Date: November 21, 2019
Title of Talk: Implementation of Act 39 and Discussion with Patients
In support of improving patient care, this activity has been planned and implemented by the Robert Larner College of Medicine at the University of Vermont and the Vermont Medical Society. The University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The University of Vermont designates this live activity for a maximum of 1 AMA PRA category 1 credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Please watch your email for a link from the Vermont Medical Society to claim your CME credit.

CME credit must be claimed within 30 days of participating in the event.
VMS Third Thursday Webinar Series
Implementation of Act 39 and Discussion with Patients

Speakers:
Allen Hutcheson, M.D.

Planning Committee Members:
Jessa Barnard, ESQ, Stephen Leffer, M.D. & Stephanie Winters

Purpose Statement/Goal of This Activity:
To learn communication strategies for end of life and palliative care patients as well as what the law means for your practice.

Learning Objectives:
Communication strategies for end of life and palliative care patients as well as what the law means for your practice.

Disclosures:
Is there anything to Disclose?  Yes ☐  No ☒

Did this activity receive any commercial support?  Yes ☐  No ☒

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Palliative Care Topic:
Responding to a Request for Hastened Death

Allen Hutcheson MD

Director, Supportive Care Service
Southwestern Vermont Medical Center
Bennington, VT
Disclosure

• I have no actual or potential conflict of interest in relation to this program/presentation.

• I will be discussing off-label uses of medications. Very off-label.
Speaker Background

• 2011- Current
  • Supportive care in cancer center with 2 onc and 1 rad onc (3 days)
  • Palliative care consultation at SVMC, SNFs, home visits (1 day)
  • Hospice Medical Director, VNA Hospice of Southwest Region, (1/4 day)
  • Primary Care Family Medicine, Hoosick Falls NY (1 day)

• Prior to 2011:
  • VNSNY Hospice Medical Director, The Bronx
  • Montefiore Medical Center, inpatient palliative care, fellowship dir.
  • Pain and Palliative Care Fellowship, Beth Israel NYC
  • Residency in Urban Family Practice, Beth Israel
  • Medical University of SC, Charleston SC, 2000
• You can do the pre-test silently in your head, but it will be so much more fun to do online all together.

• I have no financial interest in this app; my child uses it in class at school.

• I apologize if it turns out to be Russian spyware.
Practice Question: Choose your medical specialty

• A. Primary care/ pediatric
• B. Surgical
• C. Medical subspecialty
• D. Hospitalist
Is it legal in Vermont to give an injection to end a patient’s life, at his or her direct request, if his or her suffering is severe?

• A. Yes
• B. No
Is it legal in Vermont to prescribe a drug to end the life of a terminally ill patient who is not in any pain or suffering?

- A. Yes
- B. No
Is there a law in Vermont requiring physicians to inform terminally ill patients about the option of obtaining a lethal prescription?

• A. Yes
• B. No
Is there a textbook response to a request for a lethal prescription?

• A. Yes
• B. No
Should you inquire into the religious beliefs of a patient who requests a lethal prescription?

• A. Yes, routinely
• B. Only if the patient brings it up first
• C. No
Definitions: The Vermont Law regarding physician assisted death is called: (Choose multiple)

- A. Act 39
- B. Death with Dignity
- C. Patient Choice (and Control) at End of Life
- D. Compassion and Choices
A patient story

• Patient with newly diagnosed melanoma with brain mets: I am thinking about the physician assisted suicide option.

• Me: Hm. What makes you say that?

• Patient: I don’t know; I just don’t think I can handle it.

• Me: We can talk more about that.

• Patient: But what do you think about it; I just want to know your personal opinion about physician assisted suicide.

• Me: I’m not sure it should have been made a law, and it’s very difficult to get the drug from any pharmacy.

• Patient: Goodbye.
Welcome to the home of Palliative Care Fast Facts and Concepts—originally published by EPERC since 2000. Fast Facts are edited by Sean Marks, MD; Associate Professor of Medicine at the Medical College of Wisconsin.

• FAST FACTS AND CONCEPTS #156
• EVALUATING REQUESTS FOR HASTENED DEATH
• Tim Quill MD and Robert Arnold MD
Physician-assisted dying: Understanding, evaluating, and responding to requests for medical aid in dying

Authors: Timothy E Quill, MD, Margaret P Battin, MFA, PhD
Section Editor: Robert M Arnold, MD
Deputy Editor: Diane MF Savarese, MD

Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Aug 2018. | This topic last updated: Jan 12, 2018.

INTRODUCTION — Euthanasia and physician-assisted dying (PAD) burst into the United States public arena in 1988 with the publication of “it’s over, Debbie” [1]. This article stirred an emotional debate, with many people criticizing what they saw as nonvoluntary euthanasia involving a lethal injection delivered by a physician who did not know the patient and who had only ambiguous evidence of her wishes (“Let’s get this over with”) [2,3]. The case later turned out to be a fabrication. A later (true) case report describing a patient, “Diane,” with a
Background

• A patient’s request to a health care professional to help hasten death is not uncommon.
• The motivation for this request is usually a combination of
  • relentless physical symptoms,
  • progressive debility, in combination with
  • a loss of sense of self,
  • loss of control,
  • fear of the future, and
  • fear of being a burden on others.
• Some physicians are frightened by these requests, feeling that they are being asked to cross unacceptable professional boundaries.

• Others may be tempted to quickly accede, imagining that they would want the same thing in the patient’s shoes.

• But requests for a hastened death may provide awareness into a patient’s experience of suffering, and may lead to opportunities for more effective treatment if fully evaluated.
Response

• In general, the clinician should
  • clarify,
  • explore,
  • evaluate,
  • intensify treatment, and
  • support the patient
  to ensure a full understanding of the request and to ensure that all alternatives have been considered before responding.
Clarify

1. Clarify which question is being asked before responding.
   Is the patient simply having thoughts about ending his life (very common), or is he exploring the possibility of a hastened death in the future if his condition deteriorates, or is he exploring your willingness to assist right now?

   • Tell me more about that...
   • How would that work?
   • What do you mean by that?
   • How would that help you?
   • What makes you ask about that?
Support

• 2. Support the patient, and reinforce your commitment to trying to find a mutually acceptable solution for the patient’s problem and to continue to work through the process.

• This does not mean violating fundamental values, but it does mean searching in earnest with the patient and family to find a way to approach the dilemma.

• Attend to your own support by discussing the patient with trusted colleagues and/or with your multidisciplinary team.
Evaluate

3. Evaluate the patient’s decision-making capacity.
   • Is she seeing her medical condition clearly?
   • Is the request proportionate to the level of unrelieved suffering?
   • Are there dominating aspects of anhedonia, worthlessness and guilt, or is the capacity for pleasure and joy preserved in some small ways?
   • Is this request consistent with the patient’s past values?

Get help from an experienced psychiatrist or psychologist if you are unsure.
Explore

4. Explore the many potential dimensions that may contribute to the patient’s “unbearable” suffering to be sure you (and the patient) fully understand its underlying cause(s).

Sometimes it may be:

- an unrelenting physical symptom, other times
- feelings of depression, or a
- family or spiritual crisis, or perhaps a
- combination of many factors.
Empathize

• 5. Respond to the associated emotions, which may be strong and conflicted.

• Try to empathically imagine what the patient is going through and asking for.

• Distinguish your own feelings and reactions from those of the patient.
Intensify


• Depending on the patient’s circumstances, offer to increase treatment of pain or other physical symptoms, consider biological or interpersonal treatment of depression; see if an appropriate and acceptable spiritual counselor is available.

• Be creative and brainstorm potential solutions with your multidisciplinary team.
Respond

• 7. Respond directly to the request for hastened death only after this multidimensional evaluation has been completed.

• If the patient has full decision-making capacity and all alternative approaches to the patient’s unbearable suffering have been fully considered, then re-explore exactly what is being requested, and look for mutually acceptable ways to potentially respond – see Fast Fact #159 (5). Note that many patients may be looking for the potential of an escape they will never use, but a smaller number will be looking for a way to hasten death in the present.
Summary

• Clarify
• Support
• Evaluate
• Explore
• Empathize
• Intensify
• Respond
Summary

• Clarify
• Evaluate
• Explore

• Only ask questions
Patient Story

Patient with deteriorating bladder cancer: I want that shot.

Me: What shot?

Patient: The one you give to put me out of my misery; I don’t need it yet, but I think I’m going to need it at the end.

Me: The one that’s legal is a medicine you take, not an injection.

Patient: Hm.

Me: Why do you think you will need it?

Patient: I just can’t linger.

Me: What would be bad about that?

Patient: I would get stuck in a nursing home; I don’t have family, and won’t spend my final days in a nursing home, so I need to die before then.

Me: We can fix this.
Practice a skill

• With your partner...

• Patient: assume you are terminally ill, and ask partner B to help you end your life.
  • If this is absolutely morally repugnant, express your concern that a family member is making this request of a doctor.

• Physician: respond with THREE questions
  • Patient make brief responses

• Switch
Post-Test: A patient who trusts you asks if you will prescribe a lethal dose of medication. The patient is terminally ill and Likely will meet all the criteria under the law. Which is the best response?

A. Yes, as someone with a trusting clinical relationship, I can take this on for you.
B. I’m sorry, but I am not legally allowed to write such a prescription.
C. I sympathize with you, but that happens to be something I am not ethically comfortable with.
D. Why?
Questions?

“Ask your doctor if taking a pill to solve all your problems is right for you.”
AAHPM Position Statement

• AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited. However, as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks...
Administrative Details

• Act 39 passed in VT in 2013 allowing prescription of lethal meds to Vermont residents with a prognosis under six months.

• Patients must self-administer, must demonstrate capacity and make the decision themselves, must make oral and written requests with a two week waiting period.

• Only physicians may prescribe; must inform patient of prognosis and treatment options, obtain a concurring opinion of prognosis and capacity, report each prescription, and each death, to the DOH. One section requires physicians to inform terminally ill patients of all options.
Technical Details

• Standard PAD drug was secobarbital 10g: 100 100mg capsules emptied and mixed with juice into a slurry, swallowed quickly with antiemetic premedication, causes coma within an hour and death within six hours. Cost was $3500. Not available.

• Second cheaper option is DDMP2: digoxin 50mg, diazepam 1g, morphine 15g, propranolol 2g, compounded. $700.

• Only one or two pharmacies in the state participate.

• There is no list of doctors who participate in this practice. A palliative care consult is recommended. Local Vermont and Oregon physician mentors are available to physicians who want to prescribe. Through Compassion and Choices.
Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2017

Oregon Statistics
218 people had prescriptions written during 2017

- 130 ingested medication
  - 144 died from ingesting medication
    - 143 died from ingesting medication
    - 1 regained consciousness after ingesting medication; died of underlying illness
- 44 did not ingest medication and subsequently died from other causes
- 44 ingestion status unknown
  - 23 died, ingestion status unknown
  - 21 death and ingestion status pending
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2017 (N=143)</th>
<th>1998–2016 (N=1,132)</th>
<th>Total (N=1,275)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing autonomy (%)</td>
<td>125 (87.4)</td>
<td>1,029 (91.4)</td>
<td>1,154 (90.9)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>126 (88.1)</td>
<td>1,011 (89.7)</td>
<td>1,137 (89.5)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>96 (67.1)</td>
<td>769 (76.9)</td>
<td>865 (75.7)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>53 (37.1)</td>
<td>526 (46.8)</td>
<td>579 (45.7)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>79 (55.2)</td>
<td>475 (42.2)</td>
<td>554 (43.7)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>30 (21.0)</td>
<td>297 (26.4)</td>
<td>327 (25.8)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>8 (5.6)</td>
<td>39 (3.5)</td>
<td>47 (3.7)</td>
</tr>
<tr>
<td>Predictor</td>
<td>Did Not Pursue PAD</td>
<td>Pursued PAD</td>
<td>t</td>
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<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td></td>
<td>(n = 39)</td>
<td>(n = 55)</td>
<td></td>
</tr>
<tr>
<td>Depression*</td>
<td>4.7 (2.7)</td>
<td>6.2 (3.8)</td>
<td>2.19</td>
</tr>
<tr>
<td>Hopelessness*</td>
<td>2.4 (2.6)</td>
<td>5.9 (4.4)</td>
<td>4.79</td>
</tr>
<tr>
<td>Pain</td>
<td>2.5 (2.2)</td>
<td>2.8 (1.2)</td>
<td>0.75</td>
</tr>
<tr>
<td>Dismissive attachment</td>
<td>3.3 (0.8)</td>
<td>3.7 (0.7)</td>
<td>2.64</td>
</tr>
<tr>
<td>Support*</td>
<td>36.1 (3.8)</td>
<td>35.3 (7.6)</td>
<td>-0.67</td>
</tr>
<tr>
<td>Spirituality</td>
<td>39.4 (7.1)</td>
<td>31.3 (9.3)</td>
<td>-4.60</td>
</tr>
</tbody>
</table>

PAD = physician-assisted death; Depression = Hospital Anxiety and Depression Scale, Depression subscale; Hopelessness = Beck Hopelessness Scale; Pain = Wisconsin Brief Pain Inventory; Dismissive attachment = Relationship Scales Questionnaire, Dismissive Attachment subscale; Support = Duke-University of North Carolina Functional Social Support Questionnaire; Spirituality = Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being.

For all scales, higher scores represent higher levels of the construct measured.

*Equal variances not assumed.
Predictors of pursuit of physician-assisted death.

• **RESULTS:**
  - We found that PAD requesters had higher levels of depression, hopelessness, and dismissive attachment (attachment to others characterized by independence and self-reliance), and lower levels of spirituality. There were moderate correlations among the variables of spirituality, hopelessness, depression, social support, and dismissive attachment. There was a strong correlation between depression and hopelessness. Low spirituality emerged as the strongest predictor of pursuit of PAD in the regression analysis.

• **CONCLUSION:**
  - Although some factors motivating pursuit of PAD, such as depression, may be ameliorated by medical interventions, other factors, such as style of attachment and sense of spirituality, are long-standing aspects of the individual that should be supported at the end of life. Practitioners must develop respectful awareness and understanding of the interpersonal and spiritual perspectives of their patients to provide such support.
There were 52 total events that met the definition of Act 39 for this reporting period. The underlying diagnoses fall into the following general disease groups:

- 83% of cases are Cancer (43 total cases);
- 14% of cases are ALS (7 total cases); and
- 3% are other causes.

48 out of 52 events have a death certificate on file with the Vital Records’ Office. The remaining 4 cases are assumed to still be living since all deaths are reportable to the Health Department, and any Vermont resident dying in other states is reported and recorded by the Vital Records’ Office.

100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements. Among the 48 confirmed deaths, the mechanism was:

- 29 utilized the patient choice prescription (60%);
- 17 died from the underlying disease (35%);
- 1 died from other causes (2%); and
- 1 unknown (2%).
Chapter 113 : Patient Choice At End Of Life

§ 5282. Right to information

• The rights of a patient under section 1871 of this title to be informed of all available options related to terminal care and under 12 V.S.A. § 1909(d) to receive answers to any specific question about the foreseeable risks and benefits of medication without the physician's withholding any requested information exist regardless of the purpose of the inquiry or the nature of the information. A physician who engages in discussions with a patient related to such risks and benefits in the circumstances described in this chapter shall not be construed to be assisting in or contributing to a patient's independent decision to self-administer a lethal dose of medication, and such discussions shall not be used to establish civil or criminal liability or professional disciplinary action. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

thoughtful biopsychosocial evaluation in response
“Before we try assisted suicide, Mrs. Rose, let’s give the aspirin a chance.”