Medical Aid in Dying

University of Minnesota School of Nursing – Oct. 8, 2018

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Death is **not** always bad

Life is **not** always good

For many, the alternative to death is **worse**

MNHPC
MINNESOTA NETWORK OF HOSPICE & PALLIATIVE CARE

Forgo curative-directed treatment

Focus on **comfort** only

Goal is **not** to avoid death

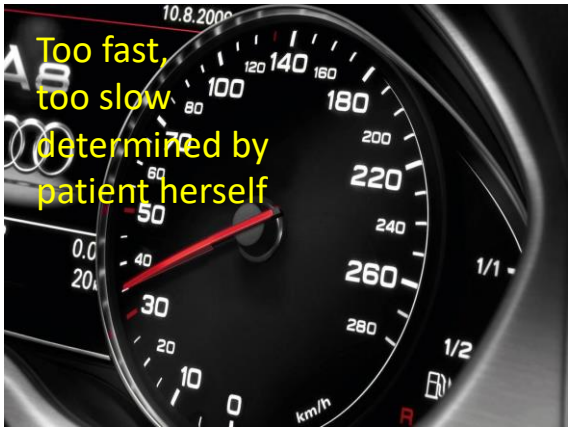
Impossible

Goal

Avoid **2** risks

Dying **too** fast

Dying **too** slow



Preference sensitive

Value laden

Why hasten death

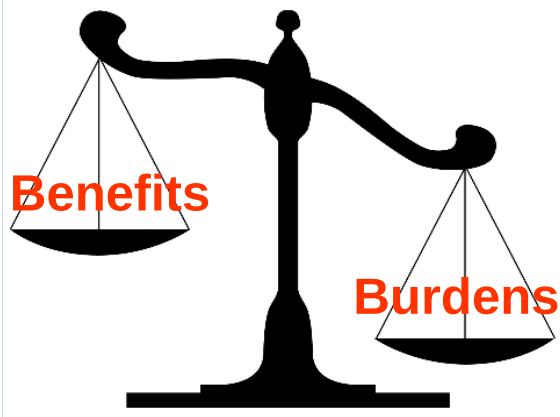
2

Physical suffering

- Pain
- Nausea
- Dyspnea
- Paralysis
- Foul-smelling wounds

Existential suffering

- Loss of control
- Psychic pain
- Anxiety
- Delirium
- Hopelessness



Self-defined quality of life

Pt **own** assessment

Pt **own** values

Pt **own** preferences

Roadmap

4

What is MAID

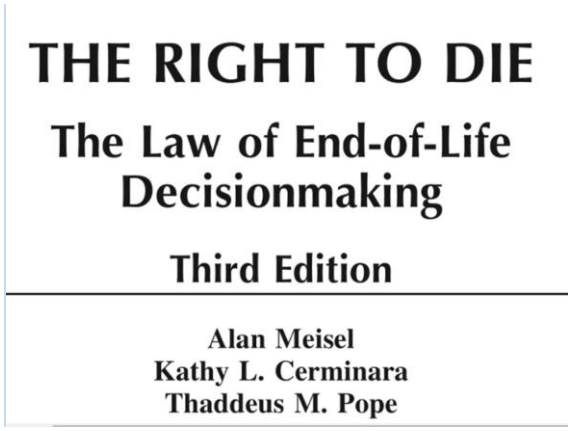
Legal status of MAID

Dying in Minnesota

MAID in Minnesota

Biography

- Advance Directives & POLST
- Hastening Death – VSED
- Hastening Death - MAID
- Medical Futility
- Surrogate Decision Making
- Right to Die & UMT
- Brain Death & Organ Donation
- Conscience Based Objections
- Healthcare Ethics Committees



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Disclosures

The New York Times

The Opinion Pages
ROOM for DEBATE

Oregon Shows That Assisted Suicide Can Work Sensibly and Fairly

Thaddeus Mason Pope is the director of the Health Law Institute at Hamline University, and a frequent legal commentator and blogger on end-of-life medical issues.

UPDATED OCTOBER 7, 2014, 12:39 PM

Opinion

VIEWPOINT

The Changing Legal Climate for Physician Aid in Dying

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While once widely rejected as a health care option, physician aid in dying is receiving increased recognition as a response to the suffering of patients at the end of life. With aid in dying, a physician writes a prescription for life-ending medication for an eligible patient. Following the recommendation of the American Public Health Association, the term *aid in dying* rather than "assisted suicide" is used to describe the practice.[1] In this Viewpoint, we describe the changing legal climate for physician aid in dying occurring in several states (Table).

Voters in Oregon and Washington have legalized aid in dying by public referendum, legislators in Vermont have done so by statutory enactment, and courts in Montana and New Mexico have done so by judicial rulings. Support for aid in dying is increasing, and it would not be surprising to see voters, legislators, or courts in other states approve the practice. Indeed, in their 2014 an advance directive statute in California,[5] courts and legislatures concluded that patients may reject their physicians' treatment recommendations even when treatment is necessary to prolong life.

Recognition of the right to refuse life-sustaining care reflected a societal consensus that people should be able to decline treatment when they are suffering greatly from irreversible and severe illness. In such cases, the burdens of continued treatment may easily outweigh the benefits, and people should not be forced to endure a prolonged and undignified dying process.[6] What is critical about the right is the desire to protect seriously ill people from intolerable suffering.

How is it possible to decide when someone's illness is serious enough that treatment can be refused? The *Quinlan* case concluded that the right to refuse life-sustaining treatment should exist when the patient's prognosis becomes very grim.[4]

MAID

End-of-life option

For **small** number of patients

Who

Adults

> 18 years old

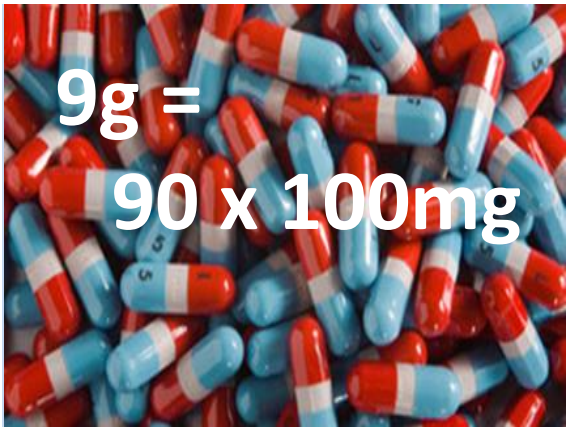
Decisional capacity

Terminally ill

6-mo prognosis

What

Ask & receive prescription **drug**



Self-administer

To hasten death

Legal Status of MAID

1994

1998

Numerous safeguards

Multiple requests

Multiple counseling

Prescribing MD

Consulting MD

Mental health MD

Voluntary

Informed

Enduring

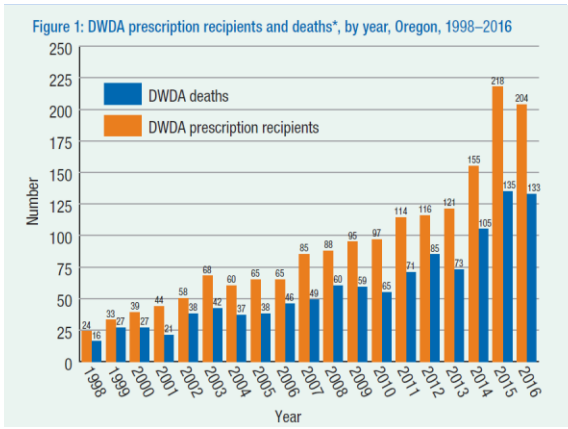
Patient safety record

Oregon Health Authority

2016

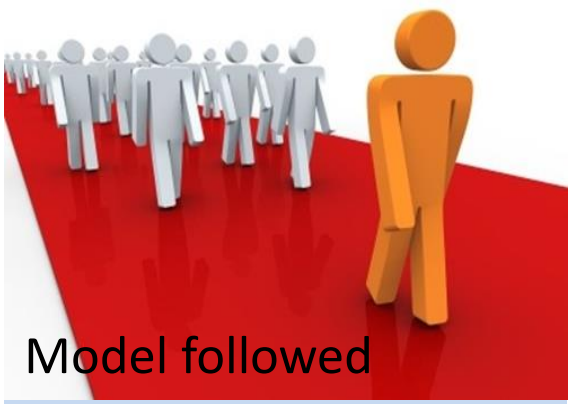
» Oregon Death with Dignity Act

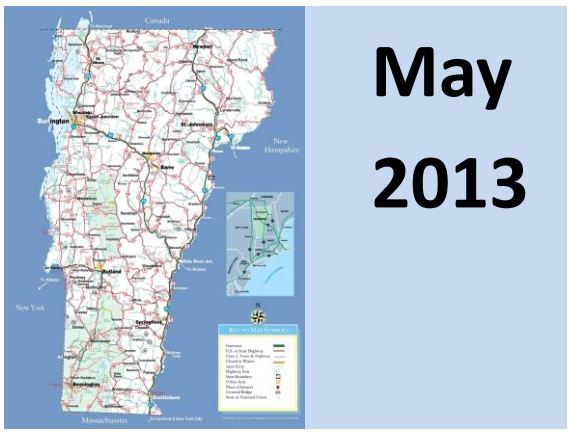
Data summary 2016



Characteristics	2016 (N=133)	1998–2015 (N=994)	Total (N=1,127)
Lethal medication			
Secobarbital (%)	86 (64.7)	582 (58.6)	668 (59.3)
Pentobarbital (%)	0 (0.0)	386 (38.8)	386 (34.3)
Phenobarbital (%)	39 (29.3)	17 (1.7)	56 (5.0)
Other (combination of above and/or morphine) (%)	8 (6.0)	9 (0.9)	17 (1.5)
End of life concerns[4]	**(N=133)**	**(N=994)**	**(N=991)**
Losing autonomy (%)	119 (89.5)	906 (91.6)	1,025 (91.4)
Less able to engage in activities making life enjoyable (%)	119 (89.5)	888 (89.7)	1,007 (89.7)
Loss of dignity (%)[5]	87 (65.4)	680 (78.8)	767 (77.0)
Losing control of bodily functions (%)	49 (36.8)	475 (48.1)	524 (46.8)
Burden on family, friends/caregivers (%)	65 (48.9)	408 (41.3)	473 (42.2)
Inadequate pain control or concern about it (%)	47 (35.3)	249 (25.2)	296 (26.4)

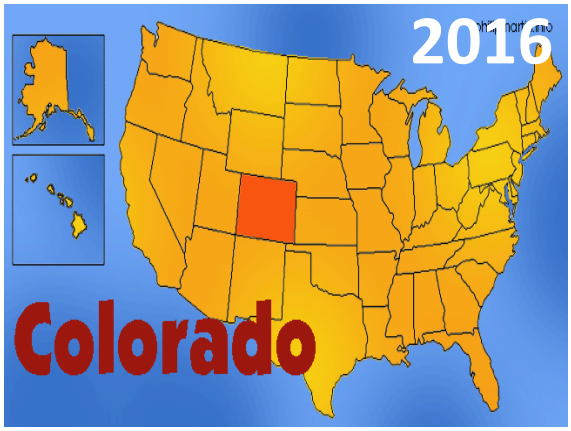
PROVEN TRACK RECORD





May 2013

Oct. 2015

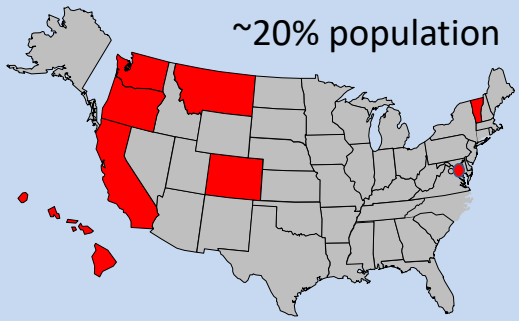


Feb. 2017

April 2018

8 states

~20% population

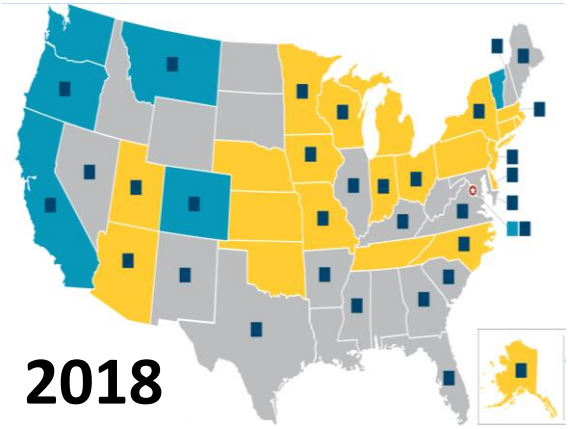


~50 years

of combined experience

Canada

Ongoing



2018

2019

Dying in Minnesota

Right to refuse

"The logical corollary of the doctrine of informed consent is that the patient generally possesses the **right not to consent,** that is, to refuse treatment."

- *Cruzan v. Missouri DOH* (1990)

Patient may refuse treatment **even** if life-saving

Every day
Right next door

Ventilator
CANH (= med Tx)
Dialysis
CPR
Antibiotics

Who is to say if amount life left to a patient is worth living

Patient herself

State interests

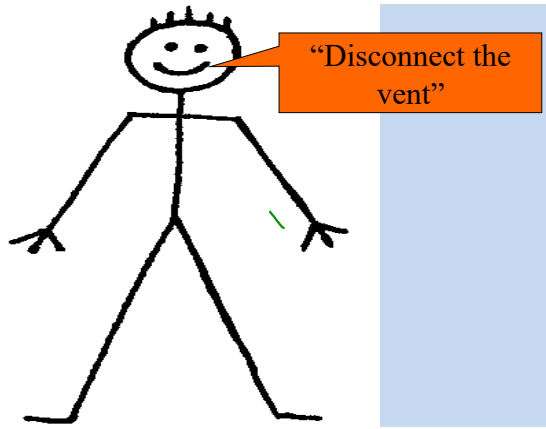
Preservation life
Prevent suicide
Protect 3rd parties
Integrity med profession

Always **outweighed** by patient's right to self-determination

Right to refuse by patient <u>with</u> capacity

Easier situation

Contemporaneous patient refusal



Sen. John McCain stops cancer treatment as remarkable life nears end

"The progress of disease and the inexorable advance of age render their verdict," his family said.

By MATTHEW DALY Associated Press | AUGUST 25, 2018 — 8:16AM

"Barbara Bush, former first lady, turns to comfort care"

Pro golfer Jarrod Lyle

Patient has capacity to make decision at hand

Patient decides

Right to refuse even when the **lacks** capacity

Patients do **not** lose right of self-determination when lose capacity

Advance Directive

2 parts
to AD

Instruct
Appoint

Instruct

FKA
"living will"

Record treatment
You want
You do not want

~~Instruct~~
Appoint

Identify someone to act on your behalf

"Agent"

"DPAHC"

Recap

Well settled law & practice

Patient **with** capacity may refuse life-saving treatment **contemporaneously**

Patient **without** capacity may refuse life-saving treatment through **advance instructions**

Patient **without** capacity may refuse life-saving treatment through decision of **authorized SDM**

This is all "**passive**" - turning off

Refusing something (chemo, CPR, ventilator, CANH, antibiotics, water)

We also already allow **active** means to hasten death

High dose Opioids

Risks respiratory depression and death

Doctrine of double effect

1. Action good in itself (not immoral)
2. Intend the good effect (foresee but not intend bad effect)
3. Bad effect not necessary for good effect
4. Proportionality (sufficiently grave reason to risk bad effect)

Allow administration of high does opioids **even** when know causes death

PSU

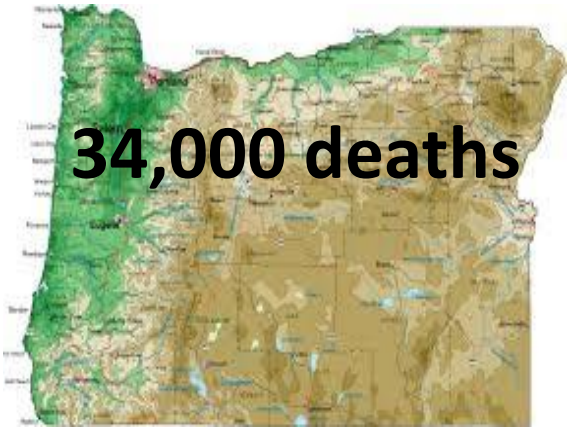
Palliative sedation to unconsciousness

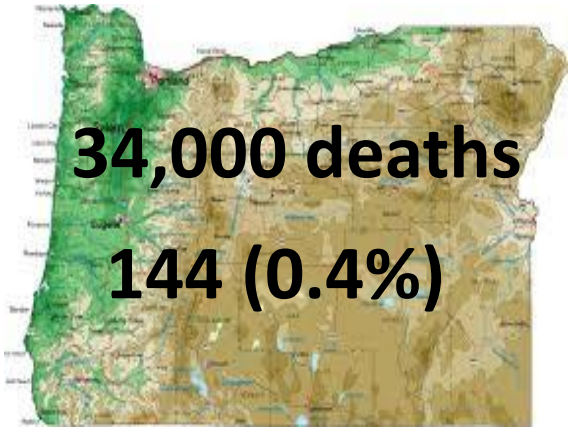
Sedation makes patient dependent on CANH

Typically, patient **refuses** CANH

Allow PSU **even** though leads to death

MAID in Minnesota





41,000 / year

Total MN deaths

CDC National Center for Health Statistics, *Deaths: Final Data for 2013*, 64(2) NATIONAL VITAL STATISTICS REPORTS (Feb. 16, 2016), http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

182 / year

MN MAID deaths

99.6%

MN deaths unaffected

41,000
182
40,818

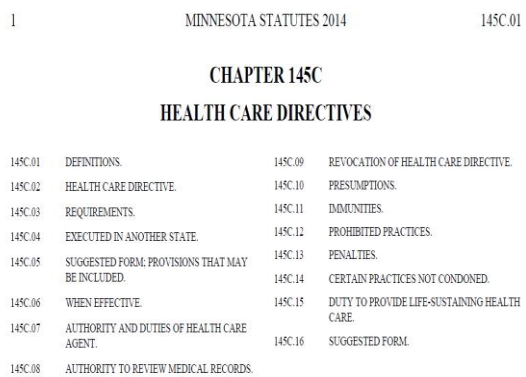
40,818

How do **they** die?

Most **also** make a deliberate decision to hasten death

Those dependent on dialysis, vents, CANH can hasten their deaths

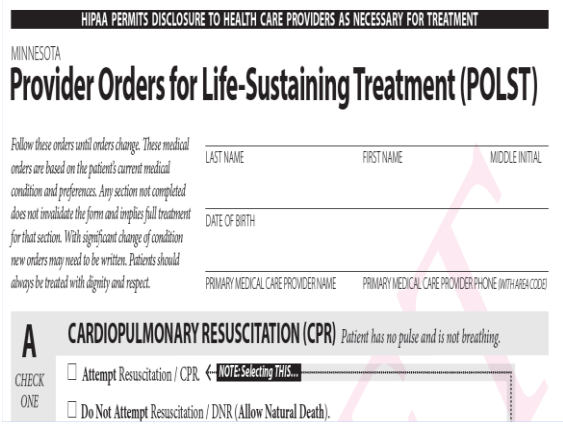
Many consent to **DNR orders**, forgoing life-saving CPR



1 MINNESOTA STATUTES 2014 145C.01

CHAPTER 145C

HEALTH CARE DIRECTIVES



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

A CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

☐ Attempt Resuscitation / CPR ← NOTE: Selecting THIS...

☐ Do Not Attempt Resuscitation / DNR (Allow Natural Death).

Equal protection

Persons similarly situated should be treated **alike**

Every day, terminally ill patients in Minnesota hasten their deaths by withholding or withdrawing treatment

Every 30 minutes

But **some** patients have no treatment to turn off or refuse

MAID gives **these** terminally ill, competent, adult patients

same freedom to accelerate their imminent death.

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