Physician Assisted Suicide & Euthanasia: Realities Beyond the Rhetoric

C. Christopher Hook, MD, FACP
Associate Professor of Medicine
Mayo Clinic, Rochester, MN

Cedarville University
September 15, 2011

Disclosures

- No financial conflicts of interest
- Dr. Hook's comments are solely his own and do not necessarily reflect the views of the Mayo Clinic and Foundation

Objective

- To contrast common public arguments and sentiments in favor of assisted suicide and euthanasia with the realities experienced in Oregon, the Netherlands, Switzerland and Belgium

Oath of Hippocrates

I swear by Apollo, the Physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

To reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

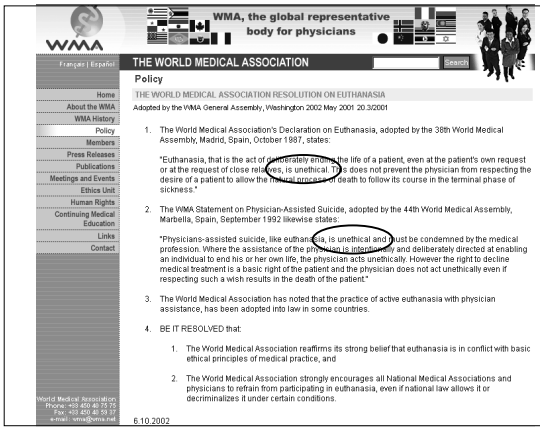
I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

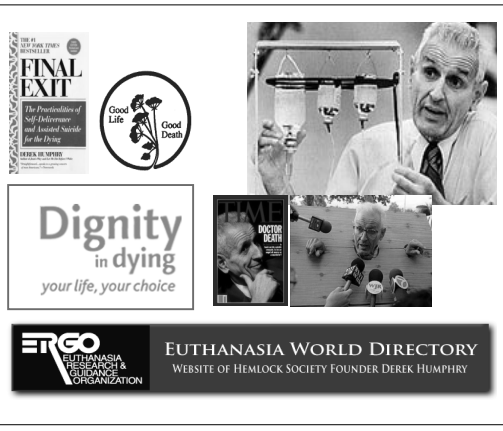
With Purity and with Holiness I will pass my life and practice my art. I will not cu… pract… benef… corru…

Whe… with … abou…

Whi… enjoy… about…

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrong doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.





PAD AROUND THE WORLD

- **Australia**
  - May 1995, Northern Territory Parliament legalizes euthanasia, 13-12, effective July 1, 1996
  - *MJ of Aust reports 3.5% of all deaths in Australia due to intentional lethal overdoses without patient request*
  - March 1997, Australian National Parliament over-rode authority of territories to enact euthanasia laws, repealing NT law
- **Switzerland**
  - 1942 Swiss Parliament passes a liberal law on PAS
  - 1998 Dignitas, an organization to assist people from other countries formed, creating suicide tourism, most dying the day they arrive in the country
  - March 2004, new law proposed requiring 6 month residency in Switzerland to obtain PAS, not passed
  - June 2006, Swiss Cabinet refuses to change policy

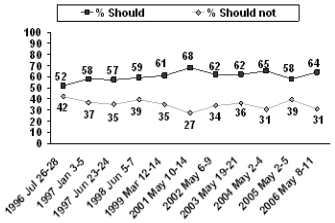
PAD AROUND THE WORLD

- **Belgium**
  - Passed law allowing euthanasia for patients in final stages of terminal disease, after a 30 day waiting period; went into effect 23 September 2002
  - First patient died within 7 days of the law going into effect, and was not in final stage of disease
  - Over 1000 killed in the first year
  - 2003 proposed to include teenagers, and to require physicians who are unwilling to perform euthanasia to refer patient to someone who will
- **Luxembourg**
  - March, 2009, enacted legislation legalizing euthanasia
- **Columbia**
  - Columbia's Constitutional Court ruled 20 May 2002 that "no person can be held criminally responsible for taking the life of a terminally ill patient who has given clear authorization to do so."

Public support for PAD (US)

Gallup News Service (19 June 2006).

When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?



No Constitutional Right to Assisted Suicide

(…but no Constitutional prohibition, either…)

- A state can assert a "legitimate interest in... prohibiting killing and preserving human life"
- [Constitution] "specially protects those fundamental rights and liberties …rooted in this Nation's history and tradition.

Washington v Harold Glucksberg, 117 S. Ct. 2302 (1997)
Vacco v Quill, 117 S.Ct. 2293 (1997)

PHYSICIAN-ASSISTED DEATH

Why?

- Fear of Pain & Suffering
- Fear of Loss of Control
- Fear of Being a Burden
- Fear of (Unbridled) Technology
- Fear of Abandonment

End of Life Concerns*			
Losing autonomy (%)	39 (93)	106 (85)	145 (87)
Less able to engage in activities making life enjoyable (%)	39 (93)	99 (79)	138 (83)
Loss of dignity (%)††	31 (82)	-	31 (82)
Losing control of bodily functions (%)	24 (57)	73 (58)	97 (58)
Burden on family, friends/caregivers (%)	16 (38)	44 (35)	60 (36)
Inadequate pain control (%)**	9 (21)	28 (22)	37 (22)
Financial implications of treatment (%)	1 (2)	3 (2)	4 (2)

Oregon Death with Dignity Act

Procedural requirements
http://egov.oregon.gov/DHS/ph/pas/faqs.shtml

- Patient:
  - Terminally ill (<6 months)
  - Age ≥ 18 years
  - Has decision-making capacity
  - Voluntary, informed decision
  - OR resident
- Two oral and 1 written requests
- Second opinion
  Verify above information
- 15-day wait period
- Reporting ("Physicians must report all prescriptions for lethal medications to the Department of Human Services, Vital Records. As of 1999, pharmacists must be informed of the prescribed medication's ultimate use.")

Oregon Death with Dignity Act

Safeguards

- Counseling if patient depressed
- Patient encouraged to notify next of kin
- Patient informed that they may rescind request at any time
- Second opinion
- Euthanasia prohibited
- Reporting mechanism

DUTCH EUTHANASIA

Substantive Requirements

- Must be voluntary
- Request must be seriously considered and enduring
- Patient must be adequately informed of his/her medical condition, prognosis and treatment alternatives
- Patient suffering must be intolerable *in the patient's view*, and irreversible
- No reasonable alternative acceptable *to the patient* to relieve the suffering

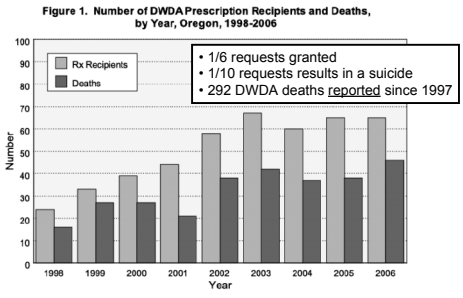
DUTCH EUTHANASIA

Procedural Requirements

- Performed only by a physician
- Must consult 2nd independent physician
- Relatives must be notified unless pt declines
- Documented in medical record
- Case should not be reported as natural death
- Examiner/Prosecutor to be notified

Oregon Death with Dignity Act

http://egov.oregon.gov/DHS/ph/pas/
New Engl J Med. 2000;342:557-563.



PAD in Oregon and the Netherlands

Reported and unreported deaths

Oregon:

- During 2006, 46 DWDA deaths
  4.7 DWDA acts per 10,000 total deaths
- "No idea" how many PAS deaths outside the DWDA (Ganzini L. Medical Grand Rounds, Mayo Clinic Rochester, 19 Feb 2003)

Netherlands:

- During 2006, 2.3% (1.8-2.5%) of all deaths or 3128 (2448-3400) deaths
- Only 18-41% cases reported as required by the law (*J Med Ethics.* 1999;25:16-21.)

The Autonomy Argument

DESIRE FOR DEATH IN THE TERMINAL

Chochinov, etal. Am J Psychiatry 112:1185-9, 1995

- 200 terminally ill patients
- 44.5% occasionally wished for death
- 8.5% had a pervasive desire to die
  - Desire correlated with pain, low family support and most significantly, the presence of depression
  - 58.8% with desire to die were depressed, as opposed to only 7.7% without such a desire
- In 2/3 of those with a f/u interview, the desire decreased during a 2-week period.

Psychological characteristics of OR patients who actually carry out PAS

Ganzini L. Medical Grand Rounds, Mayo Clinic, Rochester, MN, 19 Feb 2003.

- Minority depressed
- Very independent
  - <u>Autonomy, dignity, and independence the most common concerns</u>
  - Dread dependency
  - Sensitive to dominance
- Persuasive
- Determined
- Desire distance
- Prefer frankness
- Ganzini: “Way end of the bell-shaped curve”

PAS and AUTONOMY

Am J Psychiatry, Nov.1996, 1469-75

- 94% of Oregon Psychiatrists didn’t feel very confident that they could spot a psychiatric disorder which impaired judgement in just one consultation
- 51% were not at all confident

OREGON PAS

- Kate Cheney, an 85-year-old with progressive dementia, initially declared mentally incapable to request assisted suicide. Appeared pressured by family.
- Daughter went doctor shopping. Ultimately found physician who wrote the lethal scripts despite acknowledging, “the choices of the patient may be influenced by her family’s wishes and the daughter was somewhat coercive”.

Suicide-clinic entrepreneur: Depressed? 'We never say no'

Insists mentally ill have same rights as able-minded to choose how to die

Posted: April 16, 2006
1:00 a.m. Eastern

The founder of Dignitas – a Zurich, Switzerland, clinic that assists those with illnesses end their lives – says he wants to open a chain of "suicide clinics" in other countries to give everyone, including the mentally ill, the "the choice of a choice."

"We never say no," he said. "Even those suffering from Alzheimer's will have lucid moments in which they may choose to die once a certain point has been reached, such as when they can no longer recognise their children.

"We would never assist the death of someone with acute depression, because the depression is a symptom of the illness," said Minelli. "But if somebody comes after 10 or 12 years of depression and says they do not want to prolong their life under such conditions, then we might help them to die."

The Netherlands Experience

Ending life without explicit request by patient
New Engl J Med. 2007;356:1957-1965

Variable	1990	1995	2001	2005
No. of studied deaths†	5197	5146	5617	9965
No. of questionnaires	4900	4604	5189	5342
Most important practice that possibly hastened death — % (95% CI)				
Euthanasia	1.7 (1.5–2.0)	2.4 (2.1–2.6)‡	2.6 (2.3–2.8)‡	1.7 (1.5–1.8)
Assisted suicide	0.2 (0.1–0.3)	0.2 (0.1–0.3)	0.2 (0.1–0.3)‡	0.1 (0.1–0.1)
Ending of life without explicit request by the patient	0.8 (0.6–1.0)‡	0.7 (0.5–0.9)‡	0.7 (0.5–0.9)	0.4 (0.2–0.6)
Intensified alleviation of symptoms	18.8 (17.9–19.9)‡	19.1 (18.1–20.1)‡	20.1 (19.1–21.1)‡	24.7 (23.5–26.0)
Withholding or withdrawing of life-prolonging treatment	17.9 (17.0–18.9)‡	20.2 (19.1–21.3)‡	20.2 (19.1–21.3)‡	15.6 (15.0–16.2)
Total	39.4 (38.1–40.7)‡	42.6 (41.3–43.9)	43.8 (42.6–45.0)	42.5 (41.1–43.9)
Continuous deep sedation§	NA	NA	NA	8.2 (7.8–8.6)

* All percentages were weighted for the sampling fractions, for nonresponse, and for random-sampling deviations. CI de notes confidence interval, and NA not available.
† The number of deaths is largest in 2005 because all deaths in which the cause of death precluded physician assistance during dying were included, whereas only 1 in 12 of these deaths was included in the other study years.
‡ P<0.05 for comparison with the frequency for 2005.

LIFE-TERMINATING ACTS WITHOUT EXPLICIT REQUEST OF THE PATIENT

Pignenborg, Lancet 341:1196-99, 1993

- LAWER constitutes 0.8% of all deaths
- 41% of the time there is no knowledge of the patient's wishes
- In 30% there is no consultation with colleagues
- 83% of the time the decision was discussed with a family member

LAWER

Jochemsen & Keown, J Med Ethics 25:16-21, 1999

- In 15% of cases no discussion took place, but could have
- 50% of patients were fully competent - a discussion had at one time taken place, but the patient never requested termination
- In 17% treatment alternatives were thought to still be available by the attending MD
- In cases of analgesic overdose only 36% of time was there a request for life-shortening

DUTCH EUTHANASIA AND AUTONOMY

- 3200 of 9700 requests for assistance granted
- 35% of physicians rejected the request because in the *physician's opinion* the patient's suffering was not intolerable

EUTHANASIA & THE POWER OF MEDICINE

Henk ten Have

Thirty-five years ago the euthanasia movement started as a type of protest against medical power…
The original impetus for euthanasia, then, was individual choice and personal autonomy over their own dying. The irony of the euthanasia debate is that this protest against medical power has only served to increase medical power…This is true because the ultimate arbiter for euthanasia is not the patient but the physician.

The Equivalence Argument

Constitutional Right to Refuse Medical Care

"…the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"

Cruzan v Director, Mo. Dept. of Health, 497 U.S. 261 (1990)

"there is a "real distinction between the self-infliction of deadly harm and a self-determination against artificial life support"

In re Quinlan, 355 A. 2d 647 (1976)

Vacco v. Quill

US Supreme Court, June 26, 1997

Chief Justice Rehnquist, for the Court, rejected the "equivalence argument," which invoked the Equal Protection Clause (14th Amendment) to state that patients who had life support to refuse had an unfair opportunity to end their lives that those not requiring life support were denied.

Vacco v. Quill

US Supreme Court, June 26, 1997

"The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication...[In *Cruzan*] our assumption of a right to refuse treatment was grounded not…on the proposition that patients have a…right to hasten death, but on well established, traditional rights to bodily integrity and freedom from unwanted touching."

End-of-life decisions

	Withhold LST	Withdraw LST	Palliative sedation and analgesia	Physician-assisted suicide	Euthanasia
Cause of death	Underlying disease	Underlying disease	Underlying disease‡	Intervention prescribed by physician and used by patient	Intervention used by physician
Intent/goal of intervention	Avoid burdensome intervention	Remove burdensome intervention	Relieve symptoms	Termination of patient's life	Termination of patient's life
Legal?	Yes†	Yes†	Yes	No*	No

LST = life-sustaining treatment
‡Note "double effect"
†A number of states limit the power of surrogate decision-makers regarding LSTs
*Legal only in Oregon, Washington, and Montana

The Compassion Argument

Main Entry: **com·pas·sion**
Pronunciation: \kəm-'pa-shən\
Function: *noun*
Etymology: Middle English, from Anglo-French or Late Latin; Anglo-French, from Late Latin *compassion-, compassio,* from *compati* to sympathize, from Latin *com-* + *pati* to bear, suffer — more at PATIENT
Date: 14th century

Clinical problems with PAS in Oregon 1998-2006

http://egov.oregon.gov/DHS/ph/pas/

Enrolled in hospice	248 (86%)
Psychiatric evaluation	36 (13%)
Regurgitation	16 (6%)
Seizures	0
Awakened after taking prescription	1 (<1%)
No. of days between request and death	
Median	42 d
Range	15-1509 d
Interval between ingestion and death	
Median	25 min
Range	1 min-48 hrs
Duration of physician-patient relationship	
Median	12 wks
Range	0-1065 wks

Oregon PAS

http://www.internationaltaskforce.org/orrpt7.htm

- 1999: Cynthia Barrett of Compassion in Dying described a case of PAS that didn't go as planned
- "After he took it [the lethal dose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she called 911. The guy ended up being taken by 911 to a local Portland hospital. Revived…And taken to a local nursing facility. I don't know if he went back home. He died shortly…after that."
- This case was not included in the official Oregon report for 1999.

Oregon PAS

http://www.internationaltaskforce.org/orrpt7.htm
Associated Press, March 4, 2005.

"David Prueitt took the prescribed lethal dose in the presence of his family and members of Compassion & Choices (C & C). [C & C is the name of the merged Compassion in Dying and Hemlock Society organizations.] After being unconscious for 65 hours, he awoke. It was only after his family told the media about the botched assisted suicide that C & C publicly acknowledged the case. DHS issued a release saying it 'has no authority to investigate individual Death with Dignity cases.'"

Clinical problems with PAD and euthanasia in the Netherlands

New Engl J Med. 2000;342:551-556.

Interval from the administration of the first drug to death and the physician's assessment of the interval

Physician's Assessment	No. of Cases (%)	Interval*	
		Median	Range
		min	
Euthanasia intended†			
All cases	535	10	0.5 min–7 days
As expected	449 (84)	10	0.5 min–4 days
Shorter than expected	18 (3)	5	0.5 min–12 hr
Longer than expected	51 (10)	180	5 min–7 days
Physician-assisted suicide intended‡			
All cases	114	30	1 min–14 days
As expected	67 (59)	30	2 min–14 days
Shorter than expected	13 (11)	8	1 min–2 hr
Longer than expected	22 (19)	180	45 min–7 days

*Data on the actual interval between the administration of the first drug and death were not available for 33 cases in which euthanasia was intended and for 9 in which assisted suicide was intended.

†In 10 cases, the interval differed from the expected interval but was not specified as shorter or longer; in 7 cases, the physician's assessment of the interval was not available.

‡In five cases, the interval differed from the expected interval but was not specified as shorter or longer; in seven cases, the physician's assessment of the interval was not available.

DUTCH EUTHANASIA & ASSISTED SUICIDE

Clinical Problems - Groenewoud, etal, *NEJM 342:551-5, 2000*

- 114 cases of PAS
  - 7% experienced "complications" (e.g. vomiting)
  - 16% experienced problems with "completion" (defined as prolonged death, failure to enter coma, or achieved coma, but later awoke)
- 535 cases of Euthanasia
  - 3% experienced complications
  - 6% experienced problems with completion

Dutch Euthanasia: Responses

Canberra Times (Australia), 6/11/93.

- 1993 survey of 2,066 Dutch seniors on general health care issues
- Survey did not mention euthanasia
- 10% of the respondents indicated that, because of the Dutch euthanasia law, they were afraid (on the basis of age) that their lives could be terminated without their request

Dutch Euthanasia: Responses

http://www.nightingalealliance.org/cgi-bin/home.pl?section=3

- While a majority of Dutch citizens favor the euthanasia law, many elders:
  - Refuse hospitalization or NH placement
  - Refuse to see physicians or take medications
- The Sanctuary Association developed the "Declarations of the Will to Live", which states "the signer does not wish euthanasia"

Dutch Euthanasia: Responses

Hastings Center Report. 1989;19n1:S22(9).

Handicapped of Amersfoort: "We feel our lives threatened... We realize that we cost the community a lot... Many people think we are useless...often we notice that we are being talked into desiring death... We will find it extremely dangerous and frightening if the new medical legislation includes euthanasia."

BMJ Helping doctors make better decisions *BMJ.* 2005;331:1160.

Dignitas is investigated for helping healthy woman to die

Vienna Michael Leidig

The Swiss euthanasia group Dignitas, which claims to offer a dignified death to terminally ill people, is being investigated after a healthy German woman was given a lethal mix of drugs by providing a false medical report.

Dignitas has helped 453 terminally ill Europeans, including 30 British people, to end their lives since it started in 1998. Assisted suicide is legal in Switzerland, but of the groups registered to provide such assistance only Dignitas offers its services to foreign nationals, and it recently opened its first office abroad in Germany to recruit clients (*BMJ* 2005;331:984, 29 Oct).

In the incident under investigation a 69 year old woman, who has not been named for legal reasons, approached Dignitas with a medical report showing that she had terminal liver cirrhosis and was given a lethal dose of sodium pentobarbital drugs.

But a routine autopsy carried out by German authorities when the body was brought back from Switzerland exposed the report as a fake and added that although the woman had depression she was nevertheless physically fit.

The doctor used by Dignitas to help administer the lethal injection has also died. He committed suicide shortly after he was told that the German woman had not been terminally ill.

The Slippery Slope

Oregon PAS

http://www.internationaltaskforce.org/orrpt7.htm

- Patrick Matheny, who had ALS, was too physically disabled to take the lethal prescription himself
- A relative "actively" helped him
- Prompted the state AG office to suggest that assistance for persons with disabilities who want to die may be mandated by disability rights laws

Euthanasia in Oregon

http://vaeh.org/resources/VtLegCouncilJune2004.htm

- 1997: Dr. James Gallant euthanized 78 year-old Clarietta Day after she suffered a CVA without her consent
- Gallant ordered 2 painkillers be given every 5-10 min over 4 hours and placed a magnet over her pacemaker in an effort to deactivate it; as she did not die, he ordered a lethal dose of succinylcholine, which was administered by a nurse
- The medical board suspended his license 60 days, issued a reprimand and fined him $6,371
- Lane County DA Doug Harcleroad did not to file criminal charges despite Gallant's violation of the law

Dutch Euthanasia

Issues in Law & Med. 1994;10:123.

- 1993: Assen court of 3 judges acquitted a psychiatrist who assisted suicide of physically healthy 50 year-old woman
  - Lost 2 sons and recently divorced
- Court ruled physician justified
- Justifications:
  - Patient competent and suffering "irremediable"
  - Met Dutch criterion of putting welfare of patient above law
- Broadened application of PAD to non-physically ill

Dutch Euthanasia

Lancet. 2000;356:1666.

- Haarlem court acquitted physician who assisted the suicide of an 86 year-old man who had no somatic or psychiatric illnesses
- Patient "suffered from life itself"; he had no friends or relatives, "death had forgotten him", and "life was unbearable"

Dutch Euthanasia and Newborns

AMA News. 1995;38:4.

- Groningen court dismissed murder charge against a physician who euthanized an infant with Trisomy-13
- Court found he did not fulfill euthanasia requirements, but stated he had "no other choice than to kill the patient" since treatment was futile
- Similar case with spina bifida: http://query.nytimes.com/gst/fullpage.html?res=9D05E0DA1E38F930A15751C1A962958260

Dutch Euthanasia of 22 Newborns

Groningen protocol

New Engl J Med. 2005;352:959-962.

- All newborns had severe spina bifida
- All cases involved consultations
- All parents gave consent
- All cases reviewed by a prosecutor; no prosecutions

- Prosecutor criteria:
  - Newborn suffering and has poor QOL
  - Parental consent
  - Consultations
  - "Due care"
- Reality: Every year, 10-20 newborns euthanized (*BMJ*. 2007;334:912-913)

DUTCH EUTHANASIA

http://www.minvws.nl/images/broch-euthanasia-eng_tcm20-108102.pdf

- New Act, passed 4/10/01, effective 4/1/02
- Children 12 and older given right to request PAD
- In principle, parents or guardians will also consent, for those 12 - 15, but "in the case of a refusal by one or both of the parents, the request may be accepted if the doctor is convinced that this will mean avoiding serious suffering"
- Children under 12 in the terminal phase of an incurable illness can request PAD if agreed to by both parents and the doctor

DUTCH EUTHANASIA

January 2005

- The Dutch Medical Association has recommended that healthy patients should be allowed to have euthanasia
- "Suffering" without any specific psychological or medical diagnosis should be sufficient grounds for euthanasia
- Patient's who are "tired of life" or "suffering through living" should be allowed to die

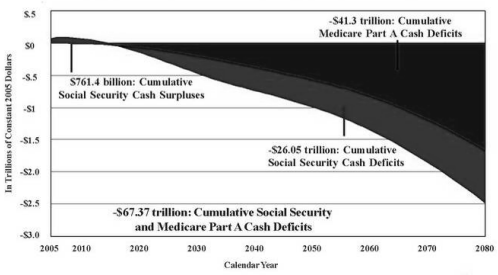
A colleague told of a patient, "A case of an old man who might have died any day. His son came to see me and said, "My wife and I have booked a holiday & we can't cancel it at this point. So we would like very much to bury Father before we leave on holiday." And this doctor went to see this old man, gave him a huge dose of morphine. He came back later to declare the man dead but he was not dead at all. The patient was very happy, because at last he had gotten enough morphine to take care of his pain!" - *Dr. Karel Gunning*

[Interview obtained by Jonathan Imbody, and transcript shared with permission for presentation]

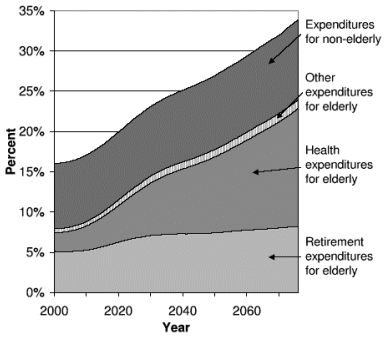
"Another story, Dr. Z. will tell you. He is an oncologist and in internal medicine. He was once asked to see an elderly lady with severe breathing problems. She might die within a fortnight. He said, "We can help you to breathe normally, but I would like to take you to the hospital." And she said, "No, I will be euthanized in the hospital." So Dr. Z said, "I can admit you personally and then I will be with you and I will help you." So she went to the hospital and was helped,…,And he went home and was free for the morning. He came back in the afternoon and the patient was dead. So he asked what had happened and a colleague said, "Whether she died now or in a fortnight's time it would have made no difference. We needed the bed for someone else." So he had her euthanized."

- Dr. Karel Gunning

Social Security and Medicare Part A Cumulative Cash Surpluses and Deficits In Constant 2005 Dollars 2005-2080



Federal spending (excluding interest on debt) as a percent of GDP.



"It is one of the tragedies of our lives that someone who wants very much to live can nevertheless have a duty to die."

- **We accept the deaths of some individuals, such as soldiers, police officers and firefighters as within their duty if in so doing their lives protected the lives of others.**
- ***The Individualistic Fantasy*: My life has no impact on others; I am disconnected from others. My life and medical decisions are my own and none of the concern of others. Rather we are members of families, communities and our species.**
- **We have a duty to die when the burden of caring for us seriously compromises the lives of others**
  - **If we cause others physical, emotional, or financial hardship, or to support us**
  - **If others legitimate needs are neglected because of the attention we require**

ASSISTED DEATH & COST CONTROL

Freedom to Die: People, Politics & the Right to Die Movement
Derek Humphrey & Mary Clement, 1998

- PAS will ultimately be accepted as an important "method of cost containment"
- Economics is "the unspoken argument"
- "greedy geezers" are "putting a strain on the health care system that will only increase and cannot be sustained"
- "…economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice"

The Economics of Death in Oregon

AMA News (9 Sept 2002)

- In 2002 Kaiser Permanente NW sought to identify physicians in the HMO who would write the lethal prescriptions, specifically asking, "Are you willing to act as the Attending Physician under the law for members who are not your patients?"
- Qual Med HMO pays for PAS, but has a $1000 cap on hospice care.

PAS and Cost Control

New Engl J Med. 1998;339:167-172.

"The most reasonable estimate is a savings of…less than 0.07 percent of total health care expenditures… Physician-assisted suicide is not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions or for the nation as a whole."

American College of Physicians -- American Society of Internal Medicine

Snyder & Sulmasy, Ann Int Med 2001; 135:209-216

The first duty of physicians must be to optimize their skills in assessing and treating pain, assessing and optimizing function, identifying depression, coordinating the efforts of other members of the health care team, and using community-based services and hospice care to decrease the typically enormous financial and emotional burdens on the patient's home life and caregivers. For the patient who directly or indirectly requests assisted suicide, the physician should first reassess how well the treatment plan is meeting the patient's medical, social, psychological, and spiritual needs and fears. The physician should explore the reasons for the request, try to understand its meaning, keep dialogue open, and affirm that he or she will not abandon the patient….

To the extent that this is a dilemma partly due to the failings of medicine to adequately provide good care and comfort at the end of life, medicine can and should do better. We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide.

Care of the Dying & Chronically Ill Patient

Good palliative care:

- Manage pain and discomforts
- Address emotional and spiritual concerns and needs
- Maximize autonomy and sense of control
- Reassure
- Human presence
  - Talk
  - Touch
  - Love
  - Legacy
- "Dignity therapy" (*J Clin Oncol*. 2004;22:1336-1340)

Dame Cicely Saunders

http://eolc-observatory.net/history/cicely.htm

"You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die."