Physician Assisted Dying and Requests for Hastened Death

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Objectives

- Review historical, legal and ethical views on PAD and Euthanasia
- Review assessment and management of requests for hastened death
- Review Oregon data on PAD
- Reflect on our own opinions, biases, generate discussion
Which best describes your opinion about legalized physician/provider assisted dying (PAD)?

a. I would comply with a request for PAD, even if it were illegal if after careful assessment I felt it was a reasonable request

b. I would comply with a request for PAD in the right clinical situation only if it were legal

c. I would not comply with PAD in any circumstance, alternatives exist, and I would not participate even if it were legal

33% 33% 33%
Your experience with requests for hastened death, in your career have you ever received a request?

1. Yes
2. No
Your experience with requests for hastened death, Have you received a request for hastened death in the past *year*?

1. Yes
2. No

[Diagram showing 50% Yes and 50% No]
Your experience with requests for hastened death,
Have you ever *honored* a request for hastened death?

1. Yes
2. No
National Survey of PAS and Euthanasia in the US, 1998

- 1902 surveys, 10 specialties, all regions of the US represented
- 18.3% had received a request since entering practice
- 3.3% of the entire sample, reported that they had written at least one prescription to be used to hasten death
- 4.7% percent had administered at least one lethal injection.

(Meier et al, NEJM 1998)
Case of Mrs. B

- 69 y.o. white female smoker, copd and large lung mass for which she refused biopsy.
- Widowed, has a son and daughter, lives independently, refusing help. Described by family as “always difficult”
- Admitted for change in mental status, new brain mets with edema, improved with RT and steroids.
- Admitted to palliative care unit w/weakness, anxiety and agitation, denied depression, pain or dyspnea.
- Functional decline, reports being unsatisfied with her existence. Asked her provider for something to “make things go faster” or to “put me to sleep,” stating “what is the point of waiting?”
Case of Mr. H

- 58 y.o. white male with ALS
- Palliative care team called, on admission when he stated he wanted to be given something to help him die
- Involved sister, patient able to speak and swallow but mostly paralyzed, completed DNR DNI and no artificial nutrition
- Expressed concerns about “losing his voice”
- Physical symptoms controlled but patient continued to present with distress and ambivalence
- Did not want to pursue legal options that might result in increased comfort and potentially hastened death via double effect
Case of Mr. D

- 39 y.o. Venezuelan male with recurrent gastric cancer admitted with carcinomatosis and non-operable malignant bowel obstruction
- Mother visited from Venezuela, first visit together in 3 years, many supportive friends and family
- Enjoyed cooking and eating, had been very active until 1 mo prior to admission
- Moved to inpatient hospice unit, IV fluids, PCA for pain, octreotide with good symptom control
- Patient requested hastened death if there was no chance of reversing current situation
- Discussed legal alternatives
Definitions

- **Euthanasia** – From Greek Eu = good and thanatos = death, meaning a good or easy death. The modern definition is giving a medication with the *intent* of causing death in the setting of incurable or painful disease.

- **Negative or passive euthanasia** refers to withholding or withdrawing life sustaining treatment. This term is not used in this way today.

- **Positive or active euthanasia** refers to a person, most often physician, giving a medication with the *intent* of causing a hastened death in setting of terminal illness.
Definitions

- **Voluntary active euthanasia** makes clear that the decision to end life is that of the patient not the physician, provider, or other interested party.

- **Physician assisted suicide (PAS)** is voluntary termination of one's own life by self administration of a lethal substance with the direct or indirect assistance of a physician. The physician does not administer the lethal medication.

- **Physician assisted death (PAD)** refers to both PAS or voluntary active euthanasia.
Definitions

- **Double Effect** is the principle whereby a patient receives medications such as opioid analgesia or benzodiazepines with the *intent* of treating severe and distressing symptoms; however, the *unintended* but predictable side effect may be to indirectly and unintentionally hasten death.

- **Palliative Sedation** is medical sedation used to treat intractable, intolerable symptoms with the intent of relieving suffering when a patient is near the end of life.
Historical perspective

- Ancient Greece and Rome – Euthanasia recorded as part of typical care in terminal agonizing conditions
- “I will not give a lethal drug to anyone if I am asked nor will I advise such a plan”
- School of Hippocrates view was a minority position
- This view was further supported by rise of Christianity
- Between 12th to 15th century European physicians opposed euthanasia consistently

(Emanuel, Ann Int Med, 1994)
Historical perspective

- Sir Thomas More, 15th century – first reference to euthanasia in English literature in *Utopia*
- Francis Bacon, 17th century - “physicians duty not only to restore the health but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve a fair and easy passage”
- 19th century advances in anesthesia, morphine identified
- Study published on ether in surgery also mentions it might be “useful in mitigating the agonies of death”
- Civil War, hypodermic morphine, studies on use of morphine to “palliate pain during death”
Historical perspective

1870, Samuel D. Williams published essay on Euthanasia:

“The main object of the essay being merely to establish the reasonableness of the following proposal: That in all cases of hopeless and painful illness, it should be the recognized duty of the medical attendant, whenever so desired by the patient, to administer chloroform or such anesthetic...so as to destroy consciousness at once and put the sufferer to a quick and painless death; all needful precautions being adopted to establish, beyond a possibility of doubt that remedy was applied at the express wish of the patient”

JAMA response called it an attempt to make “the physician don the robes of an executioner”
Historical perspective

- Early 20th century attempts to legalize euthanasia in US and Britain
- Discovery of Nazi death camps and physician role in atrocities
- 1969 bill introduced in Britain to legalize euthanasia
- 1970-80s and rise of patient autonomy, medical ethics profession and public interest in issue
Historical perspective: 1970s-1990s
Terri Schiavo
Historical perspective: 1990s to present
2014: Brittany Maynard
Drive Carefully...
Legal perspective - PAD

- PAD legal in Switzerland, Germany, Netherlands, and some US States
- Euthanasia legal in Netherlands, Belgium, Luxembourg, Canada, Colombia
- US Supreme court supports right to refuse treatment, does not constitutionally protect right to legal PAD, delegated to states
- States with legal PAD: California, Colorado, District of Columbia, Hawaii, Oregon, Vermont, Washington, Montana*
- New Jersey – passed house and assembly 3/25
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<th><strong>Con</strong></th>
<th><strong>Pro</strong></th>
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<tr>
<td>Personal patient autonomy does not outweigh professional and societal values</td>
<td>Patient autonomy</td>
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<td>Slippery slope</td>
<td>Safeguards if regulated and it is already occurring</td>
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<td>Could permanently damage provider-patient relationship</td>
<td>Moral and ethical obligations of profession extend to relieving suffering and supporting dignity</td>
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<td>Adequate access to palliative care can address concerns</td>
<td>With best pall care there will be patients with unmet need</td>
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<td>Legal alternatives exist</td>
<td>No distinction between euthanasia and withdrawal of LST</td>
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<td>Why physician?</td>
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**Ethical debate: Legalized PAD**
PAD Debate

WHAT EXACTLY IS THE LATEST ON THE ASSISTED SUICIDE DEBATE...?
Public and professional opinion

- The American Geriatric Society, American Medical Association and American College of Physicians-American Society of Internal Medicine all oppose the legalization of physician assisted suicide and euthanasia.

- The American Academy of Hospice and Palliative Medicine supports a position of “studied neutrality”
AAHPM Position Statement

AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited. However, as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks unintended long-range consequences that may not yet be discernable, including effects on the relationship between medicine and society, the patient and physician, and the perceived or actual integrity of the medical profession.
Public and professional opinion

- Public support ranges from 44-75%.
- Professional opinion polls vary widely, variations related to location, clinical training and personal characteristics such as religious beliefs.
- Professional support for legalization of PAD is generally lower than the public support.
- A 2001 study of US physicians showed 44% in favor of legalizing PAD

(Whitney et al, J Gen Int Med, 2001)
Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients With Cancer  
(Breitbart et al, JAMA 2000)

- Evaluated inpatients with terminal cancer, MMSE >20
- Assessed on multiple scales for depression, hopelessness, physical symptoms, functional status, overall well-being and quality of life
- Schedule of Attitudes Toward Hastened Death (SAHD)
Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients With Cancer  
(Breitbart et al JAMA 2000)

- 16% were depressed
- 17% with “high” desire for hastened death
- Depression diagnosis, depression severity and hopelessness were each significantly associated with desire for hastened death
- Depression and hopelessness independently contributed to DHD
- Strong association with poor spiritual well-being, poor QOL ratings, being a burden and overall symptom distress
- No association with pain
Treatment options

- Dignity Therapy, Chochinov
- Meaning-centered therapy, Breitbart
- Anti-depessant pharmacotherapy
Treatment options?

- Study comparing meaning-based group psychotherapy (MBGP) vs supportive group psychotherapy (SGP)

- 253 Advanced cancer patients, randomized to 2 groups, intention to treat analysis

- Assessed using validated tools before and after treatment and 2 months after

- MBGP patients with improvement in depression, hopelessness and DHD

Breitbart et al J Clin Onc 2015
Treatment options?

- Study of 372 patients with advanced AIDS assessed for Desire for Hastened Death (DHD) and depression
- Depressed patients treated with antidepressants
- Decreased depression was associated with decreased DHD, decreased depression was not significantly associated with antidepressant use, but those who had improved depression and were on antidepressants had biggest improvement in DHD

Breitbart et al Psychosomatics 2010
Treatment options?

- Ketamine
- Psychedelics
Importance of careful assessment

"Hmm, if I may, Mrs Hamilton, before we discuss assisted suicide, I do feel I should at least examine your husband."
Reflections

- What is “normal” in terminally ill patients?
- How do we distinguish “acceptance” from desire to hasten death?
- Is there value in this stage of life? Value in suffering?
- What do we bring into the room?
- Role of provider in assisted dying?
Oregon:

Death With Dignity Experience
Oregon Death With Dignity Act (DWDA)

- Passed initially passed in 1994, revote in 1997
- 1998 to 2007 reveal that, 541 people were given prescriptions and 341 died from ingesting the prescriptions for PAD.
- More than one-third of those receiving prescriptions did not use them
- Model for law in Washington state
Oregon: Eligibility to request PAD

- An adult (18 years of age or older)
- A resident of Oregon
- Capable (defined as able to make and communicate health care decisions)
- Diagnosed with a terminal illness that will lead to death within 6 months
Oregon: Steps necessary to receive a PAD prescription

- Patient makes two verbal requests to physician, separated by 15 days
- Patient provides written request to physician
- Prescribing physician and a consulting physician must confirm the diagnosis, prognosis and make a capacity determination. If MD believes the patient’s judgment is impaired by a psychiatric or psychological disorder, the patient referred for counseling
Oregon: Steps necessary to receive a PAD prescription

- Prescribing physician must inform patient of feasible alternatives to assisted suicide including comfort care, hospice care, and pain control.

- Prescribing physician must request, but not require, patient to notify next-of-kin of the prescription request.
Since 1997, 1967 prescriptions written under the DWDA, 1275 deaths from Rx use/ingestion

In 2017, 218 prescriptions, 130 ingestions, 143 died from ingestion deaths (130+14 ingestions from previous year Rx)

2017: 44 (20%) did not ingest and died of illness

2017: 1 ingested meds and regained consciousness, died of illness

Top reasons for request: loss of autonomy (91%), decreasing ability to participate in activities that made life enjoyable (90%), and loss of dignity (76%).
Oregon DWDA : 2017

Demographics

- In 2017: 58% male, 94% white
- Since 1997: 52% male, 96% white
- Since 1997: only 1 AA (0.1%), 1.2% Hispanic, 1.5% Asian
- 96% of patients were > 55 years old
- 58% unmarried
- 78% cancer dx
- 90% died at home
Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2017

*As of January 19, 2018
See Table 2 for detailed information
Oregon DWDA : 2017

Demographics

- 3.5% referred to psychiatry in 2017
- 90% had hospice care (up from 86% in 2007)
- 99% had health insurance (increasingly public insurance, 68%)
- Well educated, 69% with some college or more
Vulnerable populations

- 2007 study evaluating vulnerable populations in Netherlands and Oregon
- No increased risk/use for elderly, women, poor, uninsured, physically disabled, minors, mentally ill, or low educational status
- Only heightened risk found was in patients with HIV/AIDS
- Leads to question of access, rather than concern for slippery slope?

(Battin et al, J Med Ethics, 2007)
Slippery Slope revisited

- Convicted rapist murderer requested euthanasia for “incurable violent impulses and the misery of life behind bars”
- 2007-2001, 48 of 100 requests at a Belgian clinic granted permission for euthanasia for depression, schizophrenia or Aspergers Syndrome
- Belgium, legalized euthanasia for children under 12 yrs
- 44 year old anguished after a botched gender affirming surgery euthanized
Requests for hastened death

- Direct request versus veiled statements
- Requests for information about how the end will be
- Requests for reassurance about care at the end of life
- Hoarding medications for later
- Pacts with other people
Requests for hastened death

- Statements or veiled requests can be a sign of crisis
- Can be a rich clinical opportunity
- May want reassurance about non-abandonment, ability to control future symptoms and distress
- In 2007 DWDA deaths, none were evaluated by mental health
- In 2017, 5 referred referred to mental health
Responding to requests for hasten death

- What do you do?
- Do you feel your skills are adequate?
- How did you acquire these skills?
- Have you taught this skill to residents or medical students?
- Have you modeled this behavior with trainees?
Responding to requests for hasten death

- Clarify the request
- Assess and identify the underlying causes of the request, source of suffering
- Affirm your commitment to care for the patient, be honest about personal and professional boundaries while continuing to reassure the patient of ongoing support
Responding to requests for hasten death

- Address the root causes of the request when possible, identifying untreated physical, psychological, social and spiritual symptoms.
- Involve specialty colleagues including palliative care professionals, mental health clinicians, clergy or chaplaincy, social work.
Responding to requests for hasten death

- Educate the patient and discuss legal alternatives to PAD
- Consult with colleagues both to support the patient more thoroughly and to address clinicians own emotional and psychological reactions to the patients request
Legal Alternatives to PAD/Euthanasia

- Withdrawing or declining life sustaining therapies
- Voluntarily stopping nutrition and hydration
- Palliative sedation with/without artificial nutrition and hydration
- More aggressive management of existing symptoms, allowing for unintended but expected side effects which may be associated with a hastened death
Case of Mrs. B revisited

- After discussion of the above legal options, patient agreed to allow some symptoms to be more aggressively managed.
- Started standing lorazepam and haloperidol for anxiety and agitation.
- She was more sedated but still awakened to eat, able to communicate needs.
- No longer requested hastened death.
Mr H revisited

- Continued life prolonging medications for months, stopped them once swallowing and speaking became difficulty
- Never agreed to more aggressive symptom management
- Went to NH with hospice, then to inpatient hospice with respiratory distress and died within days of that event
Case of Mr. D revisited

After discussion of legal options, patient aware of outcomes and option to stop artificial hydration

Discussed views on the value and meaning in final stages of life

He never stopped his artificial hydration

No longer requested hastened death
Summary

- On going ethical and legal debates
- Having an option may be the necessary intervention in more than one third of cases
- Further study on pharmacological and psychological intervention for DHD
- Better at identifying and treating depression near the end of life
- Recognize request as both a patient crisis and a clinical opportunity
- Assess your own emotions and biases about this complex topic
Thank you!