North Coast Physician

In This Issue:

Cover Photo
"VIEW FROM EUREKA"
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California's End of Life Option Act: Woody Allen, you can rest easy now – in California

Scott Sattler, M.D.

There's a little bit of Woody Allen in us all. That's why we laugh when he expresses thoughts we share but rarely admit to ourselves… let alone to the general public. One of my favorites is "I'm not afraid of death; I just don't want to be there when it happens." This is closely followed by "Eternity is exhausting. Especially at the end."

As humans we can't help but contemplate death and dying, especially our own. It is also very human to experience a sense of fear that relates to the processes leading up to our inexorable death. We've heard stories or we've witnessed pain, disability, frustration and the loss of dignity that can occur to people at the end of their lives. No wonder that we can profoundly relate to that part of us that would love to have the option to simply 'not be there' when our death occurs. Well, it turns out that California residents will soon have that option. Woody, eat your heart out.

On June 9th, 2016 California's End of Life Option Act will take effect. It will expire on January 1, 2026 unless it is renewed. Patterned after Oregon's Death With Dignity Act (DWDA) of 1997, this law allows any mentally competent, terminally ill California resident over the age of 18 to end their life through the voluntary self-administration of an aide-in-dying drug expressly prescribed by their attending physician for that purpose. This physician must have diagnosed the individual as having a disease that is incurable and irreversible and that will, within reasonable medical judgment, result in death within six months. The patient must submit two oral requests for these medications, at least 15 days apart, and possess the physical and mental ability to self-administer the aide-in-dying drug(s). In addition, the patient must document his or her request by submitting a signed, dated and witnessed written request prior to receiving these medications. This request must be made solely, voluntarily and directly by the individual diagnosed with the terminal disease, not through an intermediary. Furthermore, a referral to an independent consulting physician is required for every patient. The role of the consultant is to confirm the attending's diagnosis and prognosis as well as to verify the patient's mental competency and intention.

The patient has the right to change his or her mind at any stage of the process. If the prescription has been filled, the patient may choose to delay taking it. Statistically, since the law was passed in Oregon in 1997, a total of 1,545 people obtained such prescriptions. Only 991 of them (64%) ingested the medications. The rest either did not fill the prescriptions or chose not to take them prior to their deaths.

After June 8th, 2016 there will be five states that allow terminally ill patients to end their lives: Oregon, Washington, Montana, Vermont and California. (FYI an October 2015 Field Poll in California showed that 65% of those polled were in favor of this law while 27% opposed.) New Mexico may soon follow. Medical aid in dying has been legal in the province of Quebec, Canada since 2014.

Q: What are the most common terminal diseases encountered under this law?

A: In the years 1998-2015 the Oregon DWDA's primary diagnoses were malignant neoplasms (77%), amyotrophic lateral sclerosis (8%), chronic lower respiratory disease (4.5%), heart disease (2.6%), HIV/AIDS (0.9%) and 'Other Illnesses' such as multiple sclerosis, Parkinson's disease, Huntington's disease, connective tissue diseases, strokes, diabetes mellitus and liver disease (6.9%).

Q: Isn't this practicing euthanasia?

A: As a point of information, it is important to note the difference between physician-assisted death and euthanasia. In assisting death, a physician prescribes medications that a terminally ill patient can choose to take if their condition becomes unbearable. In euthanasia, a physician directly administers a lethal medication that causes the patient's death in order to relieve intractable suffering. Euthanasia is illegal throughout the United States. As of October 2015 it had been legalized in the following countries: the Netherlands, Belgium, Colombia, and Luxembourg. Physician-assisted death is legal in Switzerland, Germany, Japan and Albania. It becomes legal in Canada on June 6, 2016.

Q: Aren't we assisting suicide and isn't this a felony?

A: The California legislature, the

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"Opinion", Continued on Pg 21

"Opinion", Continued from Pg 5

CMA (who did not oppose this law) and the public (see the Field Poll above) do not see this as being a criminal activity. Many view it as a humane treatment requiring the direct request and facilitation of the patient coupled to the oversight of the medical profession. It is also seen as the humanitarian part of the treatment of terminal disease. In addition, the Act clearly states this not to be considered a criminal act and requires that the cause of death be reported in these cases as the terminal illness, not suicide. The law also specifically bars enforcement of insurance suicide clauses that would deny coverage in cases falling under the aegis of this Act.

Q: How will this law affect physicians of Humboldt County and how might we best prepare to deal with such requests?

A: The law makes it clear that it is that patient's attending physician who provides the lethal prescription. It follows that the majority of requests will come to primary care physicians, neurologists, oncologists, palliative care specialists and hospice-based physicians. The law is also clear that no physician shall be required to provide aide-in-dying medications to patients.

The CMA-On Call legal service has written an excellent 14-page guide (#3459) giving a detailed discussion of the law and providing the necessary reporting forms that need to be returned to the state for statistical follow-up. This guide supplies the answers to a host of questions not addressed in this short editorial. I've read it and as state guidelines go, this one is pretty easy to follow and very thorough. Clearly this law has been well crafted. Oregon has had no reports of misuse since their program began. I would suggest that physicians who might consider caring for their terminally ill patients in this fashion download and read it. It is predictable also that many of us will be asked questions about this Act. We would be well served by downloading the guide and checking it out.

Q: What would you do, Dr. Sattler, if you acquired a terminal disease that met these criteria?

A: Ahhhhhh……good question. I really wouldn't know until the time came around of course, but today I would say this: If I were found to have a glioblastoma, knowing that my 5-year survival odds were about 1.2% and that there was a high chance of developing seizures and really nasty headaches and an intense continuous preoccupation with my physical body's discomfort, I'm pretty sure I'd ask for the meds. I'm not sure I'd use them, but I'd sure like to have them handy in case I crossed that line where living got a whole lot worse than dying could ever be. And I would want my family to remember me while I was still able to think and smile and love'em to where they could still feel it…. §

"Balanced", Continued From Pg 15

in groups who are delegated by the insurance industry to manage medical care, and to compensate those physicians. I believe that CMA policy on the issue, which essentially states that physicians should be fairly compensated for their work, will be able to guide the legislature to an equitable solution. And I also believe that dangerous outsider proposals like AB 533 make this the time for CMA to propose legislation that will resolve the issue fairly for all physicians.

The time will come this year when SSVMS and CMA call upon our members to contact our legislators, urging them to support a reasonable resolution that recognizes the importance of fair physician compensation that assures medical services will continue to be available to our patients. Our legislators listen when we, as individual physicians and constituents, advise them on matters of appropriate patient care.

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