A Physician’s Perspective on Medical Aid in Dying

David R Grube, M.D.
National Medical Director,
Compassion & Choices

“Life is meaningful because it is a story …

… and in stories, endings matter.

~Atul Gawande, Being Mortal

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Institute of Medicine

Dying in America
Improving Quality and Honoring Individual Preferences Near the End of Life

End-of-Life Options

- Pursuing Life-Sustaining Treatment
- Refusing Treatment
- Discontinuing Treatment
- Hospice
- Voluntarily Stopping Eating and Drinking (VSED)
- Palliative Sedation
- Medical Aid in Dying
Medical aid in dying is a medical practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request from her or his doctor a prescription for medication which she or he can choose to self-ingest to bring about a peaceful death.

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Majority of Americans and Doctors Support Medical Aid in Dying as an End of Life Option

● 68-74% of Americans agree with access to medical aid in dying (Gallup 2015, Harris 2014)

● 56% of Colorado Medical Society members agree with access to medical aid in dying (2016)

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Colorado End-of-Life Options Act

Coloradans overwhelmingly authorized medical aid in dying on November 8, 2016.

Where Medical Aid in Dying Is Authorized

Oregon, 1997, by ballot initiative
Washington, 2008, by ballot initiative
Montana, 2009, by court ruling
Vermont, 2013, through legislation
California, 2015, through legislation
Colorado, 2016, by ballot initiative
District of Columbia, 2017, through legislation
Colorado End-of-Life Options Act: Eligibility Requirements

- Adult
- Terminally ill
- Prognosis of 6 months or less
- Mentally capable of making informed medical decisions

Regulatory Requirements include:

- State resident
- Self-administer the medication (voluntary, conscious, and physical act to take the medication into the body)
Physician Components

Prescribing Physician ("Attending")
- Evaluate patient
- Prescribe medication
- Complete forms

Consulting Physician
- Evaluate patient
- Complete forms

Psychiatrist/Psychologist
- Consulted for an evaluation of an active mental illness that may affect patient’s ability to understand informed consent or have full mental capacity

CO EOLOA - Request Requirements

✧ Two oral requests from patient at least 15 days apart (not necessarily in person, but must confirm voluntariness of the person’s request outside of the presence of a third party)
✧ One statutory form written request signed by two witnesses (attending doctor can’t be a witness, but at least one witness can’t be employed at a facility where person is a patient/resident) - any order of requests
Attending Physician Responsibilities

1. Determine diagnosis, prognosis, capability, and voluntariness of request.
2. Refer to consulting physician to confirm #1.
3. Ensure informed decision-making.
4. Refer to a psychologist/psychiatrist if unsure of capability
5. Counsel person of importance of safe-keeping of medication, notifying kin and having a person present when taking the medication

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Attending Physician Documentation Requirements

1. Document in medical record
2. File a dispensing record with CDPHE
3. Fulfill any other reporting requirements that CDPHE may require in the future, such as a form

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Consulting Physician Responsibilities

1. Examine the patient
2. Confirm in writing the patient’s diagnosis, prognosis, capability and making an informed decision
3. Refer the patient to a psychologist/psychiatrist if unsure of capability and document such

Liability/Professional Protections

- No duty to participate
- No liability for medical providers if act in good faith under the EOLWA
- No disciplinary action taken against a licensed physician by any state medical boards for participation or declining to participate
Other Protections

- The choice to request/take aid-in-dying medication cannot affect health or life insurance status or contracts.
- Death certificate must list underlying terminal illness as the cause of death. (Attending physician or hospice medical director shall sign)
- Medical aid in dying does not constitute suicide, mercy killing or homicide under the law.

Medical Aid in Dying in Practice

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Clinical Criteria for Medical Aid in Dying

Aid-in-Dying Medication

- The type and dosage of aid-in-dying medication prescribed for the terminally ill person can vary with each individual.
- After self-administering the medication, the person usually falls asleep with 20 minutes and dies painlessly and peacefully within an hour or two.
**Medications**

NPO for 4 – 6 hours (no dairy, no heavy laxatives)

Take Usual medications

One hour prior

- **Ondansetron** 8 mg
- **Metoclopramide** 20 mg

**Secobarbital** 10 Gm (#100, 100 mg capsules)

Broken apart, crystals placed in glass, mixed with 3 – 4 oz of room temperature water

(Must be ingested in less than 90 seconds)

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**Medications**

For opioid naïve patients:

Rapid acting morphine sulfate

- **(Roxanol®)** 1,800 mg
- # 3 bottles (600 mg/btl)

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**DDMP** (compounded)

- Diazepam 1 Gm;
- Digoxin 50 mg; MS 15 Gm; Propranolol 2 Gm

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20 Years of Practice in Oregon Show that Medical Aid in Dying Works as Intended

1. Just having a prescription (on hand) for aid-in-dying medication is a comfort.
2. People use the law because of loss of dignity, because of autonomy, because of anhedonia, to minimize pain and suffering.
3. The elderly, people with disabilities, and people of color have not been coerced or abused.

Diagnosis of People Who Used the Death With Dignity Law in Oregon

Underlying Illness

- Cancer
- Other
- Heart Disease
- ALS
- CLRD
Concerns Patients Have which Lead to Use of Oregon’s Death with Dignity Law

<table>
<thead>
<tr>
<th>%</th>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>96%</td>
<td>Less able to engage in activities that make life enjoyable</td>
</tr>
<tr>
<td>92%</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>75%</td>
<td>Loss of dignity</td>
</tr>
</tbody>
</table>

Observations

- More Oregon physicians are involved in DWD (aid in dying) as attending and/or consulting physicians
- More Oregon hospices are “engaged"
- Medical aid in dying is more integrated and normalized
- Health systems are identifying “Navigators”
- Many barriers still exist
Having a Prescription for Aid-in-Dying Medication Is a Comfort

Only 64% of the 1,545 prescriptions written between 1998 and 2015 were actually used.

Medical Aid in Dying Is Not Suicide

By law, medical aid in dying is not considered suicide, assisted suicide, homicide or euthanasia.
## Medical Aid in Dying vs. Suicide

<table>
<thead>
<tr>
<th></th>
<th>State of Wellness</th>
<th>State of Mind</th>
<th>State of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>PHYSICALLY HEALTHY</td>
<td>EMOTIONAL; DEPRESSED</td>
<td>IMPULSIVE</td>
</tr>
<tr>
<td>Medical Aid in Dying</td>
<td>TERMINAL: 6 MONTHS TO LIVE</td>
<td>RATIONAL; REALISTIC</td>
<td>THOUGHTFUL WITH SAFEGUARDS</td>
</tr>
</tbody>
</table>

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## How Medical Aid in Dying Compares to Suicide and Suffering Death

<table>
<thead>
<tr>
<th></th>
<th>Time to Plan</th>
<th>Place of Death</th>
<th>Time of Death</th>
<th>Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Death (Untimely)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Protracted Death (Painful to Patient and Family)</td>
<td>YES</td>
<td>POSSIBLY</td>
<td>NO</td>
<td>SOME</td>
</tr>
<tr>
<td>Medical Aid in Dying</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

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### Compassion & Choices
## Medical Aid in Dying Is Not 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>Mental Capacity</td>
<td>Mentally Incapable (psychiatric diagnosis)</td>
</tr>
<tr>
<td>Patient <strong>wants to live</strong></td>
<td>Patient <strong>wants to die</strong></td>
</tr>
<tr>
<td>Planned; with family</td>
<td>Impulsive; alone</td>
</tr>
<tr>
<td>Death is ‘gentle’</td>
<td>Death may be violent</td>
</tr>
<tr>
<td>Normal grieving after death</td>
<td>Abnormal grief (family members wonder “what if?”)</td>
</tr>
<tr>
<td>(guilt is rare)</td>
<td></td>
</tr>
</tbody>
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## Health Insurance

**Federal prohibition:**
- Medicare
- VA

**Most private insurance pays**

**State Medicaid may pay in the future**
Integration of Medical Aid in Dying

A Call for a Patient-Centered Response to Legalized Assisted Dying

On 9 June 2016, California became the fifth state to legalize physician-assisted suicide (PAS), joining Oregon, Washington, Montana, and Vermont. More states may soon follow. Like it or not, PAS is here and is not going away. Given this reality, it is problematic that professional organizations have left physicians without sufficient support and guidance on how to provide the best possible care to dying patients seeking to exercise this legal right.

An engaged neutral stance can better help clinicians responsibly meet the needs of their patients while still respecting the diverse opinions about medical aid in dying.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Studied Neutrality</th>
<th>Engaged Neutrality</th>
</tr>
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<tbody>
<tr>
<td>Should laws allowing PAS be enacted?</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>Should physicians follow their conscience in responding to patient requests for PAS?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the association support palliative and hospice care for patients requesting PAS?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Should medical associations provide additional training/education for physicians?</td>
<td>No position</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the association train or provide skilled consultants available for any physician?</td>
<td>No position</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the association encourage the formation of institutional policies that ensure proper support for physicians and patients after PAS is requested?</td>
<td>No position</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the association support or lobby for support of research into and continuous improvement of assisted dying and end-of-life care practices?</td>
<td>No position</td>
<td>Yes</td>
</tr>
</tbody>
</table>

PAS = physician-assisted suicide.
Hospice and Palliative Care Are Improved and Better Utilized

- 92% enrolled in hospice
- 90% died at home

Positive Impact on Palliative Care

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.”
Persons dying in Oregon are less likely to be hospitalized and more likely to use hospice services at home than are persons in ... the rest of the United States

Tolle, NEJM March 2017

Positive Impact on Doctor-Patient Relationship
Patient Autonomy
What is the physician’s duty?

- Medical aid in dying is not a failure of palliative care or hospice care
- Hospice medical directors, social workers, nurses, and staff should be familiar with the process of medical aid in dying, the barriers, and the medications, etc.
- Hospices should develop polices regarding their clients who request medical aid in dying
- Hospices should respond professionally to all inquiries about end of life choices
- Hospices should adopt an “engaged” neutral position
Medical Ethics

- *Primum non nocere* (do no harm)
- Professionalism ("putting the patient first")
- Professional integrity vs. personal beliefs
- Referral?

One does not ask of one who suffers: What is your country and what is your religion?

One merely says: You suffer, this is enough for me; you belong to me and I shall help you.

*LOUIS PASTEUR 1886*
Colorado Access Campaign
Resources:

✓ www.CompassionAndChoices.org/Colorado
  ● Videos for doctors and patients
  ● Clinical criteria + fact sheets
  ● State forms
  ● Request a Speaker
  ● Find Care Tool that lists facilities’ policies
✓ Doc2Doc consultation service 800-247-7421
✓ Pharmacist2Pharmacist consultation service

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