Medical Aid in Dying: Ethical and Practical Issues

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Presenter's disclosure of conflict of interest is found at the end of this article.

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Abstract

At JADPRO Live 2022, Jonathan Treem, MD, of the University of Colorado Palliative Care, explained medical aid in dying in order to prepare advanced practitioners to feel confident to counsel a patient who inquiries about aid in dying. He explained the law and protocol for participation, the history, ethics, and data behind the intervention, and steps for what is required. Finally, Dr. Treem discussed ethical considerations that may arise as patients and clinicians consider these types of interventions.

Medical aid in dying presents a unique set of challenges for health-care providers, including determining patient capacity, managing timing issues, and addressing the intersection of state and federal laws. During JADPRO Live 2022, Jonathan Treem, MD, of the University of Colorado Palliative Care, explained the law and protocol for participating in medical aid in dying and how they vary from state to state. Dr. Treem also demonstrated the ability to counsel patients who ask about this practice while evaluating ethical considerations.

DEFINITIONS

As Dr. Treem explained, the terms "assisted suicide," "medical aid in dying," "death with dignity," and "euthanasia" are often used interchangeably, but they are distinct concepts. Euthanasia refers to a provider administering a lethal medication to end a patient's suffering and life, while physician-assisted suicide is when a patient takes a prescribed lethal dose of medication to end their own suffering. Medical aid in dying, on the other hand, is when a terminally ill patient takes a prescribed medication to achieve a death in line with their own values, regardless of their degree of suffering.

"Importantly, the patient must be dying to participate in medical aid in dying," said Dr. Treem. "Medical aid in dying is a choice of death, not a choice of continuing to live."

HISTORY OF MEDICAL AID IN DYING

According to Dr. Treem, medical aid in dying, also known as physician-assisted dying or death with dignity, has a long history in the United

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States. The first euthanasia laws were enacted in the 1910s but were generally aimed at outlawing the practice. In 1980, the Hemlock Society was founded by Derek Humphry, whose wife had a neurodegenerative illness, to advocate for the right to end one's life peacefully. The issue reached the Supreme Court in 1997 in the case of Washington v. Glucksberg, in which the Court ruled that there is no federal law that either legalizes or prohibits medical aid in dying and that it is a state's rights issue. In 1994, Oregon passed Measure 16, also known as "Death with Dignity," which allows physicians to write prescriptions for medication that will end a patient's life peacefully.

In 2006, however, the Supreme Court case Gonzalez v. Oregon upheld that a person with a DEA license could not write the prescription due to violation of the Federal Controlled Substances Act, but this was later overturned. Since then, said Dr. Treem, medical aid in dying is largely considered a legally established practice, with some states allowing it and others not.

"It's important for health-care professionals to be aware of the legality of the practice in the state they are working in," Dr. Treem added.

STATE-TO-STATE DIFFERENCES

Medical aid in dying is a legal practice in 11 jurisdictions in the United States, including Oregon, Washington, Colorado, Vermont, California, and the District of Columbia (Table 1). Public opinion polls have consistently shown that about 70% of Americans across the political spectrum support allowing individuals with degenerative, incurable diseases to access medication that will end their lives. The legality of medical aid in dying varies from state to state, with some states passed by direct ballot initiative, others by legislation, and others by legal precedent (Snyder Sulmasy et al., 2017).

"Importantly, not all patients who inquire about medical aid in dying intend to end their life with medication," said Dr. Treem. "Many see it as an insurance policy for their end-of-life care, to prevent unnecessary suffering and to maintain autonomy."

In Colorado, where Dr. Treem practices, there has been about a 20% falloff from the number of patients who get the medication prescribed to the number of patients who get it dispensed. There is also about a 30% falloff from the number of prescription recipients to the number of deaths due to ingesting the medication (Colorado Department of Public Health and Environment, 2019).

Table 1. US Jurisdictions Where Medical Aid in Dying Is Legal

State	Date Passed
California	2015
Colorado	2016
DC	2016
Hawaii	2018
Maine	2019
Montana	2009
New Jersey	2019
New Mexico	2021
Oregon	1994
Vermont	2013
Washington	2008

Note. Information from Britannica ProCon.org (2022).

Cancer is the most common diagnosis among patients pursuing medical aid in dying, said Dr. Treem, closely followed by neurologic disorders such as ALS and dementia.

"It's worth noting that the population that tends to use medical aid in dying is disproportionately secure in their access to institutional resources and their financial capabilities, tend to be more educated, have a higher gross mean income over life, and disproportionately White across the board," Dr. Treem observed. "While most people are enrolled in hospice, it's important to consider the ethical and justice implications of this trend and what barriers might exist for other populations seeking similar end-of-life options."

THE PROCESS

The process for obtaining medical aid in dying varies slightly from state to state, but generally requires two physicians, the prescribing physician, and the consulting physician (Figure 1). The patient must see the prescribing physician twice, separated by at least 15 days, except for New Mexico, which does not require a waiting period between the two visits. The consulting physician's role is to determine whether the

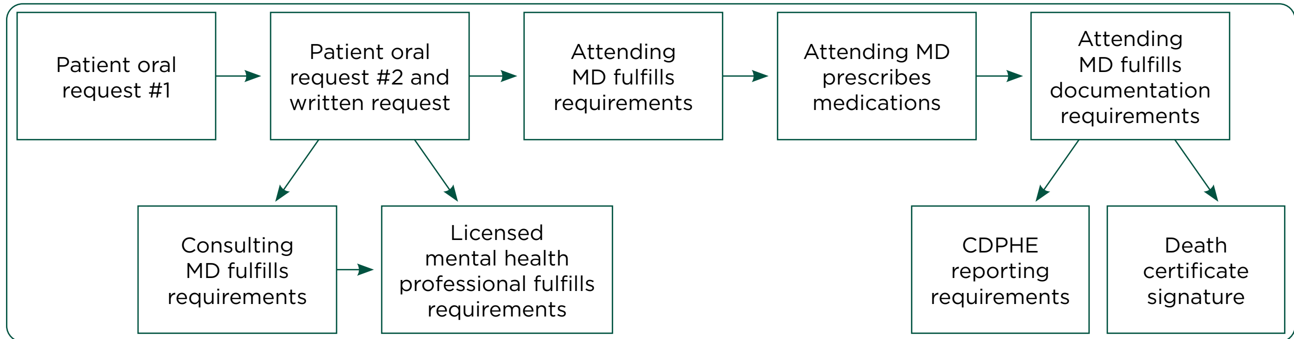

Figure 1. Colorado End-of-Life Options Act: Process overview. An Attending/Prescriber is an MD or DO, except in New Mexico where NPs and PAs may also be a prescriber. A patient may change their mind at any time during the process. CDPHE = Colorado Department of Public Health & Environment.

patient qualifies under the law, and a capacity evaluation by a psychiatrist or psychologist is required if there is a question about the patient's ability to make the decision, unless in Hawaii where it is mandatory for every person pursuing medical aid in dying.

Once the qualifications are met, said Dr. Treem, the patient must provide a written statement acknowledging their understanding and decision, witnessed by another person. This process includes two visits with a prescribing physician, one visit with a consulting physician, and a capacity evaluation if deemed necessary.

After the necessary visits and evaluations have been completed, the patient must provide a written statement, witnessed by another person, confirming their decision. The prescribing physician is responsible for collecting proof of residency, providing a risk, burden, and benefit conversation, and obtaining informed consent. The consulting physician is responsible for determining if the patient meets the legal qualifications, and the capacity evaluation must be performed by a licensed psychiatrist or psychologist.

"Medical aid in dying is intended to be a thoroughly thought-out and planned decision, not a spontaneous one," said Dr. Treem.

PATIENT REQUIREMENTS

Medical aid in dying has certain requirements that patients must meet to qualify for the procedure. These requirements include being an adult (18 years or older), a resident of the state where the procedure is taking place, having a prognosis of less than 6 months as determined by two physicians, having the capacity to make an informed decision, and the ability to self-administer the medication. According to Dr. Treem, self-administration is defined as an affirmative conscious act without which the patient would not receive the medication. Additionally, the patient must be acting voluntarily and making an informed decision, he said.

Medical aid in dying is legal in states where it is authorized, provided that the patient meets the qualifications for the procedure. Health-care providers are not obligated to participate in medical aid in dying, but they cannot prevent patients from seeking care from other providers.

"In general, only MDs or DOs can participate as the prescribing or consulting physicians, except for New Mexico," said Dr. Treem. "Institutions, such as hospitals or nursing homes, may prohibit the use of medical aid in dying on their premises, but they cannot prevent employees from writing a prescription for it."

"Institutions must also notify patients in advance of their institutional policy regarding medical aid in dying, and failure to do so can result in a violation of the law," he added.

THE PRESCRIPTION

The American Clinicians Academy on Medical Aid in Dying (ACAMAID) is a professional organization that regularly updates recommendations for the medications used in medical aid in dying. The current medication used is DDMAPh (diazepam, digoxin, morphine, amitriptyline, phenobarbital).

"The medication typically causes patients to fall asleep within 2 minutes to 2 hours, and death occurs within 30 minutes to 8 hours," said Dr.

Treem, who noted that patients are also premedicated with antinausea medication.

The medication is administered in large doses, with 1 gram of diazepam and 15 grams of morphine. Some patients may switch from propranolol to amitriptyline, which is more commonly used and has a faster onset to coma and death.

"When counseling patients considering medical aid in dying, it is important to note that the medication must be consumed within 2 minutes of administration and has an unpleasant taste," said Dr. Treem, who noted that there have been no reported cases of patients remaining awake during the dying process.

The cardiac arrhythmia is caused by the digoxin/amitriptyline, the morphine/diazepam is what incurs the sleep state, and the phenobarbital is there to prevent seizures associated with the dying process.

According to Dr. Treem, it is also important to counsel patients and their family members about what they may experience while at the bedside of a loved one during the dying process.

"Death is a process and not a sudden event as is commonly portrayed in media," he explained. "It can involve muscle twitching, irregular breathing, and difficulty with secretions, and it is important to let family members know that these symptoms are not distressing for the patient, although they can be distressing for loved ones to witness."

The onset of death can vary greatly, with some cases occurring as quickly as 30 minutes, while others may take up to 24 hours. Just because someone is still alive, however, does not necessarily mean they are suffering, said Dr. Treem.

Additionally, patients have the right to rescind their request for medical aid in dying at any time, even if the medication has been administered, and this should not affect their overall health care.

LAW NUANCES: CURRENT CONTROVERSY

Dr. Treem also noted several legal and ethical considerations surrounding medical aid in dying. In some states, he said, there may be conflicts between state laws and federal laws regarding the participation of health-care providers in medical aid in dying.

In Colorado, for example, the law states that an organization may prevent a patient from taking a medication on their premises, but may not prevent them from receiving a medication in good faith from a doctor employed by their organization. There is currently a case being tried concerning a Catholic organization firing a doctor who prescribed medication for their patient. That act of retaliation from the Catholic organization is a violation of Colorado law. The Catholic hospital's position is that federal law protects their ability to uphold organizational values in the distribution of health-care resources, and so they argue the state law conflicts with the federal law on this point.

There is also a current court case where a health-care provider is challenging the hospital's policy as it conflicts with federal protections for private and public entities to not participate in mandates that violate their religious principles. It is important for health-care providers to be aware of these legal and ethical considerations when counseling patients on medical aid in dying.

Another ethical and legal question is the "five to midnight problem," where a patient's ability to self-administer the medication may deteriorate before they are ready to do so. As Dr. Treem explained, this problem can occur in cases where a person's disease progresses rapidly and they lose the ability to cognitively understand or physically take the medication, or in cases where someone with a neurodegenerative illness loses the ability to communicate or physically self-administer the medication.

"This problem highlights the need for careful consideration of an individual's mental and physical capacity, as well as the timing of medication provision, to ensure that the person's autonomy and wishes are respected while also ensuring that the medication is taken in a safe and effective manner," he said.

Some patients have proposed death contracts as a solution, but this is not a legal option in the United States and should be pursued with legal counsel rather than medical counsel, said Dr. Treem. Other countries such as Canada and the Netherlands have implemented such practices.

MEDICAL AID IN DYING VS. ASSISTED SUICIDE

Finally, said Dr. Treem, it is important to distinguish between medical aid in dying and assisted suicide. In situations where a patient is actively suicidal and has a terminal illness, it can be a difficult ethical decision for health-care providers to make.

"In cases where a patient has a history of suicide attempts and a terminal illness, the health-care provider must consider if they are treating the terminal illness or the suicidality," said Dr. Treem, who noted that health-care providers should work with an ethics committee to make these decisions. "In some cases, the health-care provider may allow the patient to go through the process of obtaining the medication but hold the medication at the pharmacy until the patient's terminal illness has progressed to a point where death is imminent." ●

Disclosure

The presenter has no relevant financial relationships to disclose.

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