HOSPICE, PALLIATIVE CARE AND AID-IN DYING:

The Current Status of End-of-Life Policies in the United States and Their Impact on Population Health

Alina M. Perez, JD, MPH, LCSW
Kathy Cerminara, JD
Akiva Turner, JD, Ph.D, MPH

Palliative vs. Hospice Care

http://getpalliativecare.org/whatis/faq/#what-is-the-difference-between-hospice-and-palliative-care

Palliative Care	Hospice
Symptom control and pain management	Symptom control and pain management
Care provided by a team of health care practitioners	Care provided by a team of health care practitioners
Usually provided in hospitals but it could vary	Different settings
Not based on life expectancy	Limited life expectancy
Covered mostly by private insurance	Covered by Medicare, Medicaid and private insurance

Aid-in-Dying vs. Euthanasia

Aid-in-Dying

- “Practice of a physician providing a mentally competent, terminally ill patient with a prescription for medication which the patient may choose to ingest to achieve a peaceful death and thereby avoid further suffering.”

Morris v. Brandenberg (N.M. trial court 2014)

Euthanasia

- Mercy killing; causing another’s death for a beneficent reason (e.g., when he/she wants to die)

State of the Law

- All states prohibit euthanasia.

- 49 of 50 states and the District of Columbia prohibit suicide assistance, with varying definitions and applications.

- Hawaii is the exception.

    - A panel of judges and legislators there has opined that physicians may provide such assistance within the existing law in Hawaii. (*Scott Foster, Expert Panel Concurs: Hawaii Physicians Can Provide Aid in Dying, Hawaii Reporter, October 5, 2011)*

Judicial Rulings

- The Montana Supreme Court has ruled that Montana’s statutory prohibition of suicide assistance does not prohibit aid-in-dying defined as competent, terminally ill patients’ receiving assistance from physicians in ending their lives.

- A trial court in New Mexico has ruled that state’s statute unconstitutional under the state constitution, which guarantees not only “the rights of enjoying life and liberty” but also “the right to seek[] and obtain[] happiness.”

- Result: in those jurisdictions, the practice may occur.

State Statutory Authorizations

Procedurally DETAILED

- Oregon
- Washington
- Vermont until July 1, 2016

MEDICAL PRACTICE STANDARDS

- Vermont as of July 1, 2016

Detailed Statutory Process

- “First generation” of statutes -- Oregon, Washington and Vermont until July 1, 2016
- Specified patient qualifications
- Multiple patient requests
- Several physician documentation requirements
- Department of public health provides reports on the Internet
- As end result, patient obtains a prescription that he or she may use to end his or her own life
- Not uncommon for patient to pass away before choosing to exercise this power

Medical Practice Standards

- As of July 1, 2016, the section of the Vermont statute imposing stringent procedural safeguards is repealed.

- Statutory provisions effective as of that day provide that a “physician with a bona fide physician-patient relationship with a patient with a terminal condition” is neither engaging in unprofessional conduct when, nor civilly or criminally liable for prescribing a lethal dose of medication to, the patient in accordance with the law.

- Physician must ensure patient has decision-making capacity.

- Physician must inform that patient of “all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control.”

Aftermath:
Clinical Practice Guidelines

- Practice is occurring governed by the standard of care, as one must conclude it is in at least Montana and a portion of New Mexico, and as it will be in Vermont after July 1, 2016.

- Interest groups recognize need for practice guidelines.

- Working group has developed – American Medical Women's Association has endorsed.

Aid in Dying, Palliative Care and Hospice Care

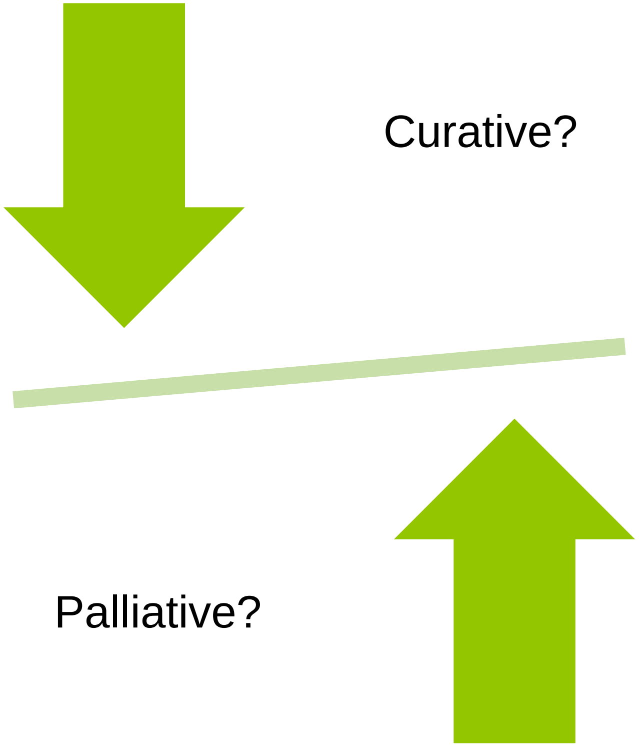
- Increased focus on pain relief.
- In states where practice is statutorily authorized, physicians are required to advise about pain relief, palliative care, and hospice, and utilization has gone up.

Issues Impacting Access, Quality and Cost of End-of-Life Care

- Dichotomy of payment
- Minority issues

Dichotomy in Today's Hospice Benefit

- Payment for palliative vs. curative services

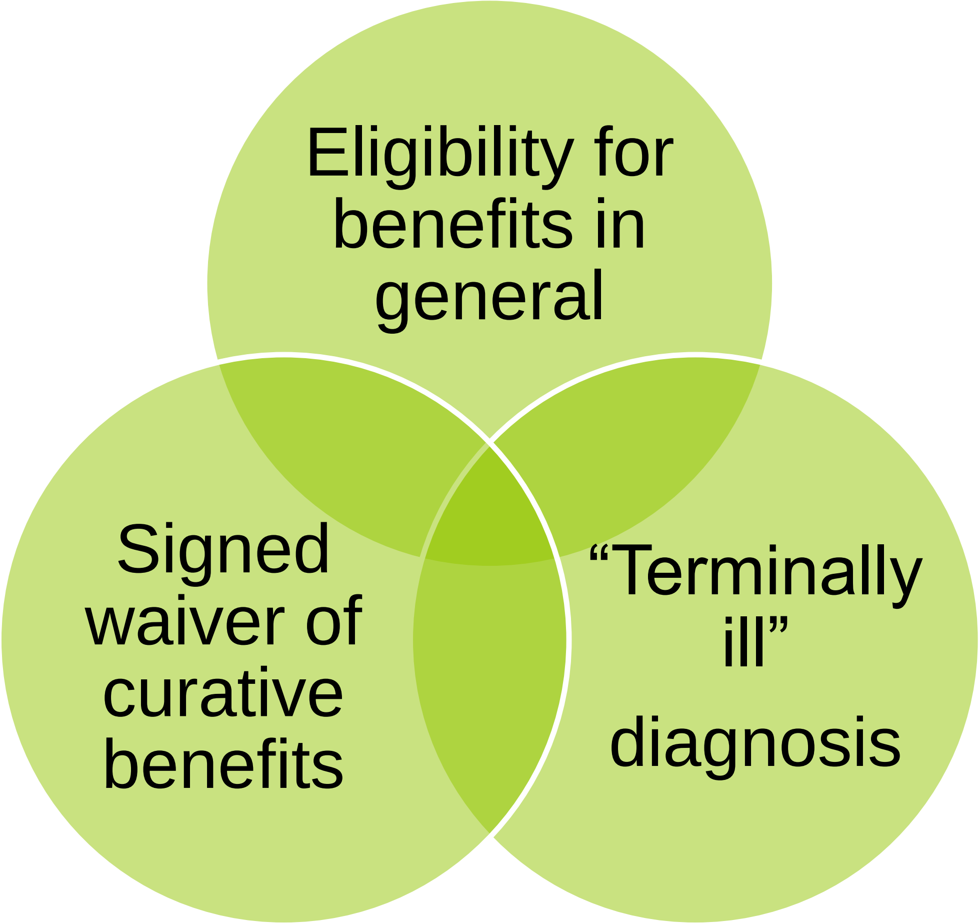


Curative?

Palliative?

Medicare* Hospice Coverage

* And Medicaid and Private Insurance, for the Most Part



Eligibility for benefits in general

Signed waiver of curative benefits

"Terminally ill" diagnosis

Findings of Research on Concurrent Care As a Model for Hospice Coverage

Earlier Access

Earlier Peace and Comfort

More Comfort and Cost-Effectiveness

Religious and Minority Groups

- Aid-in-Dying
- Disparities
- Potential Consensus

Disparate Impact

- Religious Groups

- Ethnic and racial minorities suffer disproportionately from certain cancers and serious chronic illnesses.

- The percentage of minorities that utilize hospice services and palliative care is also disproportionately low.

  - **9% African Americans**
  - **5% Hispanics**
  - 1.3 % Asians
  - 0.3% American Indians

- Minorities receive end-of-life care inconsistent with their stated wishes.

Why are racial and ethnic minorities not using palliative care and hospice?

- Ethno-Cultural
- Individual
- Institutional

Potential Impact on Minorities and Areas of Consensus

- Removing the dichotomy
  - Data collection

- Informing about the options?

Questions?

Resources

- Cerminara, K.L. & Perez, A.M. (2000). Therapeutic Death: A Look at Oregon's Law Legalizing Physician-Assisted Suicide. *J. Psychology, Public Policy & Law*, 6: 503-525.

- Meisel, A., Cerminara, K.L., & Pope, T.M. (2004 & annual supplements). Chapter 12: Criminal Liability: Assisted Suicide and Active Euthanasia, *in The Right to Die: The Law of End-of-Life Decisionmaking* (3rd ed.). New York: Wolters Kluwer-Aspen Law & Business.

- Tucker, K. (2012). Aid in Dying: Guidance for an Emerging Practice. *CHEST*, 142(1): 218-224.