Implementing EOLA at Stanford
Marina Martin, MD, MPH

Dr. Martin (marinam@stanford.edu) is clinical assistant professor, section head, Geriatric Medicine, Department of Medicine, Division of Primary Care and Population Health, Stanford University School of Medicine.

In August 2016, I met a retired physician in his 80s who was dying of prostate cancer that peppered his entire skeleton, compressing his spinal cord. He had just been discharged from the hospital to the skilled nursing facility, part of the senior community where he had lived for a decade, and I became his physician there. At that first visit, he was quiet, thin, gracious, and in pain.

A few days later, Dr. B- and his son invited me to close the door and sit with them. They asked me about dying. Dr. B- knew how he wanted to go—by taking medication on a day of his choosing that would quickly put him into a sleep from which he would never wake. He had heard that doctors sometimes helped patients with this unofficially, and wondered if that was the best way, or did I know anything about California’s new law permitting physicians to prescribe medication to aid in dying?

At times when I’ve encountered uncertain moments in physician-patient-family discussions, I resorted to “duck” mode—placid demeanor above, furious churning below. (“Oh no, where can I find my hospital protocols about the new law? Why didn’t I pay closer attention when it was discussed?! Can I, should I, will I do this?”) Dr. B- let me know that he had a few weeks’ worth of loose ends to tie up and family and friends to hug goodbye, and then he would be ready. I excused myself to get him brochures about the End of Life Act (EOLA) in California, closed the office door, and sat for a few minutes with the churning inside my head.

As a geriatrician, I’m a dedicated advocate of palliative and hospice care during the last months of life. Many of my patients die in their homes or long-term care facilities under hospice care, for which patients and families are typically very grateful. The EOLA had just become California law. I passively supported this individual right, but told myself and others that if hospice care were done properly, no one would need to avail themselves of this option.

After I frantically searched for the protocols to guide me through the labyrinth of steps that is the EOLA process, I went back to Dr. B-’s room and advised him to start hospice care. At minimum, the hospice team would help manage his severe bone pain during the required 15-day waiting period between his EOLA request and receiving the prescription. He agreed, and I was quietly thankful for the time I now had to internally process these events.

We increased the opiate doses. Intense bouts of nausea ensued, along with odd, powerful myoclonic jerks. These required clonazepam, which made him sleepy when he wanted to be alert to enjoy his grandchildren visiting from the east coast. He developed unrelenting hiccups. It became hard to tell which symptoms were from his aggressive cancer and which from the medications intended to provide him relief.

Initially, when I visited Dr. B-, he was wide-eyed with pain. Mercifully, with the hospice team’s help, the pain lessened. But his intention to take the medication to end his life did not lessen. I kept hoping he would change his mind, as his weight dropped steeply and his temples came into sharper relief. I believed he might not last the 15-day waiting period.

But he did. On day 15, a retired physician, close personal friend, and pool table adversary came to visit Dr. B-. Dr. B-’s son and his friend witnessed him sign the document stating that he wished to take a prescription medication to end his life. Although three of us were physicians, this decision did not feel at all medical—it was an experience of intense, life-affirming gravity, and, to me, it now felt completely right.

Over the days preceding, a physician colleague familiar with the legislation helped me find everything available about the medication options, how to prepare and take the medication, and what to expect. My worst nightmare was that something would go wrong at this critical moment in the life of Dr. B- and his family. I was reminded more potently than ever that this moment has an importance approaching that of birth, yet shepherding mothers and babies through that transition is performed by highly-trained clinicians. I was not alone, however, thanks to physicians in other states who had shared their knowledge through advocacy organizations. This was not something I could look up on UpToDate.

At the last minute, there was a surprise—the medication used most commonly for this purpose has been secobarbital, which would cost $3,700 because the manufacturer doubled the price one month after the physician aid-in-dying legislation was proposed in California.1 I called a dozen pharmacies to see if any could compound a new regimen from Washington state consisting of high doses of diazepam, propranolol, and morphine powders, at a fraction of the cost of secobarbital. The pharmacies were as unprepared as I was for the practical requirements of this new law.

continued on page 2
We decided to use secobarbital because it was more readily available. Dr. B’s son paid for it without telling his dad the cost, and drove an hour each way to the nearest pharmacy that could supply it within 48 hours. He then carefully cut and tapped out the powder from 100 capsules. If this seems like a painful burden to place on an already grieving family member, it is. But we were carried along by the Dr. B’s determination to die in the way he believed best and his strength fortified us as we walked by his side.

On September 1st, Dr. B refused his wheelchair, and propelled himself using a walker up a small hill from the skilled nursing facility to his apartment in the senior community. He did not wish to have any physician or hospice staff with him. His two sons and two brothers sat by his bedside when he swallowed the bitter powder in applesauce, drifted off into a coma in 10 minutes, and quietly ceased breathing two hours later. His son called me afterwards to let me know, and when I hung up the phone my eyes clouded with tears for the intense beauty and import of this moment.

A month later, my own father died of brain cancer on a different continent, in a hospital because there is no palliative or hospice care where he lived. He was given high-flow oxygen and intravenous fluids when he had pneumonia and was unable to eat or drink in his last few days. I cried many different kinds of tears then, among them tears of frustration because he—and we family members—had so little say in his care over the last days of his life, and his physical suffering was deeper and lasted longer than it needed to.

While the physiology of birth and death is essentially unvarying, no two stories of birth or death are the same. Dr. B’s is a story of a quietly brave man who asked for his right to die in his own way, and was heard and supported because the medical world is evolving, in some places at least. It is also a story of how a patient changed his physician—from one who would not stand in the way of a person’s right to end his life with medication, to one who could walk with him the whole way, using the tools of her profession to smooth his chosen path.²

References

The author wishes to thank Dr. Rex Jamison and Scott Browning for their invaluable contributions to this essay.