Physician-assisted suicide: issues facing doctors

Physician-assisted suicide is sometimes presented as differing from euthanasia and without its inherent dangers; however, it does form an integral part of euthanasia. It has been estimated that up to half of those patients supplied with lethal drugs may be unable to commit suicide unaided; for psychological or physical reasons they then require active intervention by the doctor — or euthanasia (Onwuteaka-Philipsen et al, 1997).

SUICIDE

Suicide is a solitary decision and specific act defined in law. Suicide risk is a component of severe clinical depression, and although suicides occur in those without a known preceding depression, in clinical depression, resolution of the wish to die marks a treatment response. Depression occurs in about 20% of patients with advanced cancer, but is often undetected by those caring for them. In Kissane's review of seven patients who requested euthanasia in Australia (Kissane et al, 1998), four of these had symptoms of depression, but in none was the depression appropriately managed.

Psychiatric consultation for a medical patient requesting physician-assisted suicide is relatively rare (Groenewoud et al, 1997), occurring in about 3% of the estimated 9 700 requests per annum for euthanasia or physician-assisted suicide in Dutch medical practice. Clinical depression has been accepted as a reason for euthanasia in Holland.

In arguments about death, medical practice has sometimes appeared to be endowed with an ability to prevent death itself (Ashby, 1998). Most potent drugs have both wanted and unwanted actions. When a drug is given for one effect, e.g. morphine for analgesia, but a secondary known effect occurs, e.g. sedation, adverse events arising from this secondary effect have been criticized as a smoke-screen for euthanasia.

However, palliative care is clearly distinct from euthanasia (Ashby, 1998). For palliation, a drug is given with the express intent of relieving symptoms, in response to suffering, at a dose commensurate with that suffering. To do this, doses are progressively increased by increments, usually of 50–100%, until benefit is obtained; there must be clear documentation of this titration process. Most adults with cancer pain obtain analgesia with doses of 30–200 mg of morphine orally per 24 hours, but the dose range is very wide. Patients are then maintained on this dose unless pain breaks through, when the dose is raised. If there is any evidence of toxicity, implying decreased analgesia requirements, the dose is lowered. There is no evidence that this practice hastens death (Ashby, 1998).

INFORMED CONSENT

Interactions between physician and patient require consent. As such consent is only valid if the prerequisites of information, voluntariness and patient competence are met. The patient trusts the doctor's decision-making, depending on the physician for information about the illness, prognosis and all possible interventions. The patient is vulnerable to influence by the doctor's attitude; a cure-oriented doctor, feeling that nothing can be done, may easily impart despair and a sense of hopelessness to both the patient and their family.

In the immediate period after bad news a patient's reactions of despair, disbelief, denial and searching are common. These are responses to loss: loss of a future and loss of health are commonly cited triggers to this 'bereavement response', often accompanied by depression as the patient adapts to living with uncertainty. In a progressive study of patients from diagnosis to death, factors such as care by family members, support groups, pain management and treatment of depression influenced patients not to act on their previous requests for euthanasia or physician-assisted suicide (Severson, 1997). In Kissane's study (Kissane et al, 1998) loneliness and unresolved grief were prominent features in those requesting euthanasia.

INFORMATION

Any decision-making process requires information, yet prognosis is notoriously difficult to predict. An estimated prognosis is a 'best guess' based on aggregated data about the diagnosis and disease staging, but cannot predict exactly what will happen to this individual patient. However, the patient is concerned about what will happen to him/her, rather than what happens to an arbitrary group of others. Currently the onus to act in the 'best interest of the patient' allows for treatment cessation and withdrawal decisions by professionals, but defaults towards life-conserving measures whenever doubt exists, protecting the patient from prejudice or the unscrupulous.

DECISION-MAKING

Decision-making must be voluntary and free from duress. Family dysfunction is very difficult to assess, even for a GP who may know the family relatively well, let alone the doctor providing a second opinion. Societal pressure with an increasing geriatric population and the financial stringencies of recession may also make the patient feel burdensome to society, useless, unvalued and with a duty to die. Physician-assisted suicide provides cost-savings on care; in a study of attitudes among physicians, those who practice resource-conserving medicine were significantly more likely to provide a lethal prescription at the request of a terminally ill patient (Sulmasy et al, 1998).

Interestingly, in recent years euthanasia/physician-assisted suicide has been increasing in Holland to now encompass at least one in three patients with acquired immunodeficiency syndrome (AIDS; Onwuteaka-Philipsen and van der Wal, 1998). This group's rapidly increasing uptake of euthanasia may represent changing societal norms and pressures.

PHYSICIAN-ASSISTED SUICIDE

At first sight physician-assisted suicide seems a way of devolving the physician's responsibility onto the patient. However, the physician is inherently responsible for the information given to the patient, the way that information is given and subsequent management plans. Imparting hopelessness, engendering despair, failing to relieve unremitting symptoms or distress and failure to refer to others for help all represent failures in the duty of care. Providing care is hard work emotionally and often time-consuming. For the exhausted professional short cuts in care can become increasingly tempting.

There is evidence that physicians themselves do not feel comfortable with the decision of euthanasia/physician-assisted suicide. Of those who have given a lethal injection, 23% report regretting their action (Emanuel et al, 1998). Ignorance of palliative care skills is known to persist among doctors (Grande et al, 1997). Doctors do not currently have widespread expertise in assessing mental status, diagnosing and treating depression, maximizing palliative interventions and evaluating the external pressures on patients.

Currently, prognostication is poor over functional and cognitive decline and even about life expectancy. Yet when faced with the patient's request for physician-assisted suicide, the physician would be required to judge the validity of the request. But what is the underlying reason for the request? Does the patient seek reassurance over coping with the unknown that lies ahead and help with living with uncertainty? Suffering will always occur; euthanasia will not obliterate it, but we ignore lessons from history at our peril. Euthanasia may allow a less caring society to dispose of its problems without conscience.

KEY POINTS

- Physician-assisted suicide is an integral part of euthanasia, it cannot be separated from it.
- Issues behind a request for assistance with death must be understood.
- The attitude of the doctor and of others influences the patient's decision-making.
- Depression is often undetected, and therefore not treated, in those with serious medical conditions.
- Morphine appropriately prescribed for analgesia does not shorten life.
- Patients' wishes change as disease progresses, depending on the amount of support they receive.
- Allowing doctors to kill patients, under whatever terms, allows society to abandon its duty to care in favour of utilitarianism.

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