Understanding Medical Aid in Dying

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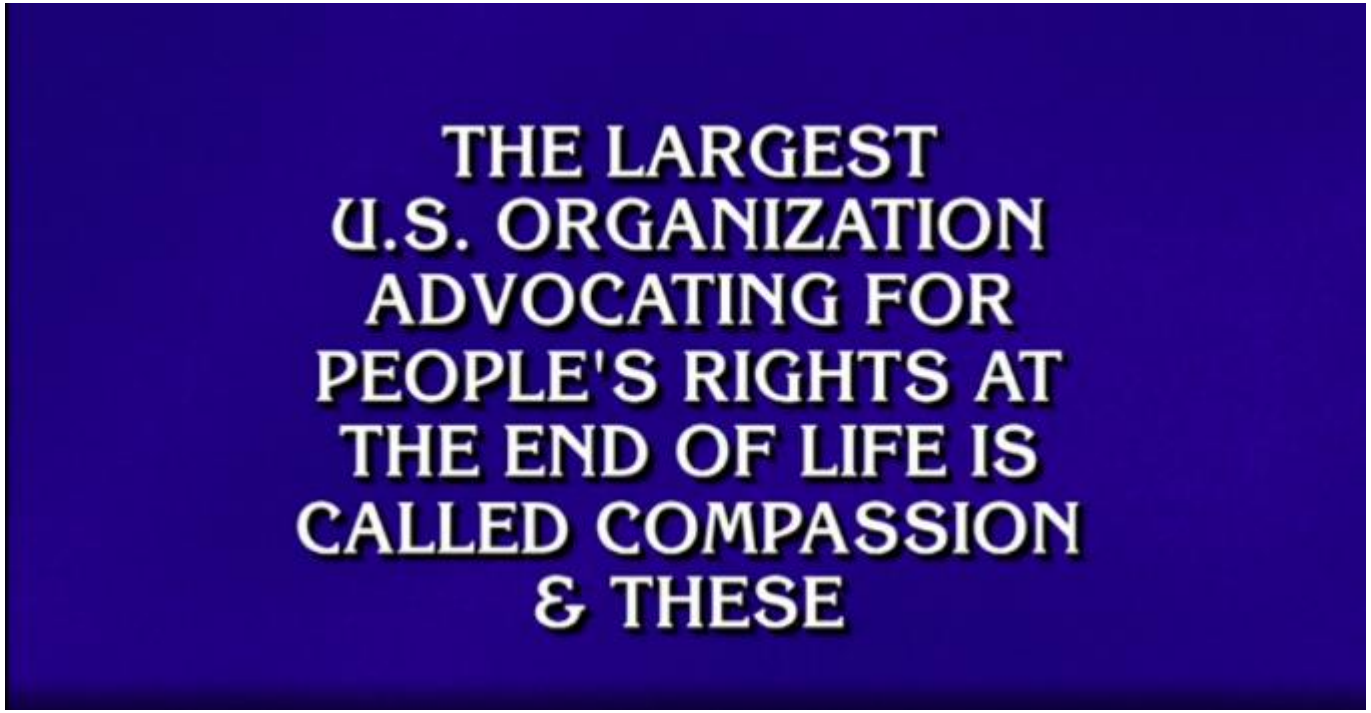
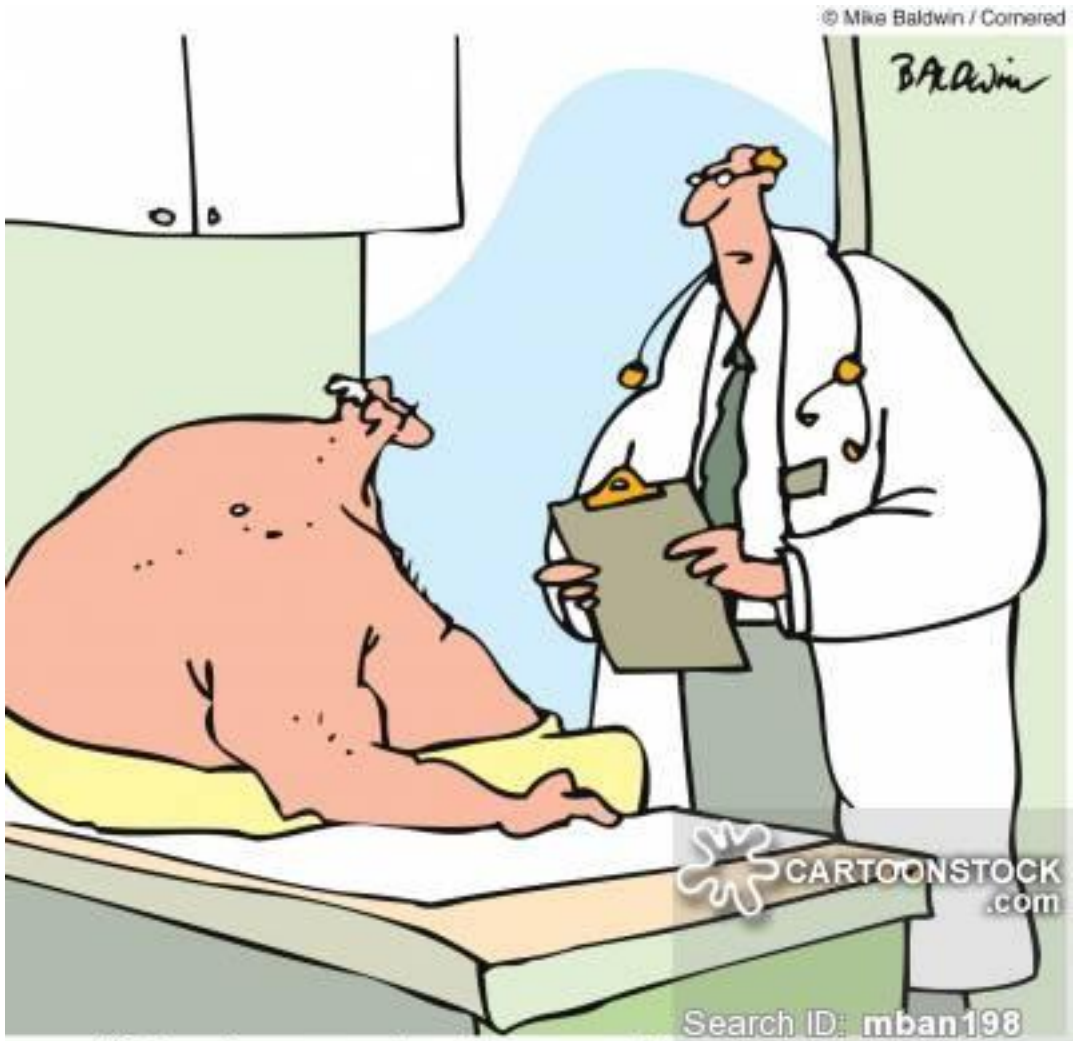
COMPASSION & CHOICES

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

Medical Aid in Dying	Suicide
Terminal diagnosis	No terminal diagnosis
Mentally capable	Mentally incapable (psychiatric diagnosis)
Patient wants to live	Patient wants to die
Planned; often with family	Impulsive; alone
Death is peaceful	Death may be violent
Normal grieving after death (guilt is rare)	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."

Aid in Dying authorized

Oregon (1997 by ballot)

Washington (2008 by ballot)

Montana (2009 by court)

Vermont (2013 by legislation)

California (2015 – by legislation)

Colorado (2016 ballot)

Washington D.C. (2016 by legislation)

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

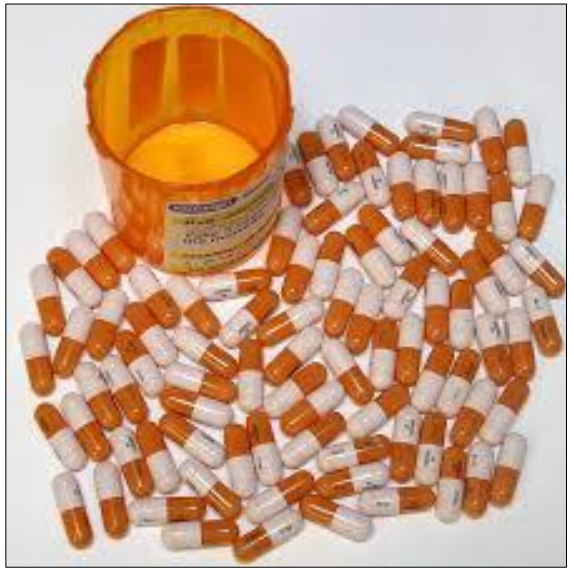
Medication

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

	1999	2016
# physicians who wrote Rx	15	104
# prescriptions written	16	204

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

JAMA: Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the U.S., Canada and Europe

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

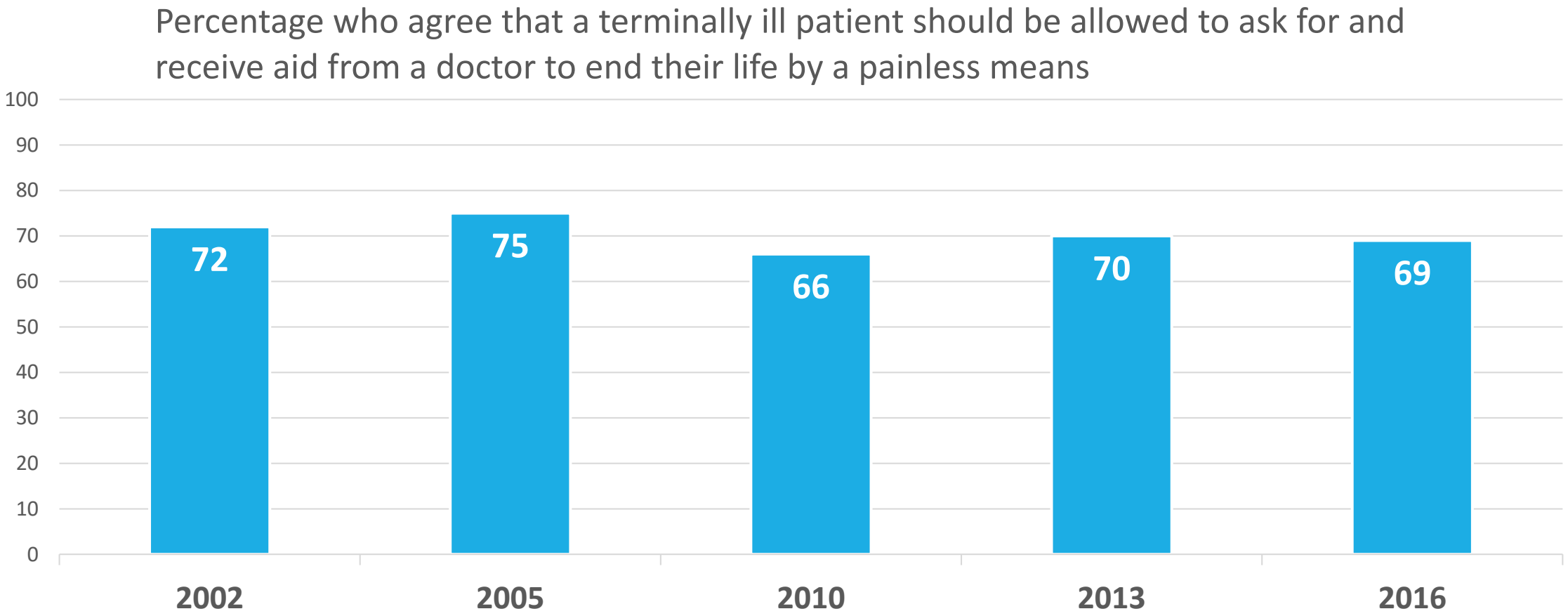
Savings < .07% of total healthcare spending in U.S.

Hospice per diem rates

Individual family finances

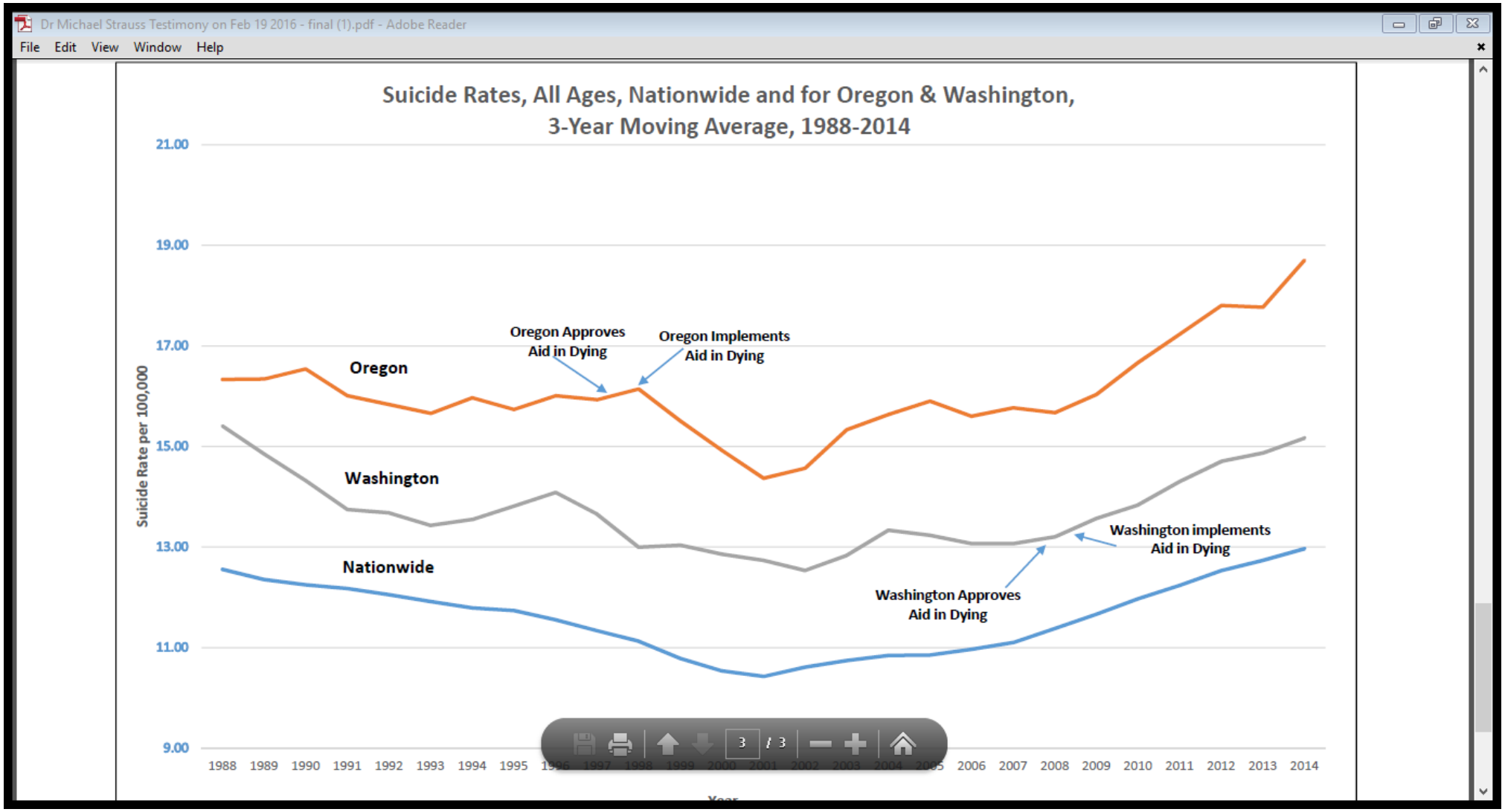
What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide? Ezekiel J. Emanuel, M.D., Phd., and Margaret P. Battin, Ph.D. N Engl J Med 1998; 339:167-172 July 16, 1998

Gallup Polls



3 Common Concerns

CONCERN	DATA SHOWS
Increased suicide rates	OR rates = national patterns
Used against vulnerable	No evidence
Undermine palliative care	Impact positive

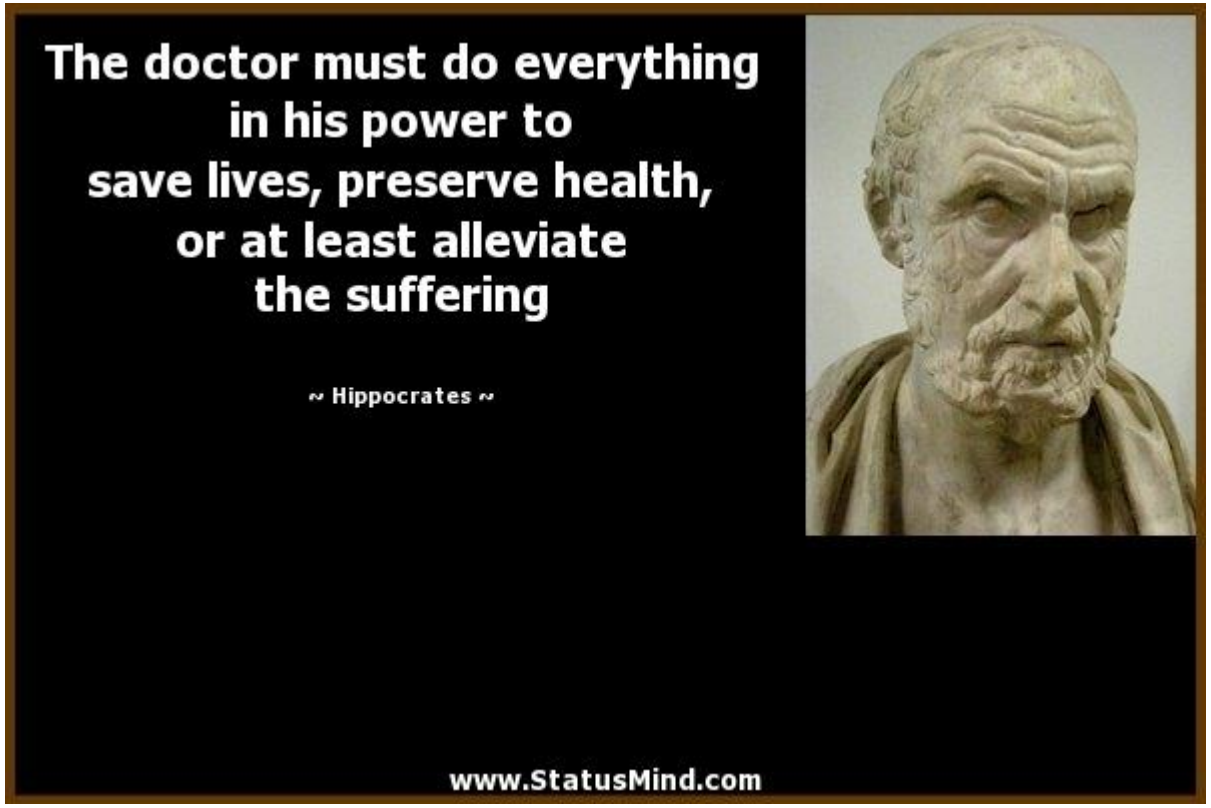

Dr Michael Strauss Testimony on Feb 19 2016 - final (1).pdf - Adobe Reader
File Edit View Window Help
Suicide Rates, All Ages, Nationwide and for Oregon & Washington,
3-Year Moving Average, 1988-2014
Suicide Rate per 100,000
21.00
19.00
17.00
15.00
13.00
11.00
9.00
Oregon
Washington
Nationwide
Oregon Approves Aid in Dying
Oregon Implements Aid in Dying
Washington implements Aid in Dying
Washington Approves Aid in Dying
3 / 3
1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014
Year

Ethical Dilemma

Competing goods

Extend life v. Alleviate suffering

Hippocratic Oath



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

Hastening Death

No difference between medical aid in dying and withdrawal of life-sustaining treatment/pall sedation

Intent is to relieve suffering and respect patient autonomy

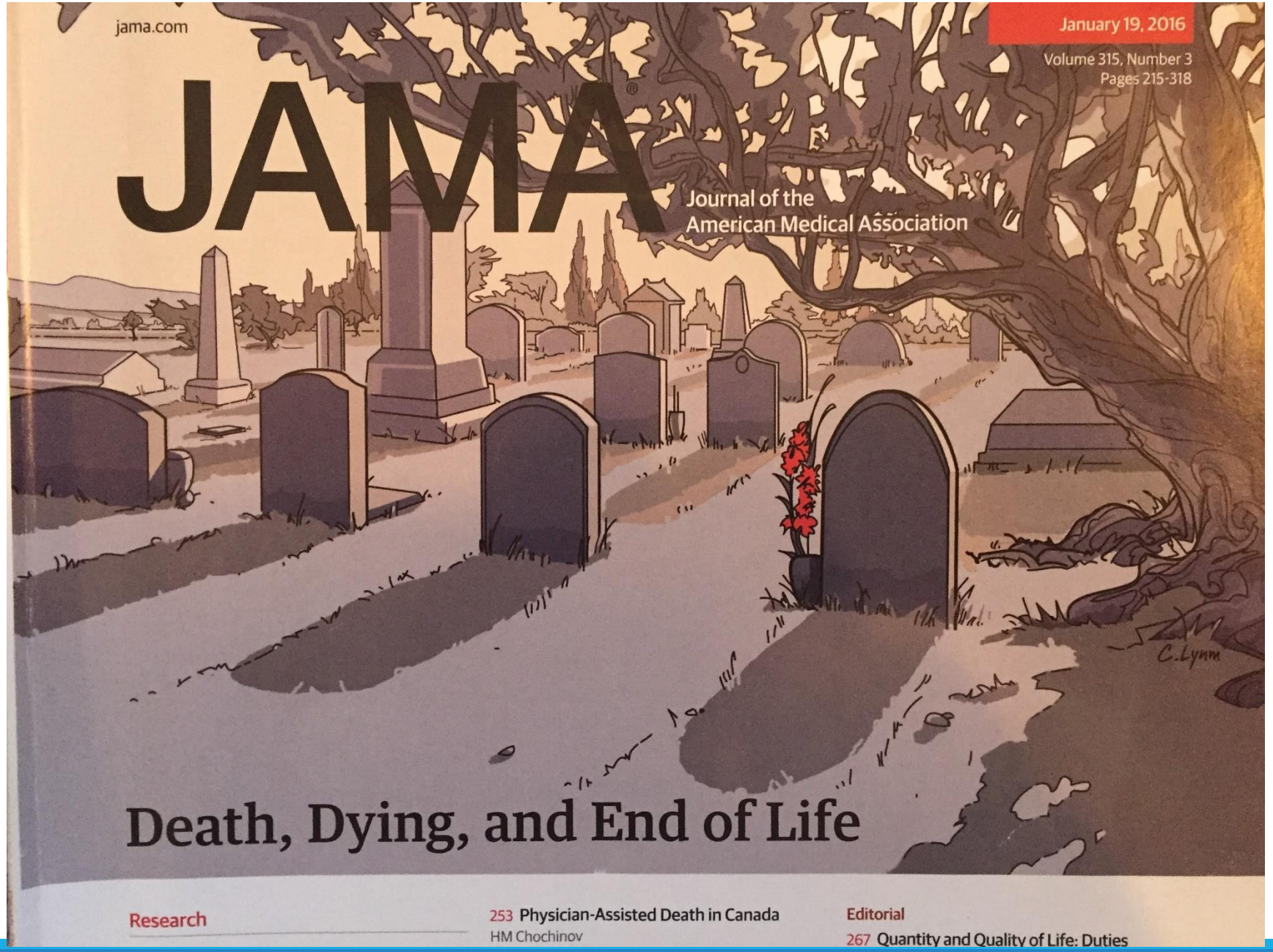
Morally acceptable

Intention to end life makes medical aid in dying distinct from withdrawing life-sustaining treatment and palliative sedation

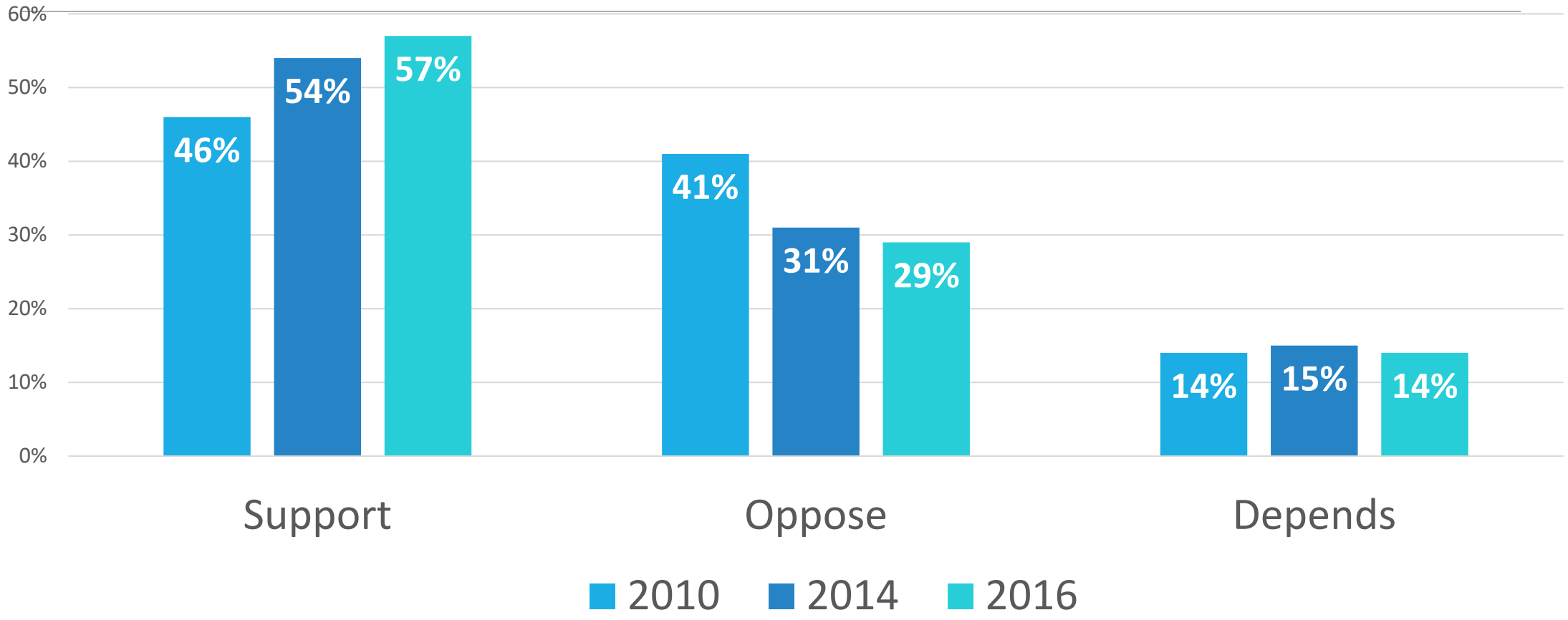
Morally wrong because life is sacred

Is Medical Aid in Dying Acceptable?

WHO DECIDES?


jama.com
January 19, 2016
Volume 315, Number 3
Pages 215-318
JAMA
Journal of the
American Medical Association
C.Lynn
Death, Dying, and End of Life
Research
253 Physician-Assisted Death in Canada
HM Chochinov
Editorial
267 Quantity and Quality of Life: Duties

Medscape Poll



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.

Council on Ethical & Judicial Affairs

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