

Program: Medical Aid in Dying

Speaker: Rebecca Thoman, MD, Doctors for Dignity

Guests: Barbara Stillwell, Charlie Morris, Avi Lagu, Midge Decker, Jo Davis, Jim Parziale, MD., Ray Duncan, Bev Hmurovic, Angela Hayes, Jackie Offett, Petra Ritchie, Elliott Berger

Attendance: 133

Scribe: John Peer

Editor: Bill Elliott

Today's presenter was Dr Rebecca Thoman. She received her M.D. from the University of Cincinnati, College of Medicine and has worked in health care policy for 20 years. She currently manages Doctors for Dignity, an initiative of Compassion and Choices, the largest US organization advocating for people's rights at the end of life.

At the outset, Dr Thoman inquired how many had a Health Care Directive (which must be executed while mentally competent). She stressed that it is also important that the Health Care Directive be available to the Healthcare Agent and the health care providers. Locked in a safety deposit box is not sufficient.

End of Life Options:

- Pursuing life-sustaining treatment
- Refusing life-sustaining treatment
- Discontinuing treatment
- Hospice/comfort care in last 6 months
- VSED (Voluntary Stopping Eating and Drinking)
- Palliative Sedation
- Medical Aid in Dying (in 18% of US)

Seven states and the District of Columbia have authorized medical aid in dying. Oregon led in 1997 by a ballot initiative followed by Washington in 2007 and Montana, Vermont, California, Colorado, Washington DC, and Hawaii.

Medical Aid in Dying is a medical practice in which a terminally-ill adult of sound mind may ask for and receive a prescription medication they may self-administer for a peaceful death if and when their suffering becomes unbearable.

Medical Aid in Dying is NOT euthanasia, assisted suicide, or death panels. The law specifically states "Actions taken in accordance the [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law."

Who qualifies?

- Adult
- Terminally ill (6 months)

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- Mentally sound – able to make health care decisions and understand the consequences Able to self-administer (swallow)

Process:

- Patient submits a written request (two witnesses, at least one being disinterested party) Doctor determines eligibility
- Doctor provides full list of alternatives
- Refers to 2nd doctor to confirm eligibility and prognosis
- If 2nd opinion does NOT concur, NO action may be taken until a comprehensive mental evaluation is completed
- If 2nd opinion does concur, patient submits a 2nd written request at least 15 days after 1st request.
- Before prescription is written, doctor must
- Confirm patient is acting voluntarily, free from coercion

- Offer alternatives
- Offer option to rescind
- Counsel on use of medication

Safeguards:

- No health care professional is required to participate
- Liability protection (criminal and civil) when process followed
- No impact on life insurance coverage

Experience from Oregon's 20 years > 1997 – 2016: (Similar results in other large states)

- 1967 patients received Rx / 1275 ingested
- 78% cancer; 11% ALS; 5% COPD
- 10% in hospice; 90% died at home
- White, educated, insured
- 3% referred to mental health

Impact

- Oregon hospice use has increased and is 2x national average
- Lower rates of ICU in last month of life
- 2/3s die at home vs 40% nationally
- Peace of mind

Patients request Medical Aid in Dying largely due to loss of autonomy (90%) and loss of pleasure (90%) followed by loss of dignity (65%), being a burden, loss of control of bodily functions, pain, and personal finances (5%)

Support among medical professionals has increased from 46% in 2010 to 57% in 2016 while opposition has decreased from 41% to 29%. As an example, the AMA opposes, but the American Academy of Family Physicians has adopted a policy of neutrality. Public support remains high at 60%. Medical Aid in Dying aims to protect a patient's rights at death; analogous to the movement a generation ago to protect a mother's rights at birth.

It is an ethical dilemma to extend life or alleviate suffering > competing good actions. Hastening death via Medical Aid in Dying is intended to relieve suffering and respect patient autonomy > morally acceptable. Hastening death by withdrawing life-sustaining treatment is morally wrong as life is sacred.

Many thanks to Dr Thoman for a very informative presentation.



Dr. Rebecca Thoman, MD