

Position Statement on Physician-Assisted Suicide and Opposition to AB 374

Association of Northern California Oncologists & Medical Oncology Association of Southern California

April 16, 2007

The Association of Northern California Oncologists and the Medical Oncology Association of Southern California, which together represent nearly 600 oncologists in both community practice and academic medicine, oppose the legalization of physician-assisted suicide (PAS) and urge Assembly Members to vote NO on AB 374.

Physician-assisted suicide is the wrong answer to the right question. The Oregon “Death with Dignity Act” and AB 374 allege to focus on patient autonomy, but the focus should be on doing everything we can to improve care at the end of life. The right answer to the question is that the dying need competent medical treatment, and that is best accomplished by the learned and timely application of hospice care and palliative medicine.

Legalizing physician-assisted suicide strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship. The physician’s primary directive is to *first, do no harm*. Physician-assisted suicide destroys the trust between the patient and doctor. Under the pretense of providing compassion, the physician is relieved of his or her primary responsibility to the patient – to safeguard life and to provide comfort to the suffering. It is the ultimate patient abandonment.

Oncologists are painfully aware of our own limitations in providing optimal palliative care in every situation. We also recognize that most members of the public, as well as many physicians in other specialties who do not treat dying patients with any regularity, do not see what we see every day in our practices. We believe that far fewer physicians would support the concept of physician-assisted suicide if they had the specific training and experience that oncologists have in dealing with these types of patients and these diagnoses. We know that cases of patients experiencing intractable physical symptoms at the end of life do exist, but this is not a justification for aid in dying. We need more research and education, not patient termination.

In this debate, it is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do *not* do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. This has been borne out in numerous studies and reports. For example, in a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada, a multivariate analysis showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient’s expressed desire or support for euthanasia/PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to

be suffering from depression or anxiety, but not somatic symptoms such as pain.¹ An important study from the Netherlands of a cohort of 138 cancer patients with a life expectancy of three months or less demonstrated similar findings.² In this study, the authors had hypothesized that patients requesting euthanasia would be unlikely to have depressed mood or affect, since it would be expected that such a request would be a well-thought out decision, particularly since euthanasia has been legal in the Netherlands since 2002. The authors expected that these patients would be more accepting of their terminal diagnosis and therefore better adjusted. What they found surprised them – depressed patients were more than four times as likely to request euthanasia as patients who were not depressed. Over 40% of depressed patients requested euthanasia. Of those who requested euthanasia, about half were depressed.

Prominent bioethicist Ezekiel Emanuel of the National Institutes of Health has written eloquently on this “depression thesis” in regards to euthanasia and PAS and notes

[R]equests for [euthanasia and PAS] tend to be guided by psychological distress rather than rational choices about a good death. This conclusion should be especially worrisome given that approximately 15% to 25% of cancer patients are depressed, and approximately 80% of requests for euthanasia or PAS come from cancer patients. When the depression thesis is juxtaposed with epidemiologic data demonstrating that, in general, suicide is approximately 30% to 50% more likely among cancer patients and that depression is a primary motivation for suicide, euthanasia and PAS look more like a method of acting on suicidal ideation than a type of termination of medical treatment.³

Depression and psychological distress are prevalent disorders in terminally ill patients and need to be sought out and aggressively treated. These can be difficult conversations between physicians and patients at the end of life, but our patients deserve this from us, and not the convenient resolution of a lethal prescription.

The vast majority of legitimate physician organizations oppose physician-assisted suicide. The California Medical Association (CMA) has reaffirmed its opposition to PAS five times since the 1980s, most recently at its House of Delegates in 2005 and again in 2006. In a February 15, 2007 press release, the CMA states

The CMA believes in humane and compassionate care for the terminally ill, including appropriate pain control and counseling for the dying and their families. But assisting someone to die is unethical and unacceptable, and is fundamentally incompatible with the physician’s role as healer.⁴

The American Medical Association states in its code of ethics:

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks

¹ Suarez-Almazor ME et al. Attitudes of terminally ill cancer patients about euthanasia and assisted suicide: predominance of psychosocial determinants and beliefs over symptom distress and subsequent survival. J Clin Oncol. 2002;20:2134-41.

² Van der Lee ML et al. Euthanasia and depression: A prospective cohort study among terminally ill cancer patients. J Clin Oncol 2005;23:6607-6612.

³ Emanuel EJ. Depression, euthanasia, and improving end-of-life care. J Clin Oncol. 2005;23:6456-8.

⁴ Accessed at <http://www.emanet.org/publicdoc.cfm/2/1/presssection2/384> April 15, 2007.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.⁵

The American College of Physicians, the nation's largest medical specialty society, states:

The profession's most consistent ethical traditions have always emphasized healing and comfort and have demurred at the idea that a physician should intentionally bring about the death of any patient. Pronouncements against euthanasia and assisted suicide date back to the Hippocratic Oath and have formed the ethical backbone for professional opposition to the practice of physician-assisted suicide.

[and]

To the extent that this is a[n ethical] dilemma partly due to the failings of medicine to adequately provide good care and comfort at the end of life, medicine can and should do better. We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide.⁶

In addition, oncologists have expressed opposition to physician-assisted suicide and euthanasia in several prominent surveys. A survey of 3200 oncologists reported at the 1998 Annual Meeting of the American Society of Clinical Oncology showed that support for physician-assisted suicide decreased by half between 1994 and 1998.⁷ In another study by Emanuel et al, 324 oncologists surveyed about their attitudes towards physician-assisted suicide showed a consistent increase in opposition to PAS over the twelve month course of the study, from an approval ranging from 18% to 46%, depending on the clinical scenario, to an approval ranging from 13% to 31% for the follow-up survey six to twelve months later. The authors conclude that, increasingly, physicians and the public do not share the same views on the ethics of physician-assisted suicide, a critical implication if physicians will be the ones asked to perform PAS.⁸

Much has been made of the Oregon experience and how it is purported to have improved hospice care in that state. It is important to study the effects of the law critically. In reviewing the publicly available report⁹ of the 38 patients who died in 2005 as a result of physician-assisted suicide, the following observations are noteworthy:

⁵ American Medical Association Code of Ethics. Last updated August 22, 2005. Accessed at <http://www.ama-assn.org/ama/pub/category/8459.htm> April 15, 2007.

⁶ Snyder L et al. Position paper: Physician-assisted suicide. *Ann Intern Med.* 2001;135:209-216.

⁷ American Society of Clinical Oncology. News Release. May 16, 1998. Accessed at http://asco.org/asco/shared/asco_print_view/1.1168_12-002167-00_18-0012696-00_19-0012698-00_20-001.00.html April 15, 2007.

⁸ Wolfe J et al. Stability of attitudes regarding physician-assisted suicide and euthanasia among oncology patients, physicians, and the general public. *J Clin Oncol* 1999;17:1274-1279.

⁹ State of Oregon, Department of Human Services, Office of Disease Prevention and Epidemiology. Eighth annual report on Oregon's death with dignity act, March 9, 2006 Accessed at <http://egov.oregon.gov/DHS/ph/pas/docs/year8.pdf> April 15, 2007.

- Despite the reporting requirements, death by physician-assisted suicide in Oregon largely occurs in the dark. There is little accurate information about what actually happens at the time of death, as physicians are not required to be present at the time of ingestion. In 2005, physicians were in attendance in only 23% of cases. Information about the actual experience of death is derived from accounts provided by other individuals who stay with the patient. Between 1998 and 2005, the time between ingestion and death ranged from four minutes to 48 hours. It is hard not to imagine that those patients who required 48 hours to die might have experienced suffering over and above that brought on by the terminal illness. Indeed, this has been the experience in the Netherlands, with a report from 2000 showing that so called “problems with completion” (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16% of cases, prompting physician intervention 18% of the time, which of course blurs the line considerably between suicide and euthanasia¹⁰.
- Even though 80% of patients had cancer, only 23% of the prescribing physicians were oncologists. Most were family practitioners, who may have had minimal training in palliative care. Oncologists are the physicians best suited to care for cancer patients at the end of life.
- Few patients requested suicide because of inadequate pain control or concern about it (24% in 2006), consistent with the findings discussed above. Loss of autonomy and decreased ability to engage in pleasurable activities were cited in excess of 78% of cases. What percentage of these cases might have been helped by aggressive psychiatric intervention or spiritual counseling?
- The percentage of patients referred to a specialist for psychological evaluation beyond that done by a hospice team decreased from 27% in 1998 to 5% in 2005. It seems implausible that over that same time period physicians prescribing lethal medications were 22% more capable of diagnosing depression or psychiatric illness.
- The median duration of the patient-physician relationship in 2005 was eight weeks, and for all patients between 1998 and 2004, it was twelve weeks. This means that the attending physician in the majority of cases would have had little more than a passing relationship with the patient and in all likelihood was not the treating oncologist. Furthermore, it strongly implies that “doctor-shopping” is occurring in Oregon. Not having longitudinal follow-up of a patient’s individual case deprives the physician of important insights into that patient’s emotional and spiritual condition and makes it more likely to miss a diagnosis of depression. Only 6% of Oregon psychiatrists are “very confident” they can determine in a single visit when depression may be affecting decisions to commit assisted suicide in the absence of a long-term relationship.¹¹

¹⁰Groenewoud JH et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med.* 2000; 342:551-556.

¹¹Ganzini L. et al. Attitudes of Oregon psychiatrists towards assisted suicide. *American Journal of Psychiatry.* 1996; 153:1469-1475.

We should not make the same mistake in California. Irrespective of one's moral or ethical viewpoint, we need to look critically at the supposed safeguards of AB 374:

- The bill is silent as to the nature of the relationship between the patient and the physician who will ultimately prescribe the lethal medication. There is no safeguard that says the attending physician must have anything longer than a 15-day relationship with the patient, let alone any requirement whatsoever that a physician trained in palliative care must be involved in the assessment of the patient.
- Section 7196.1. Physicians are wrong about a given patient's prognosis more often than they are right. A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data. Despite skill and experience, physicians often make errors in estimating a patient's prognosis, not because of a lack of information, but because new information (test results, observations of interventions, etc.) comes to light. As oncologists, every week in our practices we see patients surviving many months or even years longer than originally estimated because of variability in disease manifestations or unanticipated benefits from treatment, and we rejoice with our patients in these "errors." But if our prognosis were wrong in regards to a patient choosing a lethal ingestion, the patient pays the ultimate penalty.
- Section 7196.2. If, in the attending or consulting physician's "opinion" the patient suffers from a disorder impairing his judgment, the patient will be required to undergo counseling. The same requirement will apply to patients not enrolled in a hospice program. In other words, formal counseling by a mental health professional is not mandated in all circumstances. This is most unfortunate, since there is no question that depression, mood and thought disorders, dementia, and existential distress will be missed. Even hospice workers and physicians expert in end of life care frequently fail in this regard, let alone generalist physicians who will likely be the ones caring for these patients if the California experience were to parallel that of Oregon. For example, in one study of 25 oncology clinics, oncologists markedly underestimated the level of depression in the most severely depressed patients.¹² Moreover, the fact that the language of the bill states that the psychiatric disorder must "impair judgment" means that there is no requirement for a profoundly depressed patient to receive a trial of antidepressant medication or psychotherapy if they do not have a co-existing thought disorder impairing their judgment or reality testing. This alleged safeguard is indeed flimsy when closely examined.
- Section 7196.4. Patients requesting PAS are not required to notify their next of kin, which means that those patients already socially isolated will remain so through their death.
- Section 7196.8. As with the Oregon statute, there is no requirement that the physician be present at the time of ingestion, so ultimately we will not really know how patients are

¹² Passik SD. Oncologists' recognition of depression in their patients with cancer. *J Clin Oncol.* 1998;16:1594-1600.

dying. Documentation requirements end with physician making “a notation of the medication prescribed.” Inexplicably, Section 7197.1(a) even says that collection of information about use and compliance “shall not be a public record and shall not be made available for inspection by the public.” Only a general annual statistical report will be required. What is the rationale for cloaking the process in the same secrecy that currently exists in Oregon?

- Section 7199 (Article 5. Form of the Request). What is the guarantee that these terminal patients will be fully informed by the prescribing physician that the “potential associated risks” (line 6) of the lethal medication include the 16% risk of “failure of completion” as shown in the Dutch study cited above?

California oncologists oppose AB 374 because it is bad law, bad ethics, and bad medicine. It grants us a right that as physicians we don't want and our patients don't need. We cannot allow patients to be killed because there are times when we fail to provide the best palliative care. What we need is education of physicians and the public about hospice and palliative medicine and a removal of societal and regulatory barriers preventing their more widespread utilization. Only then will optimal end-of-life care become a reality.