

## VIEWPOINT

## HEALTH CARE POLICY AND LAW

# Early Experience With the California End of Life Option Act

## Balancing Institutional Participation and Physician Conscientious Objection

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**Effective since June 9, 2016**, the California End of Life Option Act allows physicians to provide prescriptions for a lethal dose of medication to patients with a terminal illness, decision-making capacity, and a prognosis of less than 6 months to live. The patient can ingest the medication and end his or her life.<sup>1</sup> The act outlines specific processes for physicians, patients, and health care systems to ensure that patients to whom the law applies receive all needed information regarding their options for end-of-life care and are neither impaired nor coerced into making such a profound decision. Although similar to laws in Oregon and Washington, the California law will sunset in 10 years if the state takes no further action. In the 2016 elections, Colorado became the sixth state to pass such legislation.

At Stanford, where we work, as of April 1, 2017, 13 patients have been prescribed lethal medications under the End of Life Option Act and 6 are known to have died by ingesting these medications since the law's passage. Physicians at Stanford have several options for this prescription, including secobarbital by itself, a compounded liquid mixture of phenobarbital/morphine/chloral hydrate, or the ingestion of diazepam, propranolol, morphine, and digoxin.

Stanford Health Care is participating in the End of Life Option Act. Participation by individual physicians is voluntary, however; they may opt out of prescribing or consulting for physician-assisted death. Institutions may also choose to opt out of the act, and not allow any of their employees to serve as prescribers, as the Department of Veteran's Affairs and Dignity Health, a Catholic health system, have done. In Colorado, Catholic health systems have opted out, and nearly one-third of the hospitals will not offer physician-assisted death, creating a major challenge to access.<sup>2</sup> Some hospice organizations in California have opted out as well, meaning that their medical directors cannot write a lethal prescription as hospice employees nor be present with the patient at the time of death (from the lethal prescription).

Although physicians should clearly not be forced to write lethal prescriptions, such conscientious objection affects access to physician-assisted death. There is a potential for injustice because similar patients with similar diseases and life expectancies may find wide variation in the availability of prescriptions for lethal medications. For a participating institution, such as Stanford, the potential for injustice raised the question of the institutional obligation to patients, should their pri-

mary physician opt out. In general, our policy about conscientious objection allows a physician to opt out of directly providing a service or medication that he or she objects to, but requires indirect involvement and an institutional commitment to finding another physician who is willing to provide the care. For example, if a physician in the emergency department objects to providing Plan B to a rape victim, the hospital must make every effort to respect the physician's ethical stance, without affecting the patient's care. The situation is different when physicians exercise clinical judgment, such as when a surgeon decides that a patient is not a surgical candidate. In this situation, there is no institutional obligation to find another surgeon for the patient.

A major operational challenge has been finding a physician willing to prescribe for another physician's patient and the process for that physician to write the prescription. The number of physicians willing to prescribe for others' patients has been small. The social workers and ethics consultants charged with identifying alternative prescribers found that they were burdened by taking on this responsibility, particularly for a patient from another division or department. Physicians cited concerns for being known as prescribers for physician-assisted death. Moreover, after agreeing to see the patient, they often experienced an undue urgency given the patient's prognosis and the fact that their primary physician had opted out.

After reviewing the first few cases, we addressed this urgency in subsequent cases. An alternate physician should have sufficient time and clinic visits to establish a relationship with the patient and feel confident that he or she can fulfill the necessary components of the physician-assisted death process. Although the law describes the required process elements in detail, it does not set a maximum or minimum required number of visits.<sup>1</sup>

Our experiences have also raised questions about what constitutes conscientious objection and when the institution will take on an obligation that is not required by the law.<sup>3-6</sup> A physician may place additional requirements on the process beyond the elements in the law, such as a longer waiting period between visits or insisting on psychiatric evaluation for all patients requesting physician-assisted death.<sup>7</sup> These additional requirements do not constitute a formal objection. Nonetheless, they may preclude some patients from receiving a prescription. Experience in Oregon suggests that re-

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quirements that go beyond the law are a major obstacle for patient's seeking physician-assisted death.<sup>8</sup>

One case raised questions about the distinction between conscientious objection and clinical judgment. A patient had advanced cancer and was receiving total parenteral nutrition. His prognosis was a matter of weeks, and he was interested in physician-assisted death and obtaining the prescription. He was also aware that if he stopped the parenteral nutrition he would likely die within days, a shorter period of time than for the process of physician-assisted death. Although not opposed to physician-assisted death in principle, his primary physician believed that discontinuing the parenteral nutrition would be a better option. This clinician saw physician-assisted death as a last resort, appropriate only when the patient was ready to discontinue life-sustaining treatment. Thus, physician-assisted death was not medically indicated in her view.

In other instances, patients who requested physician-assisted death were receiving ongoing disease-directed therapy. Physician-assisted death was not an indicated option, based on the judgment that their prognosis was longer than 6 months or that they lacked the ability to self-administer the medication (both required by law). In those cases, it was felt there was no institutional obligation to find an alternative physician since the patient did not meet the legal requirements specified.

The patient with advanced cancer, however, seemed to meet the requirements, because even with artificial nutrition, his prog-

nosis was less than 6 months. He wanted control over the manner of his death and options including both discontinuation of artificial nutrition and physician-assisted death. Discussion between the ethics consultant (D.M.), the consulting palliative physician, and the attending oncologist led to the conclusion that the physician's view about the appropriateness of physician-assisted death was clinical judgment, not conscientious objection. Although the patient initially expressed frustration and a desire to act quickly, he decided to discontinue artificial nutrition and was enrolled in hospice; he did not continue to pursue physician-assisted death.

Our early experiences with California's End of Life Option Act have uncovered multiple challenges with formal implementation, particularly the challenge of reconciling an institutional commitment to participate with the legal and ethical requirement that participation by individual physicians is voluntary. Although Stanford committed to the referral of established patients to a physician willing to prescribe, the details of finding an alternate prescribing physician remain complicated owing to the perceived stigma of that role and the challenge of establishing care and prescribing for a patient of a colleague. In some instances, even deciding what constitutes conscientious objection has been a practical challenge. Health care institutions that participate in physician-assisted death under applicable state laws should develop appropriate mechanisms to review, evaluate, and provide real-time guidance to help address such challenges.

#### ARTICLE INFORMATION

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