

Colorado Medical Board Policy

POLICY NUMBER: 40-06
Title: Guidelines Regarding the Treatment of Terminally Ill Patients
Date Issued: 11/12/98
Date(s) Revised: 11/14/02; 07/01/10
Reference:
Purpose: See attached guidelines introduction.

POLICY: On November 12, 1998, the Colorado Medical Board adopted the attached guidelines regarding euthanasia.

COLORADO MEDICAL BOARD GUIDELINES REGARDING THE TREATMENT OF TERMINALLY ILL PATIENTS

INTRODUCTION

The Colorado Medical Board ("Board") recognizes that people have pain and suffering associated with terminal illness which may not be effectively managed by currently available therapies. The Board also recognizes that many of these people are of sound mind and wish to direct their end of life care, including choices involving medical interventions as well as whether to begin, continue or withdraw life-sustaining artificial nutrition and hydration. Indeed, there may be patients, relatives, or an authentic proxy who request of physicians, in response to the pain or suffering associated with terminal illness, a more active approach to end the person's life. Other patients, family members and/or an authentic proxy will more readily access available palliative, social, and spiritual support to make the person's last days meaningful and as comfortable as possible.

Physicians treating patients with terminal illness may therefore be faced with the difficulty of respecting the wishes of their patients and obeying state laws which prohibit euthanasia or physician assisted suicide. The issue is further complicated as a result of the ongoing debate concerning what constitutes appropriate societal policy on euthanasia and physician assisted suicide, which continues to be a significant and emotional issue throughout the nation.

The United States Supreme Court has recently ruled that certain state legislation prohibiting assisted suicide does not violate the Due Process or Equal Protection Clauses of the United States Constitution. State laws regarding physician assisted suicide vary, ranging from legislation prohibiting physician assisted suicide (the current position in the state of Colorado) to the Oregon law (reaffirmed by voters on November 4, 1997) to allow physician assisted suicide. Many other states have rejected proposed legislation to allow physician assisted suicide and many others have yet to adopt legislation on this matter.

The Board has decided to issue guidelines to Colorado physicians to help them address the needs of their patients in a manner which is consistent with Colorado law. Guidelines do not have the legal status of laws and regulations, but guidelines can explain what activities the Board considers to be within the boundaries of professional practice. Guidelines alert licensees to unprofessional practices of concern to the Board and give physicians practical information about how to avoid these problems.

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DEFINITIONS

1. EUTHANASIA, means the direct, intentional intervention of a physician or another party to end the life of a patient whether it is taken at the patient's request, without the knowledge of the patient, or taken against the patient's wishes.

Competent patients have a moral and a legal right to refuse treatment if that is their wish. The withholding or withdrawal of medical interventions, allowing the disease process to continue its natural course leading to death, is not considered euthanasia. Physicians have an obligation to honor the wishes of their competent patients, or the authentic proxy of their incompetent patients, with respect to withholding and withdrawing undesired medical interventions.

2. SUICIDE, means the intentional termination of one's own life.

Refusing a treatment which may delay the moment of death is not suicide. However, taking a dose of medication with the intent that it be lethal, even when fatally ill, would be suicide.

3. PHYSICIAN ASSISTED SUICIDE, means a physician intentionally aiding a patient to commit suicide through any method including, but not limited to, intentionally providing a lethal dose of medication for the purpose of aiding a patient to commit suicide.

This differs from providing an adequate dose of medication for the purpose of regulating pain relief (when no lesser dose is effective) even though the dose may foreseeably, but unintentionally, hasten the moment of death.

GUIDELINES

1. Physicians shall obey Colorado law which currently prohibits both euthanasia and physician assisted suicide as defined in these guidelines. Because controversy surrounds these issues, physicians ought to respond to patient and family concerns about the pain and suffering associated with terminal illness with respect and compassion. Physicians should continue to participate in society's ongoing examination, clarification and responses to these matters.
2. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
3. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including effective pain management and greater reliance on hospice care, can alleviate the physical and emotional suffering that many dying patients experience. The foregoing, along with evaluation and treatment by a health care professional with expertise in psychological aspects of terminal illness, can often alleviate the suffering that leads a patient to desire euthanasia or physician assisted suicide.
4. Requests for euthanasia or physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Interdisciplinary interventions, including specialty consultations, spiritual care, family counseling, and other modalities should be sought as clinically indicated.

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5. Physicians should recognize that courts and regulatory bodies readily distinguish between the use of medications including opioids to relieve pain in dying patients and use in other situations. (Reference Board Guidelines for Prescribing Controlled Substances for Chronic Non-Malignant Pain)
6. The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment of a patient who possesses decision making capacity or that of an authentic proxy acting on an incompetent patient's behalf. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
7. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
8. Physicians must be vigilant in assuring that frail and debilitated persons who may appear to be terminally ill are thoroughly assessed to determine whether treatments could reverse their current condition.
9. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably, but unintentionally, hasten the moment of death.
10. Physician assisted suicide and euthanasia are fundamentally inconsistent with the physician's professional role.

CONCLUSION

Physicians must not perform euthanasia or participate in assisted suicide. Support, comfort, respect for patient autonomy, good communication, and effective pain control may decrease dramatically both the public and private requests for euthanasia and assisted suicide. In carefully defined circumstances, it would be humane to recognize that death is certain and suffering great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician assisted suicide.