Physician Assisted Death
Primary Care Update 2013
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Physician Assisted Death

• Definitions
• History
• Medical Perspectives
• Legal Perspectives
• Where are we going?
Definitions

• Physician Assisted Death (PAD)=
• Physician Assisted Suicide:
  • Doctor Prescribes a medication in a dose high enough to cause the patient’s death
• Euthanasia from the Greek term
  • “dying well” or “a good death”
• Passive Euthanasia: treatment is withdrawn or withheld, leading to death (minutes-days)
• Active Euthanasia: death is caused by a person administering a lethal dose of medication to the patient
“Voluntary”

- Principles of Medical Ethics:
- Autonomy/Independence
- Beneficence
- Justice/Fairness

INVOLUNTARY EUTHANASIA = MURDER
Definition of Death

• Ceasing of heart beat and respiration
• Ceasing of brain wave activity=
• Brain death= permanent vegetative state
• A. Unresponsive
• B. No spontaneous respiration
• C. No brainstem reflexes
• D. No brain waves (electrical activity)
The Extremes of Life

• Euthanasia/PAD is Primarily Practiced at the beginning or end of life.
• 20th Century – Many severely deformed or
• Handicapped infants were subject to euthanasia
  – “Baby Doe” Cases 1980’s
Rehabilitation Act of 1973

Child Abuse Amendments of 1986

- “Handicapped children shall not be discriminated against by a program or institution receiving Federal Funds” AND
- State Child Protective will respond in cases of “medical neglect”
- Euthanasia / PAD of infants is a non-issue:
  1. Prenatal Testing & Diagnosis
  2. Pregnancy Termination/ Abortion Services
  3. Neonatology: The Rise of the NICU/PICU
History of PAD/ Euthanasia

- Average Life Expectancy
- 1700= 36 years
- 1850=38
- 1900=48
- 1950=66
- 2000=75
- Morphine synthesized in 1803
History Euthanasia

• 400 BCE - Hippocratic Oath “Do No Harm”
• 1828 - NY outlaws assisted suicide
• 1939-45 Nazis Exterminate the disabled and mentally ill
• 1950- World Medical Association condemns Euthanasia
• 1960’s CCU/ICU and the DNR Order
• 1960’s-70’s– Hospice Movement
• 1990- Dr. Jack Kevorkian performs 1st active euthanasia in USA
• 1994 – Oregon Death With Dignity Act allows Physician assisted death
• 1997 – US Supreme Court: “No Constitutional right to die”
• 2002 – Euthanasia legalized in Netherlands & Belgium
• 2005 – Switzerland allows assisted suicide in hospitals
• 2008 Washington State legalizes Physician Assisted Suicide
• 2009 Montana Supreme Court allows Physician Assisted Suicide (Baxter v. Montana)
• 2013 Vermont – Act 39: Patient Choice At End of Life Act
Maine

• Referendum Question November 2000:
  • “Should a terminally ill adult who is of sound
    Mind be allowed to ask for and receive a doctor’s help to die?”

• YES 49%
• NO 51%
Medical Perspective

• Hospice and Palliative Care
• Dame Cicely Saunders – founder of the modern hospice movement 1960s UK
• “Comfort Care”: Emphasis on relieving pain, treating symptoms, and providing supportive care BUT NOT “ACTIVELY” Treating Disease
• 2010 : Almost 5,000 hospice-palliative care programs in the USA
• More than 50% of patients die in Hospital
• About 40% of deaths are in hospice care- 20 days
• Medicare Hospice Benefit: available to those
• With terminal condition who are expected to
• Live 6 months or less
• Global payment of $125/day
• PROBLEMS: Hospitalization AND “ACTIVE” Treatment
Double Effect and “Unintended” Consequences

- Drugs Used to treat pain and anxiety
- Morphine and benzodiazepines
- depress respirations and lower blood pressure and heart rate.
- Border Between Controlling Pain and Hastening Death?
Pendulum of Pain Control

- Pain as the “5th Vital Sign”
- Limiting Narcotic Use to “Prevent Addiction”
- Versus Liberal Narcotic Prescribing to “Control Pain”
- Acute versus Chronic Pain
- Terminal Illness versus Chronic Illness

Pain Scale

0 2 4 6 8 10
Case 1

- You are the hospitalist at a large inner city hospital. You are covering a long-term care unit where most of the patients are elderly and on ventilators.
- There is a natural disaster. The bottom floors of the hospital are flooded. There is no electricity or sanitation.
- The temperature is almost 100 degrees on the floor. You have a minimum of nursing staff who have been on duty 24 hours a day for 3 days.
• Most patients and staff have been evacuated but because your patients are so ill, it is unclear if they can or will be evacuated.

• What should you do?
Case of Dr. Anna Poux

- Arrested and charged with giving lethal injections of morphine and midazolam
- To four patients (ages 61-97) at a New Orleans Hospital three days after Hurricane Katrina in 2005.
- The charges were later dropped.
Legal Perspective

• Adults have the right to refuse unwanted medical treatment.
• A Guardian for the patient may make this decision if the patient is unable.
• In Re Quinlan (1976), Cruzan v Missouri (1990)
• In Re Schiavo (2001)
Do Patients have a RIGHT to die?

• 2 patients challenged the laws in their states
• Prohibiting physicians from assisting them in
• Their deaths/ suicides.
• They asserted the Constitution gives citizens a
right to die
• The Supreme Court Disagreed (9-0):
• Washington v Glucksberg
• Vacco v Quill (1997)
Oregon Death With Dignity Act (1994)

• Prohibits Active Euthanasia
• Adults Only
• Must have medically confirmed terminal disease
• Requires Exam by 2nd Physician
• Can not have any medical condition that would impair judgment
• After request is authorized, patient must wait 15 days and then make a 2nd oral request before RX can be written
Federal Challenge to Oregon’s Law

• Federal Government asserted that Controlled Substances Act prohibited physicians from
• Prescribing drugs unless there was “legitimate Medical purpose.” Federal Gov’t argued assisting In patient’s death was NOT such a purpose.
• Supreme Court disagreed in Gonzales v Oregon (2005)
Oregon’s Death with Dignity Act

- SUMMARY OF DATA 1998-2007 (10 years)
- Total of 341 patients died (34/year)
- Average age: 69
- About 65% had attended college or had degree
- 97% were Caucasian
- 82% underlying illness terminal cancer
- About 8% had ALS
- 86% were enrolled in hospice
- 93% died at home
- 1% had no insurance
Major End of Life Concerns (Oregon)

• 1. Loss of Autonomy
• 2. Loss of Ability to Engage in Activities that Make life enjoyable
• 3. Loss of Dignity
• 4. Between 24-50% Complained that Pain Necessitated their request for the RX
Netherlands

• PAD and voluntary euthanasia since 2002:
• 1.7% of all deaths were due to voluntary euthanasia
• 0.1% were the result of PAD
• Questionnaires were mailed to Doctors
• Response rate was 78%

Maine Law

• MRSA Title 17-A, Section 204
• Aiding (in) Suicide: a Class D crime, punishable by up to 1 year in jail and a fine up to $2,000
Case 2A

• You are the medical director of a large insurance company. There is a new cancer treatment for CML, a cancer that primarily affects the elderly. Giving the drug for 5 weeks
• Prolongs the average patient’s life by 3 months. The drug costs $4,000/week.
• Do you approve this drug and pay the claims?
Case 2B

• You are still the medical director at the same
• Large insurance company. Doctors in Vermont
• Are submitting bills for “End of Life Care Visits” and patients are submitting drug
• Claims for drugs prescribed for their Physician
• Assisted Death/Suicide.
• The Average Claim Amount for both visit and
• Drug is $350
• Do you pay these claims?
Options

• 1. Pay for Both
• 2. Pay for Neither
• 3. Pay for the Cancer Treatment, Deny the End of Life Visit/ Drugs
• 4. Pay for the End of Life Visit/ Drugs, Deny the cancer treatment
Where Are We Going?

- 4 European Countries Allow Either Physician Assisted Suicide or Active Euthanasia:
  - Belgium, Luxembourg, Netherlands, Switzerland
- 4 US States Allow Physician Assisted Suicide:
  - Montana, Oregon, Vermont, and Washington
- Passive Euthanasia= withdrawal of ventilator support and tube feedings is common in USA
• Hospice and Palliative Care is widely available
• And not controversial or contentious.
• Major issues:
• 1. Patient Acceptance (average 20 days)
• 2. “Usual Care” vs Active Disease Treatment
• 3. Hospitalization
Continuum

• 1. Failing to provide care (DNR)
• 2. Withdrawing care (stopping IV/tube feeds)
• 3. Hastening Death by “Double Effect”/Unintended Consequence (morphine)
• 4. PAD/PAS- DO gives RX (“proximate cause”)
• 5. Voluntary Euthanasia (Dr. Kevorkian)
• 6. Involuntary Euthanasia (Criminal Murder)
The Two Sides: Proponents

• Libertarian Argument:
• Physician Assisted Death Provides Patients with Autonomy and the means to control when they die

• Issues: Pain Control & Depression
• Do Doctors and the Healthcare System meet patient’s end of life needs?
OPPONENTS

• There is a Right to Life (but No right to Die)
• All life is sacred and must be preserved/prolonged/extended?
• Religious Principle: Suicide is morally wrong
• Doctors have a duty to heal
• “Slippery Slope”: PAD will lead to involuntary
• Euthanasia among the poor, elderly, handicapped, and minority groups for economic reasons and will damage our society
How does PAD relate to hospice?

• If hospice/palliative care is available, then why is Physician Assisted Suicide needed?
• 1. Not all terminally ill patients are eligible or Enrolled in hospice.
• 2. Hospice care can provide pain and symptom relief, drugs can not be prescribed to “end life”
Physician Assisted Death/Suicide

• Death: Depressing, Difficult, Emotional and Controversial Issue.
• Hospice/ palliative care a “middle ground”
• Do we really perform PAD/ PAS unobtrusively under a different name & with different intent?
• “Don’t ask – don’t tell”
Summary

• No consensus over end of life care
• Some Patients want Autonomy and Control over their Death
• Opponents cite religious/ moral arguments
• 4 States offer PAD/PAS as an option
• Many Doctors are conflicted/ opposed
• Slow societal movement to PAD/PAS
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Questions?