

EPEC

Education for Physicians on End-of-life Care

Participant's Handbook

Module 5

Physician- Assisted Suicide

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Emanuel LL, von Gunten CF, Ferris FD. The Education for Physicians on End-of-life Care (EPEC) curriculum, 1999.

Special thanks to the EPEC Team, the EPEC Advisory Group, and all other contributors.

Abstract

Most physicians have received one or more requests to help a patient end his or her life prematurely. This module focuses on the skills that the physician can use to respond both compassionately and with confidence to a request, not on the merits of arguments for or against legalizing physician-assisted suicide (PAS) or euthanasia, but using solid clinical skills. To respond effectively, physicians must know the reasons why patients ask for assistance. Depression, psychosocial factors, and anticipated distress are common reasons, but current physical suffering can also be a factor. Physicians need to be able to assess the root causes of the specific request, make a commitment to the patient's care, address each of the patient's sources of suffering, educate the patient about legal alternatives, and seek counsel from colleagues. The vast majority of requests for PAS or euthanasia should abate when approached in this way.

Key words

abandonment, burden, consultation, control, deliberation, depression, dignity, euthanasia, fears, listening, pain, physician-assisted suicide, psychological, social, spiritual, suffering

Objectives

The objectives of this module are to:

- define physician-assisted suicide (PAS) and euthanasia
- describe their current status in the law
- identify root causes of suffering that prompt requests
- understand a 6-step protocol for responding to requests
- be able to meet most patients' needs

Clinical case on trigger tape

The patient is Jack Wiley, a 33-year-old man. It has been 6 months since he learned he was HIV-positive. Mr Wiley's HIV disease is currently stabilized with a complex drug regimen. While going over prescriptions with the patient, the physician is surprised when Mr Wiley requests, "Help me when I decide it's the right time to go."

Introduction

Suffering has always been a part of human existence. Requests to end suffering by means of death through both physician-assisted suicide and euthanasia have occurred since the beginning

of medicine. Based on a recent study, 57% of physicians practicing today have received a request for physician-assisted suicide in some form or another (Back et al).

While unrelieved physical suffering may have been greater in the past, modern medicine now has more knowledge and skills to relieve suffering than ever before. Today, specialists in palliative care believe that if all patients had access to careful assessment and optimal symptom control and supportive care, the suffering of most patients with life-threatening illnesses could be reduced sufficiently to eliminate their desire for hastened death. Even when the desire persists, avenues other than physician-assisted suicide or euthanasia are available to remedy suffering and avoid prolonging life against the patient's wish.

This module presents an approach for responding to such requests, both compassionately and competently. *The focus is not on the debate to legalize PAS or euthanasia, but rather on the practical steps that a physician can take to assess the patient's request, address the root causes of the request, and ensure that the best quality of end-of-life care is practiced.*

Why patients ask for physician-assisted suicide

Patients ask physicians about physician-assisted suicide (PAS) for a variety of reasons. It is a rare patient with a life-threatening illness who doesn't think about suicide, if only in passing. Some patients may approach the physician about PAS with the intent of "thinking out loud" about their response to their present and anticipated future. Others may raise the question based on lifelong values. For some, a request for PAS is sign of patient crisis where unmet needs have built up and result in this plea for help. For all patients, the request for PAS should prompt the physician to assess the reasons for the request. Patients make requests for many different reasons that usually arise from physical, psychological, social, or spiritual suffering, or practical concerns. For some patients, the request is the first expression of unrelieved suffering.

Each person will have a unique set of needs and reasons why he or she would like to hasten death. While more research is needed, available data support a few generalizations. In all surveys, unrelieved psychosocial and mental suffering is the most common stimulus for requests. In one study (van der Wal et al), patients who were depressed were 4 to 5 times more likely to have made serious inquiries about PAS or euthanasia. Fear of future suffering, loss of control, indignity, or being a burden are also prominent reasons for requests.

Physical suffering, including pain, is a less frequent motivator than many think. In one study, pain alone was a motivator in 3% of requests, pain was one of several motivators in 46% of requests, and in the remaining 51% of requests pain was not cited as a factor at all (van der Maas). Nonetheless, the contribution of physical suffering is important. Its anticipation is a common motivator and because it is treatable (see Module 4: Pain Management; Module 6: Depression, Anxiety, Delirium; and Module 10: Common Physical Symptoms).

The legal and ethical debate

The debate about the legalization of active steps to intentionally end life as a means to end suffering remains controversial. Modern history suggests that the topic comes up for intense attention periodically. Because of the added risk of misunderstanding or overriding the patient's wishes, there is currently less support for euthanasia than for physician-assisted suicide. Nonetheless, both requests do occur and physicians need to know how to respond to either type of request.

In any discussion of physician-assisted suicide or euthanasia, it is important that the terminology be clear. Euthanasia is defined as “the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy” (Back et al). Although they may have similar goals, physician-assisted suicide and euthanasia differ in whether or not the physician participates in the action that finally ends life:

Physician-assisted suicide: The physician provides the necessary means or information and the patient performs the act.

Euthanasia: The physician performs the intervention.

As the current debate unfolds, there are 2 principles on which virtually all agree. First, physicians have an obligation to relieve pain and suffering and to promote the dignity of dying patients in their care. Second, the principle of patient bodily integrity requires that physicians respect patients' competent decisions to forgo life-sustaining treatment.

An important event in the present debate occurred in 1997, when the US Supreme Court recognized no federal constitutional right to physician-assisted suicide but did affirm that state legislatures may choose to legalize it. As of early 1999, Oregon is the only state that has voted to legalize PAS.

In contrast to the PAS debate, the right to palliative care is uniformly acknowledged. The same US Supreme Court Justices' concurring opinions supported the right of all Americans to receive quality palliative care.

Professional competence

As most physicians are likely to receive a request for hastened death, every physician must be capable of dealing with these difficult requests in a way that responds to the needs and expectations of the patient and offers the best possible care that is both ethical and legal.

The ability to respond to requests for hastened death with realistic alternatives requires a working knowledge of all aspects of palliative care. The physician must follow usual standards for information giving, know how to provide aggressive symptom control and supportive care, and be skilled at approaches to withdraw or withhold life-sustaining interventions (see Module

2: Communicating Bad News; Module 4: Pain Management; Module 10: Common Physical Symptoms; and Module 11: Withholding, Withdrawing Therapy). A physician will want to be aware of the legal issues described in Plenary 2: Legal Issues in End-of-life Care.

As effective approaches for responding to suffering may be time consuming, physicians will be more effective if they work collaboratively with other health care disciplines, ideally in an interdisciplinary team. As some requests for PAS or euthanasia can be intense, even for physicians who are skilled and experienced, access to consultative palliative care expertise, both physicians and programs, as part of the spectrum of contemporary health care is essential (see Plenary 3: Elements and Models of End-of-life Care).

6-step protocol for responding to requests for physician-assisted suicide or euthanasia

Any request for PAS should always be taken seriously. Response should be immediate and compassionate. Six steps can be identified for responding to such requests:

1. Clarify the request
2. Assess the underlying causes of the request
3. Affirm your commitment to care for the patient
4. Address the root causes of the request
5. Educate the patient and discuss legal alternatives
6. Consult with colleagues

While each step will be discussed in this module in sequence, as with other clinical protocols, these steps should integrate smoothly and flexibly into actual practice as issues arise. Depending on the particular case, while some steps may be implicit or accomplished in a few words, others may be complex and require considerable time to respond.

Step 1: Clarify the request

When a request for hastened death is first received, listen carefully to the nature of the request. Ask open-ended questions in a calm and nonjudgmental manner to elicit specific information about the type of request that is being made and the underlying causes for it. While some physicians fear that talking about suicide or hastened death will increase the likelihood that the patient will act, this fear has not been substantiated. An open discussion is more likely to reduce the intensity of the request.

Once the underlying reasons are known, more directed questions can be asked. Several examples, and the common areas to which answers may point, follow:

MD: “What makes you ask that?”

- desire for a pain-free death
- control over the dying process

MD: “What do you expect will happen without PAS?”

- understanding and expectations of the illness
- expectation of what dying will be like

MD: “What type of assistance do you want?”

- pills, injection

MD: “Who do you want to be involved? Why?”

- self, family member, physician

MD: “When do you think you want to die?”

- now
- at some later point

MD: “What do you hope to accomplish?”

- freedom from pain, disability, bankruptcy, dependency, indignity
- removing burden on others

The answer to the question, “When do you think you want to die?” will provide some indication of acuity. “What do you hope to accomplish?” will provide some understanding of the patient’s reasoning and what he or she is hoping for. During the course of the questioning, it is particularly important to learn whether the patient is imagining a future that is either unlikely or easily preventable.

As you listen to the answers, use the therapeutic effect of empathic listening. Avoid endorsing the request for PAS in a way that confirms the patient’s perception that his or her life is worthless. Remember that empathizing is not the same thing as agreeing. Premature affirmation of any perspective can propel both parties to stark choices.

Only when the patient’s point of view has been characterized will it be possible to talk about what suffering means to the patient and what assurances can or cannot be given.

Personal biases

To respond effectively to the needs of the patient, the physician must be aware of his or her own biases and the potential for countertransference. If the idea of suicide is offensive to the physician, the patient may feel his or her disapprobation and worry about abandonment.

Conversely, if the physician feels it would be best for everyone if the patient were to die soon then the patient may sense this and become more concerned about being an unwelcome burden.

Be open to the possibility that your personal reactions to the patient's suffering may give insight into his or her experience. If the physician feels weighed down by meeting with the patient, perhaps the patient is depressed.

Step 2: Assess the underlying causes of the request

A request for PAS may indicate a failure to address the full scope of a patient's needs. Focus on all 4 dimensions of physical, psychological, social, and spiritual suffering as well as practical concerns (see Module 3: Whole Patient Assessment; Module 4: Pain Management; Module 6: Depression, Anxiety, Delirium; Module 7: Goals of Care; and Module 10: Common Physical Symptoms).

Among all the psychological and physical possibilities, give particular consideration to the possibility of clinical depression or anxiety, as research indicates correlation between requests and their presence. When evaluating psychological and social issues, explore the patient's fears about his or her future.

Assess for clinical depression

Clinical depression occurs frequently and is both underdiagnosed and undertreated. It can be a source of intense mental suffering and a barrier to completing life closure and achieving a "good death."

Diagnosis of depression is more challenging in patients with advanced illness, since the physical symptoms typically associated with depression (eg, changes in appetite, weight, energy level, libido, or sleeping) frequently occur in these patients as a result of their illness.

Studies have shown that the screening question, "Do you feel depressed most of the time?" is highly sensitive and specific in the medically ill.

Feelings of pervasive helplessness, hopelessness, and worthlessness are not normal. Do not assume they are situational and leave them unattended (see Module 6: Depression, Anxiety, Delirium).

Psychosocial suffering, practical concerns

Emotional and coping responses to life-threatening illness may include a strong sense of shame, feelings of not being wanted, and/or inability to cope. Adjustment to the loss of previous function, independence, control, and/or self-image may be difficult. Each change may lead to tensions within relationships that further increase isolation and misery.

Worries about practical matters (eg, who the caregivers will be, how domestic chores will be done, who will care for dependents and pets, etc) can create considerable distress. If support is not forthcoming or is insufficient, suffering may ensue or increase. Approaches to the assessment of psychosocial issues and practical concerns are covered in Module 3: Whole Patient Assessment.

Physical suffering

A host of physical issues may accompany advanced illness. These may include pain, breathlessness, anorexia/cachexia, weakness/fatigue, nausea/vomiting, constipation, dehydration, edema, incontinence, loss of function, sleep deprivation, etc. Their presence, particularly if they are unmanaged for long periods, may markedly increase suffering. Approaches to the assessment of physical issues are covered in Module 3: Whole Patient Assessment. The management of pain is discussed in Module 4. The management of other common physical symptoms is discussed in Module 10.

Spiritual suffering

The prospect of dying may evoke seemingly unresolvable existential concerns that are then experienced as suffering. As illness advances and disability increases, the patient's sense of his or her meaning, value, and purpose in life may all come into question. If there is a sense of abandonment or punishment by God, faith and religious beliefs may be eroded and anger may ensue. Approaches to the assessment of spiritual issues are covered in Module 3: Whole Patient Assessment.

Common fears

In addition to current concerns, many patients are fearful about what the future will be like. They worry about pain and other symptoms, loss of control or independence, abandonment, loneliness, indignity, loss of self-image, and being a burden to others. While their thoughts may be unrealistic in the setting of quality care, many have witnessed suboptimal care in others that fuels their fears and fantasies.

Direct questions may be adequate to assess a patient's fears. If not, discussing a series of scenarios and preferences, as is done during advance care planning, may be helpful. When

personal values and goals of care are being discussed, clarify the things the person most wants to avoid. This may help to preempt unrealistic fears (see Module 1: Advance Care Planning).

Step 3: Affirm your commitment to care for the patient

Patients facing the end of life often have fears of abandonment. Listen to and acknowledge expressed feelings and fears. Make a commitment to help find solutions to the issues of concern, both current and anticipated. Reinforce that you want to continue to be the patient's physician until the last possible moment. Explore options to allay immediate concerns and fears.

As a request for hastened death affects everyone who is close to the patient, a commitment to the patient also affirms a commitment to the family and those close to the patient, including other caregivers.

Step 4: Address the root causes of the request

This section provides a general framework for addressing some of the potential root causes for a request for hastened death in each dimension of suffering. Start by discussing the patient's health care goals and preferences, explaining palliative care approaches and services, and describing the legal alternatives to PAS. Remember that some patients may not trust either individual health caregivers or the health care system to meet their needs. This may relate either to culture or to past experiences. It helps to discuss this lack of trust with the patient at the outset, so that the issues can be understood, if not dealt with, early (see Module 1: Advance Care Planning; Module 3: Whole Patient Assessment; Module 7: Goals of Care; and Module 9: Medical Futility).

Address psychological suffering

As psychosocial suffering leads to many of the requests for physician-assisted suicide or euthanasia, its management warrants considerable attention. Start by assessing and managing any depression, anxiety, or delirium aggressively (see Module 6: Depression, Anxiety, Delirium).

As each patient's emotional response to illness can be profound and coping responses varied, they will require careful exploration in a positive and understanding way. Supportive counseling, which involves active listening and acknowledgment of the patient's feelings, may be woven into general care, or it may be provided more intensively through dedicated individual or group counseling. Social workers and chaplains trained in supportive counseling can provide considerable assistance. Referral to trained counselors, psychologists, or psychiatrists may be required if the issues are complex and/or the risks high.

Address social suffering, practical concerns

Stresses and conflicts in the social dimension or practical aspects of a person's life can have profound effects on his or her will to live. Express interest and inquire in detail about this aspect of the patient's life:

- What is the patient's family situation? Does he or she live with someone? Are family members supportive? Are there unresolved issues?
- How is the patient's financial situation? Is health insurance available and sufficient?
- Are legal affairs in order? Does the patient have a living will, power of attorney for health care, power of attorney for business affairs, last will and testament?
- Where would the patient like to receive care? Who is there to help? Who will the caregivers be? Is there tension over the caregiving role for either party?
- Who attends to domestic chores such as cooking, cleaning, shopping, banking, bill payments?
- Are there any dependents the patient cares for, or pets? Who will care for them if the patient is not able to?

As this dimension often lies outside of the areas most physicians feel confident in addressing, consider requesting assistance from other members of the health care team (eg, social work, nursing, chaplains, occupational therapy, etc). Additional resources for help and support may be available in the community, through a health care institution, or from a local hospice or palliative care program.

Address physical suffering

Multiple studies indicate that patients with life-threatening illnesses have many physical issues that are unaddressed. If left unmanaged for long periods, each can add considerably to a patient's sense of suffering.

Today, suffering from physical symptoms because of lack of management is inhumane. Modern medicine has more knowledge and tools to manage them than ever before. Pain management is discussed in detail in Module 4; anxiety, delirium, and depression in Module 6; and other common physical symptoms in Module 10. Each symptom needs to be pursued aggressively. Successful management often requires extensive and careful thought and individual clinical trials until symptoms are brought under control. If a physician is inexperienced, consultation with expert colleagues should not be delayed.

Function is critical to maintain independence. Physiatrists, nurses, and physical and occupational therapists may be helpful and knowledgeable about the exercises and aids that can be used to optimize and maintain function and to ensure safety.

Sexuality and intimacy are integral aspects of each one of us, particularly through touch and the closeness to partners and family members we cherish. Illness and disfigurement may change the way people are able to interact. To establish individual desires and tensions, facilitate discussions between partners and key family members. Help them to look for alternatives that may be comforting.

Address spiritual suffering

The spiritual dimension of human experience is universally challenged in the face of a life-threatening illness. Each person has a sense of meaning and purpose to his or her life, and a sense of where he or she fits into the grand scheme of things. This may have a frankly religious orientation or they may be expressed through faith or a personal sense of spirituality. Nevertheless, the transcendental dimension is present in each one of us, and it is critical that this dimension be explored when a patient requests PAS or euthanasia.

Helping patients to establish or reestablish a sense of meaning and purpose is often fundamental to the relief of spiritual suffering. Encouraging them to reminisce with family and friends; assisting with life closure, gift giving, and creation of legacies may also be helpful.

Some physicians feel comfortable dealing with spiritual suffering. Others feel inexperienced and out of their depth. As these issues are critical and may be very time consuming, a skilled hospice chaplain who works with a psychiatrist or psychologist skilled in end-of-life care may bring considerable skill and support to both the patient and the physician.

While it would be ideal if the needed skills came from the patient's own pastor, do not assume that all members of the clergy are equally comfortable with the care of patients with advanced life-threatening illness. Like physicians, many have not received adequate training in chaplaincy issues and are ill equipped to deal with the profound conflicts surrounding requests for physician-assisted suicide or euthanasia. Address fears

Fear of loss of control

The autonomy and control that each one of us has over our lives and affairs is central to our personhood. While this need for control varies in some cultures, it is a central feature of Western society. For many, independence is profoundly challenged by illness that is debilitating and deprives them of mastery or control over their day-to-day activities and their sense of future.

This fear of loss of control may be further heightened by fears that their expectations and needs won't be addressed, or fears that people will do things to them that they don't want (eg, forced feeding, invasive procedures, life-sustaining therapies, etc).

The specific issues that are most important for each person to control are unique to that individual. They may include a whole range of issues, including the ability to choose day-to-day

activities and experiences that are meaningful, choices for therapies, settings of care, caregivers, etc.

The physician can be instrumental in helping the patient to continue to realize as much control as possible, given the changes in function that are likely to occur. This may take unusual flexibility on the part of the physician and the health care team. Educate and help the patient plan for aspects of medical care that are rightfully under his or her control (eg, the ability to accept or refuse any medical intervention, life-sustaining therapies, etc). Encourage the patient to select personal advocates and proxy decision makers, prepare advance directives, and plan for death. This planning can include funeral plans, wills, and disposing of personal belongings after death. Teach family members and caregivers alternate approaches to caregiving that optimize patient participation in decision making, ie, instead of “doing without asking,” encourage family and caregivers to “ask before doing.”

Fear of pain and other symptoms

While patients may find current symptoms acceptable, they frequently fear a future where symptoms will be out of control and unbearable, particularly when they are dying. Reassure the patient that almost all symptoms can be well controlled. As appropriate, discuss alternate approaches to symptom management, including anesthesia. Ensure that patients and families know that pain does not get suddenly worse as death approaches. Help them to understand the difference between pain and terminal delirium, particularly if they have known someone else who had a difficult death. As many patients fear adverse effects of medications, particularly drowsiness and confusion, discuss their management should they occur.

The possibility of end-of-life sedation, should pain or other symptoms be unbearable for the patient and unmanageable by experts, may be explored with the patient and family during advance care planning discussions. Some patients and families will find the possibility reassuring; others will not want to consider it.

Most importantly, during all of these discussions, make a commitment to keep working to manage the symptoms until they are satisfactorily controlled. Patients fear being told, “I’m sorry, there’s nothing more I can do.”

Fear of being a burden

In several studies, one of the things patients fear most about a life-threatening illness is the prospect of being a burden to others. This is, in some ways, a corollary of the fear of losing control, particularly as our culture generally does not value being dependent on others.

Try to establish why the patient does not want to be a burden. If there are caregiving issues, facilitate a discussion between the patient and family. In many cases, families are willing and eager to care for the patient, and their desires simply remain unspoken. If patients and families

are worried that family members will not have enough skill to provide adequate care, suggest home hospice care. This is the fundamental goal of the home hospice team, to help educate, train, and supplement the family in the care of the patient. Alternate care settings can be arranged as a backup if care at home does not go as planned. Home hospice agencies must make provisions for brief periods of respite care if it is needed. If there are financial issues, help the patient find information and resources that will be acceptable—many people are unaware of the services available. Social workers and nurses, who can help find solutions to issues and provide training and backup to unskilled family members, can be a significant resource to the physician to help lessen the patient’s fear of being a burden.

Fear of indignity

Patients may fear the loss of their dignity. As this is a complex concept that may include elements of being dependent, loss of control, being a burden, being embarrassed, etc, explore what it means to the particular patient.

Once the issues are clear, explore approaches to caring and resources that can help to maintain dignity. Ensure that the patient, where possible, participates in decision making. Ensure that family members and caregivers know how to approach and address these issues. Ensure that everyone has permission for their roles and each task that they will do. Reassure the patient that he or she has dignity in your eyes.

Fear of abandonment

For some patients, their worst possible fear is abandonment—by families, their friends, their physicians, or other health care professionals. This fear can be heightened by the realization that others cannot cope with the illness and the changes it brings, or the role of being a caregiver.

Explore this fear in detail with the patient and family in a family conference. Try to establish how realistic the patient’s concerns may be. If tensions seem high or there are indications that family and friends are not coping, a meeting with everyone may be helpful to assess the situation. If caregiving is becoming onerous, offer a respite break or an alternate setting for care. As appropriate, try to connect families to available supports in the community, particularly those provided by the interdisciplinary teams available through hospice and palliative care programs.

Above all, when addressing fear of abandonment, the physician must be able to honestly reassure the patient about his or her plans for being involved in ongoing care.

Step 5: Educate the patient and discuss legal alternatives

Deal with misconceptions

When making a request for PAS, patients may have misconceptions about the benefits of their requested course of action. Some may be unaware of what emotional effort goes into planning for physician-assisted suicide or euthanasia; others may be unaware of the risk of emotional consequences to family and friends, and to the personal legacy they hope to protect.

Legal alternatives

Patients may also not be aware of the legal alternatives available to them. This may be particularly true if they have not participated in discussions to clearly define their goals of care and treatment priorities. As part of the process of discussion, planning, and decision making, the physician may wish to discuss the 4 following legal alternatives to PAS:

Refusal of intervention

Patients should be clear that they have the right to consent to, or decline, any intervention (eg, surgery, chemotherapy, pacemakers, ventilators, medications including antibiotics, IV fluids) or settings of care (eg, hospitalization) if any of them seem too burdensome. They should also be aware that their choices to decline particular therapies will not affect their ability to receive high-quality end-of-life care (see Module 8: Sudden Illness).

Withdrawal of treatment

Patients should be clear that they have the right to stop any treatment at any time. This includes the cessation of fluid and nutrition, either enterally or parenterally. Again, they should know that their choices to withdraw particular therapies will not affect their ability to receive high-quality end-of-life care (see Module 11: Withholding, Withdrawing Therapy).

Decline oral intake

Patients with advanced disease often lose appetite and/or thirst. Just like any other medical decision, a competent individual can determine what goes into his or her mouth. Based on the principle of bodily integrity, force-feeding is not acceptable.

To assist with decision making, patients will usually benefit from knowledge that they will not suffer from dehydration or starvation. A detailed discussion of their potentially protective properties and the appropriate management of symptoms should they occur will usually allay fears and reduce anxiety considerably (see Module 12: Last Hours of Living).

As fluids and food are synonymous with life, and culturally ingrained, family and caregivers will likely need considerable education and support if the patient decides to cease oral intake.

Encourage them to always have food and water accessible so that the patient can change his or her mind at any time. Discuss the potential for anger and resentment if they persist in badgering or attempting to force things on the patient. Above all, recognize their desire and need to give care and refocus them on activities that will be beneficial to everyone.

End-of-life sedation

For the rare patient with unbearable and unmanageable pain, or other intractable symptoms, who is approaching the last hours or days of his or her life, the induction and maintenance of a state of sedation may be the only remaining option. Sedation in the imminently dying is intended to produce a level of obtundation sufficient to relieve suffering without hastening death. This approach has an ethical basis that derives from the importance of intended effect over possible secondary and unintended consequences. (See Module 10: Common Physical Symptoms for a discussion of intended effects and unintended consequences.)

Before end-of-life sedation is considered, it should be clear to the attending physician, members of the health care team, and consultants with expertise in palliative care that all available therapies have been tried to their limits without benefit. Individual physicians should not consider this issue without consulting others. This is not an alternative to high-quality palliative care or limitations in available resources imposed by institutions or health care funders.

If no other options are apparent, consider how the patient and family might react to this option. Advance care planning discussions and recent statements they have made may provide guidance. If the team feels that the patient and family will not perceive the discussion as a sign of abandonment, discuss the option with them and solicit their opinion. Before making a decision, it should be clear to everyone that the intent in offering sedation is to make the patient comfortable during the last days of his or her life when all other alternatives have not been successful. If anyone perceives that the intent of sedation is to kill the patient and not simply relieve suffering, the approach should not be pursued.

If the patient and family find the option acceptable and the patient chooses to receive sedation, intermittent or continuous intravenous or subcutaneous infusions of midazolam, lorazepam, propofol, or barbiturates have been used successfully to induce sedation and reduce awareness.

Opioids are not recommended if the primary goal is to induce sedation. However, if the patient has been in pain, opioids will need to be continued so that the sedated patient will not experience pain. Follow standard opioid dosing guidelines and alter doses if renal clearance decreases (see Module 4: Pain Management; Module 11: Withholding, Withdrawing Therapy; and Module 12: Last Hours of Living).

If the patient dies while receiving sedation and appropriate doses of medication were used, the death is attributable to the underlying illnesses, not the sedation.

Step 6: Consult with colleagues

A request for physician-assisted suicide may be one of the most challenging situations a physician will face in his or her practice of medicine.

Unfortunately, it is in precisely these situations that physicians may hesitate to involve someone else. There may be several reasons for such reluctance. For some the subject raises personal issues. Others may have the conviction that it is not appropriate to talk about death. A few may be reluctant to discuss requests for physician-assisted suicide or euthanasia because of the legal implications of the situation.

As requests for hastened death can have considerable personal, ethical, and legal ramifications, they should not be dealt with in isolation, but rather with the support and input of at least one trusted colleague or advisor. This person may be a mentor, a peer, a religious advisor, or an ethics consultant. Physicians may also find considerable support from nurses, social workers, chaplains, and other members of the interdisciplinary team who are involved in the patient's care.

Response to persistent requests

Requests for physician-assisted suicide occur infrequently in most physicians' careers. Clinical experience suggests that most requests will resolve if unmet needs are addressed by using the approach offered in this module.

It also remains a fact that, as of early 1999, in all but Oregon, physician-assisted suicide remains illegal. When PAS requests are declined, full comfort care should continue and the professionals should continue to work in partnership with the patient and family.

However, despite doubled and redoubled efforts to assess and address root causes of suffering and provide high-quality palliative care, requests for physician-assisted suicide and euthanasia may occasionally persist. It is not the purpose of this introductory module to discuss such rare cases. These are likely to be complex and should be handled in consultation with experts.

Summary

A request for physician-assisted suicide or euthanasia indicates unrelieved suffering. This module has presented a practical approach for physicians to use to respond to such requests. The physician needs to treat all requests seriously and compassionately, look for the root causes of the request, and work with the patient and others to relieve those root causes. Palliative care has never been as well developed and powerful in the history of medicine as it is now. Insisting on its widespread availability without legislative barriers, and making use of its resources, will relieve most of the suffering that compels requests for PAS or euthanasia. Existing legal options

for control and comfort can provide alternatives for most if not all patients who persist in their request for PAS or euthanasia.

Key take-home points

1. Physicians have an obligation to relieve pain and suffering and to promote the dignity of dying patients in their care.
2. Physicians must respect patients' competent decisions to forgo life-sustaining treatment.

Why patients request PAS

3. A request for physician-assisted suicide may be the first expression of unrelieved suffering.
4. Each person will have a unique set of needs and reasons for a request.

Step 1: Clarify the request

5. Listen carefully to the nature of the request.
6. Try to understand the type of request that is being made, and the underlying causes for it.
7. Be aware of personal biases and the potential for countertransference.

Step 2: Determine the underlying causes for the request

8. Clinical depression occurs frequently and is underdiagnosed, undertreated, and a frequent motivator for requests.
9. Emotional and coping responses to life-threatening illness may include a strong sense of shame, feelings of not being wanted, and/or inability to cope.
10. Worries about practical matters can create considerable distress.
11. Many patients are fearful about what the future will be like (pain and other symptoms, loss of control/independence, abandonment, loneliness, indignity, loss of self-image, being a burden).

Step 3: Affirm your commitment to care for the patient

12. Make a commitment to help find solutions to the issues of concern, both current and anticipated.

Step 4: Address the root causes of the request

13. Knowledge of appropriate approaches for the withdrawal or withholding of life-sustaining interventions and aggressive comfort care is essential.
14. Assess and manage any anxiety, delirium, depression, physical symptoms, social dysfunction, and practical concerns.
15. Assess and address fears of being a burden, abandonment, loss of control, indignity, future pain, and other symptoms.
16. Assess and address the sense of loss of meaning and purpose by assisting with life closure, gift giving, creation of legacies.

Step 5: Educate the patient, discuss legal alternatives

17. Patients should be clear that they have the right to consent to, decline, or stop any treatment or settings of care at any time if they seem too burdensome.
18. Patients may choose to decline regular oral intake of food and/or fluids.
19. For the rare patient with unbearable and unmanageable pain, or other intractable symptoms, who is approaching the last hours or days of his or her life, the induction and maintenance of a state of sedation is an ethical option when all other available and reasonable therapies have been tried unsuccessfully.

Step 6: Consult with colleagues

20. Don't address requests for physician-assisted suicide in isolation – consult with trusted colleagues early.

Pearls

1. Empathic listening can have a therapeutic effect.
2. Talking about suicide or hastened death, if the patient is thinking about it, may reduce, not increase their risk.
3. The question “Do you feel depressed?” is a sensitive and specific screening question in the medically ill.
4. Pain and other physical symptoms are less frequent motivators than many think.
5. Fears and the need to have some control are fundamental issues.

Potential pitfalls

1. Prematurely affirming any perspective can propel both parties to stark choices.
2. Delaying inclusion of other skilled members of the health care team.
3. Forgetting families and caregivers. They may need to be educated and supported, and their need to give care refocused.

Resources

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