IADC COMMITTEE NEWSLETTER

MEDICAL DEFENSE AND HEALTH LAW

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IN THIS ISSUE

In this issue, Constance Endelicato addresses the recent trend in "End of Life" legislation, largely influenced by twenty-nine-year-old cancer victim, Brittany Maynard, in her quest for freedom of choice. This article will explore the elements of such legislation which has expanded to five states, with numerous states anticipated to follow suit in the near future.

Death with Dignity---An Analysis of the Future Impact on Litigation

ABOUT THE AUTHOR

Constance Endelicato has over 28 years of litigation experience, specializing in the defense of health care providers. Her trial experience has afforded her membership in the American Board of Trial Advocates. She has been named by the Los Angeles and San Francisco legal newspaper, The Daily Journal, as one of the Top Women Lawyers in California. She also has been recognized by Los Angeles Magazine as one of the Top Women Attorneys in Southern California. She has received the designation of Super Lawyer in Southern California by Los Angeles Magazine, Super Lawyer in Orange County by Orange Coast Magazine, and Top Lawyer by Pasadena Magazine. She holds an AV-Preeminent Rating by Martindale Hubbell.

Ms. Endelicato is an elected Board Member of Southern California Association of Healthcare Risk Management and has been appointed to serve on the Education Development Task Force for a two year term for American Society for Healthcare Risk Management. She is a member of several organizations and sits on various committees. She is also a featured speaker at educational conferences. She can be reached at cendelicato@wshblaw.com.

ABOUT THE COMMITTEE

The Medical Defense and Health Law Committee serves all members who represent physicians, hospitals and other healthcare providers and entities in medical malpractice actions. The Committee recently added a subcommittee for nursing home defense. Committee members publish monthly newsletters and *Journal* articles and present educational seminars for the IADC membership at large. Members also regularly present committee meeting seminars on matters of current interest, which includes open discussion and input from members at the meeting. Committee members share and exchange information regarding experts, new plaintiff theories, discovery issues and strategy at meetings and via newsletters and e-mail. Learn more about the Committee at www.iadclaw.org. To contribute a newsletter article contact:

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Introduction:

Since Brittany Maynard became the voice for the right to "die with dignity", twenty-five states have heard her plea and are considering legislation. Once she was diagnosed with a terminal brain tumor, the twenty-nine year old California resident relocated to Oregon, the first state to enact Death with Dignity legislation. Such legislation affords a person with less than six months to live, the right to ingest a lethal medication. Thereafter, California enacted similar legislation which went into effect last month. This article will focus on issues in risk management and litigation including, liability for mismanagement, providers' right to opt out, Medicare and private insurance consideration, and ethical and moral issues involving conflict of interest.

I. Understanding Death with Dignity Statutes

In 1994, Oregon became the first state to enact the Death with Dignity Act which allows the terminally ill residents of the state to end their lives though voluntarily self-administration of a lethal medication, prescribed by a physician. Physician-assisted death bills had been introduced in 1989, 1991, and 1993, although none of them surpassed committee vote. Voters in Washington and California also rejected similar ballot initiatives in 1991 and 1992, respectively.

Despite its passage in 1994, implementation was delayed by court challenges for several years. The Oregon bill, Measure 16, expressly prohibited euthanasia by lethal injection. Opponents argued that the Oregon statue violated the Constitution's First and Fourteenth Amendments, as well as several federal statutes. At one point, Congress tried to block implementation, urging the U.S. Drug Enforcement Administration to penalize doctors who prescribed federally controlled drugs for dying patients to hasten their death. In 1998, Attorney General, Janet Reno, issued a reversal of the DEA's position. This was revisited in 2001, when Attorney General, John Ashcroft, authorized DEA agents to prosecute doctors. The matter was argued in the Ninth Circuit Court of Appeals and before the U.S. Supreme Court. in 2006, the U.S. Supreme Court voted to uphold the Oregon statute. Since then, it has remained unchallenged. In a survey in 2012, eighty percent of Oregonians supported the Death with Dignity Act.

Since that time, Washington state passed a Death with Dignity Act on March 5, 2009. In 2009, the Montana Supreme Court ruled that physicians may assist physicians in ending their lives by self-administration of medications. In 2013, Vermont passed the Patient Choice and Control at the End of Life Act. This year, in a nationally publicized debate, California became the fourth state to enact legislation allowing self-administration of a lethal drug when it passed its End of Life Option Act. This legislation was driven by the plea of Ms. Maynard, who was a resident of California and chose to relocate to Oregon so that she could end her life as a result of her terminal diagnosis of a brain tumor. Her story which made national news, caused her home state to quickly pass legislation based upon

her poignant plea for the freedom of choice. Since then, twenty-five states followed suit and began considering proposed legislation for similar statutes. At a meeting in June 2016, The American Medical Association announced that it will re-examine the issue of legalization, which it has previously opposed since 1992. Currently, Montana remains the only state that allows death with dignity by court decision.

The following are elements of the California End of Life Option Act which is modeled after the Oregon Act. It is codified in California Health & Safety Code Section 443.2, et seq. The Oregon Act can be found at ORS 127.865 et seq.

A. Qualification Under Death With Dignity Statutes

To qualify for the provisions under the Act, the individual seeking end of life option (hereinafter referred to as "patient") must meet numerous stringent requirements. The patient must be of adult age and a legal resident of the state. Residency is established by proof of possession of a driver's license or other identification issued by the state, registration to vote in the state, evidence that the patient owns or leases property in the state, or evidence of a filed tax return for the most recent tax year in the state.

The patient must be deemed to have the mental capacity to make competent medical decisions. He or she must have the physical and mental ability to self-administer the aid-in-dying drug. The patient must be diagnosed with a terminal illness and deemed to have less than six months to live. The diagnosis must be made by two physicians, one who is the primary or attending physician and the second, who is consulting or independent physician. The patient wishing to employ the Act must make two oral requests for authority to his or her physicians within a minimum of fifteen days apart. The request must be made by the patient. A power of attorney, conservator, agent, or surrogate, cannot make the request on behalf of the individual.

The requesting patient must also make one written request to his or her physician in compliance with statutory requirements as to the form of the request. (Health & Safety Code Section 443.2(c)). The request must be made on a specific form and must be signed and dated in the presence of two witnesses. The witnesses cannot be the attending physician, consulting physicians, or mental health specialist. Also, only one witness may be related to the requesting individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the requesting individual's estate upon death, or own, operate, or be employed at a health care facility where the patient is receiving medical treatment or resides. (Health & Safety Code Section 443.3(b), 443.3 (c), 443.3(d), and 443.11(a).)

All three requests must be received by the attending physician and not by a designee of the physician. (Health & Safety Code Section 443.3(a)). The attending physician who received the oral and written requests for an aid in dying drug must document this in the

patient chart. (Health & Safety Code Section 443.8(a) and (b)). There is a mandatory wait period of 48 hours, once all requirements are met and the patient signs a final attestation in writing of his or her desire to end life. Thereafter, the patient must self-administer the end of life drug within the Death with Dignity state.

B. Who and Where

A physician's participation is strictly voluntary. The physician must be licensed in the Death with Dignity state. The primary or attending physician must be the primary care provider for the individual and certify that the necessary criteria has been met. The primary must ensure that the patient is not subject to coercion or undue influence. He or she must determine that plaintiff has a terminal disease defined as incurable and irreversible disease that will end the patient's life within a degree of medical probability within six months. (Health & Safety Code Section 443.5(a)(1)(B), 443.1(q).)

The consulting physician must be independent and must not have had a personal or professional relationship with the patient. The attending determines the medication to be used. The two necessary physicians must be medical doctors rather than nurse practitioners or physicians assistants. The patient must ingest the medication within the state. The patient may not ingest the drug in a public place, other than a medical facility which has "opted in" and is declared as a participating medical facility.

As noted above, the primary physician is responsible for ensuring that the patient is terminal and is competent to make the decision to end his or life. The primary physician must refer the patient to the consulting physician for an independent evaluation to ensure that the patient is terminal, with less than six months to live, and that the patient is competent, not under duress and is otherwise, freely and consciously making the decision to end his or her life.

The attending physician is responsible for counseling the patient and for obtaining informed consent. Such physician is responsible for referring the patient for psychiatric consultation if it is suspected that the patient lacks competency. The attending must decide upon the medication to use and provide the medication directly to the patient, or alternatively, deliver a prescription to the pharmacy of choice of the patient. Once proper documentation is obtained, and the patient has signed the final attestation papers, the attending must ensure that 48 hours has passed prior to the time the patient ingests the medication. he or she must stop the process if at anytime, he or she is suspicious of foul play or incompetency. The attending must follow strict reporting requirements as to the patient's course.

C. Confidentiality

As with all personal healthcare information, the physicians must comply with HIPAA requirements as to confidentiality. Patients

are assigned an identifying number. There are no requirements as to what will be stated on one's Death Certificate. In Death with Dignity states, such death is not regarded as a suicide. The attending physician can list the cause of death as he or she deems appropriate. Neither the patient's, nor the physician's identity will be disclosed. The physician's identity is coded so that he or she will not suffer repercussions by those opposing the Act. Once the data is collected, the documentation is destroyed within one year in Oregon. It is expected that California will follow suit.

D. Who Pays?

Each individual's private insurance will determine what is covered. However, most federal funding does not cover the process of self-administration of lethal medication. Hence, the medical consultations, the hospital admission if for the purpose of ingesting the medication as an inpatient, and the cost of the medication will not be covered. As such, death under the Act It is not regarded as a suicide. (Health & Safety Code Section 443.18.) It does not interfere with one's right to insurance benefits under life, health, or accident policies, or with an annuity policy. (Health & Safety Code Section 443.13(b).) The cost of medication varies. It ranges based upon the drug used, the place of manufacturing, and the form of the drug, as liquid tends to be more expensive than the powder form. Some use a combination of drugs which may help to reduce the cost of the drug.

E. The Statistics

The median age of patients opting for Death with Dignity medication is 72. Approximately, 79% of the patients opting for end of life medication have been diagnosed with malignant cancer. In Oregon, since 1998, although 1,327 patients received the prescription, only 65% or 712 patients ingested it and died. In comparison, in Washington since 2008, 725 patients received the prescription, and 98% or 712 patients ingested the drug and died.

F. Protection and Immunities

Physicians are granted immunity from most potential litigation. They do not face liability for determining diagnosis, prognosis, counseling, or referral. Individuals who are present are protected from liability as long as he or she does not assist the patient in ingestion of the medication. Healthcare providers do not face liability or penalty if they participated in "good faith compliance" with the Act. Physicians are not subject to claim for neglect or elder abuse. However, sanctions are awarded against a physician for failure to comply in good faith with the Act. A participating physician may be disciplined but not reported to the Medical Board for certain violations. Finally, a physician or other individual participating in the patient's end of life course, may face criminal penalties for certain intentional acts. (Health & Safety Code Section 443.17(a)-(d); Penal Code Section 7.)

II. The Controversy

There will always be a concern that a patient or patient's support group may be attempting to abuse the system. Some argue that the existence of the law may encourage premature death. Some are concerned that unethical physicians may assist patients for the wrong reason. Family members may coerce loved ones for monetary gain or other motivating factors. There is a fear that the patient or his or her support group may abuse the medications. Physicians fear repercussions in the work place and community.

There are also cost considerations as some argue that the economically disadvantaged will use the Act to end their life due to economic strife. The cost of medical therapy may cost more than the cost of end of life medication.

There is a strong platform in favor of palliative care options. Many elderly or ill may not be knowledgeable as to other care options. Many elderly or ill may not be able to make an informed decision. Proponents for palliative care an the alternative argue that care is provided to prevent suffering without expediting demise. Further, it is argued that physicians cannot predict life expectancy. Also, how do we differentiate between the terminally ill with less than six months to live versus those who may live longer than six months but still suffer from a disease, paralysis, or debilitating pain.

III. Consideration for Organizations as to Opting In or Out

Health care organizations such as hospitals and medical groups, must take a position to opt in or out of the Act. If you do not declare, your organization will default to opt in. Participation for any provider is strictly voluntary. (Health & Safety Code Section 443.14(e)(1).) Health care providers must take certain steps to prohibit staff from participating in the Act if they have opted out. Secular Organizations and Religious Organizations have the right to opt out. The Act specifically supports opting out for "reasons of conscience, morality or ethics." Certain organizations must make decisions as to whether it provides a publicly stated philosophy. There are certain circumstances which allow the provider the right to prohibit staff from participating. If such circumstances are implemented, there are notice requirements that must be employed prior to prohibiting staff from participation.

IV. Concerns Regarding Future Litigation and Claims

Litigation remains to be seen. Oregon has had great success with no significant reporting of litigation involving death pursuant to the Act. Most patients opt to consume the end of life drug in the privacy of their own home. The stringent requirements of the Act seem to have successfully provided safeguards against abuse of the Act.

The potential for future litigation would include action against the physicians for not

complying with the Act requirements. Although the Act provides for immunity, there are still requirements for adherence to the Act. It is clear that if a physician acts intentionally to violate the Act, he or she is subject to criminal prosecution. We can anticipate that in this event, we may see challenges to civil immunity. There have not been any reported claims against hospitals for its decision to either opt in or out. One can foresee potential for litigation in this regard, although the Act specifically allows facilities and medical groups to make their own decision. Such entities must follow the appropriate protocol to make such declaration for opting out or the institution may default to status of a participating entity.

For the time being, Oregon has set the stage with great success and no significant legal ramification for paving the way with Death with Dignity legislation.

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