

**A Physician's Perspective  
on Medical Aid in Dying**  
Matt Whitaker- Access Campaign Director

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**About Compassion & Choices**

C&C is the nation's oldest, largest and most active nonprofit organization committed to improving care and expanding options for the end of life.

C&C supports, educates and advocates.

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**Overview**

- ✧ **Evolution of End-of-Life Care**
  - Public perceptions, medicine and public policy
- ✧ **Oregon Death With Dignity Act (DWDA)**
  - Physician responsibilities
  - Clinical criteria
  - Patients' rights
  - Data
- ✧ **Impact of Authorized Medical Aid in Dying**
  - Doctor-patient relationship
  - Hospice and palliative care

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“Life is meaningful because it is a story ...



... and in stories, endings matter.”

~Atul Gawande, *Being Mortal*

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### Institute of Medicine

**Dying in America**  
Improving Quality and Honoring Individual Preferences Near the End of Life



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“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”

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### Look Where You're Going



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### End-of-Life Options

- Pursuing Life-Sustaining Treatment
- Refusing Treatment
- Discontinuing Treatment
- Hospice
- VSED
- Palliative Sedation
- Medical Aid in Dying

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**Medical aid in dying** is a practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request from their doctor a prescription for medication that they can choose to self-administer to bring about a peaceful death.

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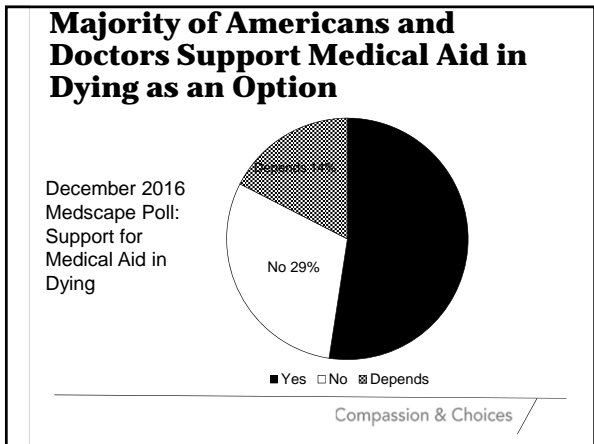
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### Integration of Medical Aid in Dying

Annals of Internal Medicine IDEAS AND OPINIONS

#### A Call for a Patient-Centered Response to Legalized Assisted Dying

John Frye, MA, and Stuart J. Youngner, MD

On 9 June 2016, California became the fifth state to legalize physician-assisted suicide (PAS), joining Oregon, Washington, Montana, and Vermont. More states may soon follow. Like it or not, PAS is here and is not going away. Given this reality, it is problematic that professional organizations have left physicians without sufficient support and guidance on how to provide the best possible care to dying patients seeking to exercise this legal right.

willing to communicate with others in their practices and profession (2). Beyond such personal considerations, the primary physician must identify a consulting physician to confirm the patient's prognosis and decision-making capacity. Ideally, the consultant is independent; however, in the absence of guidance on how to choose a consultant, primary physicians may worry about the consultant's political stance or familiarity and experience with end-of-life decision making.

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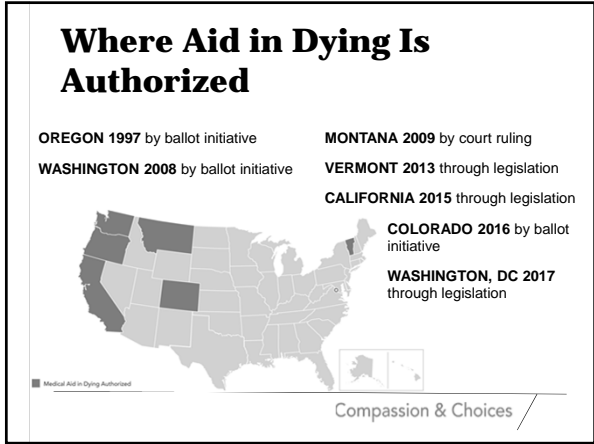
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### Clinical Criteria for Medical Aid in Dying



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### Oregon Death With Dignity Act: Eligibility Requirements



- Adult
- Terminally Ill
- Prognosis of six months or less
- Mentally capable of making informed medical decisions

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### Regulatory Requirements Include

- State resident
- Able to self-administer the medication (voluntary, conscious and physical act to take the medication into the body)

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### OR DWD – Request Requirements

- ✧ **TWO ORAL REQUESTS** from patient at least 15 days apart (not necessarily in person)
- ✧ **ONE WRITTEN REQUEST** signed by two witnesses (after both doctors' evaluation)
- ✧ Prescription may not be written until 48 hours after second oral request

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### OR DWD Physician Responsibilities

1. Inform patient of feasible alternatives:
  - Hospice care / palliative care / pain or symptom management
  - Voluntary stopping of eating or drinking
  - Declining life-sustaining treatment
  - Palliative sedation
2. Must request (but may not require) that patient notify next of kin of Rx request

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### Liability/Professional Protections

- No duty to participate
- No liability for medical providers if act in good faith under the EOLOA
- No disciplinary action taken against a licensed physician by any state medical boards for participation or declining to participate

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**ORS 127  
Patient's Rights**

- The choice to take aid-in-dying medication cannot affect health- or life-insurance status
- Death certificate may list underlying terminal illness as the immediate cause of death
- Medical aid in dying does not constitute suicide, mercy killing or homicide under the law

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**Medical Aid in Dying in Practice**



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**Over 19 Years of Practice in Oregon Shows That Medical Aid in Dying Works as Intended**

1. Having a prescription for aid-in-dying medication on hand is a comfort.
2. People use the law to minimize pain and suffering, not to save money.
3. The elderly, people with disabilities and people of color have not been coerced or abused.

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### Having a Prescription for Aid-in-Dying Medication Is a Comfort

Only 64% of the 1,749 prescriptions written between 1998 and 2016 were actually used.



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### Medical Aid in Dying Is Not Suicide

**Medical Aid in Dying**

Terminal diagnosis  
Mentally capable  
  
Patient **wants to live**  
Planned; often with family  
Death is peaceful  
Normal grieving after death (guilt is rare)

**Suicide**

No terminal diagnosis  
Mentally incapable (psychiatric diagnosis)  
  
Patient **wants to die**  
Impulsive; alone  
Death may be violent  
Abnormal grief (family members wonder "what if?")

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### Medical Aid in Dying vs. Suicide

	State of Wellness	State of Mind	State of Action
<b>Suicide</b>	PHYSICALLY HEALTHY	EMOTIONAL; DEPRESSED	IMPULSIVE
<b>Medical Aid in Dying</b>	TERMINAL: SIX MONTHS TO LIVE	RATIONAL; REALISTIC	THOUGHTFUL WITH SAFEGUARDS

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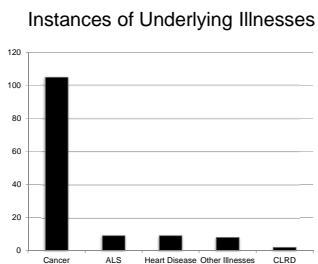
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### Diagnosis of People Who Used the Death With Dignity Law in Oregon



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### Hospice and Palliative Care Are Improved and Better Utilized

- 89% enrolled in hospice
- 89% died at home



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### Concerns Patients Have That Lead to Use of Oregon's Death With Dignity Law

90%	Less able to engage in activities that make life enjoyable
90%	Loss of autonomy
65%	Loss of dignity

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### Breakdown of Aid-in-Dying Prescription Recipients by Race

	General Public	Users of Death With Dignity Act
White	87%	96.6%
Black	1.6%	0.0%
American Indian/Native Alaskan	1.3%	0.0%
Asian	3%	1.5%
Hispanic/Latino	8%	1.5%

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### Positive Impact on Palliative Care

According to a 2015 article in the Journal of Palliative Medicine, the Oregon Death With Dignity Act may have resulted in

*“ ... more open conversation and careful evaluation of end-of-life options, more appropriate palliative care training of physicians, and more efforts to reduce barriers to access to hospice care and has thus increased hospice referrals and reduced potentially concerning patterns of hospice use in the state.”*

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### Positive Impact on Doctor-Patient Relationship



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## How Medical Aid in Dying Compares

	Time to Plan	Place of Death	Time of Death	Choices
<b>Sudden Death (Untimely)</b>	NO	NO	NO	NO
<b>Protracted Death (Painful to Patient and Family)</b>	YES	POSSIBLY	NO	SOME
<b>Medical Aid in Dying</b>	YES	YES	YES	YES

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## Support or Are Neutral on Medical Aid in Dying

- American Medical Women's Association
- California Academy of Family Physicians
- California Medical Association
- Gay and Lesbian Medical Association
- Oregon Academy of Family Physicians
- Oregon Medical Association
- Washington Academy of Family Physicians
- American Medical Student Association
- American Public Health Association

... and many other medical societies

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## Engaged Neutral Stance Toward Medical Aid in Dying

Table. Studied Versus Engaged Neutrality by Medical Associations

Topic	Studied Neutrality	Engaged Neutrality
Should laws allowing PAS be enacted?	Neutral	Neutral
Should physicians follow their conscience in responding to patient requests for PAS?	Yes	Yes
Does the association support palliative and hospice care for patients requesting PAS?	Yes	Yes
Should medical associations provide additional training/education for physicians?	No position	Yes
Does the association train or provide skilled consultants available for any physicians?	No position	Yes
Does the association encourage the formation of institutional policies that ensure proper support for physicians and patients after PAS is requested?	No position	Yes
Does the association support or lobby for support of research into and continuous improvement of assisted dying and end-of-life care practices?	No position	Yes

PAS = physician-assisted suicide.

An engaged neutral stance can better help clinicians responsibly meet the needs of their patients while still respecting the diverse opinions about medical aid in dying.

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