Death with Dignity
Evolving Legal Status of Medical Aid in Dying

Thaddeus Mason Pope, JD, PhD
University of Kentucky HealthCare
Clinical Ethics Grand Rounds
Tuesday, October 8, 2019

Thank you

Nothing
to disclose

except ...

September 2019

Informed
Consent 101
MORE IS NOT ALWAYS BETTER

2,800,000 total deaths

Opening

22%
600,000

Cancer

Control timing & manner of death

Case 1

Jenny Chumbley
2013

Chris Chumbley shot wife

600,000

Better options
6 last resort options

Most accepted
Least accepted

1. Stop life-sustaining therapy
2. High dose opioids
3. Palliative sedation to unconsciousness
4. Voluntarily stop eating & drinking
5. Medical aid in dying
6. Voluntary active euthanasia

Well-settled for decades

Kentucky Living Will Packet
**Medical Order for Scope of Treatment**

1. Stop life-sustaining therapy
2. High dose opioids
3. Palliative sedation to unconsciousness
4. Voluntarily stop eating & drinking
5. Medical aid in dying
6. Voluntary active euthanasia

---

**POSITION STATEMENT**

**Nutrition and Hydration at the End of Life**

Effective Date: 2017
Status: Revised Position Statement
Written by: ANA Center for Ethics and Human Rights
Adopted by: ANA Board of Directors

---

**The Society for Post-Acute and Long-Term Care Medicine**

Position Statement

International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide
1. Stop life-sustaining therapy
2. High dose opioids
3. Palliative sedation to unconsciousness
4. Voluntarily stop eating & drinking
5. Medical aid in dying
6. Voluntary active euthanasia

Will **not** discuss

Accepted

Not accepted

1. Stop life-sustaining therapy
2. High dose opioids
3. Palliative sedation to unconsciousness
4. Voluntarily stop eating & drinking
5. Medical aid in dying
6. Voluntary active euthanasia
Cancer

22% total deaths

Roadmap

three-fourths

6 parts

What is MAID?
Why need to legalize?

History of legalization

How has MAID been used?

2 debates

Too permissive

Too restrictive
What is 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

Seconal 90 x 100mg capsules
Aid in Dying Soon Will be Available to More Americans

July 8, 2019

Why need a statute
Across USA, since 1800s, help someone commit suicide is a **crime**

“assisted suicide prohibitions are **deeply rooted** in our nation’s legal history”

**Ky. Stat. 216.302**

“**Class D felony** ... provide the physical means by which another person commits ... suicide”

**MAID = AS**
Seconal 90 x 100mg capsules

MAID = AS
AS = felony
MAID = felony

Penalties

Ky. Stat. 532.020

1 - 5 years
Ky. Stat. 216.308 “may revoke license”

9 MAID statutes

MAID ≠ AS

MAID Criminal prohibition
MAID is legislatively authorized

BUT

No MAID statute
BUT

Considered legal

"consent of the victim... is a defense"

Mont. Code Ann. 45-2-211

Patient consent Not prohibited
Therefore,

No MAID prohibition

No need explicit authorization

N.C. Med J. 80(2):128 2019
New law would permit aid in dying; experts say it's already legal in NC

MAID must be legislatively authorized

History of Legalization

3 paths
Path 1

Litigation
US Constitution

1994

Harold Glucksberg
Substantive due process

Won 9th Cir. en banc
Won 2d Cir.

Equal protection

1997
“no”

No federal constitutional right to MAID

So...

Focus on rights at state level

“entrusted to ... laboratory of the states”
Path 2
Litigation
*state* constitutions

>15 cases

All 15
failed

Active
case

Roger
Kligler
MA

Recap
No right under **US** constitution

No right under **state** constitutions

Path 3
State statutes

**Early efforts**
- 1988 California
- 1991 Washington
- 1992 California
- 1994 Michigan

**BUT**
Legalize both euthanasia and MAID
MAID

**Self** ingestion

**Patient** takes the final overt act

---

Euthanasia

**Clinician** makes the final overt act

---

46/54

All U.S. bills focus on MAID **only**

---

1994

(1997)

---
Numerous safeguards

Multiple requests
Multiple screenings

Prescribing MD
Consulting MD
Mental health MD

Voluntary
Informed
Enduring

PROVEN TRACK RECORD
Model followed

2008

2009

2013
As of >60 years of combined experience

As of 2018:
- OR: 22
- WA: 11
- MT: 10
- VT: 6
- CA: 4
- CO: 3
- DC: 3
- HI: 1
in 2019

PROVEN TRACK RECORD

WELCOME TO NewJersey

October 2019

10 US jurisdictions
“1 in 5 Americans”

Looks like it rained a bit last night.

BUT

71m

327m

BUT Residency
“resident of ___”

Confirmed by attending physician

• Driver license
• Voter registration
• Own or lease property
• Tax return
No legal barrier

Practical barrier

Enough on legalization

Usage

60 years
1997 – 2019

How many 1459 MAID deaths

750,000 total deaths 0.2%
about the same?

249 Rx
168 die

40% more cancer deaths
350 Rx
235 die

1459 deaths
2217 prescriptions

3 different populations benefit

Use
Have
Know

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1996-2018
76% cancer

90% hospice

95% insured

Today’s debates

CA HI OR
CO ME VT
DC NJ WA
ongoing

>20 bills (2019)

nearly identical

Successful
No evidence of abuse

BUT

Criticism
Oregon model
Too permissive
Too restrictive

Capacity

At prescription
At ingestion
Ineligible for MAID

“impaired judgment . . . mental disorder”

BUT

How we screen
Mental health specialist **only if** attending or consulting refers

rare

**Oregon Death with Dignity Act**  
2018 Data Summary

4.5% (and dropping)

Many think that rate is too low
Are we **failing** to screen out impaired judgment?

No proof but ... needs study

Response

Not terminal or mature minor
That’s capacity at the time of prescription

No capacity assessment at ingestion
2 ways MAID laws are too permissive

Too protective
Unduly restrict access

Eligibility criteria

Safeguards

Eligibility criteria

Adult Terminally ill Capacity

Adult
18+

BUT

Assure voluntary & informed

NOTICE
NO PERSONS UNDER 21 ALLOWED

Allow minors to make other healthcare decisions
Mature minor rule

Response
Terminal illness

dead within 6 months

Matches hospice

BUT

Temporally strict

unbearable suffering
Opposed to MAID

Arbitrary discrimination

Let's remember what we are debating here: the most conservative voluntary assisted dying model that has ever been proposed – let alone implemented – anywhere in the world.

12 months neurodegenerative illness (ALS)
Response

2

6 → 12

Drop time altogether
Reasonably predictable

Capacity

“solely & directly by ... individual”

not advance directive
BUT

307

Terminal → no capacity

308

Capacity → not terminal

309

Response

310

311

312
Advance requests

Recap

Push to expand eligibility

Doctor acquitted of murder in landmark Netherlands euthanasia case

By Rosanne Ruohonen, CNN

Updated 9:00 AM ET, Wed September 11, 2019
adults $\rightarrow$ minors
6 mo. $\rightarrow$ longer or x
capacity $\rightarrow$ advance

Also

Push to streamline procedures

15 day wait period between requests

20 days
Assure request enduring

BUT

Undue burden cannot wait that long

During the process
Lost capacity 35%
Died 19%

Response
Waive wait period

“death is likely to occur before ... expiry of the time period”

Self ingest
Physician prescribes
Patient administers

Helps assure voluntary

BUT

2 problems

Lose ability
Complications

<table>
<thead>
<tr>
<th>Complications</th>
<th>(N=1,459)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty ingesting/regurgitated</td>
<td>28</td>
</tr>
<tr>
<td>Seizures</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
<tr>
<td>None</td>
<td>650</td>
</tr>
<tr>
<td>Unknown</td>
<td>768</td>
</tr>
<tr>
<td>Other outcomes</td>
<td></td>
</tr>
<tr>
<td>Regained consciousness after ingesting DWDA medications</td>
<td>8</td>
</tr>
</tbody>
</table>

7%
Normally, self-administered like USA

Physician administration is allowed

“physically incapable self-administration”

Avoid with clinician administration
June 2016 - October 2018

5085

5 self-administered

Attending + consulting clinician
MD or DO

BUT
Access problems

Response

Extend to NPs

Canada
Recap

Legal barriers

Eligibility criteria
Process requirements

Practical barriers
Clinicians & hospitals may opt out.

Table. Hospital Participation in the ELOA

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Permits ELOA, No. (%) (n = 106)</th>
<th>Does Not Permit ELOA, No. (%) (n = 164)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious affiliation</td>
<td>2 (2)</td>
<td>70 (43)</td>
</tr>
<tr>
<td>Teaching hospital</td>
<td>22 (21)</td>
<td>6 (4)</td>
</tr>
</tbody>
</table>
Conclusion

48,000

Kentucky deaths this year
>99%

MAID not relevant

350 Rx

235 die

References

Materials discussed in this presentation are available at http://thaddeuspope.com


Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles? HEALTH AFFAIRS BLOG (August 2018) (with Mara Buchbinder).


Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles, ASCO POST (Dec. 25, 2017).

Oregon Shows that Assisted Suicide Can Work Sensibly and Fairly, 15(2) FINAL EXIT NETWORK NEWSLETTER 7 (May 2016).


Legal Briefing: Medical Futility and Assisted Suicide, 20(3) J. CLINICAL ETHICS 274-86 (2009).

Medical Futility Blog
Since 2007, I have been blogging, almost daily, to medicalfutility.blogspot.com. This blog focuses on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning end-of-life medical treatment conflicts. The blog has received over 4 million direct visits. Plus, it is redistributed through WestlawNext, Bioethics.net, and others.

Thaddeus Mason Pope, JD, PhD
Director, Health Law Institute
Mitchell Hamline School of Law
875 Summit Avenue
Saint Paul, Minnesota 55105
T 651-695-7661
C 310-270-3618
E Thaddeus.Pope@mitchellhamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com