DEAR DR. JEFF

Jeffrey Nichols, MD, CMD

What Is a Good Death?

Dear Dr. Jeff:

Our state legislature is considering a bill legalizing physician-assisted suicide. The new law would allow physicians to refuse to participate if their conscience would not allow them to provide this procedure. Apparently, nurse practitioners and physician assistants would not be authorized at all. Although I have always been an outspoken advocate for resident autonomy, I find that this whole topic makes me uncomfortable. Even if I opt out personally, our facility may have to adapt to the new legislation. What do you suggest?

Dr. Jeff responds:

Suicide is, by its life-denying nature, shocking. Death, by contrast, is inevitable, the natural end point of life. Since the beginning of our species, the mortality rate has always been 100%, and the miracles of modern medicine have not changed that. Taxes may also be unavoidable, but that doesn’t preclude the role of a good accountant. So the notion that medical professionals should play some role in helping patients with a physiologic event sounds reasonable and appropriate to the general public, despite the pushback from a small minority that represents it as medical intrusion into the natural sphere of religion. And, after all, what is hospice care but the efforts of a health care team to assist the patient and family with the dying process?

Defining the Terms

As with many debates, such as over abortion, the selection of language tends to frame the argument. Suicide continues to have very negative connotations and the act is forbidden by most major religions. Suicide prevention is a well-established public health goal with a hotline funded through the National Institute of Mental Health as well as many local “lifelines” staffed by volunteers. Suicide prevention has its own national foundation, a national week in September, and even a World Suicide Prevention Day (September 10).

An excellent discussion of the concept of “rational suicide” was recently published by Meera Balsubramaniam, MD, MPH, of the Psychiatry Department of the New York University School of Medicine (J Am Geriatr Soc 2018;66:998–1001). It recognizes that a desire for death can exist in the absence of any major diagnosable psychiatric disease, but should be understood in the context of unconscious motivations, including the need for a sense of control, a rejection of the sick role, the damage to self-image that comes with physical decline, fantasies of reunion with dead loved ones, loss of professional identity, and financial planning concerns. (In a society where personal worth is commonly defined by material wealth — where the person with the most toys at the end of the game wins — the decision to end the game while still ahead may be rational, if not necessarily admirable.)

The American Medical Association’s Council on Ethical and Judicial Affairs recently issued a statement of continued opposition and has recommended the continued use of the term physician-assisted suicide — even when it is explicitly defined as not a suicide by the state where it occurs. Unsurprisingly, the Death with Dignity National Center describes the term physician-assisted suicide as “inaccurate.” Proponents of physician-assisted suicide generally dislike that term, preferring physician-assisted death (referred to in some literature by the even blander PAD, like peripheral artery disease) or the even more positive right to die or death with dignity.

The right to die is not a right like freedom of speech or trial by jury — nature guarantees the dubious privilege of death to everyone. And the concept of death with dignity certainly sounds like one that everyone could support. However, the proponents of this slogan tend to have a particular definition of dignity that many would not share. The dignity referred to is not respectful treatment or being maintained as comfortably as possible while death from underlying disease or diseases proceeds according to its natural course. Rather, it is maintaining control of the date and time that death will occur, often with some additional control over surroundings and costume, regardless of whether death might otherwise have occurred with or without medical treatment.

This idea could be consistent with the baby boomer’s anthem “Hope I die before I get old” (as expressed in the song “My Generation” by The Who). Indeed, the history of the death with dignity movement in the United States dates back to Derek Humphry’s Final Exit (1991), the Hemlock Society, and Dr. Jack Kevorkian in the 1980s and 1990s. The concept of death with dignity has no associated notion that the individual has a terminal illness (unless one thinks of life as a terminal illness) much less that there be intolerable symptoms from which the individual hopes to be freed. The 130-plus individuals killed or “aided” by Dr. Kevorkian with his Mercitron and Thanatron devices were relatively young, experiencing mild pain or no pain at all, and often not terminally ill.

The movement’s real rise to prominence and political acceptance has come as the baby boomer generation has reached age 65 and achieved political power. And clearly, as a physician-assisted suicide would maximize the patient’s control over timing and location, the preference has been not simply for physician expertise but also for physicians to perform the procedure. This also stems, I believe, from a larger desire for physician validation.

The term euthanasia is derived from the Greek prefix eu, which is usually translated as “good” or “well,” and Thanatos, the god or personification of death, thus implying a good or easy death. But the definition of a “good death” is highly individual and heavily culturally determined. Significant differences exist among patients, caregivers, and practitioners regarding the nature of a good death.

In the United States, active euthanasia is illegal in every venue and forbidden by every professional ethics code dating back to the Hippocratic Oath. Physicians have historically refused to participate in capital punishment based on this principle, although Dr. Kevorkian’s technique using a combination of intravenous preparations beginning with a rapid acting barbiturate was virtually identical to that being used by many states to execute prisoners. In Switzerland, the role of the physician in assisted suicide has been eliminated. A relative or friend can legally assist a patient to commit suicide. Other countries find this alternative unacceptable, and it is rarely or never discussed by advocates for the right to die.

U.S. Views

In 2018, Hawaii became the sixth state along with the District of Columbia to explicitly legalize physician-assisted suicide. Legislation is pending in several state legislatures, so the number may have increased by the time you read this. Physician-assisted suicide appears to be legal in Montana as well via a judicial decision that authorized it but did not create specific mechanisms. All the legislatively approved programs contain similar “safeguards.” The recipient of physician assistance must be at least age 18, be certified by their attending physician and a consultant to be terminally ill with a prognosis of less than 6 months to live, and competent to make medical decisions for himself or herself. Each state requires a waiting period of 2 to 15 days, after which these patients must reaffirm their wish. At that point, the physician may prescribe a lethal dose of medication that the patient must be able to self-administer.

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Most regimens used for physician-assisted suicide or euthanasia involve the use of secobarbital or pentobarbital given orally or intravenously. These are the same medications used by many veterinarians to “put animals to sleep.” Depending on the circumstances, some discomfort is possible. Occasional dosage errors have occurred, and patients have survived and awakened, requiring retreatment at higher doses.

Patient autonomy allows a patient to refuse a treatment that is not desired, and to choose among a set of alternatives based on their own weighting of risks and benefits, but it does not create the right to insist on a prescription or a treatment simply because it is desired. There is no “right” to secobarbital. But there is a right to our best efforts to relieve suffering and our best medical judgment regarding how to do that.

In states where physician-assisted suicide is legal, this practice in nursing homes has been extremely rare, in part because most facilities have opted out of the process as a matter of policy. If your state legalizes physician-assisted suicide, you are still not legally obligated either as a practitioner or as a facility, to offer or prescribe it. You will, however, have to facilitate a possible transfer to another facility that will.

Dr. Nichols is past president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.