“AID IN DYING” ESTABLISHES BEST PRACTICES

Just as with any other medical intervention, some ways of carrying out Oregon’s “Death with Dignity” law are better than others. In the more than 20 years since the passage of legalization in Oregon, clinicians there have had ample opportunity to develop best practices for physician aid in dying (AID). A recent article published in The Journal of Palliative Medicine examines the clinical criteria that have been developed over more than two decades of AID in Oregon.

The gathering and codification of these best practices has been taking place for several years now. In July 2012, “Compassion & Choices convened the Physician Aid-in-Dying Clinical Criteria Committee ... to create clinical criteria for physicians who are willing to provide AID to patients who request it.” The committee, including “experts in medicine, law, bioethics, hospice, nursing, social work and pharmacy,” used an iterative consensus process as they drafted the criteria over the course of one year.

The authors of the article detail a variety of these criteria, developed from Oregon physicians’ experience in delivering AID. They provide best practices in these areas: responding to requests for AID, ensuring informed consent, providing a prescription, and procedures for life-ending medication.

Responding to requests for AID: Patients requesting AID must receive a prompt evaluation that explores a holistic range of issues, from the spiritual to the financial. The goals of the physician are: “(1) to deter any premature action by the patient, (2) to establish whether a request reflects decisional capacity and freedom from external pressure, and (3) to ensure that the patient is considering alternatives to AID. It is important that the physician identify patient concerns that could be addressed without AID. AID must reflect a considered and voluntary choice by the patient.” If there is any question of whether the patient is suffering from a mental health condition, the physician is obliged to refer the patient to a mental health specialist for evaluation.

Ensuring informed consent: Few patients understand all of their end-of-life options, and it is the physician’s role to ensure that there is full comprehension of all the range of alternatives to AID that exist before prescribing AID. Options for managing pain and suffering should be fully explored. In addition, patients should understand that there are options for hastening death that do not involve lethal medication, such as cessation of nutrition and hydration.

Patients should be encouraged to engage in conversations with family members or loved ones about their choice. If this is problematic, the reasons for this should be explored. Physicians should carefully document the reasons for providing AID based on the patient’s medical record, and should ensure that the patient fully understands the likely consequences of receiving AID. Patients should be made aware that AID must be self-administered. “It is personally, professionally and legally valuable for the physician to obtain this validation and confirmation,” though in certain exceptional circumstances an inability to secure a second opinion should not prevent a patient from receiving AID.
Providing a prescription: Oregon, Washington and Vermont require a 15-day waiting period between the first request for receiving AID and actually obtaining lethal medication. “When a waiting period is not required by state law, physicians may know the patient well enough to determine without difficulty that the request is voluntary, rational and enduring. If physicians are uncertain about this, they should schedule a follow-up visit in 10 to 15 days to revisit the request.” Providing some space between the request and allowing the patient to act on it should usually clear up any doubt about the patient’s intentions.

“Once physicians have written a prescription for life-ending medication, they must alert the patient’s pharmacist. This allows the pharmacist to decide whether or not to participate and to have the appropriate medication available for pick-up.” The authors note that many patients never actually use the lethal medication, eventually dying from the natural progression of their disease. Having the medication on hand, however, may provide a psychological benefit. “These and other AID patients realize an improvement in their quality of life from the sense of control that comes with mere receipt (not ingestion) of the prescription.”

Procedures for life-ending medication: The authors describe the basic procedure for carrying out AID. The medication protocol is two-step. “First, the patient takes an antiemetic (e.g., metoclopramide or ondansetron). Forty-five to 60 minutes later, the patient ingests 9 g of a short-acting barbiturate (e.g., secobarbital or pentobarbital).” The authors note that some patients may wish their doctor to be present at the time of ingestion, though this is a personal matter between doctor and patient.

The authors encourage the presence of loved ones in order to provide comfort and presence to the dying. “Indeed, a gathering of family and friends can be a rich experience for all.” In order to preserve the confidentiality of patients, physicians in Oregon and Washington list the cause of death as either “respiratory failure” or the patient’s underlying illness as the cause of death. The manner of death is listed as “natural,” similar to cases when a ventilator is removed.

AID has only been legal since 1997, and even then only in a few states. Yet the experience gained so far “permits the drafting of clinical criteria to guide physicians when their patients request AID. For physicians who are willing to provide AID, it is important that they be medically knowledgeable doing so. These criteria are designed to provide that knowledge and guidance.”

The “Clinical Criteria for Physician Aid in Dying,” as well as a complete list of those who served together on the committee doing this work, are available online. (JPM, JPM - Clinical Criteria for Physician Aid in Dying)