Death and Medical Aid in Dying

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Disclosures

I have no financial disclosures to share.

This presentation has been reviewed to ensure no commercial bias.

Objectives

1. Define medical aid in dying, physician-assisted suicide (PAS), and euthanasia.
2. Identify three root causes of suffering that prompt requests from patients to hasten death.
3. Understand and discuss palliative sedation as a modality for uncontrolled suffering in palliative care.
4. Describe and discuss the Elizabeth Whitefield End-of-Life Options Act that was effective June 18, 2021, in New Mexico.

Definitions

- Medical Aid in Dying (MAID)/Physician-assisted dying/Death with Dignity
  - “A practice in which the physician provides a terminally ill patient with a prescription for a life-ending dose of medication, upon the patient’s voluntary, informed request.”
- Physician assisted suicide (PAS)-considered synonymous with MAID
- Euthanasia
  - The physician would act directly, for instance by giving a lethal injection, to end the patient’s life
  - MAID is NOT Euthanasia

Current legal and ethical status

- 10 states plus the District of Columbia now with death with dignity/medical aid in dying statue
  - Oregon 1997
  - Montana 2008 – By supreme court ruling
  - Vermont 2013
  - California 2015
  - Colorado 2016
  - Washington D.C. 2017
  - Hawaii 2018
  - Maine and New Jersey 2019
  - New Mexico 2021

https://deathwithdignity.org/news/2021/09/2021-annual-report/

Montana

- Montana's First Judicial District Court, ruled December 5, 2008: "constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally-ill patient to die with dignity.“- Judge Dorothy McCarter
- 2009 Montana Supreme Court ruled in a 5–2 decision that state law allows for terminally ill Montanans to request lethal medication from a physician under existing statutes

U.S. Supreme Court

- 2008-U.S. Supreme Court votes 6-3 to uphold an Oregon physician-assisted dying law, ruling that former Attorney General John Ashcroft overstepped his authority in seeking to punish doctors who prescribed drugs to help terminally ill patients end their lives.

https://deathwithdignity.org/learn/oregon-death-with-dignity-act-history/

American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA)-2019

- New policy position published in 2019
- AMA affirmed that physicians can provide medical aid in dying “according to the dictates of their conscience without violating their professional obligations.”
- “…thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide.”
- “Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician assisted suicide and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, CEJA recommends that the Code of Medical Ethics not be amended.”

https://www.ama-assn.org/system/files/2019-05/a19-ceja2.pdf

American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA)-2019

- “the term ‘physician assisted suicide’ describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia.”
- “terms ‘aid in dying’ or ‘death with dignity’ could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance”

https://www.ama-assn.org/system/files/2019-05/a19-ceja2.pdf

American Academy of Hospice and Palliative Medicine-2016

- “AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited.”
- “concerns about a shift to include physician-assisted dying in routine medical practice”
- “Any statutes legalizing PAD and related regulations must include safeguards to appropriately address these concerns, such as limiting eligibility to decisionally capable individuals with a limited life expectancy.”

http://aahpm.org/positions/pad

American Academy of Neurology-2018

- retired its 1998 position on “Assisted suicide, euthanasia, and the neurologist”
- “leave the decision of whether to practice or not to practice lawful physician-hastened death (LPHD) to the conscientious judgment of its members acting on behalf of their patients.”
- “make no attempt to influence an individual member’s conscience in consideration of participation or nonparticipation in LPHD.”

https://n.neurology.org/content/neurology/90/9/420.full.pdf

American Academy of Family Physicians-2018

- RESOLVED, That the American Academy of Family Physicians adopt a position of engaged neutrality toward medical-aid-in-dying as a personal end-of-life decision in the context of the physician-patient relationship, and be it further
- RESOLVED, That the American Academy of Family Physicians reject the use of the phrase “assisted suicide” or “physician-assisted suicide” in formal statements or documents and direct the AAFP’s American Medical Association (AMA) delegation to promote the same in the AMA House of Delegates

https://www.aafp.org/news/2018-congress-fmx/20181010cod-hops.html

STATES WITH A DEATH WITH DIGNITY STATUTE

- California
- Colorado
- District of Columbia
- Hawai'i
- Maine
- New Jersey
- New Mexico
- Oregon
- Vermont
- Washington

STATES WITH DEATH WITH DIGNITY LEGAL BY COURT DECISION

- Montana

STATES CONSIDERING DEATH WITH DIGNITY THIS YEAR/SESSION

- Arizona
- Connecticut
- Delaware
- Indiana
- Iowa
- Kansas
- Kentucky
- Massachusetts
- Minnesota
- Nevada
- New York
- North Dakota
- Pennsylvania
- Rhode Island

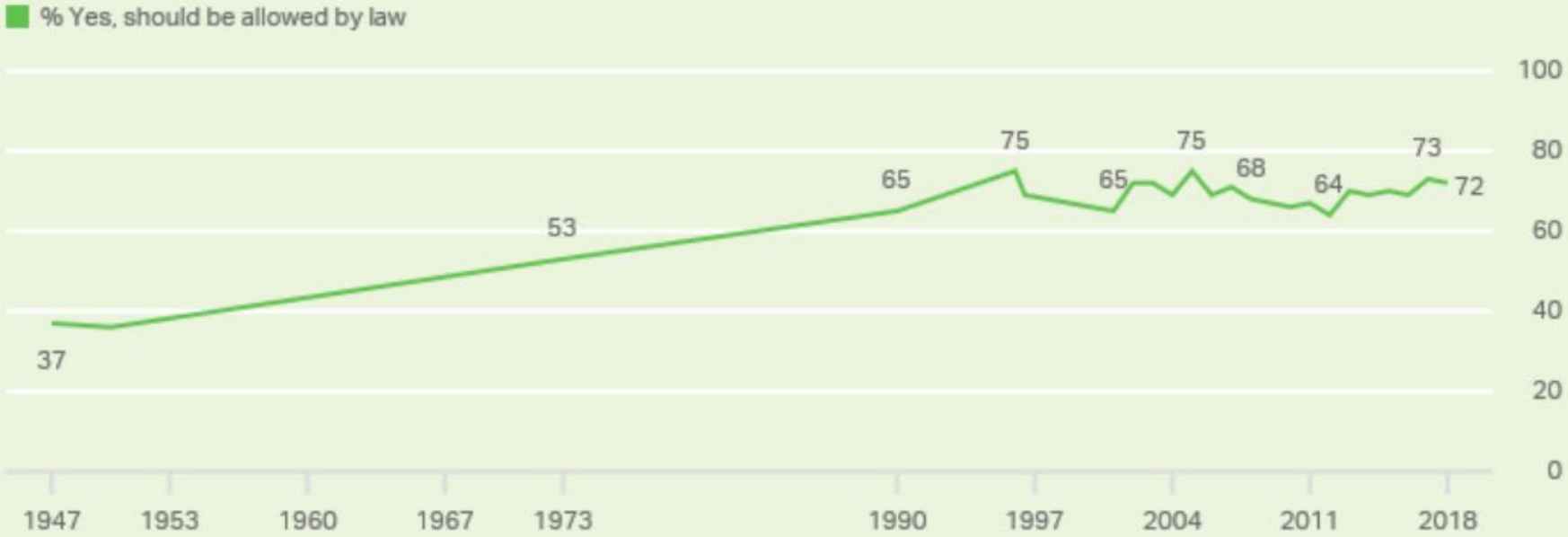
STATES WITH NO ACTIVITY THIS YEAR/SESSION

- Alabama
- Alaska
- Arkansas
- Florida
- Georgia
- Idaho
- Illinois
- Louisiana
- Maryland
- Michigan
- Mississippi
- Missouri
- Nebraska
- New Hampshire
- North Carolina
- Ohio
- Oklahoma
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Virginia
- West Virginia
- Wisconsin
- Wyoming

https://deathwithdignity.org/in-your-state/

Americans' Support for Euthanasia

When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?



GALLUP

Reasons patients seek MAID

- Data from Oregon
  - loss of autonomy (87%)
  - decreasing ability to participate in activities that made life enjoyable (90%)
  - loss of dignity (72%)
- “Poor pain control is an indication for better palliation, not death.”

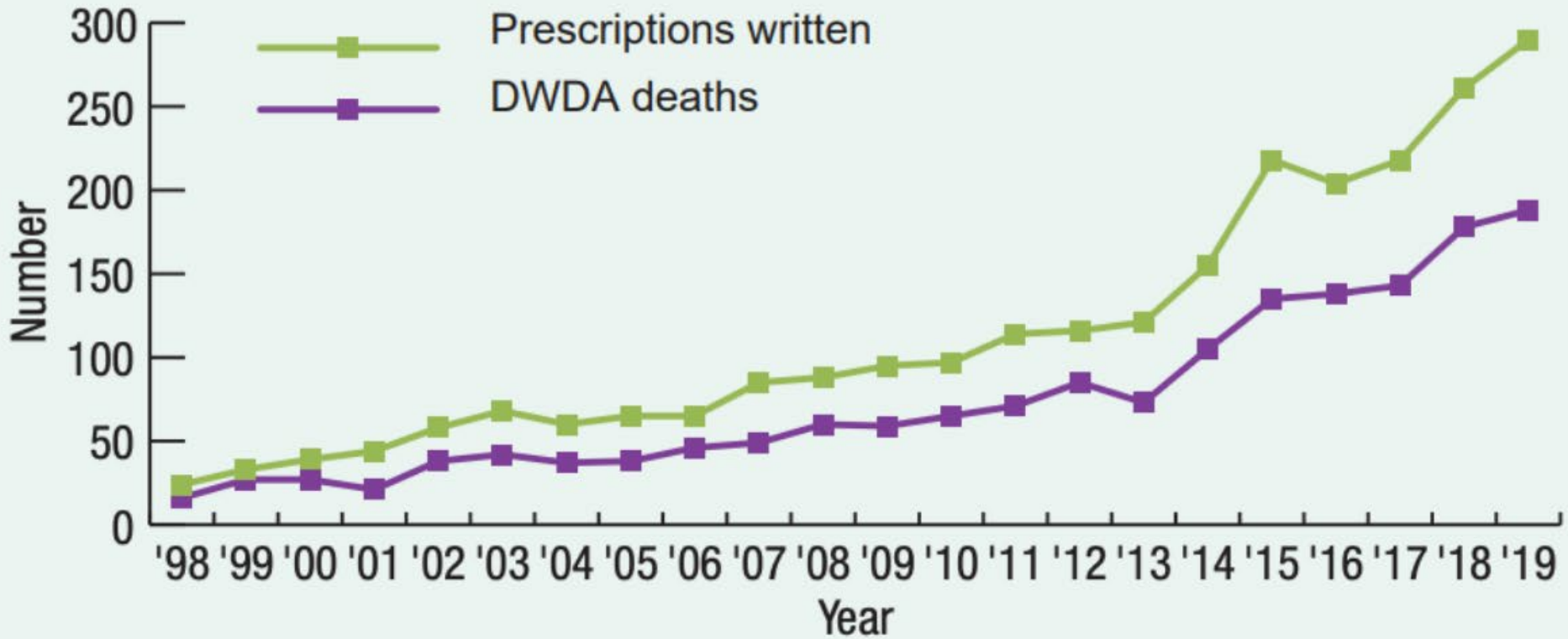
https://deathwithdignity.org/news/2020/03/2019-report-on-oregon-death-with-dignity-act/

Patients who seek MAID

- 75% were 65 years or over, with the median age of 74
- 68% had cancer
- 90% were on hospice at the time of death
- 90% died at home
- 99% had some form of health insurance

https://deathwithdignity.org/news/2020/03/2019-report-on-oregon-death-with-dignity-act/

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2019



*As of January 17, 2020

See Table 2 for detailed information

https://deathwithdignity.org/news/2020/03/2019-report-on-oregon-death-with-dignity-act/

Guidance on Responding to Requests for Physician-Assisted Dying

Determine the nature of the request.

- Is the patient seeking immediate assistance or considering the possibility of hastened death in the future?
- Is the patient airing thoughts about ending life without a specific intent or plan?
- Is the patient frustrated with living with illness, but not seriously contemplating ending life?

http://aahpm.org/positions/padbrief

Guidance on Responding to Requests for Physician-Assisted Dying

Clarify the cause(s) of intractable suffering

- Is there a loss of functional autonomy?
- Does the patient feel he or she is a burden or exhausted from prolonged dying?
- Is there severe pain or other unrelieved physical symptoms?
- Is the distress mainly emotional or spiritual?

http://aahpm.org/positions/padbrief

Guidance on Responding to Requests for Physician-Assisted Dying

Evaluate the patient's decision-making capacity

- Is there impairment affecting comprehension and judgment?
- Does the patient's request seem rational and proportionate to the clinical situation?
- Is the patient's request consistent with long standing values?

http://aahpm.org/positions/padbrief

Guidance on Responding to Requests for Physician-Assisted Dying

Explore emotional factors

- Do feelings of depression, worthlessness, excessive guilt, or fear substantially interfere with the patient's judgment?
- Does the patient have untreated or undertreated depression or other mental illness?

Guidance on Responding to Requests for Physician-Assisted Dying

Explore situational factors

- Does the patient have a poor social network?
- Are there coercive influences such as looming bankruptcy?
- Is the patient subject to emotional, financial or other forms of exploitation or abuse?

Guidance on Responding to Requests for Physician-Assisted Dying

- Utilize open-ended questions to understand the concerns that led the patient to request PAD
- Respond empathically and strengthen the therapeutic relationship through respectful and non-judgmental dialogue
- Re-evaluate and modify treatment of pain and all physical symptoms
- Identify and address depression, anxiety, and/or spiritual suffering

http://aahpm.org/positions/padbrief

Guidance on Responding to Requests for Physician-Assisted Dying

- Consult with experts in spiritual or psychological suffering when appropriate
- Consult with colleagues experienced in palliative care/hospice as needed
- Commit to the patient the intention of working toward a mutually acceptable solution for the patient's suffering

http://aahpm.org/positions/padbrief

Palliative sedation

- “the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms”
- Should only be considered for refractory symptoms
- Level of sedation should be proportionate to the patient's level of distress
- Treatment of other symptoms should be continued
- Should not be considered irreversible
- Decreased ability to interact with others, inability to change mind, inability to eat/drink

http://aahpm.org/positions/palliative-sedation

Palliative sedation

- Refractory Symptoms
  - Aggressive palliative treatments have failed or have produced intolerable side effects
  - Additional treatments are unlikely to provide adequate relief without intolerable side effects
  - Patient is likely to die before conventional treatment could work
- PS most commonly used for pain, dyspnea, delirium, N/V, agitation/restlessness, seizure, myoclonus
- One survey revealed >50% of patients receiving PS have more than one qualifying symptom; 34% received for non-physical symptoms

In Cowan JD, et al. Palliative Medicine, 2013

AAHPM Statement on Palliative Sedation

- Primary Objective:
  - Ease suffering via pharmacologic and non-pharmacologic techniques
- Must have a:
  - Specific clinical indication
  - A target outcome
  - Acceptable benefit/risk ratio

- Level of sedation proportionate to level of patient's distress
- When able, patients should participate in decision
- Continue other symptomatic treatments alongside sedation
- No guidance on medication selection – safe, effective, available

http://aahpm.org/positions/palliative-sedation

AAHPM Statement on PS

- Hastening Death
  - Palliative sedation does not alter timing or mechanism of patient's death as refractory symptoms are often associated with advanced terminal illness
  - Clear intent to palliate, not shorten survival
  - Artificial hydration/nutrition generally not expected to benefit the patient

http://aahpm.org/positions/palliative-sedation

Palliative sedation

- Estimated to be used in 15-30% of dying patients
- Provided to both cancer and non-cancer patients
- Incidence varies from 5-52%, depending on setting, patient population, cultural, ethnic, religious factors, and on how it is defined

Elizabeth Whitefield End-of-Life Options Act (HB 47)

- New Mexico's End-of-Life Options Act provides for "medical aid in dying"
- *The law went into effect June 18, 2021*

https://compassionandchoices.org/

Qualified Individual

The individual must be an **ADULT** at least 18 years old and a **RESIDENT** of NM.

The prescribing provider must determine that the individual has:

1. **CAPACITY** to understand and appreciate health care options available, including significant benefits and risks, and to make and communicate an informed decision.
2. **TERMINAL ILLNESS** which is a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgement, will result in death within 6 months.
3. **VOLUNTARILY** makes the request for MAID and is not under duress or undue influence.
4. **ABILITY TO SELF-ADMINISTER** the MAID medication by taking an affirmative, conscious, voluntary action to ingest the medications. *(Injection or IV administration are NOT allowed.)*

https://compassionandchoices.org/

Healthcare Provider

Any of the following individuals licensed in New Mexico and authorized under NM law to prescribe a medication to be used in MAID:

1. **Medical Physician**
2. **Osteopathic Physician**
3. **Advanced Practice Nurse**
4. **Physician Assistant**

At least one physician (MD/DO) must determine, after conducting an appropriate examination, that the individual is qualified. That can be the ”prescribing” provider, a “consulting” provider OR affirmation the individual is enrolled in Hospice. If the individual is not enrolled in hospice, then two providers must affirm qualifications, one of which must be an MD/DO.

Capacity

A determination of capacity shall be made only according to professional standards of care and the provisions of the NM Uniform Health Care Decisions Act, which has an underlying presumption that an individual has the capacity to make a healthcare decision.

If the prescribing or a consulting provider believes the individual may lack decisional capacity or if the individual has a current or recent history of mental illness or disability that could impair capacity for end-of-life decision-making, the individual must be referred to a mental health professional and MAID cannot proceed until such professional determines the individual has capacity to make end-of-life decisions.

If capacity must be confirmed by a **Mental Health Professional,** that means a NM-licensed psychiatrist, psychologist, master social worker, psychiatric nurse practitioner or professional clinical mental health counselor.

https://compassionandchoices.org/

Prescribing MAID

- Prior to prescribing, the provider must inform the individual of all available end-of-life care options, including palliative care and hospice.
- The prescribing provider must document all qualifications. The individual's enrollment in hospice or, if necessary, affirmation of terminal illness by a consulting provider must also be included.
- The form required by law must be completed and signed by the individual requesting MAID and witnessed by two persons, one of which must be a disinterested party. The prescriber will provide the form and then include it in the individual's health record.
- The prescription, once written, has a 48-hour hold before it can be filled UNLESS the prescriber affirms that, within reasonable medical judgement, the individual will not survive the waiting period.
- The prescribing provider will also be responsible for reporting required information to State.

https://compassionandchoices.org/

Other Provisions

- **“Right to Know”** – Healthcare providers must inform terminally ill patients of all reasonable and legally available options that meet medical standards for end-of-life care.
- By law, **“Medical Aid in Dying”** is NOT to be considered “suicide” for any purpose *(including death certificate);* and, if the law is followed in good faith, it is also not considered “assisted suicide”. *(“Assisting Suicide” remains 4th degree felony)*
- A **person** shall not be subject to criminal liability, licensing sanctions or any type of professional or employment disciplinary actions for participating or refusing to participate in MAID; or for being present when a qualified patient self-administers the medication.
- A health care entity, provider, professional organization, health insurer or managed care organization shall not subject a person to censure, discipline, suspension, loss/denial of license, credential, privileges, membership or other penalty for participating in MAID or not.

Other Provisions

- If a “**health care provider”** is unable or unwilling to participate, he/she must inform the individual, refer to another willing provider OR to an individual or entity who will assist the individual seeking MAID. No health care provider shall be required to participate.

- ”**Health Care Entity**” is an entity (not individual) licensed to provide any form of healthcare in NM, including a hospital, clinic, hospice agency, home health agency, pharmacy, group medical practice, medical home or similar entity.
  - A health care entity that prohibits MAID on premises or by employees shall provide appropriate public notice on their website and in relevant materials given to patients.
  - A health care entity shall not forbid or otherwise sanction a provider who participates off premises, off hours or outside scope of employment

End-of-Life Options

- Forego or Cease Life-Sustaining Treatment
- Palliative Care, which focuses on relief of symptoms
- Hospice, providing end-of-life comfort care and family support
- Voluntary Stopping Eating and Drinking, which will hasten death
- Medical Aid-in-Dying

https://compassionandchoices.org/

Hospice and Medical Aid in Dying

- Experience in other states – More than 90% of MAID patients are on Hospice
- MAID is the epitome of *Patient Self-Determination*, which is at center of hospice philosophy
- Level of participation can differ from hospice to hospice, including:
  - Provides emotional support in decision-making
  - Participates in logistical planning – coordination with prescriber, pick-up medications, assist patient/family to plan timing, etc.
  - Medical Director serves as consulting provider
  - Present for ingestion
  - Mix medications
  - Hospice Medical Director prescribes MAID

https://compassionandchoices.org/

Medication Ingestion

- Medication comes in powder form, specifically compounded for MAID
  - Medications to control nausea are administered beforehand
- Medication is mixed in liquid and put in a glass…straw may be used
  - May be ingested through feeding tube or rectal/Macy tube but patient must still be able to physically initiate ingestion in order to still meet **Self-Administration** requirement
- Ingestion should be completed within 2 minutes
- Sleep occurs within 2-10 minutes, then coma; death usually within 2-5 hours
- Cost of medications approx. $700

https://compassionandchoices.org/

Aid in Dying Pharmacologic Regimen

- DDMAPh
  - Digoxin 100 mg (from powder, not crushed tablets)
  - Diazepam 1 gm (1,000 mg)
  - Morphine 15 gm (15,000 mg)
  - Amitriptyline 8 gm (8,000 mg)
  - Phenobarbital 5 gm (5,000 mg)
- Pre-medicate for nausea/vomiting: Ondansetron 8mg, Metoclopramide 20mg (10mg tabs, #2)
- Sleep in 2-10 minutes, death usually in usually < 2 hours

https://www.acamaid.org/wp-content/uploads/2021/08/Pharmacology-update-8-21-2021.pdf

FOR Aid in Dying Patient

Death Day

ADDRESS _____ DATE _____

℞

Digitalis 100mg; diazepam 1gm; morphine 15gm;
amitriptyline 8gm; Phenobarbital 5gm.
Dispense as powder.

Sig: Mix to 4 ounces with apple juice or water.
Take the liquid suspension by mouth,
taking no longer than 2 minutes to swallow it all.
If burning occurs, use spoonfuls of sorbet to cool
the mouth.

REFILL _____ TIMES

_____ M.D. Aid-in-Dying Doctor, MD M.D.

DO NOT SUBSTITUTE SUBSTITUTION PERMISSIBLE

DEA NO. _____ _____

ADDRESS

BioRx Labs 1-888-550-5452 FORM NO. PD5000

https://www.acamaid.org

Red Flag Risk checklist for potentially complicated and/or prolonged AID deaths

- Gut issues:
  - Severe cachexia and/or prolonged time with no oral nutrition—associated with duodenal villous atrophy and poor med absorption.
  - Gastroparesis (delayed gastric emptying)
    - Poorly controlled nausea/vomiting = gastroparesis
    - Anticholinergic medications (Compazine, Haldol, Benadryl, hyoscyamine, others)
  - Severe constipation/obstipation
  - Partial or complete bowel obstructions.
  - GI disease, including pancreatic cancer, colon cancers, hepatic metastases
  - Ascites that is tense (peritoneal mets, and/or portal hypertension with concomitant bowel edema and compression. (For tense ascites, recommend paracentesis the day before aid in dying.)

- Swallowing concerns:
  - Too weak to actively swallow
  - Oropharyngeal or esophageal obstruction, even if partial
  - Intolerance to swallowing bitter or bad-tasting liquids.

- Medication-related concerns:
  - Very high opiate or benzo tolerance. (NOTE: no specific threshold, use judgment)

- General Factors:
  - Obesity
  - Extreme exercise history/cardiac fitness, even if remote in time.
  - Young, <55 years, or very healthy other than the primary cause of death
  - EtOH, >fifth of liquor or case of beer/day—associated with sedative resistance

- Mental Health Concerns:
  - IV (or other) drug abuse, recent or remote (may have inconsistent/incomplete drug- use reporting)
  - Waxing and waning mental capacity, and/or ability to follow instructions.

Conclusions

1. Medical Aid in Dying (MAID)/Physician-assisted dying/Death with Dignity refer to the physician providing a terminally ill patient with a prescription for a life-ending dose of medication, upon the patient's voluntary, informed request.
2. Most cited reasons for MAID are loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and loss of dignity.
3. Palliative sedation is a useful tool to treat refractory symptoms and uncontrolled suffering in palliative care.
4. Elizabeth Whitefield End-of-Life Options Act was effective June 18, 2021, in New Mexico and allows for Medical Aid in Dying in New Mexico.

Resources

END-OF-LIFE OPTIONS NEW MEXICO https://endoflifeoptionsnm.org.

Non-profit entity formed to serve as MAID information clearinghouse and referral source for providers and patients; and to educate and support individuals, healthcare providers, organizations and communities regarding the full range of end-of-life options for all New Mexicans.

COMPASSION & CHOICES https://compassionandchoices.org
or C&C's NM Organizer, Jill VonOsten jvonosten@compassionandchoices.org

DEATH WITH DIGNITY https://deathwithdignity.org

AMERICAN CLINICIANS ACADEMY ON MEDICAL AID IN DYING https://www.acamaid.org/

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