

Physician

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Medical ethics and the unconscious mind

A conflict of interests

By Robert S. Emmons, MD

My patient “George,” aged 55, developed gastroparesis after 45 years of living with Type I diabetes. Because his gut cannot absorb iron, it was necessary to treat intermittent bouts of severe anemia with IV iron infusions. During one of our visits, George informed me that he had been

feeling cold, tired, and down—all telltale symptoms of anemia. I had treated George for recurrent major depression for 20 years, but now treating him meant sending him back to his hematologist, “Dr. Winston.”

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The Compassionate Care Act

Giving Minnesotans a choice

By Sen. Chris Eaton, RN, and
Rebecca Thoman, MD

“Will you take me to Oregon?” was Dave’s plea to his son. At 95 years of age, Dave was slowly dying from end-stage cancer. His lungs, heart, and bowels were on a slow, steady decline that could take months, but his mind remained sharp. He had had a long, active life, playing golf and enjoying his grandchildren to the ripe old age of 93, when the diagnosis of melanoma was made. Since then his life had slowly declined to little more than eating, sleeping, and toileting, all of which required help. His weakness led to recurrent falls and injuries that resulted in trips to the emergency room. Dave dreaded visits to his many specialists who recommended another treatment or medication, and he hinted about his thoughts by asking his primary physician if he “knew Jack Kevorkian.” The response was a prescription for antidepressants.

Dave didn’t want to die confined to his bed, gasping for air and suffering from

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bleeding bedsores and constipation. His son, who relayed this heartbreaking story, could do little to help. Dave lingered in hospice for more than a year.

While palliative care relieved some of the pain, much of Dave's misery could not be alleviated. The family felt traumatized. Sadly, Dave's story is neither new nor unique.

The history of aid in dying

Medical breakthroughs of the past century have raised questions about what constitutes quality of life. It wasn't so long ago that removing life support, even in clear cases of medical futility, was considered murder. The landmark case of Karen Ann Quinlan in 1976 settled the debate about whether life support could legally be withdrawn from patients in a vegetative state. A decade later, the Nancy

Cruzan legal battle culminated in the Patient Self-Determination Act, which affirmed the rights of Americans to refuse unwanted medical treatment and established the primacy of patient authority in medical decision-making. In the 1980s and 90s, states codified the

role of health care agents and instituted legal protections for physicians when hastening death was an unintended side effect of treatment.

The impact of these high profile cases notwithstanding, it was Dr. Jack Kevorkian whose actions provoked the widest public discourse. He assisted more than 130 dying patients

and was prosecuted and acquitted five times before being found guilty of murder. His renegade approach and blatant disregard for the rule of law caused a backlash in the public arena, where some came to see his actions as more murderous than compassionate.

control should her symptoms become too much to endure.

Like Brittany and her family, most Americans support authorizing aid in dying at the end of life. For the past two decades, Gallup polls show that seven out of 10 Americans have indicated strong support for the idea. With the recent passage of the End of Life Option Act in California, 16 percent of the U.S. population now has access to aid in dying in five states.

Most Americans support authorizing aid in dying at the end of life.

The long road to acceptance

The medical community has been slow to accept aid in dying, but several leading professional organizations have endorsed the option, including the American Medical Women's Association, the National Physicians Alliance, and the American Public Health Association. Earlier this year, the California Medical Association (CMA) withdrew its opposition to the End of Life Option Act, adopting a stance of neutrality and sanctioning aid in dying as a legitimate option. CMA former president Luther Cobb, MD said, "CMA's focus has historically been on improving end-of-life options and enhancing palliative care and hospice for patients who are terminally ill. Ultimately, however, it's up to the patient and their physician to choose the course of treatment best suited for the situation—and CMA's new position on physician aid in dying allows for that."

The physician's role

Patient-centered care now demands that physicians relinquish the old doctor-knows-best role and instead engage with patients as partners, exploring their goals of treatment and helping meet their needs. In his best-selling book, "Being Mortal," Dr. Atul Gawande describes our predicament: *However miserable the old system has been, we are experts at it.... You agree to become a patient, and I, the clinician, agree to try to fix you, whatever*

In 1997, Oregon voters supported the groundbreaking Death with Dignity Act that authorizes terminally ill adults of sound mind to obtain medication that they may self-administer if and when their suffering becomes unbearable. By 2005, Washington voters had embraced a nearly identical law.

Current thought

The American Medical Association's (AMA) current position in opposition to "physician assisted suicide"—established in 1993—references Dr. Kevorkian and early failed attempts to authorize aid in dying. The AMA's Council on Ethical and Judicial Affairs has not rendered an opinion on the subject of medical aid in dying in recent years despite dramatic changes to the legal, social, and scientific environments.

More recently, Brittany Maynard's widely publicized story has sparked renewed public interest in access to aid in dying nationwide. The 29-year-old moved her family to Oregon in order to access medical aid to end her suffering from stage 4 brain cancer. Rather than face unrelenting headaches, seizures that left her unable to speak, and a gradual decline into paralysis, blindness, and dementia, she was able to live her final months enjoying what she loved most—her family and the great outdoors—knowing she was in

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the improbability, the misery, the damage, or the cost. With this new way, in which we together try to figure out how to face mortality and preserve the fiber of a meaningful life ... we are plodding novices.

It is our responsibility as physicians to understand that aid in dying is a medical practice defined by accepted standards of care. The public will look to us as a trusted resource as the discussion intensifies, and we have a responsibility to help moderate this vital conversation, so that it is addressed with honesty and humility rather than specious arguments based on misinformation, speculation, or hyperbole. The Oregon Public Health Division prepares annual reports on the Death with Dignity Act that refute claims that aid in dying leads to widespread abuse.

No one will be required to participate in this law.

Minnesota's Compassionate Care Act is modeled after the highly successful Death with Dignity Act (DWDA) in Oregon. To qualify, a patient must be an adult resident of the state, terminally ill, and of sound mind. A request for aid in dying must be made in writing twice, at least 15 days apart and signed in the presence of two witnesses. Two physicians must determine that a patient meets the criteria and is free from coercion. Any doubt or disagreement between physicians necessitates a third evaluation. Patients are repeatedly provided information about hospice, palliative medicine, and other treatment options. They are also given the opportunity to rescind their request at any time. Nearly 200 physicians in Oregon and Washington have followed this protocol successfully for more than 15 years.

Some argue that better hospice care would make aid in dying unnecessary, but more than 90 percent of Oregon patients who used the DWDA were enrolled in hospice at the time. The Center to Advance Palliative Care and National Palliative Care Research Center gave all four states with Death with Dignity laws an "A" rating in 2015. In their 2015 analysis of geographic variation in hospice use patterns, Shi-Yi Wang et al. noted that Oregon was the only state in the highest quartile of hospice use and the lowest quartile of potentially concerning patterns of hospice use. The authors suggested that could be attributed to its Death with Dignity Act.

There are some who oppose aid in dying for religious reasons. To them, end-of-life suffering is God's will and medical intervention to shorten the dying process is wrong. We respect this view. Freedom of religion is a foundation of our democracy. No one will be required to participate in this law, whether patient, caretaker, or physician.

In the final analysis, we hope physicians will support our view that patients should have access to a full range of options at the end of life, including aid in dying. For some patients, prolonging the dying process is not the same as extending life. Whatever our personal beliefs, as medical professionals, we have a duty to respect our patients' values and goals as they make difficult choices at the end of life. 

Sen. Chris Eaton, RN (DFL), represents Minnesota Senate District 40, which includes Brooklyn Center and Brooklyn Park. She serves as the DFL majority whip and as vice chair for the State and Local Government Committee. **Rebecca Thoman, MD**, leads Doctors for Dignity, an initiative of Compassion & Choices.

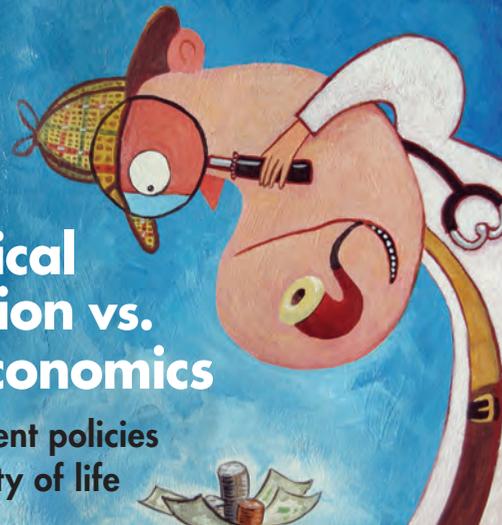
MINNESOTA HEALTH CARE ROUNDTABLE



FORTY-FIFTH SESSION

Medical Innovation vs. Medical Economics

When payment policies limit quality of life



Thursday, April 21, 2016 • 1:00-4:00 PM

Downtown Minneapolis Hilton and Towers

Background and Focus: The pace of innovation in medical science is rapidly escalating. From more accurate diagnostic equipment, to the use of genomic data, to better surgical techniques and medical devices, to new and more efficacious pharmaceuticals, breakthroughs occur nearly every day. These advances face many challenges when incorporated into medical practice. Several significant factors limit this adoption, including the economic models around how patient use of new science will be utilized. Twentieth century health insurance, medical risk management, and reimbursement models are controlling 21st century medical care and patients are the losers.

Objectives: We will review examples of recent scientific advances and the difficulties they face when becoming part of best medical practice, despite their clear superiority over existing norms. We will look at prevailing thinking behind economic models that govern how health care is paid for today. Our panel of industry experts will explore potential solutions to these problems. We will look at ways to create balance between payment models, new technology, and increased quality of life.

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