Medical Aid in Dying

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Death is not always bad

Life is not always good

For many, the alternative to death is worse

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
Physical suffering

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

Existential suffering

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

Benefits vs. Burdens

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

THE RIGHT TO DIE
The Law of End-of-Life Decisionmaking
Third Edition

Alan Meisel
Kathy L. Cerminara
Thaddeus M. Pope

Medical Futility Blog
Oregon Shows That Assisted Suicide Can Work Sensibly and Fairly

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Updated October 7, 2014, 12:00 PM

The Changing Legal Climate for Physician Aid in Dying

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. In this Viewpoint, we describe the changing legal climate for physician aid in dying occurring in several states (Table).

Voluntary Oregon and Washington have legalized aid in dying by public referendum, legislation in Vermont has 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 2016, an advance directive statute in California, "courtsiding," and other court rulings concluded that patients may reject the physician’s treatment recommendations even when treatment is necessary to prolong life. The increasing public acceptance of assisted dying is reflected in societal commentary that people should be able to decline treatment when they are suffering greatly and terminally and receive a dignified death. In many cases, the burdens of continued treatment may be outweighed by the benefits, and people should be free to choose a prolonged and undignified dying course. What is critical about the right is the desire to be relieved of suffering, and the caregiver’s burden.

How is it possible to decide when someone’s illness is serious enough that treatment can be refused? The Oregon laws concluded that the right to refuse life-sustaining treatment should exist when the patient’s condition becomes very grave.
MAID
End-of-life option

For small number of patients

Who

Adults
> 18 years old

Decisional capacity
Terminally ill
6-mo prognosis

Ask & receive prescription
drug

Self-administer
To hasten death

What

9g = 90 x 100mg

Legal Status of MAID
1994
Numerous safeguards

Multiple requests
Multiple counseling

1998
Prescribing MD
Consulting MD
Mental health MD
Voluntary
Informed
Enduring

Patient safety record

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998–2016

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2016 (N=133)</th>
<th>1998-2015 (N=994)</th>
<th>Total (N=1,127)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lethal medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>86 (64.7)</td>
<td>582 (58.8)</td>
<td>668 (60.3)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>0 (0.0)</td>
<td>386 (38.8)</td>
<td>386 (34.3)</td>
</tr>
<tr>
<td>Phenobarbital (%)</td>
<td>39 (29.3)</td>
<td>17 (1.7)</td>
<td>56 (5.0)</td>
</tr>
<tr>
<td>Other (combination of above and/or morphine) (%)</td>
<td>8 (6.0)</td>
<td>9 (0.9)</td>
<td>17 (1.5)</td>
</tr>
<tr>
<td>End of life concerns*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lossing autonomy (%)</td>
<td>119 (95.5)</td>
<td>996 (91.6)</td>
<td>1,015 (91.4)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>119 (95.5)</td>
<td>888 (90.7)</td>
<td>1,007 (90.7)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>87 (65.4)</td>
<td>680 (78.8)</td>
<td>767 (77.0)</td>
</tr>
<tr>
<td>Lossing control of bodily functions (%)</td>
<td>49 (36.0)</td>
<td>475 (48.1)</td>
<td>524 (46.8)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>65 (48.9)</td>
<td>408 (41.3)</td>
<td>473 (42.2)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>47 (35.3)</td>
<td>249 (25.2)</td>
<td>296 (26.4)</td>
</tr>
</tbody>
</table>

*Contact: Oregon Health Authority

2016

Oregon Death with Dignity Act
Data summary 2016
Model followed

May 2013

Oct. 2015
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 **with** capacity

Easier situation

Contemporaneous patient refusal

“Disconnect the vent”

>20% stop dialysis

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 29, 2018 — 8:16AM
“Barbara Bush, former first lady, turns to comfort care”

Pro golfer Jarrod Lyle

Patient has capacity to make decision at hand

Right to refuse even when the patient 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 doses 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

34,000 deaths
34,000 deaths
144 (0.4%)

41,000 / year
Total MN deaths

5.5m v. 4m

182 / year
MN MAID deaths

99.6%
MN deaths unaffected

41,000
182
40,818

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
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.
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 the same freedom to accelerate their imminent death.

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