

60 REASONS TO SUPPORT NEW YORK'S MEDICAL AID IN DYING ACT

Dr. Timothy Quill

A physician specializing in palliative care at the University of Rochester Medical Center, Dr. Quill supports the New York Medical Aid in Dying Act.



Rochester, New York

Reason #40

So that doctors can respond to each person's unique clinical circumstances using their values and preferences rather than the doctor's own.

I advocate for improving palliative care and hospice for all seriously ill patients, but consistent data show unacceptable suffering sometimes persists despite unrestrained efforts to palliate.

Some of these patients request our assistance in dying. Many are reassured by the possibility of medical aid in dying that they may never need, but knowing they could have an escape if their future suffering becomes unacceptable is reassuring.

But a small percentage of these dying patients reach a point where they are ready to die now. Although many times palliative care consultation provides adequate relief that the patient withdraws their request, some patients persist because of unrelievable, unacceptable suffering.

Consider a patient on a breathing machine with advanced lung cancer who is "ready to die" — we carefully evaluate for treatable suffering, but if they are seeing their situation clearly we "listen to the patient" and allow them to stop their life support and die peacefully. Take the life support away from the discussion, and we suddenly doubt the patient's request and the skill level of the practitioners. All such patients should go through a similar evaluation, and if their request is genuine and all efforts to relieve suffering otherwise are being carefully considered, we should respond in ways that adequately address their situation.

Currently in New York State terminally ill patients who are thinking clearly and are ready to die now have a range of inadequate options. We can simply turn them down because the entire realm makes us uncomfortable.

If they are on life supports we can help them to die indirectly by stopping them. If immediate physical symptoms are overwhelming, we can provide palliative



sedation to help them escape awareness of their suffering. We can offer the option of voluntarily stopping eating and drinking, allowing them to die of dehydration.

Consider the following patient with advanced cancer now not responding after 3 years of successful chemotherapy. He desperately wanted the possibility of medical aid in dying should his suffering become unacceptable.

If he lived in Oregon I would have offered him that possibility, and he would have found this possibility reassuring even if he never actually needed it. Eventually, he could no longer walk because both of his legs developed metastatic fractures. His pain was severe with any movement, manageable with medication only if he held completely still. He was on hospice and ready to die. A consulting psychiatrist confirmed he was thinking clearly. His only option to end his suffering in New York was to voluntarily stop eating and drinking.

Although he eventually chose this possibility, he thought it barbaric to have to starve and dehydrate himself to achieve his death in comparison to a more forthright option. It is for such patients that we are asking you to authorize the option of medical aid in dying as a last resort for terminally ill patients who feel they do not otherwise have acceptable options. More than two decades of data from Oregon suggest that this practice can be legally regulated and that it enhances rather than undermines palliative care and hospice.

Medical aid in dying is now legal in 9 US states and the District of Columbia. If I become terminally ill in the future I will welcome palliative care and hospice, but I will also find comfort in the possibility of medical aid in dying as a last resort. I hope I will never actually need it, but I would find it very reassuring to know that it is there.

To join our mission, email Amanda Cavanaugh at acavanaugh@compassionandchoices.org.

