Physician-Assisted Suicide: What You Need to Know

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“Medical Killing”

- Direct and intentional causing of death
  - Embryonic Stem Cell Research
  - Abortion
  - Infanticide
  - Assisted Suicide
  - Euthanasia

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Definitions

- Euthanasia: a physician (or nurse following physician orders) administers a lethal dose of a medication, actively causing death.
  - Voluntary Euthanasia: patient consents to and is aware of the euthanasia
  - Involuntary Euthanasia: patient is unaware of, and may be opposed to euthanasia
- Physician-assisted suicide:
  - A patient self-administers a lethal dose of a medication prescribed by a physician

Why people choose assisted suicide

- Experience of a tragic death
- Witness of terrible suffering
- Fear about suffering and pain
- Concern about loss of control
- Fear of being a burden
- Fear of the loss of “Dignity”
- Depression at end of life

Suffering vs. Pain

- Pain: Physical, Social, Psychological, or Spiritual
- Suffering: distress that is perceived
  - Increased Suffering
    - Loss of control
    - Source of pain is unknown or if the meaning is dire
    - Duration of the pain is chronic or it can’t be controlled
  - Decreased Suffering
    - When pain is understood (childbirth, sciatica, trauma)
- Minor pain can cause great suffering if uncertain
- Concern about future is a key feature of suffering

Limiting extreme suffering

- Principle of Double Effect
  - The permissibility of an action that causes harm (such as the death of a human being) as a side effect of promoting some good end.
  - It is permissible to bring about as a merely foreseen side effect a harmful event that it would be impermissible to bring about intentionally.
  - This requires the value of promoting the good end outweighs the disvalue of the harmful side effect.

Thomas Aquinas: discussion of the permissibility of self-defense
Summa Theologica (II-II, Qu. 64, Art.7)

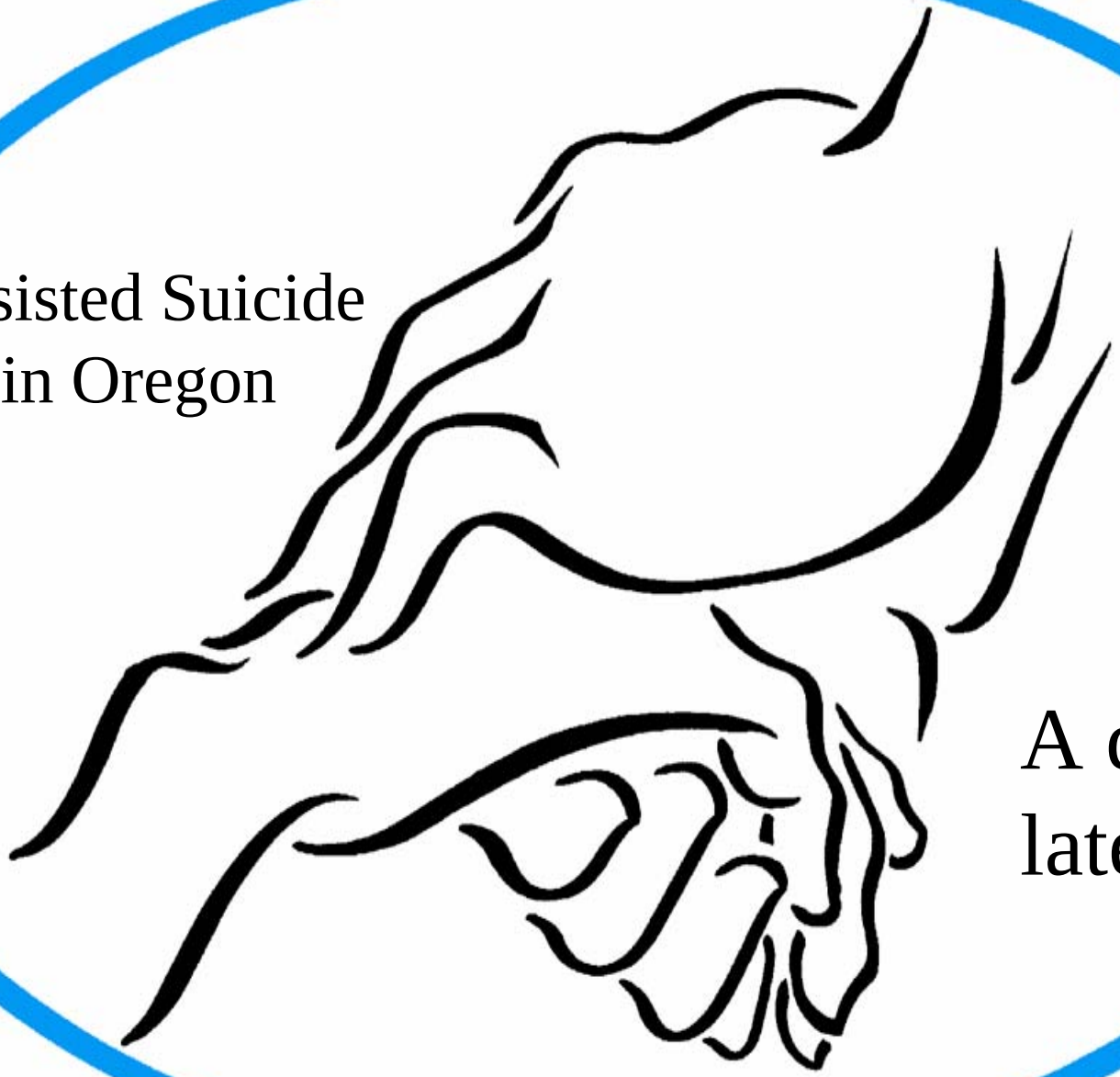
Example of "Double Effect"

- End Stage Lung Cancer
  - Short of breath
  - Chest discomfort
  - Very Anxious
- Administer IV morphine
  - Breathing easier, decreased pain
  - Much less anxiety, now relaxed
  - May hasten death, but this was not the primary intention
  - This is good medical care
- Many are confused about this

“Life-support” is a separate issue

- Life-support: Ordinary vs. Extraordinary
  - Artificial Administration Nutrition & Hydration (AAHN)
    - NG Tube feedings
    - PEG Tube placement
  - “Pulling the Plug”
    - Usually talking about ventilator support (breathing machine)
    - Tube feedings do not require a plug (just gravity)
- Patients near the end of life are in a different category
- Physician-assisted suicide (direct and intentional medical killing) is a completely different issue

Assisted Suicide in Oregon



A decade later…

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For over 2400 years the medical profession has withstood the allure of promoting death.

Historical Perspective

- Ancient Greece and Rome (500 B.C)
  - Tolerant of infanticide and active euthanasia
- Hippocrates, the Father of Medicine (460-370 BC)
  - Hippocratic Corpus
    - The physician must be able to tell the antecedents, know the present, and foretell the future, must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm.*
  - Hippocratic Oath
    - I will follow that system of regimen which, according to my ability, I consider for the benefit of my patients and abstain from what is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest such counsel.

*Of the Epidemics, Book I, Section II, Part V:

Historical Perspective

- 1st Century A.D. through Middle Ages
  - General prohibition of euthanasia and suicide
  - Ascendancy of Judeo-Christian values
- 13th Century: Thomas Aquinas
  - Suicide injures the community
  - Suicide is seen as a refusal of God's gift of life
- 1900-1930's: " Eugenics Movement"
  - Germany permits destruction of unworthy life
  - Voluntary Euthanasia bills in US and England
  - Founding of Euthanasia Society of America

Eugenics in Oregon

In 1917, Oregon established a State Board of Eugenics (one of 33 states to do this)

STATE BOARD OF EUGENICS

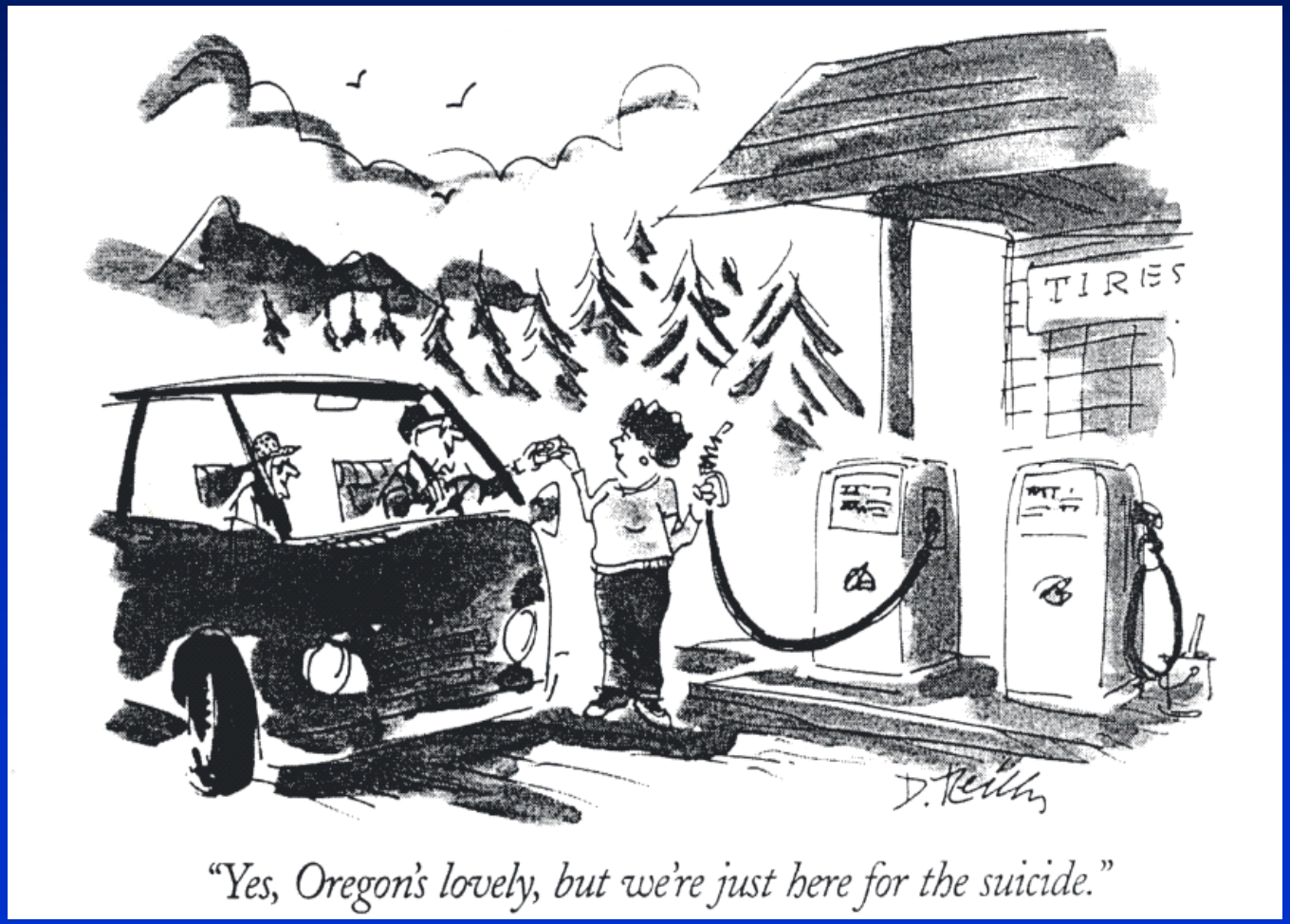
Name and address	*Position*
Dr. George E. Houck, Roseburg	President State Board of Health
Dr. C. M. Barbee, Portland	Vice-President State Board of Health
Dr. C. J. Smith, Portland	Member State Board of Health
Dr. W. B. Morse, Salem	Member State Board of Health
Dr. J. H. Rosenberg, Prineville	Member State Board of Health
Dr. W. T. Phy, Hot Lake	Member State Board of Health
Dr. R. E. L. Steiner, Salem	Supt. Oregon State Hospital
Dr. J. N. Smith, Salem	Supt. Institution for Feeble-Minded
Dr. W. D. McNary, Pendleton	Supt. Eastern Oregon State Hospital
A. M. Dalrymple, Salem	Warden State Penitentiary
Dr. F. D. Stricker, Portland	Secretary, State Board of Health

"Eugenics represents the highest type of public health work and is the greatest service to the human race. Feeble-minded, paupers, criminals, insane, and morally degenerate are a burden to civilization economically and socially. Criminals are recruited mainly from certain families. Feeble-mindedness can usually be traced to heredity." 1921 Annual Report of the Oregon State Board of Health

Historical Perspective

- 1960's Euthanasia viewed as "choice"
- 1980's Derek Humphry forms the "Hemlock Society"
- 1990's
  - Derek Humphrey's best-selling book (Final Exit) stimulates a national "Right to Die" movement
  - Jack Kevorkian assists Oregonian Janet Adkins
  - "Compassion in Dying" is founded and submits several assisted-suicide ballots in Washington and California
- 1994, the Oregon Death with Dignity Act passes
  - No other legislation has passed despite attempts in dozens of states, UK, and Canada.
- Current legislation pending Washington, Wisconsin, also being considered across Europe and SE Asia.

It is a crime to assist another person in their suicide, unless you are a physician in Oregon and the patient has less than 6 months to live.



"Yes, Oregon's lovely, but we're just here for the suicide."

Oregon's "Death with Dignity Act"

- A patient requests a deadly prescription
  - Second opinion needed (can be done over phone)
  - 2 week waiting period prior to filling
  - The doctor writes a prescription, usually barbiturates (sleeping pills) are prescribed, the same medication anesthesiologist uses in surgery
  - Voluntary reporting only, no peer-review, protection from any malpractice, protection from civil lawsuits
  - The law provides for doctor-ordered, doctor-prescribed, and doctor-directed suicide

Oregon’s “Death with Dignity Act”

- This law does not give patients any rights
- This law protects physicians from civil and criminal charges for medical killing
- By asking for a "right to die" Oregonians have given physicians “license to kill”

Assisted Suicide and the Vulnerable

Kate Cheney, age 85, died 8/29/1999

"Kate's choices may be influenced by her family's wishes and her daughter may be somewhat coercive." – evaluating psychologist

A family struggle

Is Mom capable of choosing to die?

Kate Cheney says she wants assisted suicide, but doctors and therapists wonder if it's actually her vocal daughter's wish

Kate Cheney, 85, (left) discovered in May that she had an inoperable, cancerous tumor in her stomach. Her daughter, Erika Goldstein, 64, became a strong advocate for her mother's decision to obtain a lethal prescription with Oregon's physician-assisted suicide law.

KATHRYN SCOTT OSLER/ THE OREGONIAN

Assisted Suicide and Medical Care

- The case of Michael Freeland
  - He was given a lethal prescription
  - When his doctors were planning for his discharge to his home from the hospital, one physicians wrote that while he probably needed attendant care at home, however, providing additional care may be a "moot point" because he had “life-ending medication”
  - His assisted suicide doctor did nothing to care for his pain and palliative care needs.
  - This seriously ill patient was receiving poor advice and medical care because he had lethal drugs.

Hamilton & Hamilton, Am J Psychiat 2005;162:1060-1065

Assisted Suicide and the "Slippery Slope"

11/3/97

Lawmakers will help doctor in suicide case

Dr. James Gallant of Corvallis had his license suspended after he gave a lethal injection to a patient with a fatal disease

The Associated Press

CORVALLIS — A doctor disciplined for helping a terminally ill patient commit suicide is getting the support of his state legislators.

"We're going to do what we can to help," Sen. Cliff Trow, D-Corvallis, told a crowd of about 150 people Saturday at a rally for Dr. James Gallant.

Oregonian

Gallant was disciplined by the state in connection with the March 1996 death of Clarietta Day, 78. Gallant had diagnosed her illness as a subarachnoid hemorrhage, a fatal condition that left the woman in a coma. While still conscious, Day had instructed family members not to take extraordinary measures to keep her alive.

Even though Day's family supported the doctor's actions as merciful, the state Board of Medical Examiners suspended Gallant's license to practice medicine for two months. The suspension expired Nov. 1.

The Lane County District Attorney's office is investigating Gallant for possible criminal charges.

Gallant received a standing ovation at Saturday's rally. Speaking publicly for the first time since disciplinary proceedings against him began, Gallant thanked patients and friends for their support.

"Anything that occurred, occurred because that's what the patient and family wanted," Gallant said.

The Death With Dignity Act, which voters passed in 1994, allows doctors to prescribe lethal pills to sane, terminally ill patients with less than six months to live. Court challenges have prevented the law from taking effect.

Mail ballots for Measure 51, which would repeal the assisted-suicide law, will be counted Tuesday.

Gallant prescribed a lethal injection of succinylcholine, a drug that paralyzes respiratory muscles, for Day. Injections are not allowed under Oregon's assisted-suicide law.

About 1,000 people have signed a petition demanding that insurance companies keep Gallant on their payrolls and that Good Samaritan Hospital restore his hospital privileges. They also want to change state laws they say resulted in Gallant's being treated unfairly.

- This was involuntary euthanasia (lethal injection)
- No criminal charges filed
- Two month suspended medical license
- Oregonian was deceptive, this was not suicide

Assisted Suicide and Trust

- Story of Mrs. Stevens
  - Failing chemotherapy and radiation therapy for lymphoma
  - Her physician offered ‘extra large’ amount of pain medication
  - The message was “Your life is no longer of value, you are better off dead.”
  - “We had felt much discouragement during the prior three years, but never the deep despair that we felt at that time when her trusted physician suggested suicide.”
- Even proponents don’t want their physicians to be in favor of doctor-assisted suicide

What Can We Do?

A clinical approach

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What is Dignity?

- Definition: Dignity is the quality or state of being worthy, honored, or esteemed
- Attributed Dignity (personal dignity)
  - Perception
  - Autonomy, Independence, Individualism
- Intrinsic Dignity
  - Moral quality inherent in human life
  - Inalienable from “core being” or “essence”

Intrinsic Dignity

What happens when someone asks you about Assisted Suicide

- Don’t avoid this conversation
  - If we respond by avoidance, interpreted as rejection
  - Failure to hear a “cry for help”
  - Need to ask “Why?”
- May indicate depression
  - OHSU study: more hopeless, decreased QOL
  - Not uncommon for people to think about it
- They may just be curious

Requests for assisted suicide should prompt us to look for depression and treat it

- Depressed mood or loss of interest or pleasure for 2 weeks and 4 of the following:
  - Change in sleep (insomnia or sleepiness)
  - Feelings of guilt or worthlessness
  - Lack of energy or fatigue
  - Impairment of concentration or memory
  - Change in appetite (up or down)
  - Psychomotor agitation/retardation
  - Recurrent thoughts of death or suicidal ideation

How to Preserve Dignity

- How patient/family perceive dignity
- Symptoms: need to be vigilant
- Bolster independence: equipment
- Dignity conserving strategy:
  - Hard to do in face of deteriorating health
  - Therapeutic stance: respect for whole person, feelings, accomplishments, and passions that are independent of illness

Dignity: Symptom Distress

Themes	Dignity-related questions	Therapeutic Interventions
Physical distress	"How comfortable are you?" "Is there anything we can do to make you comfortable?"	Vigilance in symptom management, Frequent assessment and comfort care
Psychological distress	"How are you coping with what is happening to you?"	Assume a supportive stance Empathetic listening Referral to counseling
Medical uncertainty	"Is there anything else that you would like to know?" "Are you getting the information you need?"	Upon request, provide accurate, understandable information and strategies to deal with future crises.
Death anxiety	"Are there things about the later stages of your illness that you want to discuss?"	

Dignity: Level of Independence

Themes	Dignity-related questions	Therapeutic Interventions
Independence	“Has your illness made you more dependent on others?”	Have patients participate in decision making, regarding both medical and personal issues
Cognitive acuity	“Are you having any difficulty with your thinking?”	Treat delirium When possible, avoid sedating medication
Functional capacity	“How much are you able to do yourself?”	Use orthotic devices, physical and occupational therapy

Dignity: Patient Perspectives

Themes	Dignity-related questions	Therapeutic Interventions
Continuity of Self	"Are there things about you that this disease does not affect?"	Acknowledge and take interest in those aspects of the patient's life that he/she most values See the patient as worthy of honor, respect, and esteem
Role preservation	"What things did you do before that were important to you?"	
Maintaining Pride	"What about yourself or your life are you most proud of?"	
Hopefulness	"What is still possible?"	Encourage and enable the patient to participate in meaningful activities
Autonomy / control	"How in control do you feel?"	Involve patient in treatment and care decisions
Legacy	"How do you want to be remembered?"	Life Project (video, audio, letters) Dignity psychotherapy
Acceptance	"How at peace are you with what is happening to you?"	Support the patient and encourage doing things that enhance sense of well being (meditation, exercise, music, prayer, etc…)
Resilience	"What part of you is strong now?"	

Dignity Preserving Practices

Themes	Dignity-related questions	Therapeutic Interventions
Living in the moment	“Are there things that take your mind away from illness and offer you comfort?’	Allow the patient to participate in normal routines or take comfort in momentary distractions (daily outings, exercise, music,etc…)
Maintaining normalcy	“Are there things you still enjoy doing on a regular basis?”	
Finding spiritual comfort	“Is there a religious or spiritual community that you are, or would like to be involved with?”	Make referral to chaplain or spiritual leader, Enable participation in spiritual practices

Social Dignity

Themes	Dignity-related questions	Therapeutic Interventions
Privacy boundaries	“What about your privacy or your body is important to you?”	Ask permission to examine patient, proper draping to safeguard privacy
Social Support	“Who are the people most important to you?” “Who is your confidant?”	Liberal polices about visitation and rooming-in, enlist others for wide support network
Care tenor	“Is there anything that is undermining your sense of dignity?”	Treat the patient as worthy of honor, esteem, and respect. Adopt a stance conveying this
Burden to others	“Do you worry about being a burden to others?”	Encourage explicit discussion about these concerns with those they fear they are burdening
Aftermath concerns	“What are your biggest concerns for the people you leave behind?”	Encourage the settling of affairs, an advanced directive, making a will, funeral plans

Conserving Dignity: Leaving a Legacy

Can you tell me a little about your life history?

When did you feel most alive?

Are there specific things that you would want your family to remember about you?

What are the most important roles you have played in life?

What are your most important accomplishments, and what do you feel most proud of?

Are there things that still need to be said, or that you would want to say once again?

What are your hopes and dreams for your loved ones?

What have you learned about life that you would want to pass along to others?

What advice or words of guidance would you wish to pass along to your (son, daughter, husband, wife, parents, other[s])?

Are there words or perhaps even instructions you would like to offer your family, in order to provide them with comfort or solace?

In creating this permanent record, are there other things that you would like included?

What to do when faced with a request for doctor-assisted suicide

- Most important thing is to connect with this person
- First priority is relief of suffering and symptoms
- Screen for depression, treat if indicated
- Use the dignity conserving interventions
- Establish short term goals
- Explore options for end of life care
- Involve care manger, family, and caregivers
- Withhold / Withdrawal of life sustaining measures
- Walk with them on this last part of their journey

What Can We Do?

Reasons for Hope

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Successful Strategies

- Strategy of the pro-death / pro-suicide movement
  1. Change the language: Create Euphemisms
  2. Disengage and marginalize physicians
  3. Promote the “success” of Oregon’s DWDA
- Our Response: Five practical approaches
  1. It all starts with improving end of life care
  2. Tell the truth about assisted suicide in Oregon
  3. Engaging health care systems
  4. Engaging physicians
  5. Take back the language

Improving End of Life Care

- For those we come in contact
  - Recognize suffering and crisis at end of life
  - Dignity preserving interventions
  - Make the last part of life the best part of life
- Promotion of “improving end of life care”
  - To all health care professionals, administrators, volunteers, parish ministries, adult education, public servants, religious, etc…
  - To the families, friends, and caregivers of those who are ill
- Increase awareness of ‘bigger’ issues
  - Redemptive aspects of suffering
  - Benefits of corporal works of mercy
  - Sanctity of all human life

The “Success” of Oregon’s DWDA

Media Applauds ‘Death with Dignity’ Lovelle Svart 1945-2007

- 62 years old; lung cancer
- Retired Librarian (Oregonian)
- Orchestrated Media Event
  - The Oregonian
  - Compassion & Choices
- “Success of DWDA”

Telling the truth about PAS in Oregon
Five Oregonians to Remember

- The vulnerable are at risk
  - Patients with dementia (Kate Cheney)
  - Patients with Depression (Michael Freeland)
- Changing roles of doctors and nurses
  - Doctors give lethal injection (Clarietta Day)
  - Nurses now getting involved (Wendy Melcher)
- It doesn't always work
  - Waking up after 5 days (David Pruitt)

What to do about Healthcare Systems

- This is everyone's concern
- Administrators and Board Members
- Clear messages about assisted suicide
- What else is needed
  - A broad-based effort aimed at consumers
  - Create consumer demand (patient and family)
  - Reach out to health care providers

Physicians for Compassionate Care Education Foundation

- Association of physicians, health professionals, associates, and friends
- Dedicated to preserving the traditional relation of the physician and patient
- Two Goals
  - Educate the health profession about assisted suicide
  - Promote the physician role to heal when possible, comfort always, and never intentionally harm.

PCCEF on Physician-Assisted Suicide

- PCCEF opposes physician-assisted suicide:
  - Changes the role of the physician in society from the traditional role of healer to executioner
  - Undermines basic trust in the patient-physician relationship
  - Endangers the value that society places on life, especially for those who are most vulnerable

PCCEF History

- 1994: OMA votes “neutral position” on Measure 16
- PCCEF was formed
  - OMA subsequently voted 123 to 1: “fatally flawed”
  - Helped to get a referral to voters (measure 51)
- PCCEF fights assisted suicide legislation
  - Similar bills failed in a dozen states and in the UK
  - Coalitions of healthcare professionals, hospice workers, disability-rights advocates, minority groups, and physicians across the world are becoming involved
  - Using information and resources provided by PCCEF

PCCEF Physician Pledge

www.pccef.org

My Pledge to my Patients

I will treat the sick according to my best ability and judgment, always striving to do no harm. Whenever I care for a terminally-ill patient, I will provide optimal comfort care until natural death.

I will also support my patients' wishes not to prolong the dying process with futile care. I will never give a deadly drug to anyone even if asked, nor will I suggest suicide.

I will always affirm and guard these ethical principles with integrity, recognizing that every human life is inherently valuable.

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PCCEF ‘Take the Pledge’ Campaign

- Doctors

  Let your patients know where you stand on physician-assisted suicide

- Patients

  Find out where all of your doctors stand on physician-assisted suicide

- Patients

  Ask your doctor to take the pledge

www.pccef.org

PCCEF in Oregon

- Educating Health Care Professionals
  - "Enhancing End of Life" conferences
  - Online (www.pccef.org) tools and information
  - Tabletop displays and adult education
- We need your help
  - Spreading the message: "Take the Pledge"
  - Growing PCCEF membership
  - Helping with financial support

Most Importantly, We Need to Take Back our Language…

- Compassion & Choices has been successful
  - Their use of language has been a key strategy
  - They have been able to be successful at avoiding the word ‘suicide’
- We need to avoid euphemisms
  - Physician assisted suicide consists of two acts
    - The physician is ordering direct medical killing
    - Direct and intentional killing is always wrong
    - The patient is committing suicide
    - Suicide is always a tragedy

Taking Back the Language

- Use the words “physician-assisted suicide”
- Do not use their language
  - “Death with Dignity” or “Aid in Dying”
- Use precise language
  - This is “situational killing” and a “suicide”

To summarize

- It starts with improving end of life care
- Practice dignity conserving techniques
  - Symptoms, Independence, and Social Dignity
- Clear messages about assisted suicide
  - Engage health care systems and providers
- Take back the language
  - Situational Medical Killing and Suicide

Questions / Discussion

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