering associated with severe and advanced diseases. Physicians should not perform euthanasia or participate in assisted suicide. (Council 5/14/92; Reaffirmed HOD 1995-80; Modified and reaffirmed HOD 2014; Replaced by HOD 2015-162).

MSSNY will continue to examine the issue through our Bio-ethics Committee and our MSSNY Council. MSSNY is committed to work with physicians and groups on both sides of this difficult question to continue to improve the access to and quality of palliative care for all of our patients, particularly in their last days.

I would like to share some personal experiences regarding the difficult circumstances to which this legislation would likely apply that I hope will provide additional nuanced information that will assist you in your deliberations.

I have practiced geriatric medicine and palliative care for over 25 years and agree that this is one of the most challenging questions for a physician personally and as a profession. I believe I am able to understand both sides of the issue and have had to deal directly with the question on a regular basis. In my practice, I have been able to have a discussion with my patients and adjust their treatment to relieve their fears and suffering.

Most physicians are deeply troubled by the potential abandonment of a patient by their physician at their time of greatest need of their physician's skill and caring. Although the proposed legislation requires two physicians to certify a patient, prognostication, particularly with regards to time left before death is one of our most difficult assessments. There is also a subset of patients admitted to hospice or otherwise are felt to have a limited life expectancy, which are misdiagnosed or have substantially less aggressive disease after optimizing their treatment. I have had patients under my care that could be legitimately certified as having a life expectancy of less than six months who have lived up to three years.

In the last year I have had a new experience, which I believe is related to societal change and attitudes toward the burden of life, not just on the patient, but on the family.

I admitted a patient to a nursing home with moderate dementia, a probable lung cancer and advanced lung disease. I did not have a pre-existing relationship with the patient or the family. After about a week at the nursing facility the family requested hospice services which were appropriate based on the patient's overall condition. I continued to treat the patient and optimized her medical regimen and she stabilized. A few months passed and one afternoon I received a somewhat angry call from a family member in Texas who wanted to know why I was keeping his mother alive. I explained that we were treating her with usual medical care and that treating her lung disease improved her comfort. That seemed to satisfy that child but over the next month or so I had multiple contentious meetings with the family who basically wanted me to euthanize their mother. The patient was able to participate in decision making initially, indicated she was comfortable and not in distress. As her dementia progressed she was less able to make her needs known. I was left then to deal with her family member who had been designated her health care proxy. With great difficulty we were able to negotiate her care until she passed. The experience was extremely traumatic for my nursing staff and her other care givers who felt they were being coerced to overmedicate the lovely woman they came to know over six months.

I am still troubled by this case, and I have had another similar experience in the last year. And I am sure similar scenarios occur countless times every day across New York in hospitals, nursing homes, and hospice.

Thank you again for the opportunity to speak with you. I'm happy to answer questions.