Physician Assisted Suicide

Disclosures:
None
Warning!!
What is the issue?
What is the definition?
Where is this legal?
What has been the experience in Oregon?
Why do patients request assistance?
What are the problems?
What are the alternatives?
What is our ultimate goal?

• “I’d rather die while I’m alive, than live when I’m dead.”
  • Jimmy Buffet
• “Assisted suicide promotes the belief that people would rather be dead than disabled.”
  • John Kelly, quadriplegic

• “Ethics is about what we do when what to do is up to us.”
  • Aristotle (paraphrased)
What is the issue?

• To relieve suffering

What is the definition?
Terminology

- Physician-assisted suicide
- Physician-assisted death (physician-aided death)
- Physician-aid-in-dying
- Physician-administered death (euthanasia)
- Medical aid-in-dying (Canada)

Cognitive illusion

- “the effect of using different terminology to describe the same outcome”
SUICIDE

• “The act of taking one’s own life voluntarily and intentionally”

• “…the phrase ‘physician-assisted death’ is both euphemistic and ambiguous. We are not talking about assisting dying. We are talking about …. intentionally helping someone to end their own life.”
  • John Keown
    • Rose Kennedy Professor
    • Kennedy Institute of Ethics
    • Georgetown University
Physician Assisted Suicide Requirements

Terminal illness with six month prognosis

Competence and intact judgment

Voluntariness

Ability to perform the life-shortening act

Why do patients request assistance?

• Existential
  • Loss of autonomy
  • Inability to participate
    • enjoyable desired activities
  • Loss of dignity
  • Spiritual suffering

• Fear of pain
• “A cry for help”
• “Are you going to help me or are you just going to kill me?”
Where is it legal?

- Oregon
- Washington
- Montana
- Vermont
- California
- Colorado
- Washington, DC
- Hawaii

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What has been the experience in Oregon?

Statistics – 2001

- Intervention most likely to result in withdrawing request for PAS
  - Referral to hospice
- Small-town physicians less likely to write script for PAS
- “burdensome” or “depressed” patients, less like to receive script
- After comprehensive palliative care was intensified
  - 46% who requested PAS changed their minds
- More likely to receive script
  - Enrolled in hospice
  - “control” as reason for request
Statistics - 20 years

• Written prescriptions – 1967
• Taken medications – 1275 (65%)
• 0.2% of deaths in OR
• Median age: 72
• Majority over 55
• Diagnosis:
  • Cancer – 78%
  • ALS 440/10,000 people
• With same underlying disease
  • College/graduate degrees predominate

“20 Years of Oregon’s DWDA”

Figure: DWDA prescriptions and deaths, 1998 to 2016.
“Deaths among FFS Medicare Beneficiaries”

- 90% in hospice
- Median time from ingestion to death
  - 25 minutes (1 minute to 104 hours)
  - GI cancers
- Seven regained consciousness
- Strongest predictor of request for PAS
  - Low self-assessed spirituality score
Statistics - 2000-2017

• 0.6% all licensed OR physicians wrote at least one script (max: 85)
• 22 were reported to Oregon Medical Board (all exonerated)
  • Incorrect documentation
  • Incomplete written consent
  • Lack of 2 witnesses
  • Not following mandated waiting period
• Psychological assessment referrals – 5% and declining

Reasons for Oregon PAS Requests

• 89% - loss of autonomy
• 89% - inability to engage in activities that make life enjoyable
• 77% - loss of dignity
• 48% - loss of bodily control
• 42% - burdensome to family
• 25% - inadequate pain control
• 4% - financial concerns
  • <2% lacked health insurance
Psychiatric/psychological evaluations

• 2.3% receiving lethal prescriptions for PAS in Oregon were referred

Parallel “ordinary” suicides?

• 43,000 Americans committed suicide – 2016
• # of “ordinary” suicides increased in parallel with PAS
• Correlation or causation?

• US Suicide Rates/100,000 population
Many LTC facilities will not allow PAS on-site

Important questions

- What role did depression play?
- Were alternative options fully presented?
- To what extent were family members unduly influencing patient choices?
- What was the rigor of the psychological evaluation for depression?
- Did prescribing physician consult with PCP, if not the same?
- Do insurance companies have a conflict of interest, $$?
- What % of cases were reported?
Two sides of the question

• Opponents
  • Look for evidence of abuse
• Proponents
  • Look for signs of reassurance

What are the problems?
First Requirement: Six month prognosis

- Imprecise
- Not clearly distinguishing
- Who is included/excluded?
- Definition options:
  - A – This specific person is nearly certain to die in six months?
  - B – This specific person is very likely to die within six months?
  - C – This specific person is more likely than not to die within six months?
  - D – 51% of people with a similar condition will be dead within six months?

Second Requirement: Possesses decision-making capacity (competence/intact judgment)

- Assessment based on:
  - Understanding
  - Reasoning
  - Appreciation of consequences
- 2/3 consulting psychiatrists
  - “decision-making evaluation is more challenging than other types of evaluation”
- 54% hospice patients (IP/OP)
  - Significant cognitive impairment
- Unique tool set
  - Prolonging health vs. hastening death
Assessing decision-making capacity

- Inter-rater variability
  - Reflects different training backgrounds
- Low reliability in middle of distribution curve
- High reliability at tails of distribution curve
- Low vs high-threshold evaluators
- What about the “unbefriended?”
  - Substituted Judgment
    - Living Will/DMPOA-Health Affairs
    - Best Interests

Assessing decision-making capacity

- What is method for evaluation?
  - Standard checklist?
  - In-depth interview?
  - Private stand-alone community physician vs. institution’s systematic procedure
- Process: (not required for any other procedure)
  - 1-Mental disorder?
  - 2-Impaired judgment?
  - 3-Causally linked?
Third Requirement: Voluntariness

- Two conditions:
  - Intentionality
  - Freedom from controlling influences (Coercion)
    - Illness itself may be considered coercive
- Difference:
  - Voluntariness to consent to physician-proposed procedure
    - GOAL = health
  - Voluntariness to consent to patient-declared procedure
    - GOAL = death

Fourth Requirement: Ability to Self-Administer

- Paralyzed
-ALS
- Can’t swallow
- GI Cancers
More issues....

**Governmental involvement**

- “This method of relieving suffering puts the state government in the position of deciding who must live and who may die based on judgments about the patient’s life.”
  - David Orentlicher, Lobeaga Law Firm
    - Professor, University of Nevada, Las Vegas
- If PAS is a “right,” is it still a medical practice?
  - If a LEGAL right, why are physicians the chosen instrument for the task?
  - “Assisted-suicide practitioners”
Monitor system

- Laws
  - Protection for physicians
    - Protected exception to criminal prohibition against homicide
- No state has a monitoring system
  - Self-reporting of PAS

Extension Expansion

- Extending/expanding
  - To vulnerable populations?
  - Open to abuse?
  - To those suffering unbearably, but not terminal?
    - Not in the US
    - Who decides that?
    - How to convince the physician?
The Disabled

- “Ableism”
  - Defining an individual by their disabilities
  - German eugenics - WWII
- Unjust discrimination
  - What about those with the inability to self-administer medication?
  - Why deny incompetent patients a “merciful” death?
- May coerce terminally-ill individuals
  - Progressive deterioration of bodily control
    - Shorten lives prematurely
    - To maintain options

Marginalized populations

Providing PAS may increase distrust
Potential abuse

- Any doctor may prescribe
  - Doesn’t need to:
    - know the patient
    - have expertise in psychological evaluation
    - be independent from second assessing physician
- Diabolical opportunity for abuse
  - Encouragement to make request
  - Physician not need to know patient
  - Sign forms as witness
  - Pick up script
  - Administer drug without witness

Cost of medication

Secobarbital - $3000-5000 for a lethal dose
### Reason for PAS request?

- “...the fact that dependence on others has become a socially sanctioned reason to be made dead is *itself* a threat to their dignity even if they are not themselves seeking assisted suicide.”
  - Daniel Sulmasy
    - Andre’ Hellegers Professor
    - Kennedy Institute of Ethics
    - Georgetown University

### Reason for PAS request?

- Control
  - (the only time a patient may truly be in control?)
- Autonomy
- Peace of mind knowing the option is available
- Loss of abilities
- Feeling like a burden
- Avoid indignity of being disabled and dependent on others
Dignity

• Less human due to?
  • Bouts of incontinence
  • Momentarily forget names of their children
  • Unable to drive car
• “I trust that it does not mean that indignities in any sense destroy our basic dignity.”
  • Daniel Callahan
    • Co-founder and President Emeritus
    • Hastings Center

Public/physician attitude change?

• “…ethical issues should be decided based on ethical arguments, not polls…”
• “Journal editors have a bias toward what is new. That means defense of the status quo is not new and does not get published.”
  Daniel Sulmasy
    • Andre’ Hellegers Professor
    • Kennedy Institute of Ethics
    • Georgetown University
The effects on families, doctors, social policy

- PTSD in families with witnessed PAS
  - Switzerland
- Patients who oppose PAS may fear physician may encourage them to consider
- Physician response
  - Not providing PAS script – abandonment
  - Writing a PAS script – encouragement
- Unintended consequences on relationships?
  - Medicine/society
  - Patient/physician
  - Perceived/actual integrity of medical profession
- Physician burnout?

Voluntary Euthanasia – Implications for Organ Donation - Canadian proposal

- Donation after circulatory determination of death (DCDD)
- “Dead Donor Rule”
  - Organ procurement after 2-10” after pulselessness
  - Results in compromised ischemic organs
- Voluntary euthanasia
  - Legal in Netherlands, Belgium, Luxembourg
  - Also permitted to donate organs
  - Best done in the operative setting (optional)
    - Euthanize the patient
    - Harvest the organs
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<th>Not a crisis</th>
<th>Therapeutic imperative</th>
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<tr>
<td>- Detracts from improving health care for aging population</td>
<td>Just because we physicians can assist our patients in committing suicide, should we?</td>
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<tr>
<td>- Number of reported cases</td>
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<td>- Low</td>
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<td>- Patients</td>
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<td>- White, wealthy, educated individuals</td>
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<td>- Few psychiatric referrals</td>
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<td>- Reasons</td>
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<td>- Autonomy, independence, control</td>
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<td>- 1/3 with a filled lethal prescription die without taking drugs</td>
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If this is just normal medicine....

- ...then why not do randomized controlled trials?
  - Best practice?
  - Most cost effective?

“Where you stand depends on where you sit”

- “A terminally ill person who applied for physician-assisted death is not choosing between living and dying, but between two different methods of dying. One is gentle, peaceful. The other would be struggling and in pain.
  - Dan Diaz, Latino Leadership Council, “Compassion and Choices”
  - Husband of Brittany Maynard
  - “The saddest point is that Brittany and Dan thought those were the only two options: gentle death or struggling painful death. How sad that no one presented the whole range of options open to them.”
What are the alternatives?

• “Look for ways to respond to request that respects patient values.”
• Hospice
• Voluntarily stopping eating and drinking (VSED)
• Stopping life-sustaining therapies
• Proportional palliative sedation
• Palliative sedation to unconsciousness

Responding to a question/request for PAS

• Not every question about PAS is a request for PAS
• “I’ll be glad to answer that question, but first please tell me what led you to ask.”
  • Seeking information
  • Talking through concerns about dying process
  • Expressing distress
  • Trying to ascertain physician’s views
Responding to a question/request for PAS

- Open-ended questions
- Respond with empathy and respect, non-judgmentally
- Re-evaluate/modify treatments/medications
- Identify depression, anxiety, spiritual suffering
- Consult as indicated
- Commit to work to mutually acceptable solution for patient’s suffering

Voluntarily Stopping Eating and Drinking

Self-initiated to accelerate dying
Patients have right to refuse life-sustaining treatment
Screen for:
- unaddressed desires/needs
- psychiatric conditions
- unaddressed symptoms
- existential suffering
- evidence of coercion

Most common symptoms:
- Thirst
- Hunger
- Dysuria
- Weakness
- Delirium
- Somnolence
Stopping Life Sustaining Therapies Interventions

• “...the refusal of care is not logically equivalent to a right to hasten death and that to equate the two is to conflate two very different things, both morally and legally.”
  • Neil Gorsuch, JD

Proportional Palliative Sedation

• Sedate for pain and dyspnea relief
Palliative Sedation to Unconsciousness

- “intentional lowering of awareness towards, and including, unconsciousness”
- When all other options are exhausted
- Patient may be sedated to unconsciousness
- May hasten death
  - “Double Effect”
  - May hasten death, but is not the INTENT to do so
  - Monitoring BP, HR, RR, consciousness level
- Removing anxiety
- Supplements “voluntarily stopping eating and drinking”

Further discussions needed

- What is the consent process for PAS if drugs don’t work as planned?
- Who is the responsible physician AFTER PAS?
- How is PAS different from/similar to suicide in other contexts?
- How has legalization of PAS affected ELC and palliative care for others?
- Do any patients access PAS because their symptoms are not being managed?
- What are the legal safeguards regarding mental health screening that fails to screen out people with impaired judgment who should not be getting a script for lethal medication?
- What is “comfort care?”
Further discussions needed

• What is the frequency of complications arising during PAS?
• What harms occur due to physicians opting out of PAS?
• How do prices of PAS drugs affect people of different socio-economic status make decisions about PAS?
• How is the 6 month prognosis requirement presently being determined where PAS is legal?
• How is presumption of mental capacity being determined?
• How often are patients referred to “low-threshold” physicians who are more likely to participate in PAS?
• How is capacity for medical decision-making assessed when patient’s ultimate goal is health vs. death?

Further discussions needed

• What is the effect of the required waiting period?
• What is the appropriate balance between legal safeguards and access to PAS?
• What are views of PAS in the disabled community?
• What is the impact of PAS on vulnerable populations (African American, underserved minority communities, low socio-economic communities) and how is PAS viewed?
• What is the effect of PAS on patients with psychiatric disorders? Does publicity about PAS trigger an increase in suicides?
Further discussions needed

• Is there a difference in the grief process for survivors of a person who completed PAS, compared to person who died a “natural” death, who stopped eating and drinking, or who committed suicide by more violent means?
• What is the psychological effect on physicians who participate in PAS?
• Does PAS contribute to or curtail physician burnout?
• Does the lack of PAS laws create a more dangerous underground practice?
• What is the impact on patients in hospice if not allowed to access PAS?
• Is the public interest in legalizing PAS part of a broader set of issues involving lack of trust in the health care system?

What is our ultimate goal?

• To provide palliative, empathetic, osteopathic care
• To provide reassurance that symptoms can be addressed
• “Quality of life is a deeply personal topic that should be discussed between the patient and doctor, yet rarely is.”
  • Omega Silva
    • Professor Emeritus
    • George Washington University


• Burt, RA. “Death is That Man Taking Names,” 2002, University of California Press, Berkley CA.


• Kim, SY. Evaluation of capacity to consent to treatment and research, New York: Oxford University Press, 2010.


