Hastened Dying and the CO End-of-Life Options Act

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Presentation Outline:
• Disclaimer/Conflict of interest statement
• Learning Objectives
• Case presentation
• Ethical Principles
• History of medically hastened death: Colorado and other states
• Stakeholder perspectives
• Personal, professional and organizational approaches to legislation, policy development and caregiver response to requests for assistance at end-of-life.
Disclaimers/Conflict of Interest

• Dr. Ruskey is an employee of Interim Healthcare of Southern Colorado, a franchise of Interim HealthCare Inc. Views expressed in this presentation and materials do not necessarily reflect the views or interests of Interim HealthCare or it’s subsidiaries.

• Dr. Ruskey is neither encouraging or discouraging individuals, providers or healthcare organizations from facilitating or participating in medical aid-in-dying. Rather, the objective of this presentation is to support NGA members and conference attendees by providing them with information to help them make informed decisions in the context of end-of-life care, and specifically related to legalized aid-in-dying.

• This presentation and materials included are not intended to be comprehensive and do not constitute legal advice. Each individual and organization should consult with legal counsel and have legal counsel review any policies related to these matters.

Learning Objectives

This session will enable participants to:

a. Describe the ethical principles that underlie medical decision making and care and how they apply to end-of-life situations and circumstances.

b. Learn the specifics of the CO EOL Options Act, and other states’ medically-hastened death policies, including utilization and outcomes.

c. Identify factors that lead individuals to hasten their dying and options for care and support to best meet their needs, including palliative care and hospice.

d. Develop understanding and tools that address personal, professional and organizational approaches to requests for end-of-life support.
“I do not want to die. But I am dying. And I want to die on my own terms.”

- Brittany Maynard

CNN.com/Opinion
Ethics

• NGA Ethical Principles

• Medical Ethics

NGA Ethical Principles:
“A guardian....”

1. ...treats the person with dignity. (Standard 3)
2. ...involves the person to the greatest extent possible in all decision making. (Standard 9)
3. ...selects the option that places the least restrictions on the person’s freedom and rights. (Standard 8)
4. ...identifies and advocates for the person’s goals, needs, and preferences. (Standard 7)
5. ...maximizes the self-reliance and independence of the person. (Standard 9)
6. ...keeps confidential the affairs of the person. (Standard 11)
7. ...avoids conflicts of interest and self-dealing. (Standard 16)
8. ...complies with all laws and court orders. (Standard 2)
9. ...manages all financial matters carefully. (Standard 18)
10. ...respects that the money and property being managed belongs to the person. (Standard 17)
Medical Ethics

- Important general values/terms:
  - Stakeholders
  - Patient/family centered care
    - Goals, values, preferences
  - Medical decision-making capacity
  - Competence (court determined)
  - Professionalism
  - Proportionality

- EOL terms and considerations:
  - No ethical distinction between refusing or discontinuing a medical intervention
  - Principle of Double Effect
  - Medical futility

- Primary model: Principism
  - Autonomy
  - Beneficence
  - Non-Maleficence
  - Social Justice

- Other models:
  - Narrative Ethics
  - Feminist Ethics
  - Etc.

The expansion of EOL options in Colorado

- 68-74% of Americans agree with access to medical aid in dying (Gallup 2015, Harris 2014). Colorado polling (and voting) similar.

- 56% of Colorado Medical Society members agree with access to medical aid in dying (2016); although only 1/3 of members indicate willingness to be directly involved.
**THE DENVER POST**

- **NOVEMBER 8, 2016** Colorado passes medical aid in dying, joining five other states
- **NOVEMBER 9, 2016** What you need to know about Colorado’s new Aid in Dying law
- **DECEMBER 7, 2016** Coloradans already inquiring about new medical aid in dying law; could take effect by end of month

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**State laws regarding assisted suicide in the United States**

- **Legal**
- **Legal by court ruling**
- **Legislation under review**
- **Illegal**

Wikipedia accessed 6-2017; created by NickCT
### Table: State Laws Authorizing Physician-Assisted Dying

<table>
<thead>
<tr>
<th>State</th>
<th>Year of Legislation</th>
<th>Patient request</th>
<th>Waiting period</th>
<th>Witnesses</th>
<th>Capacity</th>
<th>Diagnosis</th>
<th>Opt-out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon, 1997</td>
<td>2 oral and 1 written request</td>
<td>15 days between written request and prescription</td>
<td>2 witnesses required; 1 witness must not be a relative, beneficiary, employee of patient’s health care facility, or attending physician</td>
<td>If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment</td>
<td>If either physician has doubt whether the patient’s judgment is impaired, judgment must be evaluated by a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established</td>
<td>3 physicians agree death likely within 6 mo</td>
<td>Physicians may refuse to participate</td>
</tr>
<tr>
<td>Washington, 2009</td>
<td>2 oral and 1 written request</td>
<td>15 days between written request and prescription</td>
<td>2 witnesses required; 1 witness must not be a relative, beneficiary, attending physician, or employee of patient’s health care facility</td>
<td>If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment</td>
<td>If the attending physician suspects a mental disorder, patient is referred to a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established</td>
<td>3 physicians agree death likely within 6 mo</td>
<td>Physicians may refuse to participate</td>
</tr>
<tr>
<td>Montana, 2009*</td>
<td>2 oral and 1 written request</td>
<td>15 days between written request and prescription</td>
<td>2 witnesses required; 1 witness must not be a relative, beneficiary, attending physician, or employee of patient’s health care facility</td>
<td>If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment</td>
<td>If the attending physician suspects a mental disorder, patient is referred to a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established</td>
<td>2 individuals at least 18 y o and not “interested persons”</td>
<td>Physicians may refuse to participate</td>
</tr>
<tr>
<td>Vermont, 2009</td>
<td>2 oral and 1 written request</td>
<td>15 days between written request and prescription</td>
<td>2 witnesses required; 1 witness must not be a relative, beneficiary, attending physician, or employee of patient’s health care facility</td>
<td>If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment</td>
<td>If the attending physician suspects a mental disorder, patient is referred to a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established</td>
<td>2 individuals, 1 must not be related kinship, attending physician, or employee of patient’s health care facility</td>
<td>Physicians may refuse to participate</td>
</tr>
<tr>
<td>California, 2016</td>
<td>2 oral and 1 written request</td>
<td>15 days between written request and prescription</td>
<td>2 witnesses required; 1 witness must not be a relative, beneficiary, attending physician, or employee of patient’s health care facility</td>
<td>If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment</td>
<td>If the attending physician suspects a mental disorder, patient is referred to a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established</td>
<td>2 physicians agree death likely within 6 mo</td>
<td>Physicians may refuse to participate</td>
</tr>
</tbody>
</table>

*By court decision.

### CO EOL Options ACT: The Basics

- A system for Colorado residents with a terminal illness to request and self-administer aid-in-dying medication from a physician under certain conditions (CO resident, terminal dx, life expectancy < 6mo, etc.)
- Participation by hospitals and physicians is entirely voluntary.
- Policies to opt-in or opt-out must be in place to ensure they can be enforced.
- Providers and institutions should notify patients and staff of adopted policies.
CO EOL Options Act: the process:

- Patient: Oral Request
- 15 d
- Pt: 2nd Oral Request
- Pt: written request with 2 witnesses, one must be an “uninterested party”
- Attending physician: has conversations, evaluates Pt, receives written request, educates, explores options, documents process
- Consulting physician: confirms Diagnosis, prognosis, decision-making ability
- Licensed Mental Health Professional, if indicated
- Attending physician: Fills Prescription, fulfills reporting requirements, completes death certificate

THE DENVER POST

- JULY 4, 2017 10 patients got life-ending drugs in Colorado under new law

....The Colorado Department of Public Health and Environment plans to report by the end of the year how many doctors handled prescriptions, but it won’t say how many people took the drugs....

....so, what do we know from other states?....
Hastened Death, Oregon Experience: 1998-2016

Figure 1: DWOA prescription recipients and deaths*, by year, Oregon, 1998–2016

DDA, Data Summary, 2016
http://www.oregon.gov
accessed 7/1/2017

Underlying Illness, deaths via DDA

DDA, Data Summary, 2016
http://www.oregon.gov
accessed 7/1/2017

- Cancer 78%
- ALS 8%
- Lung 4%
- Cardiac 3%
- HIV/AIDS 1%
- Other 7%
Hastened Death, Oregon Experience

Most Frequently Mentioned EOL Concerns, DDA 1998-2016 decedents:

- Loss of Autonomy
- Decreased enjoyable activities
- Loss of Dignity
- Loss of control, bodily functions
- Burden on Family/friends
- Pain control
- Financial burdens of Rx

Percent with Concern, per Physician Report


Hastened Death, Oregon Experience: 2016 summary

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2016, as of January 23, 2017

- 19 people with prescriptions written in previous years ingested medication during 2016
- 114 ingested medication
- 36 did not ingest medication and subsequently died from other causes
- 133 died from ingesting medication
- 204 people had prescriptions written during 2016
- 54 ingestion status unknown
- 10 died, ingestion status unknown
- 44 death and ingestion status pending

Hastened Death, Oregon Experience: 1998-2016

- Age: median = 71yo, range: 25-102yo
- Sex: 52% male
- Race/ethnicity: 96% white, 1.3% Asian….
- Education level: 46% at least BA degree
- Insurance: 99% with some form of coverage
- Place of death: 89% at home
- Psychiatric evaluation in course of DDA: 5%
- DDA deaths with pt enrolled in Hospice: 89%


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Quality of Death and Dying in *Patients who Request Physician-Assisted Death*

<table>
<thead>
<tr>
<th></th>
<th>Requested and received PAD</th>
<th>Requested but did not receive PAD</th>
<th>Death without PAD activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=52</td>
<td>N=32</td>
<td>N=63</td>
<td></td>
</tr>
<tr>
<td>Sx: control over surroundings</td>
<td>(Avg, score, 5 = best) 3.8 / 5</td>
<td>2.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Sx: able to feed self</td>
<td>3.7 / 5</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Sx: bowel/bladder control</td>
<td>3.1 / 5</td>
<td>1.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Sx: energy to do things</td>
<td>1.1 / 5</td>
<td>.6</td>
<td>.8</td>
</tr>
<tr>
<td>Worries re strain on loved ones</td>
<td>2.8 / 5</td>
<td>1.9</td>
<td>2.4</td>
</tr>
<tr>
<td>Said goodbye</td>
<td>87%</td>
<td>69%</td>
<td>57%</td>
</tr>
</tbody>
</table>

General Impacts of MHD legislation (?): 

Lessons from Oregon, Tolle et al, NEJM, 3/2017

So, how do individual patients or patient groups feel about hastened-death options?.....
Attitudes of Patients with ALS...Towards Physician Assisted-[Dying]:

TABLE 2. CHARACTERISTICS OF PATIENTS ACCORDING TO WHETHER THEY WOULD CONSIDER ASSISTED SUICIDE.

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>WOULD NOT CONSIDER ASSISTED SUICIDE (N=44)</th>
<th>WOULD CONSIDER ASSISTED SUICIDE (N=56)</th>
<th>P VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean (95% CI)</td>
<td>mean (95% CI)</td>
<td></td>
</tr>
<tr>
<td>Level of education (yr)</td>
<td>13.5 (12.7–14.3)</td>
<td>15.0 (14.0–16.0)</td>
<td>0.02</td>
</tr>
<tr>
<td>Score for quality of life†</td>
<td>2.0 (1.6–2.4)</td>
<td>2.5 (2.3–2.8)</td>
<td>0.04</td>
</tr>
<tr>
<td>Score on Beck Hopelessness Scale‡</td>
<td>3.4 (2.4–4.4)</td>
<td>5.9 (4.9–6.9)</td>
<td>0.001</td>
</tr>
<tr>
<td>Score for importance of religion§</td>
<td>91.6 (85.5–97.7)</td>
<td>59.8 (50.0–69.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Score for religious practices¶</td>
<td>11.5 (10.8–12.2)</td>
<td>8.0 (7.4–8.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male sex</td>
<td>20 (45)</td>
<td>41 (73)</td>
<td>0.005</td>
</tr>
<tr>
<td>Thought of committing suicide in previous 2 wk</td>
<td>0</td>
<td>8 (14)</td>
<td>0.009</td>
</tr>
<tr>
<td>Wanted to die in previous 2 wk</td>
<td>3 (7)</td>
<td>17 (30)</td>
<td>0.003</td>
</tr>
<tr>
<td>Church member</td>
<td>34 (77)</td>
<td>22 (39)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Might refuse feeding tube</td>
<td>18 (41)</td>
<td>45 (80)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Might refuse cardiopulmonary resuscitation or mechanical ventilation</td>
<td>32 (73)</td>
<td>54 (96)</td>
<td>0.001</td>
</tr>
<tr>
<td>Might take pain medication to be comfortable, even if death hastened</td>
<td>33 (75)</td>
<td>55 (98)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Attitudes toward Physician Assisted-[Dying] among Persons with MS

<table>
<thead>
<tr>
<th>Ever thought about AS as an option? (505 people)</th>
<th>Yes = 30% of sample (n 154)</th>
<th>No = 70% (n 351)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL score</td>
<td>3.6/28</td>
<td>3.2</td>
</tr>
<tr>
<td># MS symptoms</td>
<td>29 sx</td>
<td>22</td>
</tr>
<tr>
<td>Role of religion: “very helpful” (n 260)</td>
<td>24%</td>
<td>76</td>
</tr>
<tr>
<td>Role of religion: “not helpful” (n 69)</td>
<td>51%</td>
<td>49</td>
</tr>
<tr>
<td>If depressed (n 191) answers would be…</td>
<td>47%</td>
<td>53</td>
</tr>
<tr>
<td>If not depressed (n 308) answers would be…</td>
<td>21%</td>
<td>80</td>
</tr>
<tr>
<td>Children less than 5 yo (n 126)</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td>No children less than 5 yo (n 478)</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td># of close friends or relatives…</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Live in state without AS law (MI, n 262)</td>
<td>30%</td>
<td>70</td>
</tr>
<tr>
<td>“ with “ (OR, n 243)</td>
<td>31%</td>
<td>69</td>
</tr>
</tbody>
</table>

Ganzini L et al. NEJM, 1998; 339: 967-973
Attitudes toward Physician Assisted-[Dying] among Persons with MS

<table>
<thead>
<tr>
<th>Ever thought about AS as an option for your care? (from previous slide)</th>
<th>Yes = 30%</th>
<th>No = 70%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>In the future, what if you….?</th>
<th>Yes = Would consider</th>
<th>No = Would not consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>...were experiencing unbearable pain?</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>...were no longer able to do anything that makes your life worth living?</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>...felt illness progression was causing family/caregiver financial burden?</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>...could no longer enjoy anything.</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>...were feeling extreme emotional distress.</td>
<td>26%</td>
<td>74%</td>
</tr>
</tbody>
</table>


Implementing a Death with Dignity Program at a Comprehensive Cancer Center

- 114 patients inquired about the Death with Dignity program between March 2009, and December 2011..... 44 did not pursue the pgm....30 initiated the process but either elected not to continue or died before completion.
- Of the 40 participants who received a prescription, all died, 24 after medication ingestion (60% of those obtaining prescriptions).
- The participants at our center accounted for 15.7% of all participants in the Death with Dignity program in Washington (255 persons) and were typically white, male, and well educated.
- The most common reasons for participation were loss of autonomy (97.2%), inability to engage in enjoyable activities (88.9%), and loss of dignity (75.0%). Eleven participants lived for more than 6 months after prescription receipt. Qualitatively, patients and families were grateful to receive the lethal prescription, whether it was used or not.

**Conclusions:** the Death with Dignity program has been well accepted by patients and clinicians.

-NEJM, April 11, 2013
JANUARY 26, 2017  About 30 hospitals opting out of Colorado’s medical aid-in-dying law. Three major health systems have announced they will not participate.

Medical providers and Organized Medicine’s Policy Response

Varied….
Reflects conflicting perspectives and opinions among members, organizations, stakeholders.
American Medical Association

- Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer. (updated 2008)

- The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life. (updated 2009)

AMA Policies: Physician Assisted Suicide, H-140.952 and H-270.965, website accessed 7-9-2017

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American Medical Association

1. The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity....

2. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

3. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death....

4. Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary....the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

5. Our AMA supports continued research into and education concerning pain management.

AMA Policy: Decisions Near the End of Life, H-140.966 (updated 2016), website accessed 7-9-2017
American Public Health Association

…..the American Public Health Association—
• Supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death….

• Rejects the use of inaccurate terms such as “suicide” and “assisted suicide” to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death.

• Encourages that where such option is available to vulnerable populations, including persons who have a disability which existed before the terminal illness, data be collected on the incidence when vulnerable populations and persons with disabilities that are independent of their terminal illness decide to hasten their death.

American Public Health Association

• Supports measures to ensure that patients eligible to receive information about death with dignity and are able to choose alternatives such as aggressive pain and symptom management, palliative care, hospice care, and care to maximize quality of life and independence.

• Supports the provision of information about the full range of end-of-life care options to terminally ill patients permitted by law in the state in which the patient is receiving care, including, for example, voluntarily stopping eating and drinking and palliative sedation. Palliative sedation is the use of medication to induce sedation to relieve a dying patient’s severe distress that cannot be controlled despite other aggressive measures53,54

• Supports a moratorium on DDA should evidence emerge that vulnerable populations are disproportionately impacted by such policies.
American College of Legal Medicine

- the ACLM filed an Amicus brief before the United States Supreme Court in 1996 in which it stated, "The term 'physician-assisted suicide' is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality....(I)t seems inappropriate to characterize requests for treatment that end life, made by suffering, terminally-ill patients, as any form of destruction or ruination of their interests. Assuming a patient's mental competence, and recognizing (the Supreme) Court's long-held commitment to the principles of personal autonomy and free will, prescribing medication intended to end life in the subject context serves --- not destroys or ruins --- a patient's interests....ACLM rejects the term 'physician-assisted suicide,' and instead refers herein to the practice in question as 'treatment intended to end life.' ....

American College of Legal Medicine

- .....the ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death, provided, however, that such person strictly complies with law specifically enacted to regulate and control such a right; and
- That the process initiated by a mentally competent, though terminally ill, person who wishes to end his or her suffering and hasten death according to law specifically enacted to regulate and control such a process shall not be described using the word "suicide", but, rather, as a process intended to hasten the end of life.

- The ACLM continues to strongly support the use of palliative and hospice care for mentally competent though terminally ill persons.

ACLM, Oct. 2008
National Medical Organizations’ stance on Hastened Death / Legislation

**Generally Supportive**
- American Public Health Assn.
- American College of Legal Med.
- Etc.

**Generally in Opposition**
- American Medical Assn.
- American Osteopathic Assn.
- American Nursing Assn.
- Etc.

“Studied Neutrality”
- American Academy of Hospice and Palliative Medicine
- Colorado Medical Society
- California Medical Association
- Etc.

Policy Example: Centura Health (Catholic healthcare system)

Centura Health has a long tradition of believing in the sanctity of life, extending compassionate care and relieving suffering. These fundamental values are reflected in the depth and breadth of support and comfort services we offer, including palliative care, hospice care, spiritual care services and mental health services, so patients and their families may live with dignity until the patient’s time of death. **Centura Health facilities and providers do not provide medical aid in dying medication or related services.**
Policy Example: Denver Health and Hospitals [as of 6/2017]

- **At this time, Denver Health and Hospital Authority has opted out of participation in these activities pending further evaluation.** We understand that we may have patients at Denver Health who seek this service, and we are supportive of our patients’ rights to do so. We are diligently evaluating how to lawfully and responsibly offer EOLOA to our patients and hope to be prepared to do so by July 1, 2017.
- In the meantime, our employed and contracted physicians, mental health professionals and all other staff are not authorized to prescribe or dispense aid-in-dying medication to Denver Health patients, cannot serve as witnesses to a written request for aid-in-dying medication, and cannot evaluate a patient’s mental capacity for purposes of requesting aid-in-dying medication under EOLOA.
- Until Denver Health is able to opt in to EOLOA, our opt-out applies at all Denver Health facilities, and to all Denver Health employees and contractors. Self-administration of aid-in-dying medication is prohibited at all Denver Health facilities.
- Upon patient request, Denver Health will provide referral assistance and transfer relevant records to another health care provider for the patient to participate in the activities permitted under EOLOA.

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**CO Healthcare System Positions:**

**Allow Prescription, Filling and Use by pts in certain facilities:**
- University of CO Hospitals and Clinics
- Kaiser Permanente

**Allow prescription but not Filling or Use of Rx in Facility:**
- Health One

**Do not allow Prescription, Filling or Use:**
- Centura Health (Adventist and Catholic Health)
- SCL (Sisters of Charity) health systems

**Policy in Development:**
- Denver Health and Hospitals (opted out as policy is developed)

Note: constantly evolving; also some inconsistency in reported policies, depending on source.
Personal, Professional and Organizational Position & Response

• Take into consideration one’s personal values, spiritual/religious and cultural perspective and professional responsibilities and ethics.
• Consider organizational mission and services offered.
• Consider legal imperatives & legal advice where indicated.
• Recognize and be respectful of individual professionals option to opt in or out.
• Utilize or refer to resources available to implement elements of the Act

Policy Considerations for Implementing the Colorado End-of-Life Options Act in Colorado Hospitals

Hospital’s Governing Board Decides Position on the Colorado End-of-Life Options Act

Yes, we will opt-in

No, we will opt-out

Written Policy & Procedures

Opt-In Policy/Procedures should consider
- Documentation requirements:
- Copy of prior records
- On-site documentation
- Advance directives and DNR
- Personnel Policies
- Facility review process
- Patient assistance process

Written Policy & Procedures

Opt-Out Policy/Procedures should consider
- Response for emergencies and non-compliant situations
- Personnel Policies

Patient/Public Notification

Notification Best Practices Patient/Public
- Website and patient right locations
- Admissions Paperwork

Employee/Professional Notification

Education Best Practices Employee/Professional
- Professional/Employee Contracts
- Medical Staff Governing Docs.
- Continuing Medical Education

Board should consider the following factors
- Available resources, including willing medical staff
- Faith- or mission-based standards
- Scope of services offered
- Opportunity for public input

Prop. 106 was passed by CO voters in 2016 with 65% support and will take effect by Jan. 2017
Responses to Requests for Aid-in-Dying: an opportunity to CARE*

✓ **Compose**: yourself and your response; source your compassion, knowledge, professionalism and best ethical approach; practice with colleagues

✓ **Ask**: Why are you asking about this now? What about your situation is leading you to wonder about this option for your care?

✓ **Respond**: according to pt desires, needs and available resources; offer support, services and additional resources as indicated.*

✓ **Engage**: in ongoing discussion; offer follow-up, provide consistent and reliable support.

*CARE acronym for EOL discussions, C. Ruskey MD, 7/1/2017

Note: If actively suicidal (i.e. immediate risk to self), respond immediately and with appropriate urgent/emergent services.

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Summary: We have...

- Considered the complexities of life, decision-making and care encountered by a young person with progressive cancer who is experiencing multi-dimensional suffering.

- Applied Ethical Principles from NGA and the medical ethics model to our thinking about medically-hastened dying.

- Reviewed the history, use and outcomes of medically hastened death in Colorado and other states.

- Shared personal, professional and organizational approaches to legislation, policies and preparation of our response to requests for assistance at end-of-life.
Resources:

- American College of Legal Medicine: http://www.aclm.org/
- American Society of Law, Medicine and Ethics: http://www.aslme.org/
- Colorado Hospital Association: https://cha.com/
- Colorado Dept of Health and Environment: https://www.colorado.gov/cdphe
  - Colorado Medical Board: Guidelines Re End-of-Life Options and Care, Policy statement 40-06, 5/18/2017
- End-of-Life Options Act website: www.CompassionAndChoices.org/Colorado
  - Doc2Doc consultation service 800-247-7421
  - Pharmacist2Pharmacist consultation service

Articles:

- Attitudes of Patients with ALS and their Care givers Toward Assisted Suicide, Ganzini et al, NEJM, 1998: 967-73
- Attitudes toward Physician-Assisted Suicide among Persons with Multiple Sclerosis, Berkman et al, NEJM, 1999: 51-64
- Lessons from Oregon in embracing Complexity in End-of-Life Care, Tolle et al, NEJM, 2016:3-201
- Responding to a Request for Physician-Assisted Death... letter of response and author reply, M L Galishoff, JAMA: 2351-2352