Medical Board of California

July 28, 2016
Care and Choice at the End of Life

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NATIONAL MEDICAL DIRECTOR
COMPASSION AND CHOICES
Goals

- Overview of Medical Aid in Dying
- Review ORS 127.8
- Review CA EOLO Act (ABX2 – 15)
- Compare the two State Laws
- Discuss the experience of the Oregon Health Authority and the Oregon Medical Board
- Consider future implications for MBC
- Q&A
Sources

- Personal Experience
- State Epidemiologist – Oregon Health Authority
  - Katrina Hedberg MD
- Oregon Medical Board
  - Joseph Thaler MD – Medical Director
  - Kathleen Haley JD – Executive Director
- National Death With Dignity Center
  - George Eighmey JD - President
“my hats....”

DRG – Personal Experience
Rural Family Practice (Philomath, OR - 38 years)

- DWD: ~ 30 patients (~ 15 Attending ; ~ 15 Consulting)

Oregon Medical Board (7 years)
(2 years as Chair / Interim Pro Tem Med. Dir.)

C&C National Medical Director (2 years)
THE ART OF MEDICINE

To cure sometimes,

to relieve often,

to comfort always…

HIPPOCRATES
End of Life Care: What is the Licensee’s role?

- To Care for the patient
- To Teach the patient/family
- To Respect the wishes of the patient
- To Comfort and Alleviate Suffering
Agenda Item 4

BRD 4 - 8

DYING
PROHIBITED

compassion & choices
End of life options:

- Full treatment
- Decline (some or all) treatments
  - Unwanted medical care
- Hospice/Palliative Care
- VSED ("terminal fasting")
- Terminal Sedation (in hospice)
- Medical Aid in Dying
Not an EOL option....

If I am ever on life support, unplug me...
Then plug me back in.
See if that works...
The Art and Science of Medicine include:

- Patient Autonomy
- Shared Medical Decision Making
- Professionalism
  - (Integrity vs Personal Beliefs)
Medical Aid in Dying - USA

- Oregon – (referendum) 1997
- Washington – (referendum) 2009
- Montana (Supreme Court) 2009
- Vermont – (leg. vote) 2013
- California – (leg. Vote) 2016
EOLO Act in California:
Patient Requests for Information

- ~ 250,000 deaths each year in California
- ~ 34,000/yr in Oregon
- ~ 3,500 requests for information each year about Death with Dignity in OR
- Projection ?: 30,000-50,000/yr in CA
Oregon: Death with Dignity  
(ORS 127.8)  
California: End of Life Option Act  
(ABX – 15)

- Laws are very similar
- Oregon has 18 years of data and experience
- California - ???
Death with Dignity

ORS 127.800-897
ORS 127.800 – .897
“Death With Dignity:”
caveats…

- Dignity is defined by the dying patient. (Dignity is not defined by the doctor, the hospice nurse, legislators, ethicists, medical boards, etc.)
- A person with a terminal illness may have a dignified death in many ways:
  - Choosing all or some treatments
  - Choosing no treatments
  - Choosing to have control of the “timing” of death
ORS 127.800 - 127.897

Death With Dignity Act (DWD)

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 - 127.897.
ORS 127

Physician Components

- Two physicians
  #1: Attending
  #2: Consulting
- Referral if psychiatric diagnosis uncovered
- Both must affirm patient eligibility

(Not PA / NP / DC / ND)
Attending Physician Responsibilities

- Two oral requests from patient
  (not necessarily in person)
  - At least \textbf{15} days apart
- Written request (after both doctor’s eval.)
  - Signed by two witnesses
- Prescription may not be written until 48 hours after second oral request
Physician Responsibilities

- Inform patient of feasible alternatives:
  - Hospice Care / Palliative Care / Pain Control
- Must request (but may not require) patient notify next of kin of Rx request
**Physician Responsibilities**

- Both Prescribing and Consulting Physicians must complete Dept. of Human Services’ (DHS) forms
- Prescribing Physician must inform DHS only if prescription is written
- Pharmacy must be informed of medication’s intended use (1999)
- Follow-up form w/in 10 days of patient’s death (rev. 2010)
Statistics
(ORE. PUBLIC HEALTH DIV. ANNUAL REPORT 2/2016)

- **2015:**
  - 218 DWDA prescriptions written
  - 132 DWDA deaths (61%)
  - (2014 = 155 / 105) (67%)

- **Since 1997:**
  - 1,545 DWDA prescriptions written
  - 991 DWDA deaths (64%)
  - (38.6/10,000 deaths)
**DWDA prescription recipients and deaths by year, Oregon, 1998-2016**
2015 - OR DWD

- 218 prescriptions by 106 physicians
  - 1 – 27 prescriptions
  - 5 referrals for mental health evaluation
- 92.2% in hospice
- 90% died at home
- 99% had health insurance
Since 2010, Follow-up Questionnaire:
to determine circumstances at death

- Only when physician or nurse present
- Voluntary
- Time to death (5 min – 34 hours)
- 2015 data: 27 cases
  - 14 physician
  - 13 nurse
The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals
(March 1998; 4th Revision December 2008)

Chapter 12
Responding to Professional Non-Compliance
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Guidelines

The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals
Guidelines

12.1 - Health professionals must report to the appropriate licensing and certifying board professionals who engage in medical incompetence or unprofessional conduct.

12.2 - If there is a concern about the conduct of a professional in another health care discipline, there is an ethical obligation to act. There may be a requirement for institutional or professional board reporting.
Guidelines - 2

- 12.3 - If a health professional has questions about the appropriateness of a practice relative to comfort care or participation in the Oregon Death with Dignity Act, he/she should consult the staff of the appropriate licensing board for guidance.
Guidelines - 3

12.4 - Physicians and other health care providers with prescriptive authority need to ensure that patients receive sufficient dosages of appropriate medications for the relief of pain and suffering. The Oregon Medical Board encourages physicians to employ skillful and compassionate pain control for dying patients. The Oregon Medical Board investigates allegations of **under prescribing** for pain in the same manner as **over-prescribing**.
Guidelines - 4

- **12.5** - Licensees should not report another professional to the licensing board simply because the other professional has cooperated with the request for a prescription under the Oregon Act. The Oregon Medical Board does not consider **good faith compliance** with the Oregon Act unprofessional conduct.
Oregon Health Authority

- Types of concerns
  - ‘Pure paperwork’ (vast majority)
    - Investigate and have Licensee correct
    - Refer to OMB if non-compliance
  - Possible violation of ORS 127.8
    - Refer to OMB
  - Approximately 2/year
  - No increase over last ten years in spite of increase in DWD cases
Oregon Medical Board

- Review all OHA referrals
- “Letter of Concern” to Licensee if apropos
  - 1 - 2 per year
- Med. Dir. may request information/charts (rare)
- Open investigation for cases with concerns
  - No cases opened in last five years (more?)
- **No disciplinary actions by OMB in 18 years of ORS 127.8**
**EOLO Act – CA (vs.) DWD Act – OR**

- Residency (specific*)
- Attending Physician
  - Responsible for checklists
  - **Must see patient alone**
- Consulting Physician
  - “Independent” (*sic*)
- 48 Hour Attestation Form
- Language Interpreter (forms)
- Death Certificate?
  - (10 YEAR SUNSET)

- Residency (non-specific**)
- Attending Physician
  - Forms
- Consulting Physician
  - Forms
- Prescription
  - Not electronic or FAX
- Death Certificate
  - Cannot list DWD
California EOLO Act

- 443.5 (a) Before prescribing an aid-in-dying drug, the attending physician shall do ... the following:
  - ...Confirm that the individual is making an informed decision ... by discussing with him or her ... the feasible alternatives or additional treatment options including, but not limited to, ... hospice care, (and) palliative care ...
California EOLO Act

- 443.5 (cont’d)
- (5) Counsel the qualified individual about the importance of … the following:
  - (A) Having another person present when he or she ingests the aid-in-dying drug prescribed ….
  - (B) Not ingesting the aid-in-dying drug in a public place.
  - (C) Notifying the next of kin of his or her request for an aid-in-dying drug. (A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason).
  - (D) **Participating in a hospice program.**
  - (E) Maintaining the aid-in-dying drug in a safe … location
443.14. ... a person shall not be subject to civil, criminal, administrative, employment, or contractual liability or professional disciplinary action for participating in good faith compliance with this part, including an individual who is present when a qualified individual self-administers the prescribed aid-in-dying drug.
Attending Physician – Definitions:

- Oregon: "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- California: “Attending physician” means the physician who has primary responsibility for the health care of an individual and treatment of the individual’s terminal disease.
Consultant – Definition

- Oregon: "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

- California: “Consulting physician” means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.
Attestation Form (CA only)

Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. ..... the completed form shall be delivered by the individual’s health care provider, family member, or other representative to the attending physician to be included in the patient’s medical record.
Barriers for Citizens
(Social Justice)

- LACK OF EDUCATION (of both citizens and licensees)
- OR: process cannot often, in reality, be completed in 15 days; median time for DWD is 48 days
- OR: some communities (Roseburg) have no licensees who participate
- Medical providers opposed to the law have provided patients with misinformation or delayed the patient from starting the process until it is too late
Medical Board of California

California End of Life Option Act – Effective June 9, 2016

AB 3215 (Eggman, Chapter 1) establishes the End of Life Option Act (Act) in California, which becomes effective on June 9, 2016 and will remain in effect until January 1, 2026. This Act gives a mentally competent, adult California resident who has a terminal disease the legal right to ask for and receive a prescription from his or her physician to hasten death, as long as required criteria is met.

- AB 3215 End of Life

The law requires physicians to meet specific criteria if they are going to participate in this Act and prescribe aid-in-dying drugs to patients. The following resources give an overview of the requirements of the law for both physicians and patients:

- The Medical Board of California’s (Board) analysis of this bill
- Overview of the California End of Life Option Act – Winter 2016 Newsletter
- California Medical Association On Call Document

The law requires specified forms to be completed before the aid-in-dying drugs can be prescribed and additional forms after the drugs have been prescribed. These forms must be submitted to the California Department of Public Health (CDPH) and also included in the individual’s medical record.

- Attending Physician Checklist and Compliance Form
- Consulting Physician Compliance Form
What might be the MBC potential concerns

- The **intent of the law**, and how to deal with Licensee’s who violate it
- “Pure paper” complaints – what to do?
  - e.g. “Attestation Form”
- Dealing with complaints
  - Legitimate and non-legitimate
- Responding to opponents
Endoflifeoption.org

- Website includes:
  - A policy library for navigating health systems across the state (FIND CARE)
  - Videos and fact sheets for physicians, pharmacists, and patients
  - Information in both English and Spanish
www.endoflifeoption.org
Chapter 1: Medical Aid in Dying and the Physician's Role
Chapter 2

Chapter 2: What a Physician Should Consider When Responding to a Patient's Request
Chapter 3

The Clinical Practice of Medical Aid in Dying: Chapter 1

Chapter 3: The Medical Aid-in-Dying Process and Liability Protections
Clinical Criteria for Physician Aid in Dying

David Orentlicher, MD, JD; Thaddeus Mason Pope, JD, PhD; and Ben A. Rich, JD, PhD; Physician Aid-in-Dying Clinical Criteria Committee

1) How to respond to a patient’s request for medical aid in dying
2) How to assess patient decision making capacity
3) How to address other significant issues
Conclusions (OR)

- Medical aid in dying is not commonly used
- There are barriers and the law is not necessarily easy to navigate
- The OMB has not uncovered licensees who have violated the intent of the law
- The unexpected consequences are good:
  - Improved end of life care, no “slippery slope,” no abuse of disabled, poor, etc.
One does not ask of one who suffers: What is your country and what is your religion?
One merely says: You suffer, this is enough for me: you belong to me and I shall help you.

LOUIS PASTEUR MD  1886
Resources: Compassion and Choices

- www.endoflifeoption.org
- YouTube: *The Clinical Practice of Medical Aid in Dying* (all six chapters)
- Doc2Doc 1-800-247-7241
- California Hotline 1-800-893-4548