Understanding Medical Aid in Dying

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COMPASSION & CHOICES

Relevant to the content of this CME activity, Dr. Thoman indicated she has no financial relationships to disclose.
Who We Are

THE LARGEST U.S. ORGANIZATION ADVOCATING FOR PEOPLE'S RIGHTS AT THE END OF LIFE IS CALLED COMPASSION & THESE
Modern Medicine
“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”
End-of-Life Options

• Pursuing Life-Sustaining Treatment
• Refusing Life-Sustaining Treatment
• Discontinuing Treatment
• Hospice
• VSED
• Palliative Sedation
• Medical Aid in Dying (18%)
Definitions

Medical aid in dying is a medical practice in which a terminally-ill adult of sound mind may ask for and receive a prescription medication they may self-administer for a peaceful death if and when their suffering becomes unbearable.
Medical Aid in Dying is NOT

- Euthanasia
- Suicide or Assisted Suicide
- Death panels

“Death with Dignity” v. “End-of-Life Option”
# Medical Aid in Dying v. Suicide

<table>
<thead>
<tr>
<th>Medical Aid in Dying</th>
<th>Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminal diagnosis</td>
<td>No terminal diagnosis</td>
</tr>
<tr>
<td>Mentally capable</td>
<td>Mentally incapable (psychiatric diagnosis)</td>
</tr>
<tr>
<td>Patient wants to live</td>
<td>Patient wants to die</td>
</tr>
<tr>
<td>Planned; often with family</td>
<td>Impulsive; alone</td>
</tr>
<tr>
<td>Death is peaceful</td>
<td>Death may be violent</td>
</tr>
<tr>
<td>Normal grieving after death (guilt</td>
<td>Abnormal grief (family members wonder “what if?”)</td>
</tr>
<tr>
<td>is rare)</td>
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</table>

| **Normal grieving after death (guilt is rare)** | Abnormal grief (family members wonder “what if?”) |

- **Terminal diagnosis**: Medical Aid in Dying requires a terminal diagnosis, whereas Suicide does not.
- **Mentally capable**: Medical Aid in Dying requires the patient to be mentally capable, whereas Suicide can be impulsive and alone.
- **Patient wants to live**: Medical Aid in Dying requires the patient wants to live, whereas Suicide requires the patient wants to die.
- **Planned; often with family**: Medical Aid in Dying is planned and often with family, whereas Suicide is impulsive and alone.
- **Death is peaceful**: Medical Aid in Dying ensures peaceful death, whereas Suicide may be violent.
- **Normal grieving after death**: Normal grieving after death is rare in Medical Aid in Dying, whereas Suicide may lead to abnormal grief (family members wonder “what if?”).
Legally

“Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”
<table>
<thead>
<tr>
<th>State</th>
<th>Authorization Method</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>by ballot</td>
<td>1997</td>
</tr>
<tr>
<td>Washington</td>
<td>by ballot</td>
<td>2008</td>
</tr>
<tr>
<td>Montana</td>
<td>by court</td>
<td>2009</td>
</tr>
<tr>
<td>Vermont</td>
<td>by legislation</td>
<td>2013</td>
</tr>
<tr>
<td>California</td>
<td>by legislation</td>
<td>2015 –</td>
</tr>
<tr>
<td>Colorado</td>
<td>ballot</td>
<td>2016</td>
</tr>
<tr>
<td>Washington D.C.</td>
<td>legislation</td>
<td>2016</td>
</tr>
</tbody>
</table>
Who qualifies?

- Adult
- Terminally ill - 6 month prognosis
- Mentally capable of making informed health care decisions
- Able to self-administer (voluntary, conscious, and physical act to take the medication into the body)
- Residency
Process

• Patient submits written request (two witnesses, at least one must be disinterested party)
• Doctor determines eligibility
• Doctor provides full list of alternatives
• Refers to second doctor for confirmation of eligibility and prognosis
Process cont.

• If second opinion does NOT concur, NO action may be taken until a comprehensive mental health evaluation is completed.

• If second opinion does concur, patient submits a second written request (no earlier than 15 days from the first request).
Process cont.

• Before prescription is written, doctor must
  • Confirm patient is acting voluntarily, free from coercion
  • Offer alternatives
  • Offer option to rescind request
  • Counsel on use of medication
Clinical Criteria for Medical Aid in Dying
Medication

**Step One – antiemetic**
Taking metoclopramide (Reglan, 20 mg) and ondansetron (Zofran, 8 mg) is recommended about one hour prior to taking the barbiturate.

**Step Two – short-acting barbiturate**
Prescribe Secobarbital (Seconal, 10 g) in powder form to be mixed with liquid and ingested within 120 seconds

*The time to death from ingestion ranges from five minutes to several hours.*
Alternatives

Pentobarbitol

Combination:
Phenobarbitol + Chloral hydrate + Morphine
Protections

• Documentation

• No health professional or institution is required to participate (may opt out)

• Liability protection – when health professionals follow the steps, they are protected from criminal and civil liability

• No impact on health or life insurance policies
Death Certificate

Cause of death = disease (same as with VSED or pall sed)
Oregon data

1. Since 1997:
   - **1,749** patients received Rx/**1,127** patients ingested
2. 79% cancer; 7% ALS; heart & lung 11%
3. 90% enrolled in hospice; 89% died at home
4. white, >65, educated, insured

Source: Oregon Public Health Division 2016
Oregon data cont.

1. 104 physicians participated (204 Rx written)
2. No abuse, no physician disciplined, no legal action
3. Duration of physician-patient relationship = 12 weeks
4. Duration from request to ingestion = 46 days
5. Duration from ingestion to….
   unconsciousness = 5 - 15 minutes
   death = 25 minutes – 3 hours
Physician Participation in Oregon

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td># physicians who wrote Rx</td>
<td>15</td>
<td>104</td>
</tr>
<tr>
<td># prescriptions written</td>
<td>16</td>
<td>204</td>
</tr>
</tbody>
</table>
Data from California (June – December 2016)

1. 258 requests; 191 prescriptions written (by 173 physicians); 111 ingested

2. Median age = 73

3. 84% in hospice

4. 65% cancer; 20% ALS/Parkinson

5. White, educated, insured
Other Countries

NETHERLANDS

• “suffering” not “terminal”
• physicians may administer
• children 12 – 17
• dementia – health care directive
• elderly (if suffering)

CANADA

• “grievous and irremediable”
• physician may administer
Medical aid in dying is

A component of hospice care NOT an alternative to hospice care
Not a Failure of Palliative Care

- Requests not related to pain
- Majority enrolled in hospice
- Palliative Care excellent where MAID is common: Belgium, Oregon
- VALUES influence decision
Reasons

• Loss of autonomy (90%)
• Loss of pleasure (90%)
• Loss of dignity (65%)
• Being a burden (49%)
• Loss of control of bodily functions (37%)
• Pain (35%)
• Finances (5%)
Reasons

**RESEARCH - FAMILIES**
- Desire for control
- Poor quality of life
- Loss of independence
- Loss of dignity
- Fear lack of self-care
- Want to die at home
- Not want to be a burden

**RESEARCH – PHYSICIANS**
- Loss of independence (57%)
- Poor quality of life (55%)
- Ready to die (54%)
- Wanted control (53%)
- Physical pain (43%)
- Loss of dignity (42%)
- Financial burden (11%)
Impact

- Oregon hospice use has increased since DwD and is now DOUBLE the national average
- Lower rates of ICU in last month of life
- 2/3 die at home (compared to 40% nationally)
- POLST and HCR online registries
- Peace of mind

All 4 states with DwD received “A” grade in 2015
According to a 2015 article in the Journal of Palliative Medicine, the Oregon Death With Dignity Act may have resulted in

“… more open conversation and careful evaluation of end-of-life options, more appropriate palliative care training of physicians, and more efforts to reduce barriers to access to hospice care and has thus increased hospice referrals and reduced potentially concerning patterns of hospice use in the state.”
Financial Incentive

Savings < .07% of total healthcare spending in U.S.

Hospice per diem rates

Individual family finances

Gallup Polls

Percentage who agree that a terminally ill patient should be allowed to ask for and receive aid from a doctor to end their life by a painless means
### 3 Common Concerns

<table>
<thead>
<tr>
<th>CONCERN</th>
<th>DATA SHOWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased suicide rates</td>
<td>OR rates = national patterns</td>
</tr>
<tr>
<td>Used against vulnerable</td>
<td>No evidence</td>
</tr>
<tr>
<td>Undermine palliative care</td>
<td>Impact positive</td>
</tr>
</tbody>
</table>
Ethical Dilemma

Competing goods

Extend life v. Alleviate suffering
Hippocratic Oath

The doctor must do everything in his power to save lives, preserve health, or at least alleviate the suffering

-- Hippocrates --

www.StatusMind.com
Medical Ethics

- Patient autonomy - decision-making free from coercion
- Beneficence – intent is to do good or benefit the patient
- Non-maleficence – do no harm
- Social justice – fair distribution of scarce resources
Double Effect – St. Thomas Aquinas

under certain conditions
it’s permissible to do
something with a morally
good intended effect and a
morally bad unintended
side effect
<table>
<thead>
<tr>
<th>Hastening Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difference between medical aid in dying and withdrawal of life-sustaining treatment/pall sedation</td>
</tr>
<tr>
<td>Intent is to relieve suffering and respect patient autonomy</td>
</tr>
<tr>
<td>Morally acceptable</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Intention to end life makes medical aid in dying distinct from withdrawing life-sustaining treatment and palliative sedation</td>
</tr>
<tr>
<td>Morally wrong because life is sacred</td>
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</table>
Is Medical Aid in Dying Acceptable?

WHO DECIDES?
State Physician Surveys

- Colorado Medical Society: 65% favor
- Maryland State Medical Society: 58% favor
- Massachusetts Medical Society: 60% favor

Surveys in development:
1. Medical Society of the State of New York
2. Arizona Medical Association
Engaged Neutrality

American Academy of Hospice & Palliative Medicine
American Academy of Legal Medicine
American Medical Women’s Association
GLMA: Health Professionals for LGBT Equality
AAFP Chapters: Oregon, California, New York
State Medical Associations: Oregon, California, Colorado, Vermont, Maryland, Minnesota, Maine, Nevada, Washington D.C., Massachusetts
Notable Exception

OPPOSED: American College of Physicians

www.acponline.org
AOA Code of Ethics

It seeks to transcend the economic, political, and religious biases, when dealing with patients, fellow physicians, and society. It is flexible in nature in order to permit the AOA to consider all circumstances, both anticipated and unanticipated. The physician/patient relationship and the professionalism of the physician are the basis for this document.
AOA Policy on End-of-Life Care

The alternative to physician-assisted suicide is physicians who are committed to providing excellence in end of life care and continuing to attend their dying patients.
AMA Code of Medical Ethics

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.
Resolution 015 asks that our AMA and its Council on Ethical and Judicial Affairs study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying”. 
Discussion

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www.CompassionAndChoices.org/D4D