


Physician Aid in Dying: Its Time Has Come for Maryland

Michael J. Strauss, MD, MPH, and Terri L. Hill, MD

Physician Aid in Dying — What is it?

End-of-life care, having seen extraordinary progress over recent decades, addresses most of the complex needs of terminally ill patients for whom a cure is not an option (see "When Cure Is Not Possible: The Role of Palliative Care," page 22) For some, however, suffering continues despite our best efforts.

Physician Aid In Dying (AID)—sometimes termed death with dignity or physician-assisted suicide—refers to a medical practice in which patients with decision-making capacity and a prognosis of six months or less may request, and physicians may prescribe, life-ending medication for self-administration, provided specific requirements are met (see Figure 1). In 1997, Oregon became the first state to legalize the practice, followed by Washington (2009), Montana (2009), Vermont (2013), and California (2015). On November 8, 2016, Colorado voters passed a referendum permitting AID, with implementation likely in December 2016. In November 2016, the Council of the District of Columbia approved a resolution permitting AID. The resolution will become law unless the U.S. Congress intervenes. Most other states are considering, or have considered, similar legislation.

Bills modeled after the Oregon law were introduced in the Maryland General Assembly during 2015 and 2016 legislative sessions and later withdrawn because of inadequate legislative support. In both years advocates and opponents gave testimony at hearings, with physician representation on both sides. Having closely observed and been involved with these proceedings, we recognize that controversy surrounds AID and misinformation confuses the discussion. With the legislation likely to be re-introduced in 2017, we address particular concerns raised by physicians.

Strong Protections For Patients and Providers

To protect potentially vulnerable individuals, the Maryland bill strictly limits patient participation by setting requirements for minimum age, residency, diagnosis, prognosis, and mental capacity. These protections are considerably stronger than protections under current Maryland law permitting palliative sedation and voluntarily stopping eating and drinking (VSED), physician actions that may also hasten patient death (see Figure 2 and article by Khurana et al., page 24). As in states where AID is authorized, physician participation would be voluntary, and those who operate in good faith protected from liability.

No Slippery Slope

In the more than thirty years of combined experience of states authorizing AID, there has been no evidence of abuse or coercion of individuals to elect AID, no expansion of the medical conditions for which AID is allowed, and no lowering of the age requirement.

Benefit for the Few

In Oregon, between 1998, when the law went into effect, and 2016, 1,545 patients have received, and only 991 have taken, a prescription for lethal medication.[2] The low rate is attributed

Figure 1: Key Provisions and Protections of Maryland's End-of-Life Option Act

Patient
- 18 years of age & legal resident
- "Terminal illness" – within reasonable medical judgment a prognosis likely to result in death within 6 months
- Capable of self-administering medication
- Must have capacity
- Requests aid in dying
- Initial verbal request
- Written request (at least 3 days later) with 2 witnesses (one not a family member)
- 2nd verbal request – at least 15 days after initial request

Attending Physician
- Meets with patient privately to prevent coercion
- Informs patient of
  - Medical diagnosis and prognosis
  - Feasible alternatives - palliative care and hospice
- Determines if patient has capacity or refers to mental health professional
- Informs / counsels patient that he/she
  - may wish to notify next of kin
  - may rescind request at any time
- Counsels patient about importance of
  - another person present when taking medication
  - not taking medication in public place
  - participating in hospice program
  - preparing an advance directive

Other Provisions
- **Consulting Physician** – corroborate patient's terminal illness, prognosis, and capacity
- **Psychiatrist / Psychologist** – if consulted, determine capacity
- Nobody is required to participate
  - Attending Physician
  - Consulting Physician
  - Psychiatrist or Psychologist
  - Pharmacist
  - Nursing home, hospital, etc.
- Patient can rescind at any time
- Coercing patient is a felony

Figure 2. End-of-Life Option Act Has Stronger Protections Than Two Current Maryland Laws Impacting End of Life

Requirements	Voluntarily Stopping Eating and Drinking — VSED (as of 1993)	Palliative Sedation (as of 1999)	Aid in Dying (End-of-Life Option Act of 2016)
Physician Meets with Patient Alone	No	No	Yes
"Cooling Off" Period	No	No	15 days
Consultation With a Second Physician	No	No	Yes
Two Witnesses, One of Whom Cannot Be **An Heir** **A Relative**	 Yes No	 No No	 Yes Yes
Physician to Obtain Mental Health Evaluation if Concern about Patient's Capacity	No	No	Yes
Interpreter, If Necessary, When Physician Meets Independently with Patient to Determine If There Is Coercion	No	No	Yes

partly to Oregon's excellent end-of-life care, with more than 90 percent of AID patients enrolled in hospice in the last six months of life. Inability to engage in activities that make life enjoyable, loss of autonomy, and perceived loss of dignity (i.e., incontinence, inability to care for oneself) are the leading concerns given by AID patients. For some patients, having the prescription eases fear over whether the pain of living or process of dying will become too much to bear, even if they never take the medication.

Strong Public Support

Although few people exercise the AID option, multiple surveys, both nationwide and in Maryland, show large support for having it available, with 60 to 70 percent of adults in support and 25 to 35 percent opposed. Fully 65 percent of MedChi's physicians endorsed changing its position to "support" or "neutral" (see Figure 3). Some have said that most people are only one bad death away from supporting AID laws.

Figure 3. Maryland Physicians and the General Population Support Aid in Dying

		Individuals Surveyed (respondents)	Support	Oppose	Neutral, Other or Don't Know
Physicians	MedChi Survey (June-July 2016)	Maryland Physicians (n=455)	**54%**	**42%**	4%
	Medscape National Survey Fall 2014	>17,000 physicians nationwide	**54%**	**31%**	15%
Maryland Residents	Momentum Analysis Maryland Poll Feb 2016	Maryland Voters (n=1,100)	**65%**	**26%**	9%
	Washington Post - Univ of Maryland Poll October 2015	Maryland Adults (n=1,006)	**60%**	**33%**	7%
	Goucher Poll Feb 2015	Maryland Residents (n=794)	**60%**	**35%**	5%
National Polls	Gallup Poll May 2016	Adults Nationwide (n=1,025)	**69%**	**27%**	4%

Psychiatric Consultation When Needed

Those who provide day-to-day care for the terminally ill—internists, geriatricians, oncologists, and palliative care/hospice physicians—routinely help patients make life-and-death decisions, a process that requires evaluating capacity and depression, and treating appropriately. Therefore, the AID bills that have been before the Maryland legislature have not required psychiatric clearance for patients receiving AID, although both directed physicians to request a psychiatric evaluation if they have questions about the patient's psychological status or capacity. The bill likely to be introduced in 2017 is expected to have the same provisions. It should be noted that a number of mental health screening tools are available for physicians to use in such situations.[3]

Neither Suicide Nor Euthanasia Nor Dr. Kevorkian

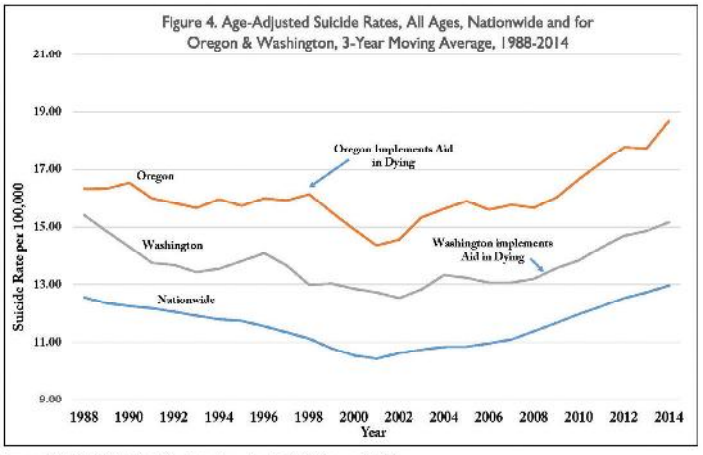
Suicide is an act of desperation and the product of irrational thinking.

Euthanasia, or "mercy killing," is the administration of a lethal medical dose to another for the purpose of ending a life. Dr. Jack Kevorkian's infamous device that helped patients end their lives required substantial assistance, thereby necessitating one person to assist in taking another's life and meeting the euthanasia definition.

AID is considered an act of acceptance, a rational response to the reality that, despite all therapeutic efforts made in the individual's battle to live, the disease process has won. To call it suicide disregards the patient's desire and efforts to live. AID laws not only require that patients self-administer the medication, but also legally defines the act as other than suicide.

Some argue that this is a distinction without a difference, but supporters dispute a claim of moral or legal equivalency between a clinically depressed teenager shooting herself in the head, a Twin Towers occupant on 9/11/01 leaping to avoid being burned alive, and a suffering end-stage cancer patient opting to take life-ending medication.

Some opponents have claimed that aid-in-dying laws have led to an increase in suicide rates (excluding AID cases), citing a recent peer-reviewed study.[4] Such claims are simply wrong. A careful reading of that study shows, and in the body of the paper the authors themselves concede, that after controlling for potential confounding variables, the finding of an effect was "no longer statistically significant." In addition, a simple graph of Centers for Disease Control and Prevention suicide data (see Figure 4) shows that suicide rates in Oregon and Washington have closely tracked national trends.[5,6]



Source: 1999-2014 data: http://wonder.cdc.gov/controller/datarequest/D76
1988-1998 data: http://webappa.cdc.gov/sasweb/ncipc/mortrate9.html

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No Violation of Profession Ethics or the Hippocratic Oath

As physicians, we often confront profound ethical questions: Start or stop chemotherapy in a cancer patient? Initiate or cease ventilator support after a devastating stroke? The questions raised in AID are of a similar nature.

Living 2,400 years ago, Hippocrates could not envision today's medical practices.[7] Yet the oath, still administered in contemporary iterations to new physicians, remains an ethical standard of our profession. Not all directives of the original oath have survived as relevant. Of those that have, the dictums to "help the sick according to my ability and judgment, but never with a view to injury and wrong-doing" and to "abstain from all intentional wrong-doing and harm" are the focus in AID debates. The fundamental question becomes whether they are broken by granting or by not granting patients' informed requests to bring their lives to a peaceful end, at a time and amid surroundings of their choosing, through AID.

A modern interpretation of the oath might be: Do what is right for the patient.

A Call for Engaged Neutrality

Organized medicine, including the American Medical Association (AMA) and American College of Physicians, has generally opposed AID. However, the AMA House of Delegates recently referred AID for additional study. In September 2016, MedChi restored its "neutral" position from that of "opposed."

It is recognized that physicians' training does not include the topic of AID or the use of pharmacologic agents for the purpose of ending life. Thus, there is a call for "engaged neutrality," whereby professional groups allow for diverse views and for the development of support materials for participating physicians in states in which AID is practiced.[8] Organizations in Oregon and elsewhere have developed clinical guidelines to ensure that AID practices prioritize quality of care and professionalism.[3,9,10]

Conclusions

Hospice, palliative care, palliative sedation, medical marijuana, and alternative and holistic modalities provide relief for most, but not all, terminally ill patients who experience severe physical, emotional, or even existential pain. For the small minority who continue to suffer despite our best efforts, AID is another option.

We believe AID, a patient initiated and controlled means of pharmacologically accelerating imminent natural death, is a legitimate addition to the choices for those confronting a difficult death. Freeing patients, their loved ones, and physicians to discuss all concerns and options openly, and without fear of external judgment or the pall of criminality, is consistent with our responsibility to act compassionately. In deciding whether to assent to a request, physicians can take into account the patient's physical, emotional, and spiritual status; the patient's expressed wishes; unique circumstances; and the physician's own moral convictions.

It serves no one—the patient, the medical community, or society at large—to deny patients the opportunity to consider this option and whether it is right for them.

Michael J. Strauss, MD, MPH, is a retired internist and health policy consultant and an advocate for aid in dying. He can be reached at michael@michaeljstrauss.com. Terri L. Hill, MD, is a board-certified plastic surgeon and member of the Maryland House of Delegates where she serves on the Health and Government Operations Committee and has served on the Death-with-Dignity Workgroup. She can be reached at tlhill@unmaskthebeauty.com.

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