Responding to Legal Requests for Physician-Assisted Suicide

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In 1998, 15 terminally ill Oregon residents ended their lives with overdoses of medications supplied legally by their physicians. Many more people consider this possibility. This paper examines the ways in which the physician's response to requests for assisted suicide may change in an era of legalization, articulates some of the resulting conceptual challenges, and provides practical advice to physicians facing such requests.

In areas where it is legal, assisted dying becomes one of the many options that can be freely considered for terminally ill patients with extreme suffering. Some patients even view assisted death as a right that can be expected on demand. We consider the ethical implications of disclosing assisted dying to patients as an option of last resort and suggest that physicians working in environments where assisted dying is legal are obliged to do so. However, we conclude that physicians should not encourage patients to hasten death even when practicing in jurisdictions that allow assisted dying. Furthermore, without abandoning the model, we suggest that strict informed consent does not fully address patients' needs at this time. Physicians must also focus on patients' broader biopsychosocial concerns and help them identify solutions through empathic listening and emotional support.

We provide a framework and vocabulary for physicians to use when responding to requests for assisted suicide. Physicians should clarify the request, explore and address the patient's concerns, achieve a shared understanding of the goals of treatment, search for less harmful alternatives, express to the patient what they are willing to do, discuss the relevant legal issues, and share their decision making with colleagues.

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In 1998, 15 terminally ill Oregon residents ended their lives with overdoses of medications supplied legally by their physicians (1). Eight others received prescriptions but never used them. Many more patients probably considered hastening death but did not do so. In a Boston study, 27% of patients with cancer had thought about asking their physicians to assist them in death, yet only 2% had actually discussed the matter with their physicians (2).

Several thoughtful pieces have been written to guide physicians who receive requests for assistance in dying, and all address the major medical, psychosocial, and spiritual issues facing dying patients who wish to end their own lives (3–6). Cole (4) avoids the question of physician participation altogether, and Emanuel describes a protocol that prohibits physicians from ever assisting in dying (5). Block and Billings (3) and Quill (6), although more sympathetic to hastened death, wrote at a time when assisted suicide was illegal in all states.

The Oregon referendum legalizing physician-assisted suicide dramatically alters this landscape. If there is no evidence of significant abuse or backlash, other states may follow suit (7–11). If they do, physicians are likely to face new ethical challenges as they weigh requests from patients. The nature of communication between physicians and patients regarding decisions at the end of life would change. Discussing assisted dying would no longer be taboo, and physicians could raise the possibility of assisted suicide as one of many options to be freely considered. Patients who encounter physician refusals would be empowered to bring their requests to other physicians who may not know them as well, as was done in six of the Oregon cases (1). Finally, some patients may view assisted dying as a right that can be expected on demand. This paper will articulate some of the conceptual challenges inherent in an era of legalization and will provide practical advice to physicians facing requests for assisted dying. This paper uses the terms "assisted suicide" and "assisted dying" interchangeably.

Some Conceptual Issues

The ethical framework for discussions about assisted dying begins with informed consent (5, 12). Physicians must discuss the risks, benefits, and likely outcomes of assisted suicide. They must also discuss

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alternatives to suicide, including the possibilities of palliative care. This model assumes rational decision making and also assumes that when patients raise the possibility of assisted dying, they are, in fact, asking for a hastened death rather than using the request to express unmet needs or to manipulate their situation. Furthermore, it assumes that the patient desires and is capable of rational decision making at this emotionally difficult time. In some cases, however, none of these assumptions may be true.

Informed consent is usually invoked to protect patients' informational and decisional needs. However, when patients approach this issue from an extreme consumerist perspective, they may actually reverse the quality of the interaction and place the physician in the role of providing consent (4). Physicians' fiduciary relationships to their patients require that they still be able to respond empathically to concerns and try to understand and address the issues that are leading to a person's decision.

Because of these complexities, it may be inadequate to obtain strict informed consent without attending to the emotional and cognitive state of the patient. Without abandoning informed consent, we recommend that such discussions be viewed in a more collaborative or therapeutic model of communication that focuses on the biopsychosocial concerns of the patient and, through empathic listening and emotional support, helps the patient identify a solution that addresses these concerns. With regard to advance directives, we have learned that patients vary in their desire for information and participation and that needs other than informed consent may predominate (13–20).

Assessing Decision-Making Capacity

It is universally agreed that patients who request assisted dying must demonstrate decision-making capacity. However, medicine has traditionally viewed a desire to end one's life as a sign of depression. If this is true, then no patient who expresses such thoughts could meet standards for decision-making capacity. The presumption that clinically depressed patients are wholly incapable of making rational requests to end their lives seems far too facile. Certainly, some requests are motivated by treatable depressions, and appropriate interventions must be offered. However, a desire to escape interminable suffering is not necessarily irrational. Requests for assisted suicide do not in themselves constitute a lack of decision-making capacity, but expert consultation should be used to clarify these issues with potentially depressed patients (3).

Disclosure of the Option

Physicians are ethically obligated to explore in meaningful ways patients' requests for assisted dying. If such requests are sustained despite attempts at presenting other viable choices, physicians should discuss patients' options under the law. However, discussing assisted dying with patients who do not explicitly request this option is problematic. In jurisdictions where assisted dying is legal, under the strictest definition of informed consent physicians would seem to be obligated to disclose to all terminally ill patients their right to assisted dying.

At the very least, requirements for truth telling would incline physicians to disclose the available options to the terminally ill patient who is looking for a way out of intractable suffering. For example, many terminally ill patients may not be aware that they have other choices, such as terminal sedation or the voluntary cessation of eating and drinking; both of these options are legal and, for many, ethically acceptable ways of ending one's life (21). In a state where it is legal, assisted dying must be added to this list. Withholding such information does not allow a patient to make a fully informed decision and would violate a reasonable formulation of the notion of informed consent.

Some may wonder whether describing these alternatives connotes endorsement of them and whether raising the issue risks motivating a patient to commit an action that would not have occurred otherwise. Clearly, simply mentioning options does not imply endorsement. In medicine, we routinely describe to patients options that we consider unwise in the interest of full disclosure. In the course of caring for dying patients, physicians frequently explore issues of depression and suicidal tendencies. Not to do so with patients who are thinking seriously about assisted suicide would be to leave them alone with their thoughts and vulnerable to increased anguish. Asking patients who may be thinking about suicide to talk about their feelings is more similar to reflecting or naming their feelings than to encouraging suicide. For example, we do not worry that a physician will induce depression where none existed by telling a patient that he or she seems depressed. Rather, the physician is clarifying an interpretation of the patient's mood. Analogously, some persons may be liberated by the knowledge that they could end their suffering by stopping a life-sustaining treatment; such knowledge could give them the strength to go on.

Giving a Recommendation

Traditionally, provision of information in the informed consent process is thought to be value-neutral. In reality, however, information can be

framed in various ways that will have different implications for decision making (22). Some argue that physicians aid informed consent by providing recommendations as long as patients understand them to be opinions, not statements of medical fact (23, 24). In addition to receiving information on risks and benefits, most patients want to know what their physician thinks is best for them. Although they may choose to reject the physician's opinion, it is one more piece of data on which to base their decisions.

That said, should physicians ever disclose their personal views on assisted dying to patients? It may be in patients' interests to know their physicians' stance immediately so that they can consider changing physicians if necessary. However, a physician's focus on his or her own beliefs may shift the attention away from the patient. For example, telling patients too early that one is opposed to assisted suicide on principle may deter them from disclosing their deepest concerns (25). In addition, we must be mindful of the power of medical authority when talking to patients (26). Patients fear their physicians' disapproval and may not easily distinguish the fine line between open and appropriate disagreement and coercion. Patients may construe a physician's abrupt declaration of opposition to assisted dying as a conversation stopper and a form of abandonment (27). Many dying patients are simply searching for someone to help ease their dying.

Avoiding a sense of abandonment is one of the central dilemmas facing physicians who receive requests for assisted dying. Physicians who are personally opposed to assisted death and cannot comply with a patient's request do not want their patients to feel that they are not "with them" through the end. Such physicians must find a way to demonstrate their commitment even when they will not assist with the patient's death. Because suicide is the final act of a patient's life, not being there "at the end" may carry considerable symbolic meaning. Of course, simply writing a prescription does not ensure that a patient will not feel or be abandoned. However, physicians must be attentive to the nuances of abandonment experienced by patients and must seek effective ways to reassure patients that they will receive supportive care.

We have suggested that physicians may need to disclose the option of assisted suicide and should delay sharing their opposition to the practice. However, can a physician ever recommend assisted suicide? Can a physician ever tell a patient that, in light of his unmitigated suffering, taking his own life would be the best choice? As stated earlier, physicians are expected to aid patients in decision making by offering recommendations that are medically sound and seem to be compatible with patients' values. Recommendations help patients evaluate decisions within the framework of their physicians' experiences.

Nevertheless, recommending that someone kill himself seems inappropriate for several reasons, even if assisted suicide can be committed legally. First, given the general prohibition against killing, there seems to be a difference between reluctantly helping patients end their lives and encouraging patients to die. Second, no matter how many patients they care for, physicians can claim no more expertise about the personal experience of death and suffering than patients. Finally, in capitated payment systems and other systems of financial incentive, it may actually benefit the physician or health care organization if the patient dies sooner. Patients must never fear that assisted suicide is recommended on the basis of financial interest.

When trying to decide how much information to disclose to a patient about options for assisted dying, physicians must view the risks for unintended coercion and abandonment in tandem with risks for violations of obligations to tell the truth. Routine terminal care is not likely to include descriptions of all options, and physicians should not encourage patients to hasten death. Even when physicians believe that dying is the best option for a patient, such communication is fraught with too many hazards. Instead, in jurisdictions where it is legal, physicians should describe the process by which assisted suicide is handled and help the patient understand what the act would involve in medical and social terms. Physicians who are willing to assist in suicide should make it clear that they will help the patient if necessary but that their job is to try to help the patient find a way to make that option unnecessary (21).

The Role of Good Communication

Good communication in response to a patient's request can have a tremendous effect not only on the choices that the patient will make but also on the quality of dying (18). A conversation about a patient's desire to end his or her life can be a form of therapy, and discussion itself may therefore palliate. It is an opportunity to address and respond to the patient's greatest fears and concerns.

Many factors cause patients to express a wish for an early death. Pain, fatigue, or dyspnea alone are usually insufficient reasons to end one's life, given the potential for their palliation (1). Rather, the deepest suffering motivates suicide. This includes fears of dependency or being a burden, feelings of abandonment, frightening psychiatric symptoms, hopelessness, and spiritual crisis (3, 6). Since the legalization of physician-assisted dying, Oregon physicians have recognized such issues and have im-

proved their skills in palliative care (28, 29). However, many physicians are still poorly prepared to address these domains of suffering, and we encourage them to enlist their colleagues in chaplaincy, nursing, social work, and psychology, as well as community-based clergy and other local resources, in order to respond appropriately.

A physician's willingness to enter into such a vital conversation demonstrates a commitment to avoiding abandonment. Because patients and families will probably be sensitive to a physician's ambivalence about assisting in dying, the physician's own clarity about the issue will enhance this important therapeutic encounter (30). Professionals should explore their own beliefs in these areas before engaging patients in discussion.

We offer physicians practical responses to patients' requests for assisted suicide. Our approach extends the work of others by offering ways to explore options without providing recommendations when hastening death is legal (3–6, 31). The suggested responses emphasize that listening to patients and exploring issues empathically are by far the most important skills.

Practical Suggestions for Engaging in the Dialogue

Identify, Acknowledge, and Clarify the Request

Physicians should allow patients an opportunity to share their thoughts and feelings fully. When a physician seems reasonably certain that a patient is asking for assistance in dying, it is appropriate to address the request directly. For example, "I hear you saying that you might consider hastening your death. How were you hoping that I might be able to help you?"

In other cases, patients may vaguely suggest a request, to which physicians might respond, "You've referred several times to 'wishing it were all over.' Though you haven't quite said it, it sounds like you're thinking that there are alternatives to dying naturally. Can you share with me what you're thinking in that regard?"

Finally, in some cases physicians will want to explore what may seem to be implied suicidal thoughts. For example, "You've shown great courage in living with your illness. I want to support you in every possible way. I'm wondering if you ever think about a point at which the pain and struggle would be more than you can bear. Have you given any thought to what your alternatives might be? Those are also questions you can think about with me."

Explore the Patient's Concerns and Address Physical, Psychosocial, and Spiritual Suffering

A physician can begin a discussion of a patient's concerns by asking, "What is the worst part of your condition right now for you?" If that does not lead to a clear vision of what makes the patient's suffering intolerable, the physician could tell the patient, "In my experience, other people's thoughts about ending their lives seem to be connected to one or more of a number of factors: their belief that their pain will never get under control, their feelings of despair about a burden they have put on their loved ones, or a sense that they can find no meaning in continuing life. Do your thoughts fall into one of those categories?" Through discussion, patients afraid of burdening their loved ones may realize that committing suicide could actually create an additional burden (32).

Achieve a Shared Understanding of the Goals of Treatment

Physicians should discuss with the patient what can reasonably be expected of treatment. Patients and physicians should develop the goals of that treatment collaboratively, focusing not only on physical symptoms but also on the capacity to live meaningfully (33). For example, patients often report that there is still a special event, such as the birth of a child or a wedding, that itself would define a continuing desire to live. If such a patient is suffering uncontrolled physical symptoms that prompt his wish to die, managing those physical symptoms in anticipation of the important event becomes a fundamental treatment goal. The physician can say to the patient, "I know how important it is for you to get to the wedding. I'm not sure how well we can manage these symptoms until then, but why don't we try? Afterward, we can certainly reconsider what we're going to do next."

Implement the Treatment Plan. If Goals Cannot Be Achieved, Search for Less Harmful Alternatives

If initial efforts are not successful in relieving suffering, the physician should consult experts in palliative care and other appropriate professionals. However, if a patient has requested assistance in dying contingent on the success of agreed-upon treatment goals that interventions are failing to achieve, the physician must plot a new course. With the patient who remains competent and communicative, it is necessary to begin a dialogue that acknowledges that the goals of treatment cannot be achieved and that all options for palliative care have been exhausted. At this point, it is useful to search for less harmful and more universally acceptable options. For example, if pain is the problem, the

physician can promise to increase doses of analgesic agents until the patient achieves relief or escape. If the patient is receiving life-sustaining treatments, they can be discontinued. The physician should consider whether terminal sedation or cessation of eating and drinking are possibilities.

If Interest in Suicide Remains, Clarify the Level of Participation That the Patient Expects and That Is Conscientiously Acceptable

A few patients will continue to request assistance in dying despite the best efforts of the primary physician and expert consultants. The physician should clarify exactly what the patient is requesting—a prescription or more active involvement? This may be the most difficult point in the process, when physicians must confront the hard question of what they are willing to do to hasten death. The physician's own values and beliefs must be clarified for the patient to ensure that misunderstanding on either part does not occur.

Some physicians will be willing to participate in assisted dying under appropriate circumstances. They could say, "As you know, the law allows me to prescribe medications that you could use to end your life. There are situations in which I may be willing to do this to relieve your suffering. Let's talk more about this option."

Other physicians will be unwilling to prescribe lethal medication but may feel comfortable raising terminal sedation or voluntary cessation of eating and drinking as other options. They may say, "Although the law allows doctors to prescribe medication which might be used to end your life, personally I'm unable to participate in that way. However, I'd like to suggest other options, short of taking a lethal medication, that might hasten your death and bring your suffering to an end. For example, you could completely stop eating and drinking, and you would die within 2 to 3 weeks. People who choose this option experience little discomfort and maintain their dignity and control. We could also sedate you to unconsciousness, recognizing that you'll never wake up."

Other physicians may consider any activity that hastens death unacceptable. They may say, "Although the law allows doctors to prescribe lethal medication, my own conscience does not allow me to do that. I am sure that other physicians in our community would consider that possibility with you." Physicians who are comfortable doing so should refer patients to colleagues who may be more willing to participate.

When physicians are unwilling to assist in a patient's request, they must be exceedingly careful to avoid any sense of abandonment. They may say, "Although I cannot in good conscience prescribe a lethal medication as the law allows, I want to assure you that I will not abandon you. I will continue to do my best to address your concerns, and I am always willing to use medications to relieve your pain and suffering, even if these medications might hasten your death. I will be there with you to the end."

Offer All Relevant Information about Legal Framework and Realistic Options

The informed consent model applies most directly when patients and physicians are ready to proceed with assisted dying. Patients must understand their options under the law. This includes knowing how to go about enacting an assisted death under applicable statutes. It also includes addressing such tough issues as what to do if the attempted suicide fails or if patients change their mind midstream. If at all possible, such issues should be discussed with the patient and other family members because the latter are likely to be directly involved in the act of assisting in the dying or are expected to have some role in what subsequently occurs (34). In addition, the family must face the emotional consequences after an assisted suicide.

Clarify Feelings about the Patient's Request and Speak with Colleagues

Physicians should not go it alone. Many of the emotions felt by the patient, such as hopelessness and frustration with current therapies, are shared by the physician. When patients express a wish to die, physicians may also feel abandoned.

Conclusion

We have attempted to consider ways in which physicians could respond to patients' requests to end their lives. Legalization of physician-assisted suicide places worrisome new demands on physicians. The willingness to explore one's own response to suffering, finitude, death, and hope is crucial to any profound participation in these conversations. If legal physician-assisted suicide becomes more common, reports from the "front lines" will provide more sophisticated direction to physicians facing a changing moral frontier. What legalization of assisted suicide will certainly do, however, is forge a new covenant between caregiver and patient.

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