

# Report of the Committee on Physician-Assisted

## SUICIDE AND EUTHANASIA

In 1994 the Board of the American Association of Suicidology selected a Committee on Physician-Assisted Suicide and Euthanasia. It was asked to review the issues emerging in the growing controversy concerning euthanasia, physician-assisted suicide, palliative care, and the medical treatment of dying patients. Having discussed the issues together after extensively reviewing published materials, the committee now submits this report.

At this time, the committee recommends that the American Association of Suicidology take no positions on physician-assisted suicide or euthanasia. Further, we do not recommend the support of legislation, for or against, any of these matters. Quite apart from the diverging, deeply held moral and ethical positions on these issues that divide our organization and our society, much research is needed to answer many important questions before this association might properly take positions on these problems. Research can never answer all the wrenching questions associated with physician-assisted death, but it can certainly inform the debate. In this report, we identify some of the research questions, attempt to clarify the areas of difference, and highlight several sectors of the discussion that should be of concern to all who espouse positions, favorable or unfavorable, in matters of physician-assisted suicide and euthanasia.

We have decided to submit this "white paper" in spite of the reservations of some who fear that it is inappropriate for the American Association of Suicidology to speak out on these matters at all. It has been argued that ours is an organization the purpose of which is suicide prevention and the study of suicide. We are not a political organization, and the medical care of the dying is outside our purview. Most of the Committee believe, however, that the collective experience and knowledge that we can bring to the subject enable us to offer some perspective on these questions, and that though we cannot presume to settle them, we may offer some clarification and throw some light (no more heat is needed) on the controversies.

Since 1994 this committee has studied a voluminous amount of published material and we have been generously assisted through correspondence and discussion with Dr. Ira Byock, Dr. Herbert Hendin, and Dr. Timothy Quill.

### THE CURRENT ENVIRONMENT

As the committee has tried to address its task, the breadth and intensity of the controversy have increased to such an extent that new books, newspaper commentaries, and articles appear almost daily. The sensational media treat-

ment of the activities of Dr. Jack Kevorkian, who has assisted in the suicides of a number of patients, has captured and even inflamed the imagination and the suspicions of the public. This is the stormy context in which we now submit our report.

A referendum approved by the citizens of Oregon in November of 1994 permitting physicians to give prescriptions for lethal doses of drugs to incurable patients has been declared unconstitutional by the U. S. District Court. Similar referenda legalizing physician-assisted suicide and physician-administered euthanasia failed in Washington, Michigan, Iowa, and California. Voters in other states (Massachusetts, New Hampshire, and New Mexico, among others) are seeing or shortly will see similar measures on their ballots.

There are now seven distinct right-to-die societies in the United States, among which the most prominent are Choice in Dying, Americans for Death with Dignity, the Hemlock Society, and Compassion in Dying. For the most part these bodies advocate assisted suicide and euthanasia. By all indications the membership of these organizations is growing as public distrust of the health delivery system deepens.

Opposition to this movement comes from many sources, including the American Medical Association, the American Nurses Association, the American Geriatrics Society, the Roman Catholic Church, Hospice, the National Legal Center for the Disabled, and such groups as the International Anti-Euthanasia Task Force. Individual, non-organizational opposition is strong. The two sides do not agree whether humane care for the terminally ill requires the legalization of assisted suicide or euthanasia.

Those foreign observers who have published studies of assisted suicide and euthanasia in the Netherlands (these practices are accepted there) have come to similar conclusions: Euthanasia, originally intended for exceptional circumstances, has become a common way for dealing with serious or terminal illness. Intended to provide greater autonomy for patients, euthanasia has actually increased physician's control over patients' deaths.<sup>1</sup>

The Dutch government's own commissioned study shows that more than a thousand patients a year are given euthanasia without their consent. In a significant number of cases annually physicians take actions that might end, or are intended to end, the lives of competent patients without any preliminary discussion with them. The Dutch, who dislike the term "involuntary euthanasia," call such events "termination of the patient without explicit request."<sup>2</sup> About three thousand cases of physician-assisted death (euthanasia or assisted suicide) in which the patient requests it are taking place in the Netherlands annually. This represents about 3% of all deaths in that country.<sup>3</sup>

The Dutch experience raises important questions about the possibility of abuses in the United States, though knowledgeable scholars from the Netherlands do not believe there is any pattern of abuse in that country, which is culturally much more homogeneous.<sup>4</sup> The U.S. health care system is fragmented and economically driven. Whereas in the Netherlands close relationships between patients and physicians of many years standing are very usual, in this country patient-physician relationships have never been more impersonal. At the clinical level, end-of-life decisions are surrounded by complex psychological and interpersonal influences that are extremely difficult to

assess in the absence of a close, long-lasting relationship between the patient and the physician.

## GUIDING CONSIDERATIONS

Several important considerations have guided us that should be made explicit. First of all, there is profound disagreement among the membership of the American Association of Suicidology as to whether there is such a thing as rational suicide. There are thorny difficulties that turn on the precise meaning of commonly used words. The matter is difficult because the differences, though subtle, really matter. We have addressed the difference, for instance, between "reasonable" and "rational" suicide.<sup>5</sup> There are differences of meaning and nuance between expressions such as "physician-assisted suicide," "physician-assisted death," and "physician aid-in-dying."

Further, some hold that euthanasia has nothing to do with suicide, while others are convinced that in the context of terminal illness, the choice to die is essentially a choice of suicide.

Although euthanasia in the last days of life may have little to do with ordinary suicide, clinical experience suggests that those patients who respond to crises of grave illness suicidally are not different from those who respond to other life crises in the same way.

The members of the American Association of Suicidology differ over fundamental political, cultural, and religious issues. We do not agree on the appropriate role of the law and the claims of society when they come into conflict with issues of individual liberty. Some of us believe that legitimization of euthanasia and assisted suicide without providing more sophisticated psychological safeguards than those that have been proposed in recent referenda will inevitably result in various kinds of abuse. Others are confident that well-planned legislation will prevent abuse, or even that, by bringing physician aid-in-dying out into the open, legislation will protect against abuse of the terminally ill that is occurring now.

Plainly, full ethical consensus on issues of this magnitude cannot be reached by the committee nor the membership of the American Association of Suicidology. Our cultural, political, ethical, and religious groundings are too diverse. Some agreement is nevertheless possible. The committee has a consensus that involuntary euthanasia can never be condoned, and we further agree that intolerable, prolonged suffering of persons in extremis should never be insisted upon, against their wishes, in single-minded efforts to preserve life at all costs. Apart from these two statements what you have before you is not a position paper. Some of those who reviewed earlier drafts of this report have detected a subtle bias in favor of euthanasia and physician-assisted suicide. Others have detected an opposite bias. We have nevertheless tried to produce a balanced report. It is not our intention to influence premature closure on the discussion of these very difficult questions.

Every suicide is a complex matter. Even in cases where much clinical information is available it is not possible to know all determinants. The issue is further complicated by the fact that self-performed or physician-assisted suicides in terminal illness are not usually reported as such. Nevertheless, we do

believe that more study is needed, and we are convinced that the interpersonal and psychological aspects of end-of-life decisions are often ill understood and overlooked.

The committee, aware of the intense public polarization that has occurred over the issue of abortion, senses that a comparable furor may arise over the subjects addressed in this report. Hoping to promote open and intelligent discussion of the issues, *inside and outside our organization*, it has tried to identify the principal points of agreement and disagreement at hand, even though members may differ respecting the ethical choices they may imply.

## DEFINITIONS AND ILLUSTRATIONS

That controversy should arise in this difficult field of discussion is inevitable, but simple miscommunication has led to much unnecessary dispute. Many of the terms used in this debate mean different things to different people. For purposes of this report, we list here the committee's understanding of some of the basic terms. In order to clarify the application of these terms, we have annexed scenarios of imaginary cases to show what we mean.

Some readers of preliminary versions of this report have objected that the report in general, and the imaginary cases in particular, seem to legitimize, or excuse, euthanasia and physician-assisted death. We do not advocate for or against. Nevertheless, for this report, we do not shirk from the need to *discuss* euthanasia. The moral distinction between, on the one hand, providing a terminal, suicidal patient with a tank of carbon monoxide and a gas mask (for example), and on the other hand, holding that mask over the face of a pleading patient who, by virtue of disease, is incapable of holding the mask himself, is uncertain. To some, the distinction appears minor; to others, it is enormous. The former instance is, of course, physician-assisted suicide; the latter, euthanasia. Euthanasia is indisputably a type of homicide, but the moral issues associated with the two examples mentioned here are so related that to discuss physician-assisted suicide while shunning any discussion of euthanasia seems disingenuous.

### Death Associated with Palliative Care

Death associated with palliative care is death due (at least in part) to medications and/or other treatment given to a patient for the explicit purpose of relieving suffering. Caregivers may be aware of the potential for death as an outcome of palliative care, but death is not the goal of palliative care.

The patient is a wasted 87-year-old man in an intensive care unit suffering from widely metastatic pancreatic cancer. He has received all the conventional therapy and is now suffering intolerable pain and intense restlessness, unaffected by the usual doses of drugs. The physician knows higher doses of opiate combined with sedatives may suppress the patient's respiration, but, having discussed the dangers with both the patient and his family, he administers larger doses anyway, explicitly recognizing that the goal of therapy at this stage is relief of pain, not prolongation of life. The

patient's suffering is relieved, but he subsequently dies in his sleep during the night.

### Suicide

Suicide is the act or an instance of deliberately taking one's own life.

A chronic alcoholic man has been drinking at home. His health is deteriorating, and he has recently lost his job. His children are grown and have moved away; his wife has left him. Despondent and suffering from clinically diagnosable depression, he shoots himself in the head with the handgun he keeps in his bedside drawer.

### Assisted Suicide

Assisted suicide is the deliberate and knowing provision of information, the means, and/or help to another person for an act of suicide.

A 30-year-old homosexual patient who had witnessed the painful deaths of many of his friends suffering from AIDS himself developed late complications of the illness and was in considerable physical pain. The options of good palliative care had been fully described to him, and he understood them, but he said he did not want to lie drugged for weeks or more waiting for death, even if he was free from physical suffering. He asked the physician to give him a lethal prescription for barbiturates so he could kill himself at home. This the physician did.

### Euthanasia

Euthanasia is the act or practice of causing the death of persons suffering from incurable conditions or diseases in order to alleviate or prevent uncontrollable suffering.

*Active* euthanasia has come to mean some deliberate action that results in the death of such a person. *Passive* euthanasia implies permitting the death of such a person by withholding action as a result of which death follows. (Withholding and/or withdrawing life sustaining treatment is an example of passive euthanasia.)

*Voluntary* euthanasia implies that the person who is to die gives informed consent. *Involuntary* euthanasia implies that the person who is to die refuses to give informed consent, or, when presumably competent, is never asked for consent. *Involuntary* euthanasia is a synonym for murder. *Nonvoluntary* euthanasia implies that the person who is to die is incapable or incompetent to give informed consent.

*An Example of Active, Voluntary Euthanasia.* A 35-year-old musician lay immobile in bed, unable to swallow her own secretions, so deteriorated from amyotrophic lateral sclerosis that she could no longer eat or speak, but she remained able to nod her head. She had told her physician long before that when her disease reached this stage she did not want to live any

longer, and had asked for a lethal injection to end her life. On several occasions he asked her if she now wanted the injection she had asked for before. Each time she nodded her head, "yes." With the full knowledge and consent of her family he gave her a lethal injection of barbiturates.

*An Example of Passive, Voluntary Euthanasia.* A 35-year-old musician lay immobile in bed, unable to swallow her own secretions, so deteriorated from amyotrophic lateral sclerosis that she could no longer eat or speak, but she remained able to nod her head. In this example the patient had told her physician long before that when her disease reached this stage she did not want to live any longer, and asked him then to withhold food and medicines so she would die. The physician asked the patient on several occasions if she was ready to die, and she consistently nodded her head to signal *yes*. He obtained the consent of the family and discontinued the tube feedings, though the patient was given small amounts of cracked ice orally to keep her comfortable. She died in a few days.<sup>6</sup>

*An Example of Active, Nonvoluntary Euthanasia.* A wasted 87-year-old man is dying in an intensive care unit, diagnosed with widely metastatic pancreatic cancer. He has received all conventional therapy, and is suffering from intolerable pain unaffected by high doses of morphine normally considered safe. The physician knows higher doses of morphine may suppress the patient's respiration. The patient is confused but obviously in pain, shifting in and out of delirium, unable to understand and unable to give consent. There are no known family or friends. The physician administers a lethal dose of sedative, with the explicit intent of causing the patient's death to end his suffering.

## PROBLEM AREAS

Among the difficult issues around which controversy builds, the committee was able to identify four about which we wish to offer some comment. These are general socioeconomic and cultural considerations, the difficulties in assessing and treating depression in patients who wish to die, the unsettled questions concerning the efficacy of palliative care, under ideal as well as ordinary circumstances, and some practical remarks concerning assisted suicide in the absence of a physician.

### Social, Cultural, and Other General Considerations

The identification of persons who might be eligible to request physician-assisted death would inevitably be influenced by the evolution of social and medico-legal consensus. The terminally ill are widely identified as a suitable class for assisted dying, but others may come to be included as appropriate candidates, according to the way they are regarded by others. In Holland more than one patient with intractable depression who persisted in her wish to die was afforded euthanasia (e.g., the Chabot case). The participating physician was convicted of a criminal offense on technical grounds but never punished.<sup>7</sup>

Offering euthanasia or assisting in the suicides of psychiatric patients is repugnant to many; the great majority of psychiatrists in the United States would find such a policy repellent, and would recall the extermination of chronic psychiatric patients under the Nazi regime, although admittedly most such deaths were hardly voluntary.<sup>8</sup> Some argue that the victims of slow, deteriorating illnesses not necessarily immediately terminal (amyotrophic lateral sclerosis, for instance) should be afforded assistance in dying if they wish it.

The life conditions of socially and economically disadvantaged persons in American society invite depression, discouragement, and sometimes despair. There would appear to be no small risk that the socially and economically advantaged would find it economically tempting to encourage premature death for their disadvantaged counterparts, or that the poor, ignorant, and disadvantaged would be too ready to give up on themselves. Life events and the nature and extent of available social supports are well understood to influence both the onset and the outcome of depressive disorders and suicidal states.

In the United States good health care is unavailable to many, especially to poor or near-poor people. Medical services are delivered impersonally, often on a catch-as-catch-can basis, and few low-income persons have long-standing relationships with a physician who knows them well. The practice of medicine is in an economic crisis, and the current development of so-called managed care favors the delivery of the least care possible. Euthanasia and assisted suicide would be good business for many insurers, reducing the overall cost of care for expensive patients in nursing homes and other chronic-care facilities.<sup>9</sup>

Many who request assistance in suicide (and who support the legalization of physician-assisted suicide) fear burdening their families financially, and want to die sooner, rather than later, to preserve family resources. Inevitably, some family members would become enthusiastic for assisted-suicide or euthanasia for reasons of personal financial gain. In the United States people are routinely pauperized when they fall seriously ill and do not die quickly. Health care reform needs to address this issue; financial suffering in the sick and dying can be remedied by means other than dying quickly if federal and state governments will pay attention.

Research shows that in the United States men commit suicide about three times more often than women. Perhaps this is because Americans view suicide as an act of independent self-determination, something inherently masculine. Should suicidal death take on the color of passive compliance, would it seem more acceptably feminine? Would a physician's assistance make suicide more permissible and acceptable for women?<sup>10</sup>

Systematic data on physician-assisted suicide in the United States are unavailable, but a number of cases have been described in newspapers and in professional periodicals. We found one study reporting on characteristics of persons who asked for assisted suicide. In this report physicians were asked to give information about the last one or two patients who had asked for help in dying. Sixty percent were men, and the physicians complied with about a fourth of these requests. No information was given on whether physicians were more likely to comply with women's or men's requests for assisted death, nor was it learned whether women were more likely than men to actually take the medicine prescribed for use in suicide.<sup>11</sup> Kevorkian's cases have been the most widely publicized. Most of his assisted suicides have been women, a majority

of whom were between forty and sixty years old. Though poor health was mentioned as a factor in all, a third of Kevorkian's cases were not terminally ill. Obviously Diane, the patient whose suicide was assisted by Dr. Quill, was a woman.

The available evidence, though unsystematic, raises the question as to whether women may be more likely to feel (and to be made to feel) obligated to kill themselves when they are sick, especially if they are old. There is evidence to suggest that Americans are more likely to feel that an elderly woman's decision to commit suicide is more reasonable than a man's.<sup>12</sup> Most American physicians are men, and it has been claimed that death by suicide is more acceptable to men than it is to women.<sup>13</sup> Do not these findings suggest the likelihood that because of prevalent social attitudes physicians would be more likely to take at face value a woman's request for assistance in death than a man's?

In the United States more elderly women than elderly men are poor, widowed, live alone, suffer from chronic illness, and have limited access to medical insurance and family care. They would appear to be at great risk either to be pressured, or to feel pressured, into suicide or euthanasia to relieve others of the financial and emotional burden of caring for them.

A number of recent studies document the attitudes and practices of U. S. medical personnel concerning assisted suicide and euthanasia. Physicians appear to be divided on the question of legalization, with 31% to 60% expressing neutral or positive attitudes towards legalizing these practices.<sup>14</sup> From 12% to 21% of surveyed physicians reported having been asked for a prescription of a lethal dose of medicine. Two to seven percent complied.<sup>15</sup> Finally, a 1996 study of U. S. critical care nurses found that 17% had received requests for assistance in suicide or euthanasia from patients or family members, and 20% of the nurses reported engaging in such practices.<sup>16</sup>

Additional research is needed to address such questions as these: What influence do concurrent life stressors have on attitudes toward death in the terminally ill? How can those events and their impacts be reliably measured? Do terminally ill women and men evaluate life stressors differently? Do the composition and extent of terminally ill persons' social support networks influence their attitudes toward suicide and euthanasia? Are women more likely to perceive themselves as a burden when ill? What impact is the choice of assisted death likely to have on important relationships between the dying and others close to them, and on the course and outcome of bereavement for the survivors?

### The Problems Concerning Depression

Depression is among the thorniest problems in the thicket around issues of physician-assisted death. The word *depression* ranges in meaning from ordinary sadness to a major psychiatric syndrome, but some level of low spirits, even if *not always at the level of significant clinical depression*, is almost always present in those who face the end of their lives. The need to distinguish normal grief or sadness from its potentially treatable, pathological variants is one of the challenges facing those who wish to legalize physician-assisted death.<sup>17</sup> For example, Oregon's now defunct Measure #16 forbade physicians' issuing lethal

prescriptions until it was shown that "the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment".<sup>18</sup> One of the Court's findings in striking down this measure was that treating physicians are poorly equipped to discern whether a patient's judgment is impaired because of depression or some other mental disorder. Measure 16 left this very important determination to treating physicians alone, and failed to require consultation with psychiatrists or psychologists.<sup>19</sup>

Inasmuch as depression is widespread among those suffering terminal illnesses, the correct diagnosis of clinical depression is the paramount concern of those who must identify psychiatric or other disorders that may impair judgment in those who seek a voluntary death. Among patients with advanced cancer, for example, at least a fourth have significant symptoms of clinical depression.<sup>20</sup>

Beyond sadness, clinical depression is characterized by a series of symptoms that often may be as readily ascribed to the patient's medical condition, or the treatment of the condition, as well as to any primary depression as such.

Many depressed patients have little or no insight into their disorder, and the more elderly often deny any mood disturbance, though the other indicia of depression are evident. Many patients have demonstrable cognitive changes—thinking is slowed, decision-making difficult and labored, and I. Q. falls. Many physically compromised elderly patients abuse alcohol or prescription drugs that can profoundly alter thinking and impair decision making processes.<sup>21</sup>

Primary care physicians fail to diagnose clinical depression in at least half their ambulatory patients who suffer from it.<sup>22</sup> They are not demonstrably better at identifying even the more severe cases of depression. Its assessment in patients with terminal illness is complicated, but certainly possible. Certainly the assessment and treatment of depression in the seriously physically ill can be taught, and the treatment is usually effective.

## ASSESSMENT

Characteristic depressive symptoms include loss of interest in usually pleasurable activities, loss of appetite and energy, sleep disturbance, and difficulty concentrating, as well as psychomotor slowing, feelings of worthlessness, and thoughts of death.<sup>23</sup> Depressed persons complain more of diffuse physical symptoms and show less tolerance for functional limitations and for pain than those who are not. Pain and the nutritional and metabolic effects of physical illness may themselves cause clinical depression, as may many commonly used medications (e.g., chemotherapeutic agents and analgesics). Among the risks for critically ill persons' seeking a physician's assistance in an early death, therefore, is the chance that their physical symptoms may be incorrectly attributed exclusively to depression. On that basis the request for assistance in dying might be denied. Conversely, symptoms resulting entirely or partially from a clinical depressive disorder may be incorrectly attributed to the terminal physical condition. Suicide or euthanasia might follow without a treatable depression's recognition and treatment. Additional research and training are needed if physicians' ability to distinguish depression as a natural response to dying from depression as an independent syndrome is to improve.

Further complicating the problem is the fact that we are only beginning to learn about the prevalence of suicidal thoughts or wishes in people with terminal illness. Neither do we know to what extent the presence of such thoughts is correlated with expressed suicidal behavior, nor how wishes for death in the critically ill relate to depressive illness. About 5% of the total population at any given time suffers from major depression with some level of suicidal thinking. From this it must follow that some fraction of terminally ill patients will suffer from clinical depressions that coincide with their illnesses but do not arise from them. Such patients are likely to attribute their depression and suicidal thinking to their terminal illnesses, however.

The few studies that have been conducted of patients nearing death suggest that suicidal ideation rarely occurs in the absence of a clinical depressive syndrome.<sup>24</sup> The available data are scant. Clinical experience suggests, however, that though patients in severe pain may ask to be put out of their misery, they often change their minds when the pain is treated. Much additional research into these questions is needed.

The presence of a mental disorder may certainly impair the ability to make a reasoned decision about ending one's life. In its most extreme form, clinical depression can have a profound impact on rational thinking. In the less severe forms that are more characteristic of terminal physical illness, however, little is known about the influence of depressive symptoms on rational thought and end-of-life decisions.<sup>25</sup> Neither have we as yet developed reliable (consistently reproducible) means for the assessment of that influence. How then are we to assess a terminally ill person's capacity (mental competence) to request assistance in dying in the face of mild, moderate, or severe mood disturbance? Lacking tools, clinicians ordinarily assume that mild forms of mood disturbance do not impair judgement about end-of-life decisions, just as they often assume that more severe clinical depressions do. Neither assumption may be correct. We need further research, therefore, if we are to understand how depression and its associated affective states (e.g., hopelessness) influence decision making in the face of terminal illness.

## TREATMENT

Many argue that when significant symptoms of a mood disorder are present, treatment should be attempted before any request for assistance in dying is granted. With resolution of the depressed state, it is argued, the capacity to weigh the available options (including assisted death) may improve, and the attitude toward death may change.

There is a tendency to take a dying person's request for help in dying at face value, and to assume that the principal determinants of the request are those the patient names—the inevitability of death, the deteriorated quality of life, discomfort, and others. Mental health professionals are well aware that unconscious motives may color such decisions, however, and that requests for help in dying are multidetermined.

Many carefully conducted studies show that approximately 80% of persons with clinical depression will respond to treatment with medications and/or psychotherapy. Clear guidelines exist for prescription and conduct of antide-

pressant treatments.<sup>26</sup> But severely medically ill patients have rarely been included in depression research because of their greater sensitivity to side effects and drug interactions, and because their response to treatment is far more difficult to measure. In general, treatment of depression in the terminally ill with both medications and psychotherapy is more complex, and requires more technical expertise, than the treatment of patients with uncomplicated depression. Anxious not to compound their patients' discomfort, even those physicians who correctly diagnose clinical depression often provide less than optimal treatment for it, unreasonably fearing the side-effects of antidepressant drugs, and leaving the depression untreated, or only partially treated.

It is not true that the most pain-ridden, physically most distressed terminally ill patients are more likely to become depressed or suicidal when compared to others less afflicted. Many physicians and nurses are not aware of this fact, and it confuses their judgement.

Obviously problems exist at a number of levels. Not only do health care providers require more extensive training in the treatment of depression in the terminally ill, but research has yet to be conducted that supplies the knowledge on which that training should be based. (The palliative medicine literature includes some valuable research and discussion on depression in the terminally ill, but more needs to be done.) Among the questions that remain to be addressed by research are these: What forms of depression should be expected to respond to treatment in the terminally ill? What psychotherapies are most effective for their treatment? What pharmacotherapeutic approaches are most effective, and how can risks be minimized? What constitutes "adequate" treatment of depression in the face of terminal illness, after which no further hope of response should be expected?

### Further Research Needs: Other Unanswered Questions

When someone requests assistance in dying, we may assume multiple forces determine the choice, and that depression or other psychiatric difficulties are likely to be only some among many considerations. We need to grasp as much as we can about all these influences if we are fully to understand and to come to some sensible judgement about the reasonableness of any given request. Among others, there will be factors pertaining to the terminal condition itself, factors intrinsic to the individual, and factors arising from the psychosocial environment.

*Characteristics of the terminal condition* that may influence decisions to ask for help in dying are the nature and extent of its associated pain, the level of functional disability, and possibly neurobiological changes resulting from the illness or its treatment that influence behavior and/or cognitive processes.

We have long understood that pain and disability may precipitate depression and, among the terminally ill, suicidal thinking.<sup>27</sup> Furthermore, physicians in general tend to underestimate the analgesic needs of critically ill patients. No data are available, however, regarding the proportion of undermedicated individuals who would still choose physician-assisted suicide or euthanasia were more effective pain control and illness management available to them. Physicians need better education not only about the recognition and assessment of

depression, but they need better training about pain management and analgesic strategies.

Recent advances in research on the psychobiology of self-destructive behaviors strongly suggest that alterations in brain neurochemistry underlie aggressive suicidal acts.<sup>28</sup> Similar evidence suggests a neurobiological etiology for some depressive disorders. No consideration has yet been given by researchers to the question of whether disease or treatment associated neurobiological changes may contribute to the emergence of the wish for death in some seriously and terminally ill people. This too is an area of high priority for future research.

*Characteristics of the individual* that may influence the election of assisted suicide or euthanasia arise from personality organization and previous life experience. Several studies have identified a distinctive pattern of personal traits among men with cancer who took their own lives.<sup>29</sup> Others have noted the influence that having lost a loved one to debilitating illness may play in the survivor's end-of-life decisions.<sup>30</sup> We lack any studies that address the place of such considerations in motivating patients who request assistance in dying. This lack is complicated by the fact that many suicides and assisted suicides in terminal illness are not reported as such. Such cases are very difficult to assemble for study.

Questions remaining to be answered by research include: Are people with certain personality traits or temperaments more likely to ask for assisted suicide or euthanasia in the face of terminal illness than individuals with a different personality structure? Do the associated factors influencing that choice differ between individuals as a function of that personality style? How would the nature of one's past experience with serious physical illness (e.g., observing a parent die a painful death with cancer, or intimate knowledge of one who committed suicide under such circumstances) influence one's personal attitudes towards suicide or euthanasia?

### Ignorance Respecting Palliative Care

The committee agrees that American medicine has failed sufficiently to develop and promote the intelligent practice of palliative care. Because much remains unknown, there is a good deal of controversy between able but differing experts. Dr. Ira Byock, a Hospice-associated physician who opposes the legalization of physician-assisted suicide, claims that virtually all terminal suffering can be relieved with currently available methods of palliative care if they are used correctly.<sup>31</sup> On the other side, Dr. Timothy Quill, the well-known physician who provided a lethal dose for his leukemia patient Diane and published an account of the case in *The New England Journal of Medicine*, estimates that, although the vast majority of dying patients die comfortably (or at least tolerably) when good palliative care is available, some do not. For these he believes physician-assisted death should be available when palliative care does not work.<sup>32</sup> Some claim that about 15% of terminally ill patients die miserably even with the best palliative care. Others insist that this is an overstatement. Though Quill and Byock agree that physician-assisted suicide or euthanasia should not be substituted for good palliative care, they disagree about how to approach those few patients who are threatened with terrible suffering in spite of the usual palliative measures. For these Quill advocates physician assisted suicide

or euthanasia; Byock believes that the exceptional case can be managed with deep sedation.

To argue that pain control is the only issue in the controversy between palliative-care partisans and assisted-suicide/euthanasia partisans is to oversimplify a complex matter. Studies of voluntary active euthanasia in the Netherlands show that pain is not the only issue—in only 5% of the cases was pain the sole reason for the patients' applications for assisted death, though it was a factor in a much larger proportion.<sup>33</sup> A most important issue is the matter of patient autonomy. In facing inevitable death, has the dying patient no right to meet it as he or she will? And what of the role of depression? Can depressed patients (many seriously ill and dying patients are depressed) really make competent, autonomous decisions? Byock argues that all physical suffering can be controlled with presently available means in all circumstances (profound sedation or in extreme cases anaesthesia could be employed).

All physical distress can be controlled....Certainly some small percentage of patients will have to accept sedation for the control of physical distress. Percentages of patients requiring terminal sedation also vary but will be fairly small. But there are *no* patients for whom combination of analgesia and sedation would not be effective at producing a comfortable sleep state.<sup>34</sup>

Byock's remarks throw doubt on the assertion that pain and discomfort cannot be alleviated under optimal circumstances, but it would appear that optimal palliative care cannot be taken for granted in the United States. Physicians are often ill-prepared to provide sophisticated programs of counseling, analgesia, and sedation. Some physicians confuse adequate palliative care, in which drugs are given only with the intent to preserve comfort, with euthanasia, and fail to treat pain adequately for fear patients will die. Though ignorance of the principles of good palliative care is probably the primary reason, there may be other attitudinal (countertransference) problems that interfere with good management of the dying.

It is also argued that even could pain and suffering be fully controlled, prolonged sedation of a terminally ill patient for whom there is no hope for recovery is equivalent to or morally worse than euthanasia. Profound sedation (anaesthesia) in effect suspends patients' conscious existence, sometimes, perhaps, without their full consent. All such patients die because they can neither eat nor drink, unless supplied artificially. Many feel that prolonged sedation that will end only in death is pointless and repugnant.<sup>35</sup> There are many differences of opinion as to this point of view.

The question of nonphysical suffering is a complicated one. When it is alleged that pain cannot be controlled, it is essential to consider whose pain, and the nature of the pain. Is the distress physical or emotional? If it is emotional, can it be alleviated by counseling or psychoactive medicine? If the pain is not the patient's, but that of others, what assistance can be offered them?

There is a tendency to view the emotional suffering of the terminally ill as somehow qualitatively different from the emotional suffering of others who are physically well. There is probably no such qualitative difference. In the absence of terminal physical illness the solution that suicide or euthanasia offers to

emotional suffering does not ordinarily offer itself as an acceptable alternative. No one proposes physician-assisted suicide or euthanasia for the chronically abused and mistreated or those caught in intolerable socioeconomic circumstances.

The claim that upwards of 15% of terminally ill patients suffer miserable deaths needs clarification and elucidation. Is the misery to which reference is made the misery of the patient, or does it include the misery of onlookers? Are some deaths that look bad to observers not really so hard for the patient? Under what circumstances does the misery and suffering take place, and whose is it?

When patients can die in reasonable comfort the last weeks and days of their lives are often marked by remarkable personal integration and growth. Energetic reminiscence often takes place, farewells are said, self-forgiveness and self-acceptance rise, and old angers and hurts are let go. Patients can be seen to grow in peace and in wisdom. So can the surrounding families and friends. Premature interruption of life by ill-timed medical interventions may deprive dying persons and those who are close to them of opportunities for major personal maturation.<sup>36</sup> At the same time, reports from the Netherlands suggest that patients who chose an assisted death may also undergo profoundly meaningful experiences of summation and leavetaking.

We plainly need more research to characterize the nature of terminal care as it is practiced, and to establish what the limitations may be of optimal palliative care. The education of physicians in this area is woefully insufficient.

### **Specific Problems Associated with Physician-Assisted Suicide**

To date most of the discussion of physician-assisted suicide presumes a scenario in which a physician, having agreed with a patient that suicide is reasonable, often supported by the opinion of an independent consultant, gives the patient a prescription for a deadly amount of a suitable drug. Filling it, the patient proceeds to take an overdose, either orally, or by injection, in the physician's absence.

While this committee does not endorse physician-assisted suicide, we are aware that little attention has been paid to the high likelihood of serious accidents inherent in such a scenario. Vomiting may occur as the patient slips into a coma, with aspiration of the vomitus. Should isolated patients change their minds they may nevertheless choke to death in a panic, or, if rescued, die of pneumonia. In the absence of the physician, those who attend patients in their suicides will usually be untrained to deal with such complications as aspiration. For instance, morphine, barbiturates, or other compounds from time to time produce states of confusion. Confused patients in states of intoxication may experience terror, panic, or become assaultive. And what are friends and relatives to do should the suicidal patient, slipping into a coma, change his mind, and beg for rescue?

If physician-assisted suicide is ever to be legitimized, does good medical judgment require that it should never be carried out in the absence of a physician? It may be argued that if a physician is in attendance, and if the physician is prepared to intervene to bring about the patient's death in the event

that a self-administered dose is insufficient or results in vomiting, panic, or assault, there is little moral difference for the physician between actively providing euthanasia, or assisting at a suicide.

It can be further argued that providing a patient a lethal prescription and then absenting oneself from the bedside thrusts inappropriate responsibility on the untrained friends or family who may be present when the patient attempts to die. To be taken into account are the emotional impact on those who witness the suicide, the subsequent risk for their self-reproach, or the possible consequences should one or more of the witnesses be overcome with feeling and try to abort the attempt. Were a physician present when a suicide attempt went wrong, he might be prepared actively to intervene and provide euthanasia if necessary.

Others argue that the presence of the physician would put pressure on the patient to end his life. If no physician is in attendance, it is easier to change one's mind. Ambivalence is inevitably present in such situations, goes the argument. The physician should do nothing to tip the balance in the direction of death, even by standing by when the patient prepares to take his life, since the doctor's presence might make it more difficult to delay.

## RECOMMENDATIONS

1. The committee recommends that the American Association of Suicidology take no position on physician-assisted death nor euthanasia.
2. At present we cannot recommend the support of legislation on these matters, either favoring physician-assisted suicide or euthanasia, or forbidding it. Much research is needed further to elucidate too many important unanswered questions.
3. We urge that the American Association of Suicidology form its own continuing study committee further to examine these issues, to assess and promote continuing research, and, if appropriate, to offer further reports in the future.
4. We recommend that the American Association of Suicidology develop educational programs on these subjects. A special day in the annual preconference program with special invitations to knowledgeable participants is also suggested.
5. We recommend that the American Association of Suicidology work with medical and nursing organizations, psychological and gerontological organizations, schools, and other interested groups to promote the study, development, teaching, and availability of good palliative care.
6. We recommend that the American Association of Suicidology work with medical and nursing organizations, psychological and gerontological organizations, schools, and other interested groups to ensure that physicians, nurses, psychologists, and other caregivers are properly trained and sensitized to the need for respecting patients' wishes regarding their care in the event of terminal or otherwise grave illness. Patients need help to make their wishes known before such conditions develop. Broader and fuller understanding of "living wills," health-care power of attorney documents, and similar instruments are needed.

## NOTES

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2. van der Maas, P. J., van Delden, J. J. M., & Pijnenborg, L. (1992). *Euthanasia and other medical decisions concerning the end of life*. New York: Elsevier. See Table 6.7 on p. 64, Table 7.7 on p. 75, and pp. 87, 57-69, and 181-187.
3. Prof. Rene Diekstra, personal communication.
4. Prof. Rene Diekstra, personal communication.
5. See the 1994 Spring and Fall issues of *Newslink* (the newsletter of the American Association of Suicidology) for comments by David J. Mayo and John T. Maltzberger.
6. Patient refusal of nutrition and hydration can be classed with such commonly accepted practices as patient-initiated refusal of mechanical ventilation, renal dialysis, or antibiotic use. It can be argued that refusal of medical intervention by a competent patient does not involve any act of commission or omission by the physician. In that view, this example would be one of suicide, not voluntary passive euthanasia. Others reject the use of "suicide" in such cases, and prefer to call them deaths through treatment withdrawal. See Byock, I. (1995). Patient refusal of nutrition and hydration: Walking the ever-finer line. *American Journal of Hospice and Palliative Care*, March-April, pp. 8-13. Also Bernat, J. L., Gert, B., & Mogielnicki, R. P. (1993). Patient refusal of hydration and nutrition: An alternative to physician-assisted suicide or voluntary active euthanasia. *Archives of Internal Medicine*, 153, 2723-2728.
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