Responding to Requests to Hasten Death in a NO-MAID State

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Objectives

- Describe MAiD laws, processes, patient profile
- Discern motivations for inquiring about hastening death
- Appropriately respond to requests to hasten death

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Medical Aid Dying in the US

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First, Some Definitions

Palliative Care

Specialized medical care for people living with serious illnesses. It is focused on providing patients with relief from the symptoms and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

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First, Some Definitions

Palliative Care

Provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

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First, Some Definitions

Euthanasia

Physician or other clinician/ technician administers lethal dose of medication to relieve irremediable suffering.

In some countries*, legally allowed and regulated, requiring certain patient criteria and process steps

Illegal in the U.S.

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First, Some Definitions

Medical Aid in Dying

Legally defined process by which a physician may prescribe a lethal dose of medications to a mentally capable patient with a terminal illness, to be self-administered at a time and place of the patient's choosing.

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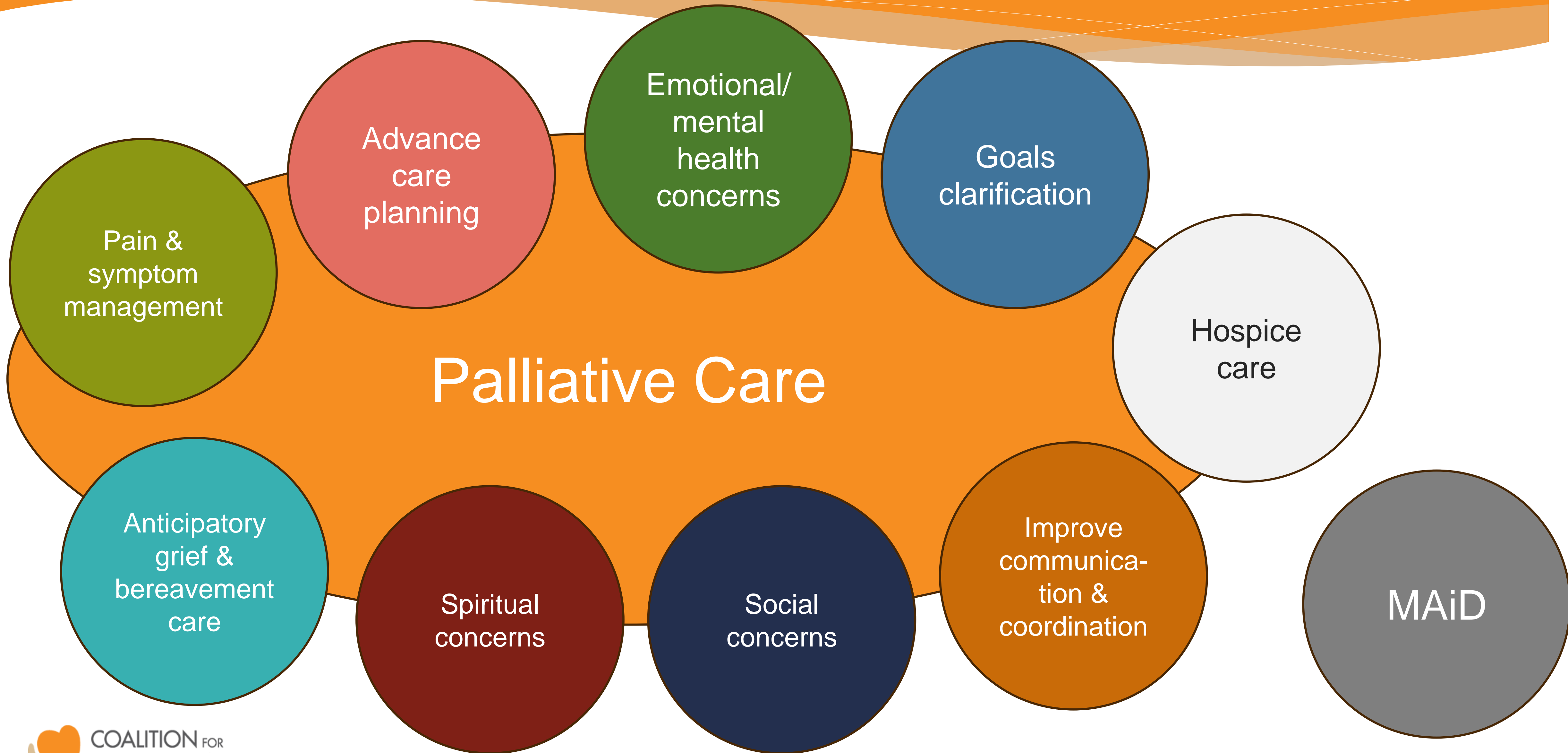

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Terminology

- Physician-assisted suicide
- Physician-assisted death
- Physician aid in dying
- Aid in dying
- Self-directed death
- Self-deliverance
- "Death with dignity"
- Medical aid in dying
- Medically assisted dying

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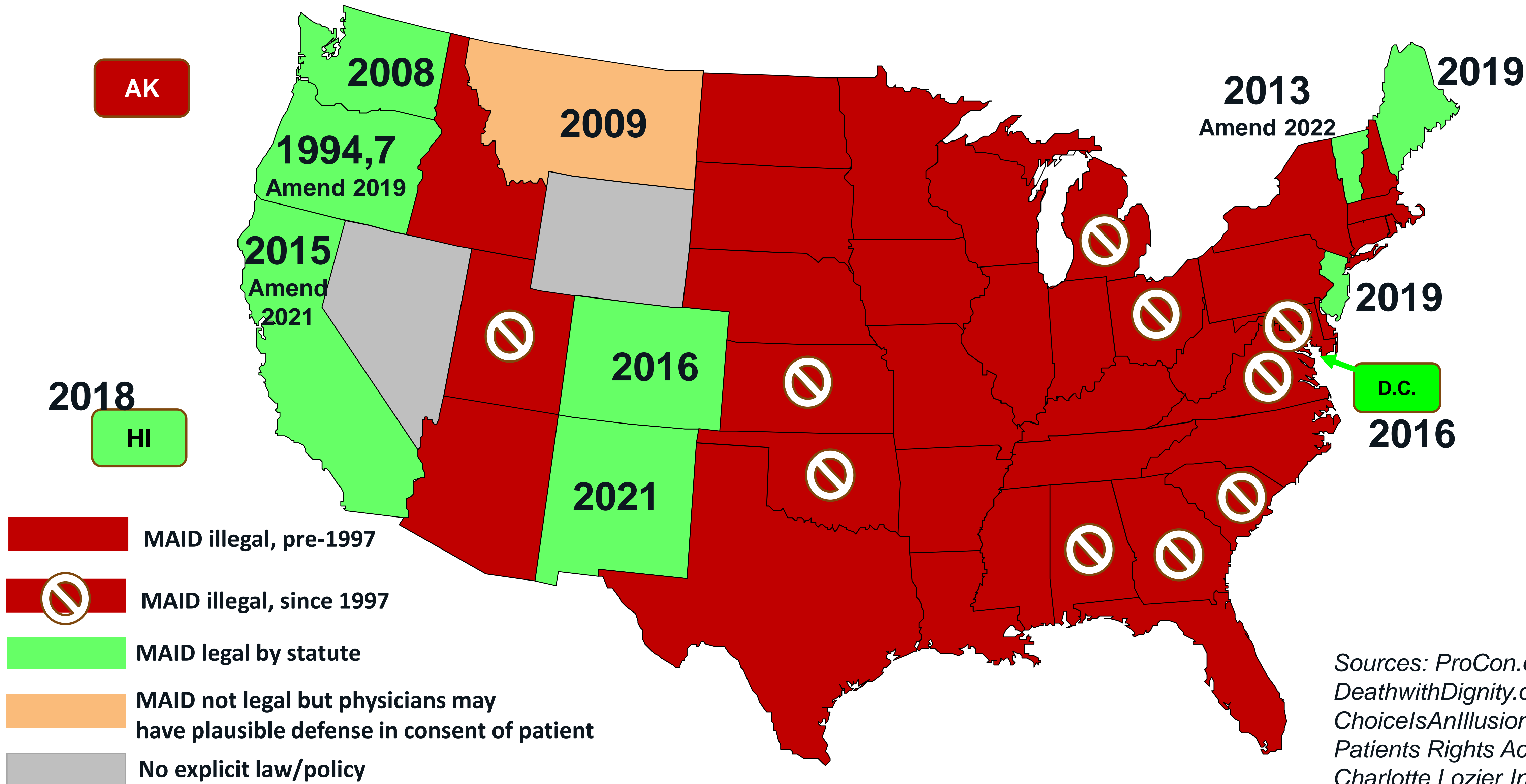
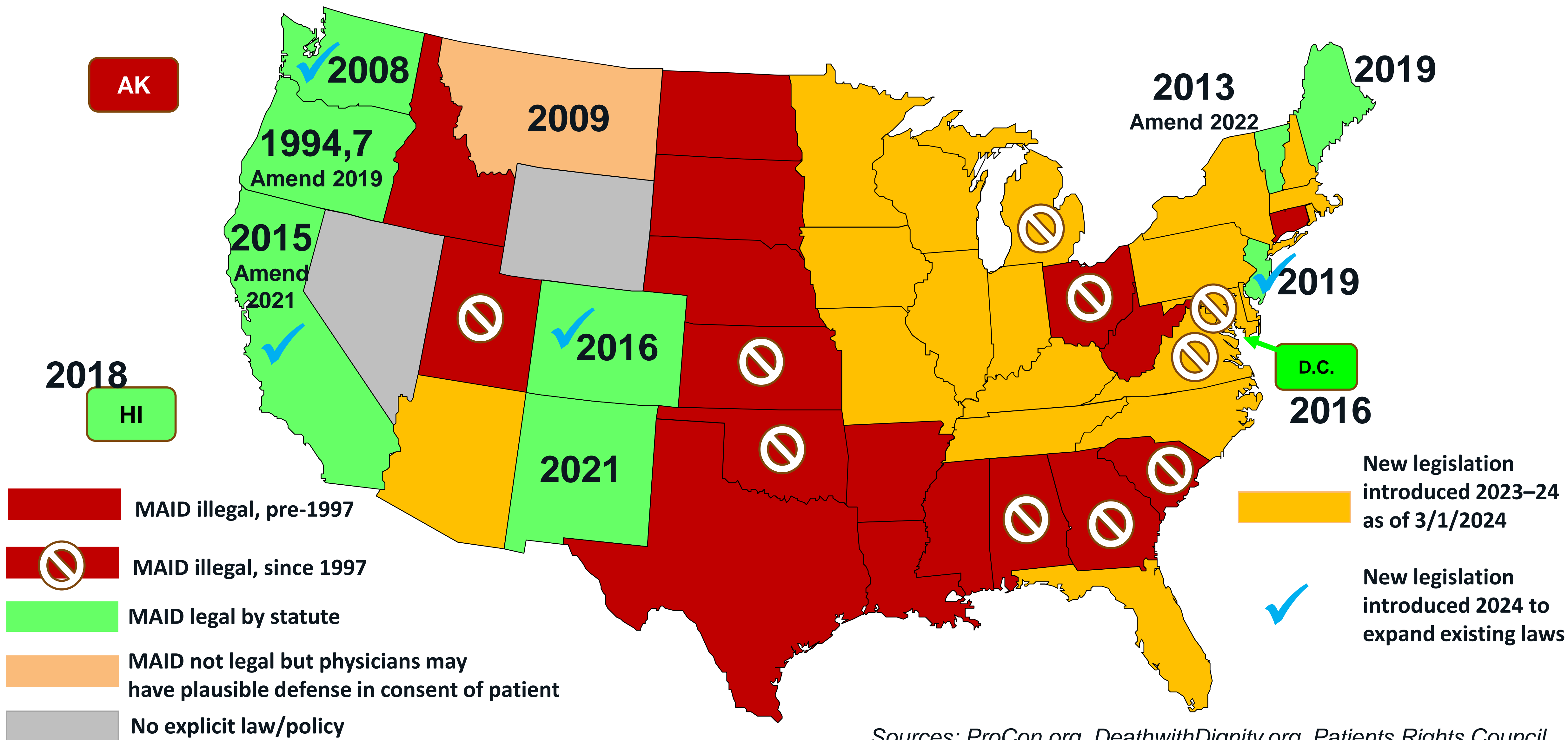
Status of MAiD Nationally



Sources: ProCon.org, DeathwithDignity.org, ChoiceIsAnIllusion.org, Patients Rights Action Council, Charlotte Lozier Institute

New Legislation, 2024



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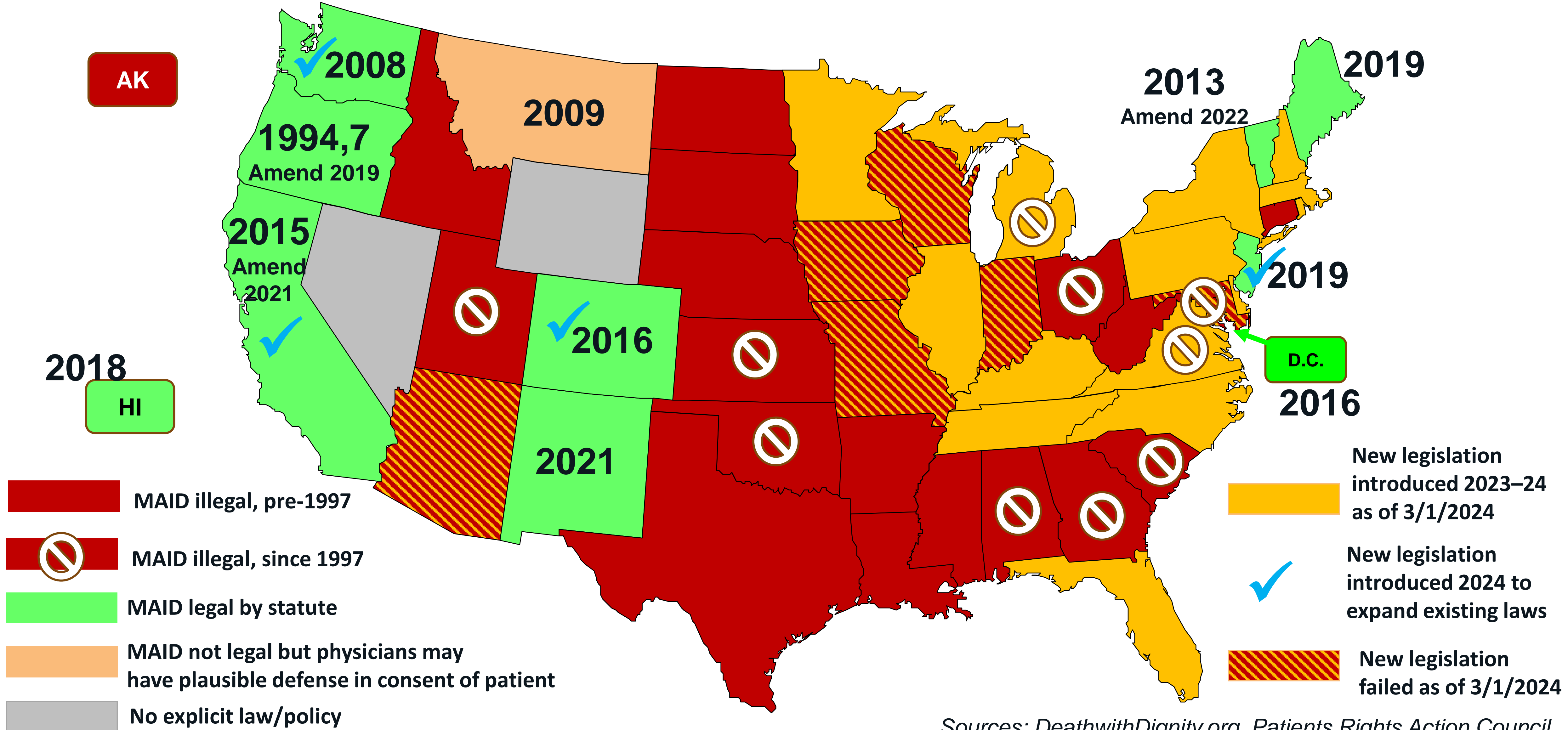

Sources: DeathwithDignity.org, Patients Rights Action Council

So What's the Big Deal?

PRO

- Compassion (Beneficence)
  - Role of medicine to relieve suffering
  - Limits of medical intervention
  - Iatrogenic harm
- Patient autonomy
  - Natural right to die
  - Recognition of "rational suicide"

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So What's the Big Deal?

CON

- Risk of implicit or explicit coercion, exploitation (Justice)
  - "Option" may become "obligation"
- Contrary to the role of medicine, providers (Nonmaleficence)
  - Relieve patient of suffering, not life
  - Stall momentum for cures, interventions
  - Stall momentum for palliative care

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Still a Big Deal

Favorable	Neutral	Opposed
	• AAHPM (2016) • AAFP (2022) • ANA (2019) • APA (psychol; 2017) • ASHP (2015) • APhAssoc (2004) • NASW (2004)	• ACP (2017) • AMA (2023) • AMDA (1997) • HPNA (2017*) • IHPCA (2017) • NHPCO (2021)

Roundup of U.S. medical & surgical society position statements:
Only 12 of 150 societies have any statement at all

(Barsness et al., 2020)

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AMA Code of Ethics, 2023

- “It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.
- Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”

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MAiD Process & Utilization

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Common Process

- Patient:
  - 2 oral; 1 written requests
  - Written request witnessed
- Self-administer medications
  - Usually means ingest
- Attending Physician (in NM & WA: MD, NP, PA):
  - Terminal diagnosis
  - 6 mos or less prognosis
  - Mental capacity
  - Inform of risks, alternatives
  - Prescribe or dispense meds
  - Report to state

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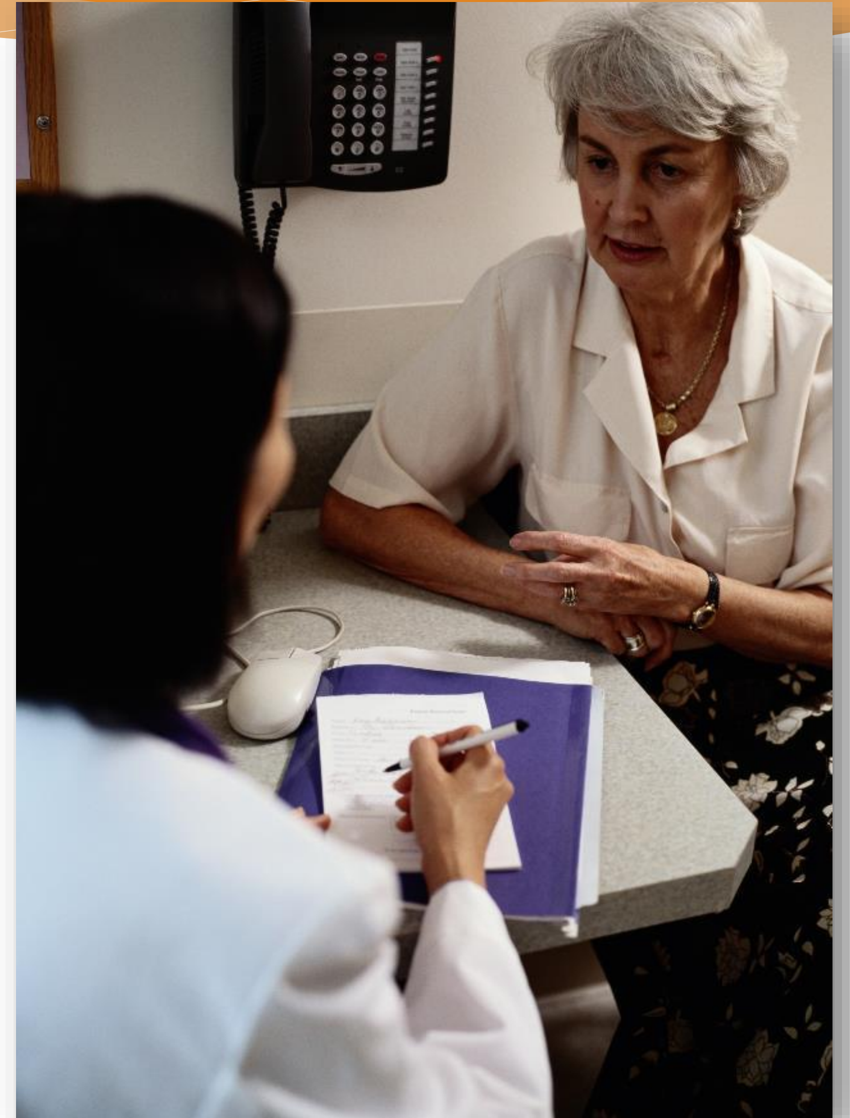
Common Process

- Consulting Physician (in NM: must be MD):
  - Confirm diagnosis, prognosis, capacity
- Mental health consultant (req'd in HI):
  - Confirm capacity



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If Process Followed

- For physicians/APPs:
  - No civil, criminal liability
  - No disciplinary actions, effect on employment
  - No sanction or penalty
  - Records can't be disclosed

- For patients:
  - No effect on admission, discharge, provision of care
  - No effect on life insurance, benefits
  - Death certificate lists terminal illness as COD

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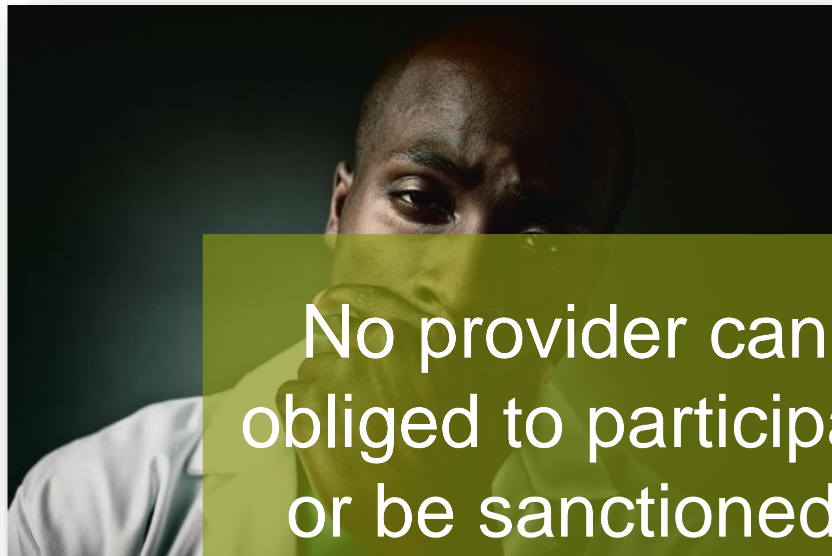
What Else?



No provider can be obliged to participate – or be sanctioned for participating, not participating

Entities can prohibit ingestion, participation on premises and (in some states) within employment or contract

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Who Is Using MAiD, Where, and Why?

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Who?

- 65+ yo
- Male
- White
- Not married
- Some college or higher education
- Cancer as terminal illness
- In hospice at TOD
- Has health insurance

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Where?

- At home

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Why?

Reason for requesting	OR (1998–2022)	WA (2009–2022)
Loss of autonomy	**90***	**89**
Less able to engage in activities that make life enjoyable	**90**	**88**
Loss of dignity	**72**	**74**
Burden on family, friends/caregivers	48	52
Loss of control of bodily functions	44	50
Inadequate pain control, or concern about it†	28	38
Financial implications of treatment	5	8

*All percents rounded; †"or concern about it" only in OR

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Mainly Existential Concerns

Quality of life

Meaning and purpose

Loss of personal intactness and agency

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Reason for requesting	OR (1[illegible]22)	WA (2009–2022)
Loss of autonomy	[illegible]	**89**
Less able to [illegible] enjoyable	[illegible]	**88**
Loss o[illegible]	[illegible]	**74**
Burden on fami[illegible]	48	52
Loss of cont[illegible]	44	50
Inadequate pain contr[illegible] concern about it	28	38
Financial implications of treatment	5	8

*All percents rounded

ALL REPORTED BY ATTENDING PHYSICIAN AFTER DEATH OF PATIENT

Kaiser Permanente First Year Report

Patient Motivation	Rank in OR/WA
1. Suffering	n/a
2. Unable to enjoy daily activities	2
3. Inadequate pain control	6
4. Being a burden to family/friends	5
5. Loss of dignity	3
6. Loss of autonomy	1
7. Financial concerns	7

(Lawry, 2023; Nguyen et al., 2018)

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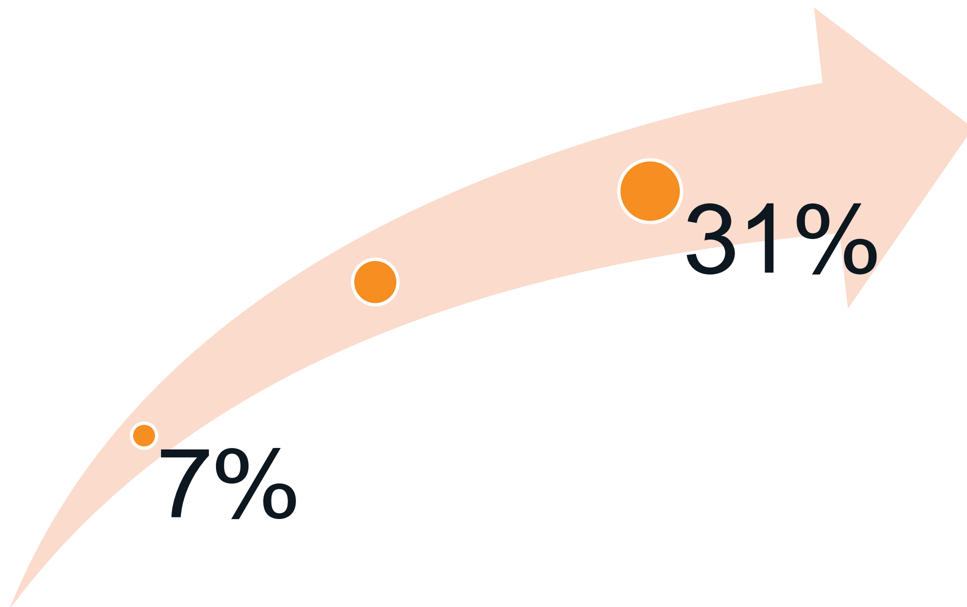
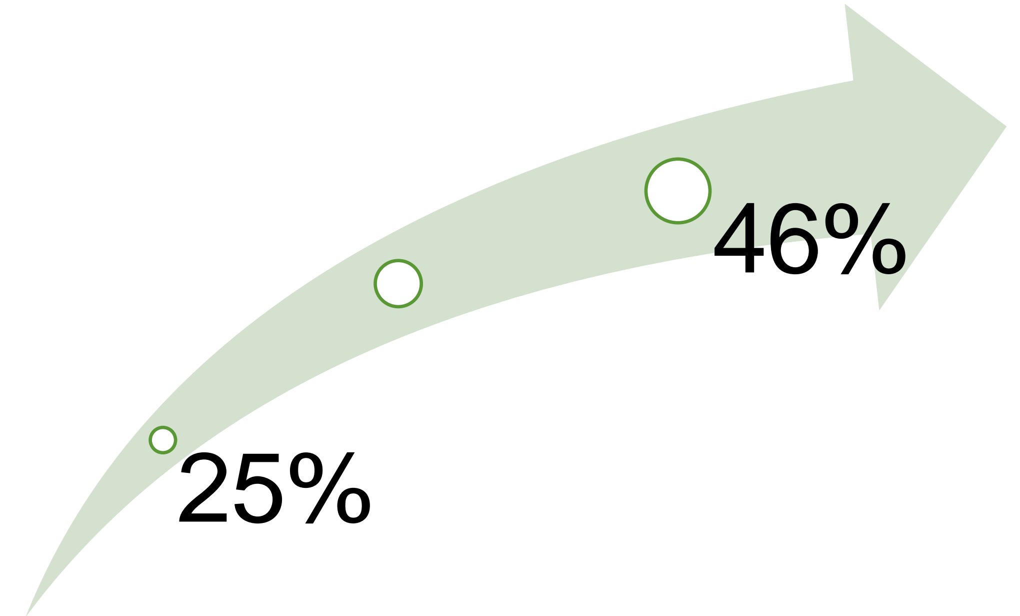
"Inadequate Pain Control, or Concern About It"

Oregon, 1997 & 2022



Washington, 2009 & 2022



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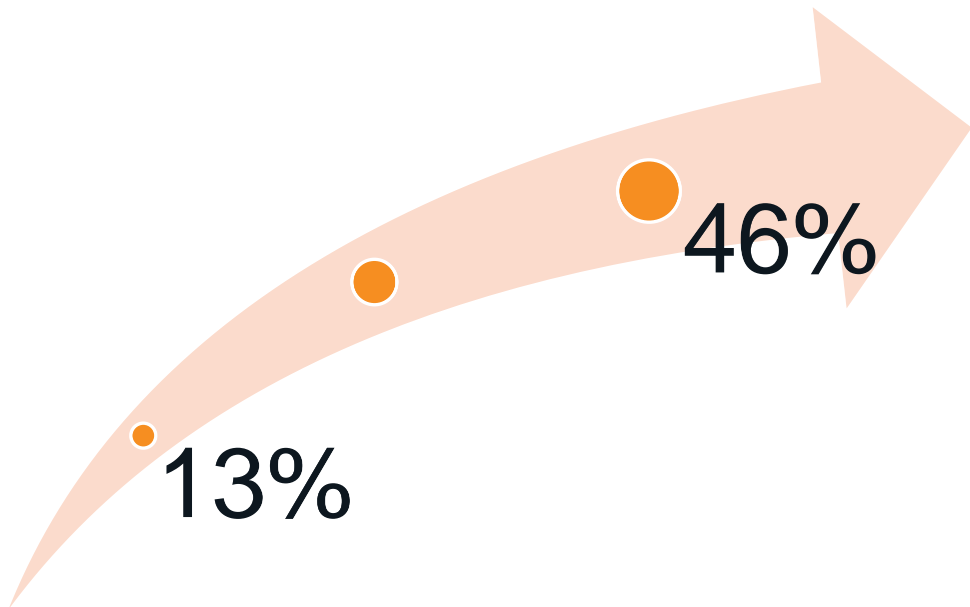
"Burden on Family/Caregivers"

Oregon, 1997 & 2022



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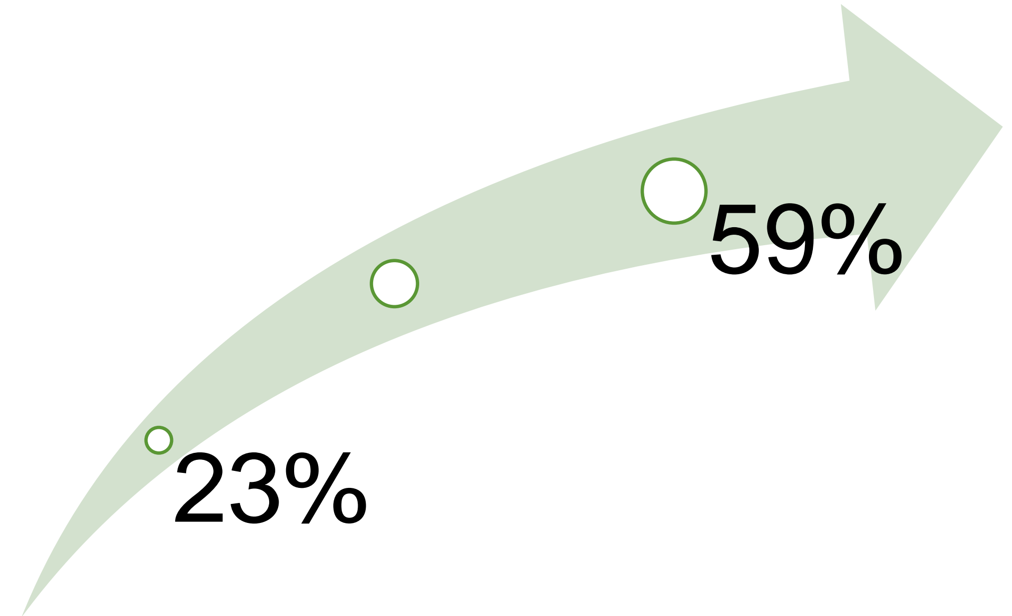

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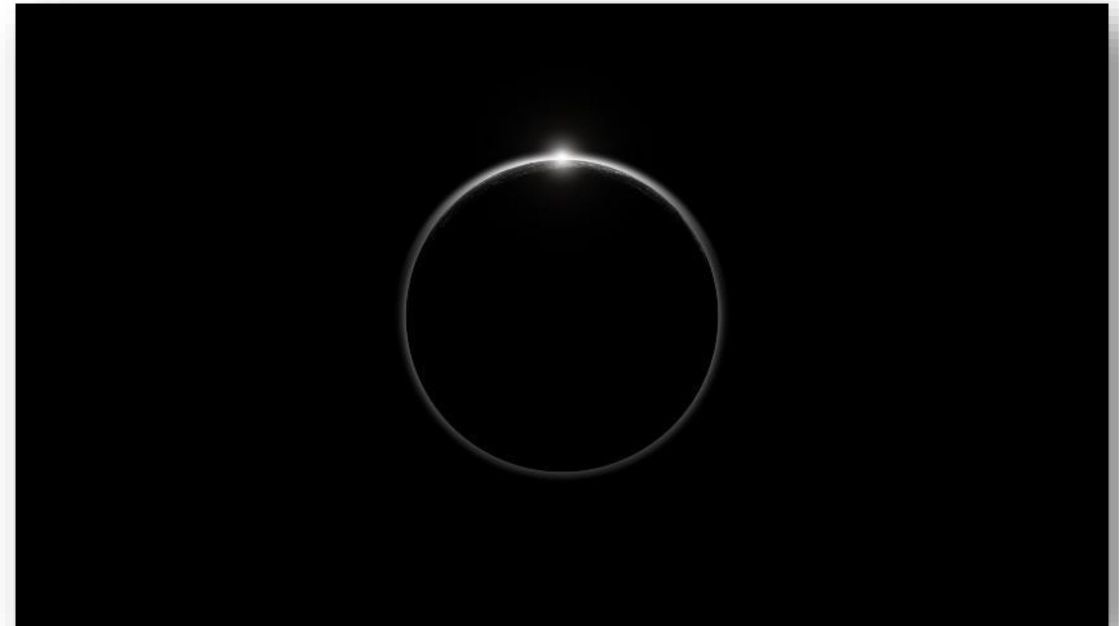
Not Uncommon Concerns!

"I don't mind dying . . . As long as I don't have to be there when it happens."

—*Woody Allen*



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Responding to Requests to Hasten Death

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Some Clinicians' Experience

- "Just having discussion about MAiD opens the box to ask all … questions."
- "I think it caught doctors' attention, and they said we have to be really aggressive with pain control and expand what we do to keep people comfortable.…"
- "I felt a higher commitment … so that she would not have to go through with it."
- "I felt like I was a failure."

Oregon Experience: Hospice RNs/SWs
(Ganzini et al., 2002)

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Some Clinicians' Experience

- "It opened my eyes more to my control issues, realizing I'm not in charge.... I was really not part of her decision. It was bigger than me."
- "He wasn't ... in a lot of pain.… And he wanted to die in a certain way. And he did it."
- "We need to look at that population [who desire control] and see if there's something we can do as well for them as we've done for people in pain."

Oregon Experience: Hospice RNs/SWs
(Ganzini et al., 2002)

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AMA Guidance

"Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

1. Should not abandon a patient once it is determined that cure is impossible.
2. Must respect patient autonomy.
3. Must provide good communication and emotional support.
4. Must provide appropriate comfort care and adequate pain control."

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Responding to Requests to Hasten Death

- Legalistic
  - "I'm sorry, but even though I support you in this difficult time, I can't participate is assisting you with PAD."
  - A "Just say No" approach misses all that we must say Yes to
- Technical
  - "So, to obtain the prescription, you must …" followed by explanation of details of the law
- Empathic
  - "I'm glad you asked me about this, but before I answer may I ask more about what led you to ask this question?"

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Responding to Requests to Hasten Death

1. Clarify the request
2. Understand the motivation
3. Affirm your commitment to care for the patient
4. Begin to address problems or concerns
5. Discuss legal and ethical options

(Nowels, VandeKeift, & Ballentine, 2018)

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Responding to Requests to Hasten Death

"Jeanine" is 63

- COPD, O2 5 LPM
- Type 2 diabetes and hypertension
- Hospitalized 3x in past 8 mos.
- Reports severe fatigue, restricted lifestyle, loss of appetite, insomnia
- QOL poor and declining
- Spouse "exhausted," "doesn't get out much"; "Not the retirement we were hoping for"
- Worried about depleting finances
- ***"I'm just sick of being sick . . . Can't we just get this over with?"***

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CHECK YOURSELF BEFORE YOU WRECK YOURSELF

Responding to Requests to Hasten Death

1. Clarify the request
2. Understand the motivation
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5. Discuss legal and ethical options

- "Request" may be oblique
- Often not a request for death but request for help with living
- Paying attention, addressing concerns may ease or even extinguish request
- *"Help me understand . . . "*
- *"Are you asking . . . "*
- *"How can I help . . ."*

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Responding to Requests to Hasten Death

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- Typical timing: at diagnosis, when symptoms worsen, support decreases
- Look for recent change
- Listen/assess for pain, depression, hopelessness, fear
- *“What’s worst for you right now?”*
- *“What do you fear is coming?”*
- *“What will be better if . . .”*
- *“Do you feel depressed most of the time?”*

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- Disease progression has effects across dimensions
- Isolation, diminished value as person
- Dismissing distress will only deepen it
- Clearly state intention to care
- *"I will work with you to make your life the best it can be . . ."*
- *"Let's focus on a few things we can improve right now while we figure out long-term issues, too."*

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Responding to Requests to Hasten Death

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- Step up pain and symptom management as indicated
- Assess for suicidal ideation; if indicated, employ prevention techniques
- Manage expectations for outcomes; negotiate timeframes for reevaluation
- Address fears, existential concerns
- Obtain assistance from team members
- Assess caregiver burden; enhance support

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Responding to Requests to Hasten Death

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2. Understand the motivation
3. Affirm your commitment to care for the patient
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- Discontinuing burdensome therapies
- Palliative sedation if symptoms severe and intractable
- VSED

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