Right to Die: An Overview for Hospice Clinicians

Pharmacist Corner Objectives:

1. Describe legal considerations of the right to die in the United States
2. Understand the pharmacologic management of physician assisted death
3. Identify clinical pearls and tips for navigating the right to die by state
4. Address commonly asked questions for providers and patients
5. Share resources for more information

WHAT IS THE RIGHT TO DIE MOVEMENT?

The “Right to Die” describes a patient’s choice to pursue a medically assisted death. Assisted death offers terminally ill patients a legal way to end their life by taking a lethal dose of medication as prescribed by a physician. This should not be confused with euthanasia, the act of a physician ending a patient’s life with a lethal injection, which is not legal in any US state. Proponents for the 'Death with Dignity' movement advocate for education and state legislation that codifies one’s end-of-life options to allow eligible individuals to voluntarily request and obtain this medication to hasten death in a peaceful and dignified manner in an environment of their choice.

WHAT IS THE CORRECT TERMINOLOGY WHEN DISCUSSING ONE’S RIGHT TO DIE?

Terminology when discussing sensitive matters such as one’s right to die is critical in ensuring that the issue is not misunderstood or misconstrued. To remain accurate in describing the process of a patients right to die, the preferred terms include:

- “Death with Dignity”
- “Physician Assisted Death”
- “Physician Assisted Dying”
- “Aid in Dying”
- “Physician Aid in Dying”
- “Medical Aid in Dying”

Terms such as “Assisted Suicide” and “Euthanasia” should be avoided as they are not accurate to the current Death with Dignity laws and mischaracterize the process as it exists today.

WHERE IS THE RIGHT TO DIE RECOGNIZED IN THE UNITED STATES?

To date, ten states and Washington DC (See Appendix 1.1) have authorized physician assisted dying. In these states patients do not need to apply to state health departments or participate in state programs, rather it is up to eligible patients and licensed physicians to implement and act on a case-by-case basis.

HOW DO PATIENTS QUALIFY FOR MEDICAL AID IN DYING?

To protect both patients and providers participating in aid-in-dying in these states, strict eligibility requirements exist and may vary slightly. Broadly these requirements include:

- Strict patient eligibility requirements without exception including but not limited to being an adult, a state resident, mentally capable, able to self-administer and ingest the medications, and having a terminal diagnosis with a prognosis of six months or less to live.
- The patient must request the medication in writing as witnessed by at least two people who can attest that the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses may be required to not be a relative of the patient, anyone who would be entitled to any portion of the patient's estate, an owner, operator, or employee of a health care facility where the eligible patient is receiving medical treatment, or the patient's attending physician. This request **cannot** be included in an advance directive, living will, or end of life care document.
- Patients may rescind the request at any time.
- Two physicians, one of whom is the patient's attending physician, familiar with the patient's case, must confirm the terminal diagnosis, and confirm that the patient is of sound mind.
- States may have a waiting period related to the writing or dispensing of the prescription.
- Physicians must comply with strict reporting requirements for each request as mandated by state laws.

PHARMACOLOGIC MANAGEMENT OF PHYSICIAN ASSISTED DEATH

The type and dosage of medication utilized in aid-in-dying cases should be tailored to each individual with the goal of allowing the patient to fall asleep peacefully within 20 minutes and die painlessly within an hour or two. Special considerations should be used in patients with GI absorption issues, CV wellness, obesity, alcoholism, and acquired tolerance to opioids and benzodiazepines. To ensure a smooth process for the patient and their loved ones, it is recommended for the prescribing physician to call the pharmacist to let them know the prescription is on the way and to address any questions from the pharmacy team up front.

No death with dignity laws tell physicians exactly what prescriptions may be utilized by patients. Historically pentobarbital and secobarbital were agents used in physician assisted death, however as of 2019 these agents became unavailable. While protocols remain varied, below are a few common regimens utilized and their associated pearls.

Common Medication Protocols for Physician Assisted Death

Protocol Acronym	Medications	Medications Given One Hour Prior	Patient Preparations
DDMA	• Digoxin 100 mg • Diazepam 1 gm • Morphine 15 gm • Amitriptyline 8 gm	• Ondansetron 8 mg • Metoclopramide 20 mg	Patients should remain NPO for 4-6 hours, including no dairy or heavy laxatives. Patients may take their usual comfort medications as desired. DDMA medication/powder may be mixed with liquid for patient consumption immediately before ingesting.
D-DMA	• Digoxin 100 mg, given separately 30 minutes prior to other medications. • Diazepam 1 gm • Morphine 15 gm • Amitriptyline 8 gm		
DDMAPh	• Digoxin 100 mg • Diazepam 1 gm • Morphine 15 gm • Amitriptyline 8 gm • Phenobarbital 5 gm		
D-DMAPh	• Digoxin 100 mg, given separately 30 minutes prior to other medications. • Diazepam 1 gm • Morphine 15 gm • Amitriptyline 8 gm • Phenobarbital 5 gm		

PHARMACOLOGIC FREQUENTLY ASKED QUESTIONS

What can be expected after ingestion of DDMA?

While timelines for each patient vary, the healthcare team can prepare the patient and their family for a general timeline after ingestion.

Timeline Post DDMA Ingestion		
Sleep	2-40 minutes after ingestion	Initial drowsiness occurs, followed by deep sleep and loss of consciousness
Coma	Minutes to hours after consumption	Sleep progresses to coma with slowed and irregular breathing.
Death		Average time to death ~2 hours but ranges widely between 6 min and 12 hours.

Will a patients insurance cover aid-in-dying medication?

In most cases, private insurances will not cover the cost of aid-in-dying medications, however in some states Medicaid programs may.

How should the patient and their caregivers store the medication?

At the time of dispensing, the pharmacist should counsel patients and their caretakers on how to properly store and handle the prescribed medications as well as how to dispose of them if they are unused.

Where can patients take the medication?

Patients may self-administer and ingest the medications at a place of their choosing, though many states have laws prohibiting consumption in a public place. Similarly, if taken outside the state where it was obtained, the patient may lose legal protection.

Who disposes of the medications if it is never used?

Each state's laws may have specific instructions for disposal of unused medications, however because many of the medications are controlled substances physicians must report all prescriptions for lethal medications to their state's health department. Similarly, pharmacists must report on dispensing these medications. Additionally, because many patients are enrolled on hospice care at the time of their death

it is the responsibility of the hospice to create a policy for medications left after a patient's death and to educate caregivers about the disposal.

What options do patients have if their state does not allow physician aid in dying?

Patients should discuss with their hospice or palliative care providers about their options. Measures such as voluntarily stopping eating and drinking, stopping treatment, or use of palliative sedation can take anywhere from several days to several weeks to result in death. Stopping treatment or medication may lead to unanticipated effects or pain.

What are the residency requirements under Death with Dignity laws?

Legal state residency is a requirement for accessing Death with Dignity laws. You must provide adequate documentation to your attending physician to verify that you are a current resident of the jurisdiction.

Where can patients and providers find more information regarding Death with Dignity laws?

Please see references below for state laws, organizational resources, and more.

SUMMARY

Right to die legislation can be complex and intimidating to navigate for both patients and providers. Still, patients deserve to be informed of all their options for end of life, and providers of all disciplines can be valuable resources to help guide these patients and caretakers. Comprehensive and compassionate communication between patients, their families, and healthcare providers is essential in facilitating a clear understanding of the legal landscape, eligibility criteria, and the pharmacologic management involved in the right-to-die process. Additionally, providers can play a crucial role in offering emotional support, addressing concerns, and collaborating on personalized end-of-life plans, ensuring a dignified and peaceful transition for patients facing this profound decision. As advocates for patient autonomy and well-being, healthcare professionals can navigate the intricacies of right-to-die legislation with empathy and expertise, further fostering an environment of understanding and support.

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Appendix 1.1

States Where Physician Assisted Death is Authorized	
State	**Name of Act**
Oregon	Oregon Death with Dignity Act
Washington	Washington Death with Dignity Act
Montana	*Baxter V. Montana*
Vermont	Vermont Patient Choice and Control at the End of Life Act
California	**California End of Life Option Act**
Colorado	Colorado End of Life Options Act
Washington DC	D.C. Death With Dignity Act
Hawai'i	Hawai'i Our Care, Our Choice Act
New Jersey	New Jersey Medical Aid in Dying for the Terminally Ill Act
New Mexico	New Mexico Elizabeth Whitefield End-of-Life Options Act

