Law: Right to Try, Right to Die, Right to Deny

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Disclosure statement:
“Dr Gianutsos has no actual or potential conflict of interest associated with this presentation”
What Will We Be Discussing?

- Right to Try - Right-to-Try Unapproved Drugs Law (Federal)
- Right to Die - Assisted Suicide Laws (State)
- Right to Deny - Pharmacist Conscience Clauses (State)

Learning Objectives

- At the completion of this activity, the participant will be able to:
  - Describe how right to try laws differ from FDA sanctioned early access programs.
  - Discuss the benefits and risks for patients who may take advantage of right to try laws.
  - Describe state assisted suicide programs.
  - Identify the characteristics of conscience clause programs for pharmacists.
  - Characterize how conscience clauses and patient participation in right to try and assisted suicide programs may affect pharmacy practice.
Right-To-Try (RTT) Laws

• Existed in 41 states (including CT).
  • Other 9 were considering.
• Federal Law Approved
  • By Senate in 2017
  • Final version approved by the House on May 22, 2018 by a vote of 250-169, 22 Democrats joining all 228 Republicans.
  • Signed into law by President Trump on May 30, 2018.

Question

• Should terminally ill patients be permitted to try unapproved/investigational drugs?
  • A. Yes.
  • B. No.
  • C. Not Sure.
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https://health.wusf.usf.edu/post/right-try-may-be-hard-implement#stream/0

https://www.researchgate.net/publication/308045230_Omics-Informed_Drug_and_Biomarker_Discovery_Opportunities_Challenges_and_Future_Perspectives/figures?lo=1
What is the RTT Law?

- **Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017.**
  - (Sec. 2) This bill amends the Federal Food, Drug, and Cosmetic Act to exempt, from specified requirements and restrictions under that Act and other laws, the provision of certain unapproved, investigational drugs to a terminally ill patient who has exhausted approved treatment options and is unable to participate in a clinical trial involving the drugs.
  - The manufacturer or sponsor of an eligible investigational drug must report annually to the Food and Drug Administration (FDA) on any use of the drug in accordance with these provisions. The FDA shall post an annual summary report of such use on its website.
  - The bill limits the liability of a sponsor, manufacturer, prescriber, or dispenser that provides, or declines to provide, an eligible investigational drug to an eligible patient in accordance with the bill.

Definitions

- **Eligible Patient:** A patient--
  - (A) who has been diagnosed with a life-threatening disease or condition.
    - The term life-threatening is defined* as (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and (2) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical trial analysis is survival.
  - (B) who has exhausted approved treatment options and is unable to participate in a clinical trial involving the eligible investigational drug, as certified by a physician.
- **Eligible Investigational Drug:** An investigational drug—
  - (A) for which a Phase 1 clinical trial has been completed;
  - (B) that has not been approved or licensed for any use.
Exemptions

• “the Secretary may not use a clinical outcome associated with the use of an eligible investigational drug pursuant to this section to delay or adversely affect the review or approval of such drug.”
  • Unless “use of such clinical outcome is critical to determining the safety of the eligible investigational drug; or \( (B) \) the sponsor requests use of such outcomes.”

Existing FDA Programs

• Accelerated Approval
  • Priority Review
  • Breakthrough Therapy
  • Accelerated Approval
  • “Fast Track”
• Accelerated Access
  • Various “Compassionate Use” Programs
General Requirements for Expanded Access

• Patient must have a serious or immediately life-threatening disease or condition.
• Have no comparable or satisfactory alternative therapy.
• The potential benefit must justify the potential risks of the treatment.
• Providing the drug must not interfere with or compromise the drug development program.


How Did We Get Here?

• First efforts in 1962 – informal program on patient-by-patient basis.
• Throughout most of the 1980s, people with AIDS and their advocates were highly critical of the FDA and other government agencies involved in drug development.
  • There was a perception that government scientists were more interested in maintaining the scientific standards of clinical trials than in providing new options for patients who were dying as a result of HIV infection.
• First regulations in 1987.
• In October 1988, the FDA announced immediate implementation of a formal plan to reduce the time required for human testing of drugs for life-threatening and severely debilitating diseases, such as AIDS, Parkinson's disease, and certain aggressive cancers.
Prompted by AIDS Activists

Demonstrators from the organization ACT UP protest in front of the headquarters of the Food and Drug Administration. (1987)


Why is it Needed?

• RTT removes FDA from decision.
• Advocates:
  • Patient autonomy.
    • “there’s no more fundamental right than the right to save your own life. RTT guarantees that freedom by ensuring that patients are in control of the treatment they receive when facing terminal diagnosis.” Goldwater Institute.
  • FDA is an obstacle.
Pause to Ponder

• Ms. X is a 45-year-old professional woman with a teenage son who is a long-time patron of your pharmacy.
• She has been diagnosed with late-stage cancer and has been given less than a year to live.
• Her treatment with conventional therapy including anti-neoplastic drugs has not proven to be successful.
• She has learned of a novel biologic agent that has just completed Phase I clinical trials.
• As her trusted advisor on drugs, she asks for your advice about seeking access to this new drug.
• What do you tell her?
Broad Opposition

• RTT Act was opposed by the American Cancer Society and the American Lung Association.
• Four former heads of the FDA expressed their opposition to the bill. In a joint statement issued while Congress was considering RTT legislation.
  • “There is no evidence that either bill [Senate or House version] would meaningfully improve access for patients, but both would remove the FDA from the process and create a dangerous precedent that would erode protections for vulnerable patients.”

What Harm Can it Do?

• General issues raised by RTT detractors:
  • The risks caused by removing the FDA from the process.
  • RTT is unnecessary
  • RTT will interfere with clinical trials and hinder a broader distribution of therapeutic agents
  • It does not accomplish its intended goals
  • It is a slippery slope to generally weakening FDA oversight of drugs
What is the Risk?

- Most new agents fail in the clinical testing phase.
  - In at least one analysis, 50% of agents making it to Phase III of clinical testing did not make it to the market.
    - The problem is not unique to the United States; a recent study in the United Kingdom found that only 18% of drugs advanced from Phase II to Phase III.
    - Success rate for oncology drugs is about 5%.
  - Clearly, completing Phase I is no guarantee of success or safety.

Right to Ask

- Companies are not required to comply with the request.
- Some companies (e.g., Pfizer and Janssen) will make their investigational drugs available only through a process that involves FDA oversight (i.e., existing compassionate use programs).
- Many experts believe most companies will not release drugs until Phase III.
Exploitation?

• “Dying patients and their families are vulnerable; we could become victims to the likes of snake oil salesmen offering ‘treatments’ that could kill rather than cure.”

• “Treatments that work need to be monitored so their success can push forward randomized clinical trials that will decide if they work on a broader scale. And we need to know when treatments don’t work, so that the deaths of these patients are not in vain and that their failures aren’t repeated.”
  • Dr. Steffanie Strathdee, Associate Dean of Global Health Science at the University of California, San Diego

“Slippery Slope”

• Who else?
• Will it weaken FDA oversight?
Next Phase?

• “N of 1 trials” (personalized trials)
• Before Phase 1
• Company files “expanded access IND”
  • *In vitro* and animal data
  • Generally antisense oligonucleotide targeted at the gene mutation
    • Customized therapy to specific gene mutat
• $\$\$
  • Self funded or internet funding.

Has It Helped?

• Drug companies are required to submit an annual summary that details the use of an investigational drug under Right to Try.
  • The information has not yet been made public.
  • FDA indicated the agency has proposed a rule to outline the actual requirements of reporting.
  • Remains unclear at this point.
• As of Sept 2019 two participants (one is named)
Question

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  - C. Not Sure.

Assisted Suicide (“Death with Dignity”)
“Dr. Death”

- Championed by Dr. Jack Kevorkian who assisted at least 130 patients between 1989-1998.
  - Attached pts to euthanasia device that he invented.
  - Delivered saline, thiopental, KCl.
  - Convicted of second-degree murder in 1998; served 8 years of 10-25 year sentence.

General Concept

- Death with dignity statutes allow mentally competent adult state residents who have a terminal illness with a confirmed prognosis of having 6 or fewer months to live to voluntarily request and receive a prescription medication to hasten their inevitable, imminent death.
State Laws

- 8 states (plus DC) have laws “Death with Dignity” Laws
  - Oregon.
  - California
  - Colorado
  - DC
  - Hawaii
  - Maine
  - NJ
  - Vermont
  - Washington
  - Montana is evolving.

Legal Efforts

- First state Oregon.
  - Despite SC upholding state bans.
  - Bush administration attempted to ban the practice by deeming PAS to be an ‘illegitimate medical practice’, a violation of the Controlled Substances Act. In 2006, the Supreme Court overruled this effort in Gonzalez v Oregon, reaffirming that states have the right to legislate over the practice of PAS.
  - More than 1500 Oregonians have been prescribed medications.
Oregon

• “An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.” (Oregon Revised Statutes Ch. 127.805 §2.01)
  • "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.
• Two physicians must confirm the patient’s residency, diagnosis, prognosis, mental competence, and voluntariness of the request.
• Two waiting periods, the first between the oral requests (15 days) and between receiving and filling the prescription (48 hours).

Oregon (2)
Why?

• Data from Oregon:
  • Most common reasons for requesting medical aid in dying were:
    • NOT unbearable pain and suffering.
    • Loss of autonomy (97.2%)
    • Inability to engage in enjoyable activities (88.9%)
    • Loss of dignity (75.0%)
    • Many are clinically depressed.

• Data from Washington
  • The most common reported illnesses were cancer (79%), respiratory disease or other illnesses (12%), and amyotrophic lateral sclerosis (9%).

Drugs

• Usually barbiturate (most commonly pentobarbital [10 gms.] or secobarbital [9 gms.])*.  
• Practice Points
  • Usually prescribed as liquid, to be mixed with juice due to bitter taste.
  • Should be taken on empty stomach to increase absorption.
  • Often preceded by anti-emetic (e.g., metoclopramide).
  • Reconsideration after dosing is a medical emergency.

* Usual dose is 100 mg.
Dispensing

- In Oregon, physician may dispense if registered dispensing practitioner.
- If sent to pharmacy, pharmacy must be notified in advance.
  - May be dispensed to pt, physician or agent (e.g., family member).
  - Pharmacist must provide counseling.

Pharmacist Duty

- In Oregon, pharmacists are required to complete and submit, within 10 calendar days of dispensing a lethal medication dose, a pharmacy dispensing record form with the following information:
  - Patient’s name and date of birth;
  - Prescribing physician's name and phone number;
  - Pharmacist’s name, address, and phone number;
  - Medication name and quantity dispensed;
  - Dates the prescription was written and dispensed.
- In Washington, 30 days.
Other States?

More Trauma

- Cost of secobarbital increased more than 7-fold between 2010-2016.
  - Lethal dose may cost up to $5000.
    - Manufacturer (Valeant) accused of price-gouging.
  - Generally not covered by insurance, Medicare or Medicaid.
  - Pts turning to compounding pharmacies or alternatives.
Other Drugs

- Phenobarbital + morphine + chloral hydrate.
- Cocktail of diazepam + morphine + digoxin + propranolol.
- Midazolam.

- Wide span of drug effect.
  - Range of 1 minute – four days. (Oregon)

Concern

- Informed consent?
- Possibility of abuse (e.g., coercion from family members) cannot be adequately assessed.
CT

- In Connecticut, a supreme court judge rejected the request of two physicians (who feared prosecution) to prescribe lethal doses of medication in the case of Blick v. Connecticut in June 2010.
- Ct - should be left to legislature.
  - Bill introduced in January 2019; has not made it out of committee.

Conscience Clause
Conscience Clause

• Health providers can generally refuse services based on personal beliefs.
    • Some states subsequently passed laws designed to allow physicians and other direct providers of health care to refuse to perform or assist in an abortion, and hospitals to refuse to allow abortion on their premises.
    • Expanded to sterilization.

Pharmacists

• Conscience clauses give *pharmacists* the right to refuse to perform certain services if it violates their religious or personal beliefs or values.
  • Most common: refusal to provide emergency contraception.
  • State laws vary – some provide patient protection, some do not, some do not permit pharmacists to refuse service.
Pause to Ponder

• A Michigan woman says a pharmacist for a regional supermarket chain denied her medication prescribed to treat her miscarriage because it was against his religious beliefs.
  • Prescribed Misoprostol (off-label).
  • Pharmacist - “As a good Catholic male,” he could not “in good conscience fill the prescription” because he thought she wanted to use it to end her pregnancy.
  • Woman – “A pharmacy should not be able to deny patients medication prescribed by their doctors based on the personal beliefs of a particular employee.” Asked for another pharmacist or to transfer Rx; pharmacist allegedly said no. Claims he “berated” her.
  • Physician - "crucial for her to take ... in a timely manner to avoid having to undergo a more invasive surgical procedure."
    • She had to travel 3 hours to her home pharmacy to get Rx filled.

Question

• What would you do if you were the pharmacist on duty?
  a. Fill the prescription as you would any other prescription.
  b. Refuse to fill the prescription.
  c. Ask another pharmacist to fill the prescription.
  d. Fill the prescription but provide special level of counseling.
Examples

• Wisconsin - Requires that a pharmacy dispense lawfully prescribed contraceptive drugs and devices and shall deliver contraceptive drugs and devices restricted to distribution by a pharmacy to a patient without delay.

• Washington - Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies, or provide a therapeutically equivalent drug or device in a timely manner consistent with reasonable expectations for filling the prescription.
Examples

• Arkansas - Physicians, pharmacists and private institutions cannot be required to fill a prescription if their refusal is based on religious or conscientious objection.

Examples

• New York - In the case of a pharmacist who realizes they have a moral objection to providing a certain medication, the pharmacist has a professional obligation to take appropriate steps to avoid the possibility of abandoning or neglecting a patient. When a pharmacist begins practice in a professional setting, they should take steps that may include notification to the owner and supervising pharmacist if their beliefs will limit the drug products they will dispense.

• California – A pharmacist may refuse to dispense a drug on ethical, moral or religious grounds but the pharmacy must establish protocols to ensure that the patient has timely access to the prescribed drug.
Federal

• No Federal Law
• Supreme Court refused to hear an appeal from 9th Circuit COA decision (2015) that Washington regulation that all pharmacies “must stock and dispense emergency contraceptive drugs” regardless of religious or moral reasons did not violate religious freedom.

• But guidelines.
  • Enforced by Office of Civil Rights at HHS.
  • In 2018, OCR issued proposed rule.
    • Would increase protection for religious health care practitioners.
    • “The Department proposes to revise regulations previously promulgated to ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of such Federal laws.”

Connecticut

• No law.
Pause to Ponder

• Would you fill a prescription for a terminally-ill patient who is contemplating committing suicide?