For Hannah, Amy, Asher, and Madeleine, and now Max

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ISSUE 5

Should Physicians Be Allowed to Assist in Patient Suicide?


ISSUE SUMMARY

YES: Physician Marcia Angell asserts that a physician's main duties are to respect patient autonomy and to relieve suffering, even if that sometimes means assisting in a patient's death.

NO: Physician Kathleen M. Foley counters that if physician-assisted suicide becomes legal, it will begin to substitute for interventions that otherwise might enhance the quality of life for dying patients.

Since the early 1980s physicians, lawyers, philosophers, and judges have examined questions about withholding life-sustaining treatment. Their deliberations have resulted in a broad consensus that competent adults have the right to make decisions about their medical care, even if those decisions seem unjustifiable to others and even if they result in death. Furthermore, the right of individuals to name others to carry out their prior wishes or to make decisions if they should become incompetent is now well established. Thirty-eight states now have legislation allowing advance directives (commonly known as "living wills").

The debate in specific cases continues (see, for example, the issue on withholding food and nutrition), but on the whole, patients' rights to self-determination have been bolstered by 80 or more legal cases, dozens of reports, and statements made by medical societies and other organizations.

As often occurs in bioethical debate, the resolution of one issue only highlights the lack of resolution about another. There is clearly no consensus about either euthanasia or physician-assisted suicide.

Like truth telling, euthanasia is an old problem given new dimensions by the ability of modern medical technology to prolong life. The word itself is Greek (literally, happy death) and the Greeks wrestled with the question of whether, in some cases, people would be better off dead. But the Hippocratic Oath in this instance was clear: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to that effect." On the other hand, if the goal of medicine is not simply to prolong life but to reduce suffering, at some point the question of what measures should be taken or withdrawn will inevitably arise. The problem is: When death is inevitable, how far should one go in hastening it?

The majority of cases in which euthanasia is raised as a possibility are among the most difficult ethical issues to resolve, for they involve the conflict between a physician's duty to preserve life and the burden on the patient and the family that is created by fulfilling that duty. One common distinction is between active euthanasia (that is, some positive act such as administering a lethal injection) and passive euthanasia (that is, an inaction such as deciding not to administer antibiotics when the patient has a severe infection). Another common distinction is between voluntary euthanasia (that is, the patient wishes to die and consents to the action that will make it happen) and involuntary—or better, nonvoluntary—euthanasia (that is, the patient is unable to consent, perhaps because he or she is in a coma).

The two selections that follow address a particularly controversial aspect of this issue. Is it ethical for a physician to assist in a hopelessly ill patient's suicide? Marcia Angell argues that sometimes hastening death should be an option for physicians although "reluctantly as a last resort." Angell states that a physician must consider patient autonomy and suffering when deciding upon care. Kathleen M. Foley contends that the medical profession should take the lead in developing guidelines for the end of life. This means that one must not confuse compassion for a patient's suffering with competence in care.
Marcia Angell

The Supreme Court and Physician-Assisted Suicide—The Ultimate Right

The importance and contentious issue of physician-assisted suicide, now being argued before the U.S. Supreme Court, is the subject of the following two editorials. Writing in favor of permitting assisted suicide under certain circumstances is the journal's executive editor, Dr. Marcia Angell. Arguing against it is Dr. Kathleen Foley, co-chief of the Pain and Palliative Care Service of Memorial Sloan-Kettering Cancer Center in New York. We hope these two editorials, which have in common the authors' view that care of the dying is too often inadequate, will help our readers in making their own judgments.

--Jerome P. Kassirer, M.D.

The U.S. Supreme Court will decide later this year whether to let stand decisions by two appeals courts permitting doctors to help terminally ill patients commit suicide.1 The Ninth and Second Circuit Courts of Appeals last spring held that state laws in Washington and New York that ban assistance in suicide were unconstitutional as applied to doctors and their dying patients.2,3 If the Supreme Court lets the decisions stand, physicians in 12 states, which include about half the population of the United States, would be allowed to provide the means for terminally ill patients to take their own lives, and the remaining states would rapidly follow suit. Not since Roe v. Wade has a Supreme Court decision been so fateful.

The decision will culminate several years of intense national debate, fueled by a number of highly publicized events. Perhaps most important among them is Dr. Jack Kevorkian's defiant assistance in some suicides since 1990, to the dismay of many in the medical and legal establishments, but with substantial public support, as evidenced by the fact that three juries refused to convict him even in the face of a Michigan statute enacted for that purpose. Also since 1990, voters in three states have considered ballot initiatives that would legalize some form of physician-assisted dying, and in 1994 Oregon became the first state to approve such a measure.4 (The Oregon law was stayed pending a court challenge.) Several surveys indicate that roughly two thirds of the American public now support physician-assisted suicide,5,6 as do more than half the doctors in the United States,6,7 despite the fact that influential physicians' organizations are opposed. It seems clear that many Americans are now so concerned about the possibility of a lingering, high-technology death that they are receptive to the idea of doctors' being allowed to help them die.

In this editorial I will explain why I believe the appeals courts were right and why I hope the Supreme Court will uphold their decisions. I am aware that this is a highly contentious issue, with good people and strong arguments on both sides. The American Medical Association (AMA) filed an amicus brief opposing the legalization of physician-assisted suicide,8 and the Massachusetts Medical Society, which owns the Journal, was a signatory to it. But here I speak for myself, not the Journal or the Massachusetts Medical Society. The legal aspects of the case have been well discussed elsewhere, to me most compellingly in Ronald Dworkin's essay in the New York Review of Books.9 I will focus primarily on the medical and ethical aspects.

I begin with the generally accepted premise that one of the most important ethical principles in medicine is respect for each patient's autonomy, and that when this principle conflicts with others, it should almost always take precedence. This premise is incorporated into our laws governing medical practice and research, including the requirement of informed consent to any treatment. In medicine, patients exercise their self-determination most dramatically when they ask that life-sustaining treatment be withdrawn. Although others may sometimes consider the request ill-founded, we are bound to honor it if the patient is mentally competent—that is, if the patient can understand the nature of the decision and its consequences.

A second starting point is the recognition that death is not fair and is often cruel. Some people die quickly, and others die slowly but peacefully. Some find personal or religious meaning in the process, as well as an opportunity for a final reconciliation with loved ones. But others, especially those with cancer, AIDS, or progressive neurolologic disorders, may die by inches and in great anguish, despite every effort of their doctors and nurses. Although nearly all pain can be relieved, some cannot, and other symptoms, such as dyspnea, nausea, and weakness, are even more difficult to control. In addition, dying sometimes holds great indignities and existential suffering. Patients who happen to require some treatment to sustain their lives, such as assisted ventilation or dialysis, can hasten death by having the life-sustaining treatment withdrawn, but those who are not receiving life-sustaining treatment may desperately need help they cannot now get.

If the decisions of the appeals courts are upheld, states will not be able to prohibit doctors from helping such patients to die by prescribing a lethal dose of a drug and advising them on its use for suicide. State laws barring euthanasia (the administration of a lethal drug by a doctor) and assisted suicide for patients who are not terminally ill would not be affected. Furthermore, doctors would not be required to assist in suicide; they would simply have that option. Both appeals courts based their decisions on constitutional questions. This is important, because it shifted the focus of the debate from what the majority would approve through the political process, as exemplified by the Oregon initiative, to a matter of fundamental rights, which are largely immune from the
been in injection of a lethal drug is active and directly causes the patient's death. Assistance without the consent of the patient or a proxy. In contrast, euthanasia by the doctor's role is considered passive and the cause of death is the underlying disease, however, there will always be a few patients whose suffering simply cannot be adequately alleviated. And there will be some who would prefer suicide to any other measures available, including the withdrawal of life-sustaining treatment or the use of heavy sedation. Surely, every effort should be made to improve palliative care, as I argued 15 years ago, but when those efforts are unavailing and suffering patients desperately long to end their lives, physician-assisted suicide should be allowed. The argument that permitting it would divert us from redoubling our commitment to comfort care asks these patients to pay the penalty for our failings. It is also illogical. Good comfort care and the availability of physician-assisted suicide are no more mutually exclusive than good cardiology care and the availability of heart transplantation.

Permitting assisted suicide would put us on a moral "slippery slope." Although in itself assisted suicide might be acceptable, it would lead inexorably to involuntary euthanasia. It is impossible to avoid slippery slopes in medicine (or in any aspect of life). The issue is how and where to find a purchase. For example, we accept the right of proxies to terminate life-sustaining treatment, despite the obvious potential for abuse, because the reasons for doing so outweigh the risks. We hope our procedures will safeguard patients. In the case of assisted suicide, its voluntary nature is the best protection against sliding down a slippery slope, but we also need to ensure that the request is thoughtful and freely made. Although it is possible that we may someday decide to legalize voluntary euthanasia under certain circumstances or assisted suicide for patients who are not terminally ill, legalizing assisted suicide for the dying does not in itself make these other decisions inevitable. Interestingly, recent reports from the Netherlands, where both euthanasia and physician-assisted suicide are permitted, indicate that fears about a slippery slope there have not been borne out.

Assisted suicide is a threat to the economically and socially vulnerable. The poor, disabled, and elderly might be coerced to request it. Admittedly, overburdened families or cost-conscious doctors might pressure vulnerable patients to request suicide, but similar wrongdoing is at least as likely in the case of withdrawing life-sustaining treatment, since that decision can be made by proxy. Yet, there is no evidence of widespread abuse. The Ninth Circuit Court recalled that it was feared Roe v. Wade would lead to coercion of poor and uneducated women.
to request abortions, but that did not happen. The concern that coercion is more likely in this era of managed care, although understandable, would hold suffering patients hostage to the deficiencies of our health care system. Unfortunately, no human endeavor is immune to abuses. The question is not whether a perfect system can be devised, but whether abuses are likely to be sufficiently rare to be offset by the benefits to patients who otherwise would be condemned to face the end of their lives in protracted agony.

Depressed patients would seek physician-assisted suicide rather than hold for their depression. Even in the terminally ill, a request for assisted suicide might signify treatable depression, not irreversible suffering. Patients suffering greatly at the end of life may also be depressed, but the depression does not necessarily explain their decision to commit suicide or make it irrational. Nor is it simple to diagnose depression in terminally ill patients. Sadness is to be expected, and some of the vegetative symptoms of depression are similar to the symptoms of terminal illness. The success of antidepressant treatment in these circumstances is also not ensured. Although there are anecdotes about patients who changed their minds about suicide after treatment, we do not have good studies of how often that happens or the relation to antidepressant treatment. Dying patients who request assisted suicide and seem depressed should certainly be strongly encouraged to accept psychiatric treatment, but I do not believe that competent patients should be required to accept it as a condition of receiving assistance with suicide. On the other hand, doctors would not be required to comply with all requests; they would be expected to use their judgment, just as they do in so many other types of life-and-death decisions in medical practice.

Doctors should never participate in taking life. If there is to be assisted suicide, doctors must not be involved. Although most doctors favor permitting assisted suicide under certain circumstances, many who favor it believe that doctors should not provide the assistance. To them, doctors should be unambiguously committed to life (although most doctors who hold this view would readily honor a patient's decision to have life-sustaining treatment withdrawn). The AMA, too, seems to object to physician-assisted suicide primarily because it violates the profession's mission. Like others, I find that position too abstract. The highest ethical imperative of doctors should be to provide care in whatever way best serves patients' interests, in accord with each patient's wishes, not with a theoretical commitment to preserve life no matter what the cost in suffering. If a patient requests help with suicide and the doctor believes the request is appropriate, requiring someone else to provide the assistance would be a form of abandonment. Doctors who are opposed in principle need not assist, but they should make their patients aware of their position early in the relationship so that a patient who chooses to select another doctor can do so. The greatest harm we can do is to consign a desperate patient to unbearable suffering—or force the patient to seek out a stranger like Dr. Kevorkian. Contrary to the frequent assertion that permitting physician-assisted suicide would lead patients to distrust their doctors, I believe distrust is more likely to arise from uncertainty about whether a doctor will honor a patient's wishes.

Physician-assisted suicide may occasionally be warranted, but it should remain illegal. If doctors risk prosecution, they will think twice before assisting with suicide. This argument wrongly shifts the focus from the patient to the doctor. Instead of reflecting the condition and wishes of patients, assisted suicide would reflect the courage and compassion of their doctors. Thus, patients with doctors like Timothy Quill, who described in a 1991 Journal article how he helped a patient take her life, would get the help they need and want, but similar patients with less steadfast doctors would not. That makes no sense.

People do not need assistance to commit suicide. With enough determination, they can do it themselves. This is perhaps the cruelest of the arguments against physician-assisted suicide. Many patients at the end of life are, in fact, physically unable to commit suicide on their own. Others lack the resources to do so. It has sometimes been suggested that they can simply stop eating and drinking and kill themselves that way. Although this method has been described as peaceful under certain conditions, no one should count on that. The fact is that this argument leaves most patients to their suffering. Some, usually men, manage to commit suicide using violent methods. Percy Bridgman, a Nobel laureate in physics who in 1961 shot himself rather than die of metastatic cancer, said in his suicide note, "It is not decent for Society to make a man do this to himself." My father, who knew nothing of Percy Bridgman, committed suicide under similar circumstances. He was 81 and had metastatic prostate cancer. The night before he was scheduled to be admitted to the hospital, he shot himself. Like Bridgman, he thought it might be his last chance. At the time, he was not in extreme pain, nor was he close to death (his life expectancy was probably longer than six months). But he was suffering nonetheless—from nausea and the side effects of antiemetic agents, weakness, incontinence, and hopelessness. Was he depressed? He would probably have freely admitted that he was, but he would have thought it beside the point. In any case, he was an intensely private man who would have refused psychiatric care. Was he overly concerned with maintaining control of the circumstances of his life and death? Many people would say so, but that was the way he was. It is the job of medicine to deal with patients as they are, not as we would like them to be.

I tell my father's story here because it makes an abstract issue very concrete. If physician-assisted suicide had been available, I have no doubt my father would have chosen it. He was protective of his family, and if he had felt he had the choice, he would have spared my mother the shock of finding his body. He did not tell her what he planned to do, because he knew she would stop him. I also believe my father would have waited if physician-assisted suicide had been available. If patients have access to drugs they can take when they choose, they will not feel they must commit suicide early, while they are still able to do it on their own. They would probably live longer and certainly more peacefully, and they might not even use the drugs.

Long before my father's death, I believed that physician-assisted suicide ought to be permissible under some circumstances, but his death strengthened my conviction that it is simply a part of good medical care—something to be
done reluctantly and sadly, as a last resort, but done nonetheless. There should be safeguards to ensure that the decision is well considered and consistent, but they should not be so daunting or violative of privacy that they become obstacles instead of protections. In particular, they should be directed not toward reviewing the reasons for an autonomous decision, but only toward ensuring that the decision is indeed autonomous. If the Supreme Court upholds the decisions of the appeals courts, assisted suicide will not be forced on either patients or doctors, but it will be a choice for those patients who need it and those doctors willing to help. If, on the other hand, the Supreme Court over turns the lower courts' decisions, the issue will continue to be grappled with state by state, through the political process. But sooner or later, given the need and the widespread public support, physician-assisted suicide will be demanded of a compassionate profession.

References
2. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).
3. Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).
Competent Care for the Dying
Instead of Physician-Assisted Suicide

While the Supreme Court is reviewing the decisions by the Second and Ninth Circuit Courts of Appeals to reverse state bans on assisted suicide, there is a unique opportunity to engage the public, health care professionals, and the government in a national discussion of how American medicine and society should address the needs of dying patients and their families. Such a discussion is critical if we are to understand the process of dying from the point of view of patients and their families and to identify existing barriers to appropriate, humane, compassionate care at the end of life. Rational discourse must replace the polarized debate over physician-assisted suicide and euthanasia. Facts, not anecdotes, are necessary to establish a common ground and frame a system of health care for the terminally ill that provides the best possible quality of living while dying.

The biased language of the appeals courts evinces little respect for the vulnerability and dependency of the dying. Judge Stephen Reinhardt, writing for the Ninth Circuit Court, applied the liberty-interest clause of the Fourteenth Amendment, advocating a constitutional right to assisted suicide. He stated, "The competent terminally ill adult, having lived nearly the full measure of his life, has a strong interest in choosing a dignified and humane death, rather than being reduced to a state of helplessness, diapered, sedated, incompetent." Judge Roger J. Miner, writing for the Second Circuit Court of Appeals, applied the equal-rights clause of the Fourteenth Amendment and went on to emphasize that the state "has no interest in prolonging a life that is ending." This statement is more than legal jargon. It serves as a chilling reminder of the low priority given to the dying when it comes to state resources and protection.

The appeals courts' assertion of a constitutional right to assisted suicide is narrowly restricted to the terminally ill. The courts have decided that it is the patient's condition that justifies killing and that the terminally ill are special—so special that they deserve assistance in dying. This group alone can receive such assistance. The courts' response to the New York and Washington cases they reviewed is the dangerous form of affirmative action in the name of compassion. It runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care.

Both circuit courts went even further in asserting that physicians are already assisting in patients' deaths when they withdraw life-sustaining treatments such as respirators or administer high doses of pain medication that hastens death. The appeals courts argued that providing a lethal prescription to a terminally ill patient to commit suicide is essentially the same as withholding life-sustaining treatment or aggressively treating pain. Judicial reasoning that eliminates the distinction between letting a person die and killing runs counter to physicians' standards of palliative care. The courts' purported goal of blurring these distinctions was to bring society's legal rules more closely in line with the moral value it places on the relief of suffering.

In the real world in which physicians care for dying patients, withdrawing treatment and aggressively treating pain are acts that respect patients' autonomous decisions not to be battered by medical technology and to be relieved of their suffering. The physician's intent is to provide care, not death. Physicians do struggle with doubts about their own intentions. The courts' arguments fuel their ambivalence about withdrawing life-sustaining treatments or using opioid or sedative infusions to treat intractable symptoms in dying patients. Physicians are trained and socialized to preserve life. Yet saying that physicians struggle with doubts about their intentions in performing these acts is not the same as saying that their intention is to kill. In palliative care, the goal is to relieve suffering, and the quality of life, not the quantity, is of utmost importance.

Whatever the courts say, specialists in palliative care do not think that they practice physician-assisted suicide or euthanasia. Palliative medicine has developed guidelines for aggressive pharmacologic management of intractable symptoms in dying patients, including sedation for those near death. The World Health Organization has endorsed palliative care as an integral component of a national health care policy and has strongly recommended to its member countries that they not consider legalizing physician-assisted suicide and euthanasia until they have addressed the needs of their citizens for pain relief and palliative care. The courts have disregarded this formidable recommendation and, in fact, are indirectly suggesting that the World Health Organization supports assisted suicide.

Yet the courts' support of assisted suicide reflects the requests of the physicians who initiated the suits and parallels the numerous surveys demonstrating that a large proportion of physicians support the legalization of physician-assisted suicide. A smaller proportion of physicians are willing to provide such assistance, and an even smaller proportion are willing to inject a lethal dose of medication with the intent of killing a patient (active voluntary euthanasia). These survey data reveal a gap between the attitudes and behavior of physicians; 20 to 70 percent of physicians favor the legalization of physician-assisted suicide, but only 2 to 4 percent favor active voluntary euthanasia, and only approximately 2 to 13 percent have actually aided patients in dying, by either providing a prescription or administering a lethal injection. The limitations of these surveys, which are legion, include inconsistent definitions of physician-assisted suicide and euthanasia, lack of information about non-respondents, and provisions for maintaining confidentiality that have led.

to inaccurate reporting. Since physicians' attitudes toward alternative assisted suicide have not been studied, there is a void in our knowledge about the priority that physicians place on physician-assisted suicide.

The willingness of physicians to assist patients in dying appears to be determined by numerous complex factors, including religious beliefs, personal values, medical specialty, age, practice setting, and perspective on the use of financial resources. Studies of patients' preferences for care at the end of life demonstrate that physicians' preferences strongly influence those of their patients. Making physician-assisted suicide a medical treatment would be so strongly dependent on these physician-related variables would result in regulatory impossibility. Physicians would have to disclose their values and attitudes to patients to avoid potential conflict. A survey by Emanuel et al., demonstrated that psychiatrists' responses to requests to evaluate patients were highly determined by their attitudes. In a study by Emanuel et al., depressed patients with cancer said they would view positively those physicians who acknowledged their willingness to assist in suicide. In contrast, patients with cancer who were suffering from pain would be suspicious of such physicians.

In this controversy, physicians fall into one of three groups. Those who support physician-assisted suicide see it as a compassionate response to a medical need, a symbol of nonabandonment, and a means to reestablish patients' trust in doctors who have used technology excessively. They argue that regulation of physician-assisted suicide is possible and, in fact, necessary to control the actions of physicians who are currently providing assistance surreptitiously. The two remaining groups of physicians oppose legalization. One group is morally opposed to physician-assisted suicide and emphasizes the need to preserve the professionalism of medicine and the commitment to "do no harm." These physicians view aiding a patient in dying as a form of abandonment because a physician needs to walk the last mile with the patient, as witness, not as an executioner. Legalization would endorse justified killing according to these physicians, and guidelines would not be followed, even if they could be developed. Furthermore, these physicians are concerned that the conflation of assisted suicide with the withdrawal of life support or adequate treatment of pain would make it even harder for dying patients, because there would be a backlash against existing policies. The other group is not ethically opposed to physician-assisted suicide and, in fact, sees it as acceptable in exceptional cases, but these physicians believe that one cannot regulate the unregulatable. On this basis, the New York State Task Force on Life and the Law, a 24-member committee with broad public and professional representation, voted unanimously against the legalization of physician-assisted suicide. All three groups of physicians agree that a national effort is needed to improve the treatment of the dying. Yet it does seem that those in favor of legalizing physician-assisted suicide are disingenuous in their use of this issue as a wedge. If this form of assistance with dying is legalized, the courts will be forced to broaden the assistance to include active voluntary euthanasia and, eventually, assistance in response to requests from proxies.

One cannot easily categorize the patients who request physician-assisted suicide or euthanasia. Some surveys of physicians have attempted to determine retrospectively the prevalence and nature of these requests. Pain, AIDS, and neurodegenerative disorders are the most common conditions in patients requesting assistance in dying. There is a wide range in the age of such patients, but many are younger persons with AIDS. From the limited data available, the factors most commonly involved in requests for assistance are concern about future loss of control, being or becoming a burden to others, or being unable to care for oneself and fear of severe pain. A small number of recent studies have directly asked terminally ill patients with cancer or AIDS about their desire for death. All these studies show that the desire for death is closely associated with depression and that pain and lack of social support are contributing factors.

Do we know enough, on the basis of several legal cases, to develop a public policy that will profoundly change medicine's role in society? Approximately 24 million Americans die each year. We have almost no information on how they die and only general information on where they die. Sixty-one percent die in hospitals, 17 percent in nursing homes, and the remainder at home, with approximately 10 to 14 percent of those at home receiving hospice care.

The available data suggest that physicians are inadequately trained to assess and manage the multifactorial symptoms commonly associated with patients' requests for physician-assisted suicide. According to the American Medical Association's report on medical education, only 5 of 126 medical schools in the United States require a separate course in the care of the dying. Of 2014 residency programs, only 26 percent offer a course on the medical and legal aspects of care at the end of life as a regular part of the curriculum. According to a survey of 1068 accredited residency programs in family medicine, internal medicine, and pediatrics and fellowship programs in geriatrics, each resident or fellow coordinates the care of 10 or fewer dying patients annually. Almost 15 percent of the programs offer no formal training in terminal care. Despite the availability of hospice programs, only 17 percent of the training programs offer a hospice rotation, and the rotation is required in only half of these programs; 9 percent of the programs have residents or fellows serving as members of hospice teams. In a recent survey of 55 residency programs and over 1400 residents, conducted by the American Board of Internal Medicine, the residents were asked to rate their perception of adequate training in care at the end of life. Seventy-two percent reported that they had received adequate training in managing pain and other symptoms; 62 percent, that they had received adequate training in telling patients that they are dying; 38 percent, in describing what the process will be like; and 32 percent, in talking to patients who request assistance in dying or a hastened death (Blank L: personal communication).

The lack of training in the care of the dying is evident in practice. Several studies have concluded that poor communication between physicians and patients, physicians' lack of knowledge about national guidelines for such care, and their lack of knowledge about the control of symptoms are barriers to the provision of good care at the end of life. Yet there is now a large body of data on the components of suffering in patients with advanced terminal disease, and these data provide the basis for a comprehensive approach to the care of the dying.
for treatment algorithms. There are three major factors in suffering: pain and other physical symptoms, psychological distress, and existential distress (described as the experience of life without meaning). It is not only the patients who suffer but also their families and the health care professionals attending them. These experiences of suffering are often closely and inextricably related. Perceived distress in any one of the three groups amplifies distress in the others. Pain is the most common symptom in dying patients, and according to recent data from U.S. studies, 56 percent of outpatients with cancer, 82 percent of outpatients with AIDS, 50 percent of hospitalized patients with various diagnoses, and 36 percent of nursing home residents have inadequate management of pain during the course of their terminal illness. Members of minority groups and women, both those with cancer and those with AIDS, as well as the elderly, receive less pain treatment than other groups of patients. In a survey of 1177 physicians who had treated a total of more than 70,000 patients with cancer in the previous six months, 76 percent of the respondents cited lack of knowledge as a barrier to their ability to control pain. Other physical symptoms are also prevalent among the dying. Studies of patients with advanced cancer and of the elderly in the year before death show that they have numerous symptoms that worsen the quality of life, such as fatigue, dyspnea, delirium, nausea, and vomiting. Along with these physical symptoms, dying patients have a variety of well-described psychological symptoms, with a high prevalence of anxiety and depression in patients with cancer or AIDS and the elderly. For example, more than 60 percent of patients with advanced cancer have psychiatric problems, with adjustment disorders, depression, anxiety, and delirium reported most frequently. Various factors that contribute to the prevalence and severity of psychological distress in the terminally ill have been identified. The diagnosis of depression is difficult to make in medically ill patients. Percent of the Oregon psychiatrists surveyed by Ganzini et al. were not confident that they could determine, in a single evaluation, whether a psychiatric disorder was impairing the judgment of a patient who requested assistance with suicide.

Attention has recently been focused on the interaction between uncontrolled symptoms and vulnerability to suicide in patients with cancer or AIDS. Data from studies of both groups of patients suggest that uncontrolled pain contributes to depression and that persistent pain interferes with patients' ability to receive support from their families and others. Patients with AIDS have a high risk of suicide that is independent of physical symptoms. Among New York City residents with AIDS, the relative risk of suicide in men between the ages of 20 and 59 years was 36 times higher than the risk among men without AIDS in the same age group and 66 times higher than the risk in the general population. Patients with AIDS who committed suicide generally did so within nine months after receiving the diagnosis; 25 percent had made a previous suicide attempt, 50 percent had reported severe depression, and 40 percent had seen a psychiatrist within four days before committing suicide. As previously reported, the desire to die is most closely associated with the diagnosis of depression. Suicide is the eighth leading cause of death in the United States, and the incidence of suicide is higher in patients with cancer or AIDS and in elderly men than in the general population. Conwell and Caine reported that depression was undiagnosed by primary care physicians in a cohort of elderly patients who subsequently committed suicide; 75 percent of the patients had seen a primary care physician during the last month of life but had not received a diagnosis of depression.

The relation between depression and the desire to hasten death may vary among subgroups of dying patients. We have no data, except for studies of a small number of patients with cancer or AIDS. The effect of treatment for depression on the desire to hasten death and on requests for assistance in doing so has not been examined in the medically ill population, except for a small study in which four of six patients who initially wished to hasten death changed their minds within two weeks. There is also the concern that certain patients, particularly members of minority groups that are estranged from the health care system, may be reluctant to receive treatment for their physical or psychological symptoms because of the fear that their physicians will, in fact, hasten death. There is now some evidence that the legalization of assisted suicide in the Northern Territory of Australia has undermined the Aborigines' trust in the medical care system; this experience may serve as an example for the United States, with its multicultural population.

The multiple physical and psychological symptoms in the terminally ill and elderly are compounded by a substantial degree of existential distress. Reporting on their interviews with Washington State physicians whose patients had requested assistance in dying, Back et al. noted the physicians' lack of sophistication in assessing such nonphysical suffering.

In summary, there are fundamental physician-related barriers to appropriate, humane, and compassionate care for the dying. These range from attitudinal and behavioral barriers to educational and economic barriers. Physicians do not know enough about their patients, themselves, or suffering to provide assistance with dying as a medical treatment for the relief of suffering. Physicians need to explore their own perspectives on the meaning of suffering in order to develop their own approaches to the care of the dying. They need insight into how the nature of the doctor-patient relationship influences their own decision making. If legalized, physician-assisted suicide will be a substitute for rational therapeutic, psychological, and social interventions that might otherwise enhance the quality of life for patients who are dying. The medical profession needs to take the lead in developing guidelines for good care of dying patients. Identifying the factors related to physicians, patients, and the health care system that pose barriers to appropriate care at the end of life should be the first step in a national dialogue to educate health care professionals and the public on the topic of death and dying. Death is an issue that society as a whole faces, and it requires a compassionate response. But we should not confuse compassion with competence in the care of terminally ill patients.
References

1. Reinhart, Compassion in Dying v. State of Washington, 79 F. 3d 790 9th Cir. 1996.
2. Miner, Quill v. Vacco 80 F. 3d 716 2nd Cir. 1996.
POSTSCRIPT

Should Physicians Be Allowed to Assist in Patient Suicide?

In June 1997, the U.S. Supreme Court ruled unanimously that there is no constitutional right to physician-assisted suicide. The ruling, however, did not foreclose state legislation in this area.

Oregon became the only state to legalize physician-assisted suicide by passing the Death with Dignity Act in November 1997. Then Attorney General John Ashcroft's 2001 effort to overturn this law was struck down by a federal court. Under this law, a person who is mentally competent and suffering from a terminal illness (likely to die within 6 months) may receive lethal drugs from a physician. The person has to consult two doctors and wait 15 days before obtaining the drugs.

In the first 6 years since the law went into effect, 171 patients (out of a total of over 53,000 Oregonians with the same underlying diseases) took lethal medications. Rates of participation were higher among those who were divorced or never married, had more education, and had HIV/AIDS, amyotrophic lateral sclerosis (Lou Gehrig's disease), and cancer. Physicians reported that patient requests stemmed from concerns related to loss of autonomy, decreasing ability to participate in enjoyable activities, and loss of dignity, not from unbearable pain. The full report from the Oregon Department of Human Services is available at http://www.dhs.state.or.us/publichealth/chs/pas/pas.cfm.

Researchers led by Susan Tolle in Oregon found that, regardless of legalization, many more people consider physician-assisted suicide than follow through with it. Patients who were black, older, and more religious were less likely to consider physician-assisted suicide than others who were similarly ill. The complexity of the process to obtain a lethal drug—a safeguard against misuse—also may be a barrier to those who do not fulfill their intentions (Susan W. Tolle, et al., "Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide," Journal of Clinical Ethics, Summer 2004).

In the Netherlands, euthanasia—defined as "the intentional termination of the life of a patient at his or her request by a physician"—was legalized in 2002. The practice had occurred before then without repercussions for the physician. About 9,700 requests are made each year. Those who oppose the practice claim that not all requests are voluntary.