February 1, 2004
Psychiatric Times. Vol. 21 No. 2

Commentary: The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care

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Euthanasia is a word coined from Greek in the 17th century to refer to an easy, painless, happy death. In modern times, however, it has come to mean a physician's causing a patient's death by injection of a lethal dose of medication. In physician-assisted suicide, the physician prescribes the lethal dose, knowing the patient intends to end their life.

Giving medicine to relieve suffering, even if it risks or causes death, is not assisted suicide or euthanasia; nor is withdrawing treatments that only prolong a painful dying process. Like the general public, many in the medical profession are not clear about these distinctions. Terms like assisted death or death with dignity blur these distinctions, implying that a special law is necessary to make such practices legal--in most countries they already are.

Compassion for suffering patients and respect for patient autonomy serve as the basis for the strongest arguments in favor of legalizing physician-assisted suicide. Compassion, however, is no guarantee against doing harm. A physician who does not know how to relieve a patient's suffering may compassionately, but inappropriately, agree to end the patient's life.

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Patient autonomy is an illusion when physicians are not trained to assess and treat patient suffering. The choice for patients then becomes continued agony or a hastened death. Most physicians do not have such training. We have only recently recognized the need to train general physicians in palliative care, training that teaches them how to relieve the suffering of patients with serious, life-threatening illnesses. Studies show that the less physicians know about palliative care, the more they favor assisted suicide or euthanasia; the more they know, the less they favor it.

What happens to autonomy and compassion when assisted suicide and euthanasia are legally practiced? The Netherlands, the only country in which assisted suicide and euthanasia have had legal sanction for two decades, provides the best laboratory to help us evaluate what they mean in actuality. The Dutch experience served as a stimulus for an assisted-suicide law in Oregon--the one U.S. state to sanction it.

I was one of a few foreignresearchers who had the opportunity to extensively study the situation in the Netherlands, discuss specific cases with leading Dutch practitioners and interview Dutch government-sponsored euthanasia researchers about their work. We all independently concluded that guidelines established by the Dutch for the practice of assisted suicide and euthanasia were consistently violated and could not be enforced. In the guidelines, a competent patient who has unrelievable suffering makes a voluntary request to a physician. The physician, before going forward, must consult with another physician and must report the case to the authorities.

Concern over charges of abuse led the Dutch government to undertake studies of the practice in 1990, 1995 and in 2001 in which physicians' anonymity was protected and they were given immunity for anything they revealed. Violations of the guidelines then became evident. Half of Dutch doctors feel free to suggest euthanasia to their patients, which compromises the voluntariness of the process. Fifty percent of cases were not reported, which made regulation impossible. The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they "terminated the lives of patients without an explicit request" from the patient. Another third of the physicians could conceive of doing so.

An illustration of a case presented to me as requiring euthanasia without consent involved a Dutch nun who was dying painfully of cancer. Her physician felt her religion prevented her from agreeing to euthanasia so he felt both justified and compassionate in ending her life without telling her he was doing so. Practicing assisted suicide and euthanasia appears to encourage physicians to think they know best who should live and who should die, an attitude that leads them to make such decisions without consulting patients--a practice that has no legal sanction in the Netherlands or anywhere else.

Compassion is not always involved. In one documented case, a patient with disseminated breast cancer who had rejected the possibility of euthanasia had her life ended because, in the physician's words: "It could have taken another week before she died. I just needed this bed."

Since the government-sanctioned Dutch studies are primarily numerical and categorical, they do not examine the interaction of physicians, patients and families that determines the decision for euthanasia. Other studies conducted in the Netherlands have indicated how voluntariness is compromised, alternatives not presented and the criterion of unrelievable suffering bypassed. A few examples help to illustrate how this occurs:

A wife, who no longer wished to care for her sick, elderly husband, gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to have his life ended; the doctor although aware of the coercion, ended the man's life.

A healthy 50-year-old woman, who lost her son recently to cancer, refused treatment for her depression and said she would accept only help in dying. Her psychiatrist assisted in her suicide within four months of her son's death. He told me he had seen her for a number of sessions when she told him that if he did not help her she would kill herself without him. At that point, he did. He seemed on the one hand to be succumbing to emotional blackmail and on the other to be ignoring the fact that even without treatment, experience has shown that time alone was likely to have affected her wish to die.

Another Dutch physician, who was filmed ending the life of a patient recently diagnosed with amyotrophic lateral sclerosis, says of the patient, "I can give him the finest wheelchair there is, but in the end it is only a stopgap. He is going to die, and he knows it." That death may be years away but a physician with this attitude may not be able to present alternatives to this patient.

The government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands when 50% of Dutch cases of assisted suicide and euthanasia are not reported, more than 50% of Dutch doctors feel free to suggest euthanasia to their patients, and 25% admit to ending patients' lives without their consent.

Euthanasia, intended www.psychiatrictimes.com/display/article/10168/1358126originally for the exceptional case, became an accepted way of dealing with serious or terminal illness in the Netherlands. In the process, palliative care became one of the casualties, while hospice care has lagged behind that of other countries. In testimony given before the British House of Lords, Zbigniew Zylicz, one of the few palliative care experts in the Netherlands, attributed Dutch deficiencies in palliative care to the easier alternative of euthanasia.

Acknowledging their deficiencies in end-of-life care, the Dutch government has made an effort to stimulate palliative care at six major medical centers throughout the country in the past five years in the hope of improving the care of dying patients. Simultaneously, initiatives for training professionals caring for terminally ill patients were undertaken. More than 100 hospices were also established.

Even if the Dutch experience suggests that engaging physicians in palliative care is harder when the easier option of euthanasia is available, for a significant number such training has become a welcome option. A number of physicians who received the training have publicly expressed their regrets over having previously euthanized patients because they had not known of any viable option. Such expressions of regret would have been inconceivable five years ago.

Developments of the last five years may be having a measurable effect. In contrast to a 20% increase in euthanasia cases from 1991 to 1995, the number of euthanasia cases in 2001 was no greater than in 1995. If education of Dutch doctors by palliative care instructors is successful, a gradual reduction in the number of cases of assisted suicide, euthanasia and involuntary euthanasia cases will be a measure of that success.

Oregon is experiencing many of the same problems as the Netherlands but is not doing nearly as much to combat them. Although legalizing only assisted suicide and not euthanasia, Oregon's law differs from the Dutch in one respect that virtually builds failure into the law.

Intolerable suffering that cannotbe relieved is not a basic requirement for assisted suicide in Oregon as itstill is in the Netherlands. Simply having a diagnosis of terminal illness with a prognosis of less than sixmonths to live is considered a sufficient criterion. This shifts the focus from relieving the suffering of dyingpatients desperate enough to consider hastening death to meeting statutory requirements for assisted suicide. It encourages physicians to go through the motions of offering palliative care, providing serious psychiatric consultation or making an effort to protect those vulnerable to coercion.

In Oregon, when a terminally ill patient makes a request for assisted suicide, physicians are required to point out that palliative care and hospice care are feasible alternatives. They are not required, however, to be knowledgeable about how to relieve either physical or emotional suffering in terminally ill patients. Without such knowledge, the physician cannot present feasible alternatives. Nor are physicians who lack this knowledge required to refer any patient requesting assisted suicide for consultation with a physician knowledgeable about palliative care.

The inadequacy of palliative care consultation in Oregon was underscored by a survey of Oregon physicians who received the first 142 requests for assisted suicide since the law went into effect. In only 13% of cases was a palliative care consultation recommended, and we do not know how many of these recommendations were actually implemented.

Two Oregon cases illustrate how compromised the offer of palliative care can become. The first patient, referred to by her physician as "Helen," was the first known case of physician-assisted suicide in the state. The case was publicized by the Compassion in Dying Federation, an advocacy organization for physician-assisted suicide.

Helen, an Oregon woman in her mid-80s, had metastatic breast cancer and was in a home-hospice program. Her physician had not been willing to assist in her suicide for reasons that were not specified and a second physician refused on the grounds that she was depressed.

Helen called Compassion in Dying and was referred to a physician who would assist her. After her death, a Compassion in Dying press conference featured a taped interview said to have been made with Helen two days before her death. In it, the physician tells her that it is important she understand that there are other choices she could make that he will list for her--which he does in only three sentences covering hospice support, chemotherapy and hormonal therapy.

Doctor: There is, of course, all sorts of hospice support that is available to you. There is, of course, chemotherapy that is available that may or may not have any effect, not in curing your cancer, but perhaps in lengthening your life to some extent. And there is also available a hormone which you were offered before by the oncologist, tamoxifen, which is not really chemotherapy but would have some possibility of slowing or stopping the course of the disease for some period of time.

Helen: Yes, I don't want to take that.

Doctor: All right, OK, that's pretty much what you need to understand.

A cursory, dismissive presentation of alternatives precludes any autonomous decision by the patient. Autonomy is further compromised by the failure to mandate psychiatric evaluation. Such an evaluation is the standard of care for patients who are suicidal, but the Oregon law does not require it in cases of assisted suicide.

Physicians must refer patients to licensed psychiatrists or psychologists only if they believe the patients' judgment is impaired. A diagnosis of depression per se is not considered a sufficient reason for such a referral. However, as with other individuals who are suicidal, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. In any case, studies have also shown that non-psychiatric physicians are not reliably able to diagnose depression, let alone to determine whether the depression is impairing judgment.

Not all of the factors justifying a psychiatric consultation center on current depression. Patients requesting a physician's assistance in suicide are usually telling us that they desperately need relief from their mental and physical suffering and that without such relief they would rather die. When they are treated by a physician who can hear their desperation, understand their ambivalence, treat their depression and relieve their suffering, their wish to die usually disappears.

The psychiatric consultation as envisioned by the Oregon law is not intended to deal with these considerations. It is only concerned with the more limited issue of a patient's capacity to make the decision for assisted suicide to satisfy the requirement of informed consent. The story of Joan Lucas, whose suicide was also facilitated and publicized by Compassion in Dying, points out how such a gatekeeper role encourages seeking psychological or psychiatric consultation to protect doctors, rather than patients.

Lucas, an Oregon patient with amyotrophic lateral sclerosis, attempted suicide. Paramedics were called to her house, but her children sent them away, explaining, "We couldn't let her go to the ambulance. They would have resuscitated her."

Lucas survived her attempt and was assisted in suicide 18 days later by a physician who gave interviews about the case to an Oregon newspaper on condition of anonymity. He stated that after talking with attorneys and agreeing to help aid Lucas in her death, he asked her to undergo a psychological examination. "It was an option for us to get a psychological or psychiatric evaluation," he told the newspaper. "I elected to get a psychological evaluation because I wished to cover my ass. I didn't want there to be any problems."

The doctor and the family found a cooperative psychologist who asked Lucas to take the Minnesota Multiphasic Personality Inventory (MMPI). Because it was difficult for Joan to travel to the psychologist's office, her children read the true-false questions to her at home. The family found the questions funny, and Joan's daughter described the family as "cracking up over them." Based on these test results, the psychologist concluded that whatever depression Joan had was directly related to her terminal illness--a completely normal response. His opinion is suspect, the more so because while he was willing to give an opinion that would facilitate ending Joan's life, he did not feel it was necessary to see her first.

Data from patient interviews, surveys of families of patients receiving end-of-life care in Oregon, surveys of physicians' experience and data from the few cases where information has been made available suggest the inadequacy of end-of-life care in Oregon.

Oregon physicians have been given authority without being in a position to exercise it responsibly. They are expected to inform patients that alternatives are possible without being required to be knowledgeable enough to present those alternatives in a meaningful way, or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment without a requirement for psychiatric expertise or consultation. They are expected to make decisions about voluntariness without having to see those close to the patient who may be exerting avariety of pressures, from subtle to coercive. They are expected to do all of this without necessarily knowing the patient for longer than 15 days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is encouraged, physicians are protected from the con-sequences, and patients are left unprotected while believing they have acquired a new right.

The World Health Organization has recommended that governments not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for their citizens. All states and all countries have a long way to go to achieve this goal.

People are only beginning to learn that with well-trained doctors and nurses and good end-of-life care, it is possible to avoid the pain of the past experiences of many of their loved ones and to achieve a good death. The right to such care is the right that patients should demand and the challenge that every country needs to meet.
