Responding to Requests to Hasten Death—A Physician Perspective

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Objectives

At the conclusion of this session, the participant should be able to:

1. Define some ethical and legal principles related to assisted suicide
2. Explain the process of physician assisted death
3. Distinguish between symptom control, palliative sedation, and assisted suicide
Disclosures

• I have no relevant conflicts of interest related to this topic.
Case 1

- 67M with metastatic lung cancer is hospitalized
- Dyspnea, insomnia, anxiety, pain worsen
- Doc, I can’t live like this any more.
- How can you help my suffering?
Case 2

- 35F with CNS lymphoma and intractable seizures
- After family meeting, life support (ventilator) is withdrawn
- Patient is a bit tachypneic, which improves with an opioid infusion
- Dad says, “Doc, can you make it go any faster?”
Definitions

• Death with Dignity
  – Can refer to an end-of-life option, state legislation regarding such an option, or organizations that promote it

• Physician assisted suicide/physician assisted death
  – After full evaluation, physician may provide a lethal prescription

• Euthanasia
  – Physician/provider administers medication that hastens death

• Palliative sedation
  – Medications given to decrease awareness in order to relieve intractable suffering at the end of life
Ethical Considerations

1. Killing vs allowing to die

2. Principle of double effect
Killing vs. allowing to die

• Patients and surrogates have the right to refuse any life sustaining therapy
• Removing and refusing are the same
• Allows the underlying illness to run its course

Truog. CCM 2008;36:953.
Principle of “double effect”

• Ethical rationale for providing relief of pain and other symptoms with sedatives when this may have foreseen (but not intended) consequence of hastening death

• Distinction lies in the clinician’s intent
  – Alleviate pain, discomfort, dyspnea

• Sedatives and analgesics do not actually hasten death

Truog. CCM 2008;36:953.
Legality

• US states:
  – Oregon: passed 1994, enacted October 1997
  – California: passed October 2015, enacted June 2016
  – Vermont, Montana: discussions

• In Illinois:
  – Not legal
  – Advocacy groups: Final Options Illinois
  – http://www.finaloptionsillinois.org/
Internationally

• Europe:
  – Netherlands, Belgium, Switzerland, Luxembourg
  – Physician may even prepare the drugs... but the patient must take it themselves

• Canada:
  – Rejected 5-4 by Canadian Supreme Court in 1993
  – Unanimously passed in 2015
  – Canadian Society of Palliative Care Physicians states that most of its members do not want to aid patients in dying

Attaran NEJM 2015
Ethical perspectives

• Controversial
• Critics’ objections and fears:
  1. Permitting patients to take their own lives will worsen the quality of palliative care
  2. Discrimination: vulnerable groups
  3. Slippery slope: expansion to non-terminal patients
  4. Abuse: mental illness, coercion by relatives
  5. Undermines the sanctity of life: primarily religious
  6. Medical community: American Medical Association opposes

Prokopetz NEJM 2012
First: Explore
The Meaning Behind the Patient’s Request

• Regardless of your personal views, explore
• Provide reassurance: no abandonment, symptoms will be treated
• Exploration can be a potent therapeutic intervention
• Address
  – uncontrolled pain
  – other physical symptoms
  – psychological or existential distress

Bascom JAMA 2002;288:91.
Practically: How is it done?
Oregon Experience

• Patient qualifications
  – Adult Oregon resident
  – Terminal disease (less than 6 months to live)
  – Maintains decision making capacity
  – Mental health condition excluded (esp depression)

• Attending physician must consult with a second physician

• Continue to offer alternatives, exploration, comfort

• After all this, 15 day waiting period before prescription can be written

The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals.
Ganzini NEJM 2000.
Practically: How is it done?

Oregon Experience

- Prescription filled by pharmacy
- What drugs are used?
  - Barbiturates
  - Strong anti-epileptics
  - No symptom relief
  - Usually secobarbital 9-10 g or pentobarbital 10 g
  - For comparison, 100-200 mg for sedation
- Drug taken at a time of patient’s choice
- How long does it take?
  - Median time to unconsciousness 5 mins
    - range 1-38 min
  - Median time to death 25 mins
    - range 1 min to 48h

Okie NEJM 2005.
How can we proceed?

• Counseling—Dr. Gerhart to discuss
• Aggressive symptom control: medications directed specifically toward symptoms
• Palliative sedation if symptom directed treatment fails
  – High dose benzodiazepines
  – Low dose propofol or barbiturates
• Always remember the principle of double effect
Propofol and barbiturates

• Used in Palliative Sedation, PAD, and Euthanasia

• Difference is how and why they are administered
Case Conclusions

• Case 1: 67M with lung cancer
  – Symptoms aggressively managed but still with distress
  – Patient was sedated with high dose benzodiazepines
  – Patient was allowed to pass naturally

• Case 2: 35F with CNS lymphoma
  – Appeared comfortable, non-verbal
  – Opioids were maintained for RR 20-30
  – Patient was allowed to pass naturally
Thank you

• We will take questions together after the conclusion of Dr. Gerhart’s talk


4. Bascom PB, Tolle SW. Responding to requests for physician assisted suicide: “These are uncharted waters for both of us...”. JAMA 2002; 288: 91-98.

