Responding to Requests for Physician-Assisted Suicide

"These Are Uncharted Waters for Both of Us. . . ."

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Studies of dying patients have shown that about half would like the option of physician-assisted suicide (PAS) to be available for possible future use. Those percentages decrease significantly with each step patients take toward action. Studies show that although about 10% of patients seriously consider PAS, only 1% of dying patients specifically request it, and 1 in 10 of those patients actually receive and take a lethal prescription. However, most patients' desires for PAS diminish as their underlying concerns are identified and addressed directly. To help identify concerns motivating a patient's request for PAS, physicians should talk with patients about their expectations and fears, options for end-of-life care, goals, family concerns and burdens, suffering or physical symptoms, sense of meaning and quality of life, and symptoms of depression. A patient with advanced amyotrophic lateral sclerosis (ALS) who requested PAS illustrates how a hasty response may adversely affect patient care and the health care team. Although physicians should remain mindful of their personal, moral, and legal concerns, these concerns should not override their willingness to explore what motivates a patient to make this request. When this approach is taken, suffering can be optimally alleviated and, in almost all cases, the patient's wishes can be met without PAS.

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THE PATIENT'S STORY

Mr G is an unmarried 47-year-old truck driver, living in Oregon. In January 2001, he experienced persistent pain in his arm following an industrial accident. When weakness developed, his primary care physician, Dr J, referred him to a neurologist, who diagnosed him as having amyotrophic lateral sclerosis (ALS).

Mr G's disease progressed with unexpected speed and was not responsive to any medical interventions. Mr G had a close relationship with Dr J and openly discussed his wishes for end-of-life care. He completed an advance directive indicating his desire to receive no life-sustaining treatments such as cardiopulmonary resuscitation (CPR), tube feeding, or mechanical ventilation. He also mentioned to Dr J that he might consider physician-assisted suicide (PAS) as he neared death.

Within months of diagnosis, Mr G lost the ability to ambulate and care for himself. Because he had no family caregivers, he was transferred to a skilled nursing facility, where he continued to reside. Dr J did not follow up patients at this facility, so Mr G's medical care was transferred to Dr R, the facility's house physician.

In the 6 months that followed, Mr G's disease progressed rapidly. When he began having difficulty speaking and swallowing and was nearing death, Mr G asked Dr R to help him end his life. Dr R did not respond directly to the request, nor did he explore it further. Instead, he referred Mr G to a home hospice program. Mr G reported to the hospice social worker that he had asked Dr R for PAS. When the social worker contacted Dr R to confirm the request, Dr R became angry at her for discussing PAS with Mr G. Because of his moral opposition to PAS, Dr R chose to discontinue caring for Mr G. Dr L, the hospice medical director, then became Mr G's physician.

PERSPECTIVES

Mr G consented to be interviewed by a Perspectives editor but had become too weak to participate prior to the scheduled interview. A Perspectives editor interviewed the hospice social worker, Ms T, who referred to case notes to provide Mr G's perspective. This Perspectives editor also interviewed Drs R and L.

DR R: *We didn't really talk about assisted suicide. He brought it up to me several months ago. He pretty much stopped me in the hall and wanted to know what my thoughts were about it and if I was prepared to help him.*

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Table 1. Reported Reasons Why Patients Request Physician-Assisted Suicide*

Being a burden[17,18,21,28,29]
Being dependent on others for personal care[18,30]
Loss of autonomy[21,29]
Loss of control[18]
Loss of control of bodily functions[21,29]
Loss of dignity[17,18,28,30]
Loss of independence[28]
Loss of meaning in their lives[17]
Pain or physical suffering[17,21,28-30]†
Poor quality of life[28]
Ready to die[28]
Saw continued existence as pointless[28]
Tired of life[30]
Unable to pursue pleasurable activities[21,28,29]
Unworthy dying[30]
Wanted to control circumstances of death[28,29]

*Listed alphabetically because prevalence cannot be compared across dissimilar studies.
†Patients concerned about future pain were not necessarily reporting pain at the time the request was made.

DR L: *Mr G had discussed PAS with Dr J when his diagnosis was first made, at least in a conjectural sense, as something that he might want in the future.*

MS T: *He let us know right away that he wanted physician-assisted suicide.*

The controversy of euthanasia and PAS has long existed,[1] and the debate has returned to the fore as concern over care of the dying has increased.[2-10] Several major medical societies have taken a stand opposing PAS and euthanasia.[11,12] The intent of this article is not to debate the morality of PAS (the prescribing of lethal medications for patients to self-administer) or euthanasia (physician-administered lethal injection), but instead to explore Mr G's request and the subsequent reactions of his physicians, and to provide guidance on ways in which physicians may constructively respond to requests for PAS, irrespective of their moral and ethical position or legal concerns.

As clinicians know, it is not uncommon for patients with terminal illness to consider PAS.[13-15] Many physicians will receive a specific request for PAS from a patient.[16-19] Physicians may feel uncomfortable discussing these requests. Although physicians should remain mindful of their own personal concerns, these concerns should not override their willingness to explore the motivation behind the patient's request. When a physician responds to requests for PAS with avoidance or rejection, opportunities to alleviate suffering may be missed.

An exploration of the request can proceed effectively if the physician listens to the patient respectfully, acknowledging that the physician's role, as part of the larger health care team, is to provide care, give information, and respond to suffering regardless of the physician's moral view. These discussions may lead to a greater understanding of a patient's fears and sense of suffering. When such an approach is taken, suffering will be optimally alleviated and, in almost all cases, the patient's wishes will be met without PAS.[20,21]

CONSIDERING PAS

Patients who initially consider PAS are, in part, exploring their options at the end of life. Their most pressing question may have changed from "Why me?" to "What next?" Some patients speculate that if faced with unbearable suffering, they would choose PAS. An initial request for PAS should be interpreted as a call for information about the future and an appeal for a commitment to respond to anticipated suffering. Patients and their families are eager for the physician to provide guidance about what lies ahead. They benefit from the assurance that the physician is committed to responding effectively to their suffering, no matter how difficult or complex.[22,23] The physician who responds with avoidance, dissuasion, or rejection has failed to hear the patient's cry.

Why Do Patients Consider PAS?

DR R: *He wanted to be empowered by having that choice. He wanted to end it on his own terms.*

Each patient who requests PAS brings a unique personal history to the request. Powerful stories have been written about the complex issues behind some patients' decisions to hasten their own deaths.[6,24-27] Survey data provide some guidance as to the range of concerns that may motivate requests. In general, physical symptoms rarely serve as the primary or sole motivation behind the request. Instead, individual values appear to have primacy (TABLE 1).[17,18,21,28-30] In a study of 100 patients with ALS, those willing to consider PAS were less religious, scored higher on measures of hopelessness, and had a sense of diminished quality of life. Such patients did not differ in levels of pain and suffering, degree of disability, social support, use of hospice care, or frequency of depression compared with those who would not consider PAS.[14] Among patients with acquired immunodeficiency syndrome (AIDS), pain, severity of disease, and functional impairment were not associated with desire for PAS.[13] In Washington state, 828 physicians responding to a survey reported that patients who requested PAS highlighted issues such as loss of control, being a burden, being dependent on others for personal care, and loss of dignity as concerns motivating the request. Uncontrolled pain and financial pressure were rarely perceived to be primary factors.[18]

How Often Do Patients Consider PAS?

Obtaining conclusive data about the frequency of requests for PAS poses several challenges. Definitions vary depending on the investigator and the goals of the study. If "consideration of physician-assisted suicide" is defined to include patients who want the option to be available for possible future use, then approximately half of the patients in some studies qualify as considering the option. In a survey of 378 patients with AIDS, 55% reported considering PAS as an option for themselves.[13] In a study of 100 patients with ALS, 56% agreed with the statement: "Under some circum-

stances I would consider taking a prescription for medicine whose sole purpose was to end my life." Nearly all these patients wanted the option available for future use. One individual indicated the desire to take the medication immediately.[14]

Other studies show that smaller numbers of patients seriously consider PAS. In Utah, 16% of 1114 family members randomly identified from death certificates reported that their loved one would have wanted PAS or euthanasia had it been available.[15] Importantly, the degree of interest in pursuing PAS may vary over time. Emanuel et al[31] conducted a prospective study of 988 terminally ill patients from 6 states, examining the frequency, durability, and outcome of requests for PAS. In an initial interview, 60.2% of patients supported PAS in the abstract while 10.6% of patients reported seriously considering euthanasia or PAS for themselves. At a second interview 2 months later, a similar number (10.3%) were considering PAS. However, nearly half of those were newly contemplating PAS and half of those previously considering PAS were no longer considering the option.

How Often Do Patients Request PAS?

Although many patients will consider PAS, a smaller number will make a specific request for it. Among the 256 patients who died during the course of the study by Emanuel et al,[31] 4 (1.6%) made a specific request of their physician for euthanasia or PAS. In Oregon, data suggest that about 1% of dying patients will make a specific request for PAS of their physician. Of these patients, approximately 1 in 10, (0.1% of all dying patients) will die by PAS.[21,28] Among selected populations, use of PAS may be substantially higher, as in the Netherlands, where both PAS and euthanasia are legal, physicians of patients with ALS reported that 35 (17%) of 203 chose to die by means of euthanasia and 6 (3%) died by means of PAS.[32]

MORAL AND LEGAL FRAMEWORK

DR R: *These were uncharted waters for both of us, and it was very emotional. I wasn't comfortable with assisted suicide even though, in his place, I could see myself wanting to do the same thing. I wasn't comfortable, as a physician, crossing the line into assisted suicide. I've never intentionally killed someone, and I'm not prepared to.*

MS T: *Mr G said he had asked Dr R about PAS and his words were "Dr R is right on board with me." The patient was 100% sure that Dr R was "on his side."*

Physicians vary in their moral beliefs and actions regarding PAS. In a 1995 statewide survey of Oregon physicians, 60% of 2761 responding physicians agreed that PAS should be legal in some cases. However, only 46% were willing, if PAS were legal, to prescribe lethal medication. Dr R was similar to the 31% of Oregon physicians unwilling to prescribe for moral reasons.[19] In a national study, 11% of 1902 physicians surveyed said they would be willing to "prescribe a medication for a competent patient to use with the primary intention of ending his or her own life" under current legal constraints.[17] Thirty-six percent would do so if the practice were legal.

Some physicians provide lethal prescriptions to terminally ill patients, even in jurisdictions where the practice is illegal. In Oregon prior to legalization of PAS, 7% of 2761 physicians surveyed reported having written a prescription knowing the patient intended to use it to take his or her own life.[19] In a national survey, 3.3% of 1902 physicians surveyed reported that they had written a prescription for a lethal dose of medication.[17] Participation is not equal across the specialties. In a national survey, 10.8% of 3288 oncologists reported having performed PAS during their career.[33] Fifty-three percent of 228 physicians in San Francisco caring for patients with AIDS reported having granted a dying patient's request for PAS.[16]

In the Netherlands, PAS and euthanasia have been practiced openly for approximately 20 years. These practices have been recently codified into law and formal guidelines established.[34] Oregon is the only state in the United States to have legalized PAS. Other states (Washington, California, and Maine) have voted on state initiatives on PAS or euthanasia, and in each case, voters rejected the initiatives.

The Oregon Death With Dignity Act arose as a citizen initiative passed by Oregon voters in November 1994. Implementation was delayed by legal injunction until October 1997 when an appellate court lifted the injunction. Almost simultaneously, in November 1997, Oregon voters rejected a ballot measure to repeal the Death With Dignity Act and the law went into effect. On November 6, 2001, US Attorney General John Ashcroft issued a directive interpreting the federal Controlled Substances Act to prohibit the use of controlled substances such as barbiturates in PAS. Physicians who write prescriptions with the intent of providing the means for their patient's suicide would be subject to investigation and potential prosecution, according to the directive.[35] On April 17, 2002, US District Court Judge Robert Jones overturned Ashcroft's directive, allowing the Oregon Death With Dignity Act to remain in effect.[36]

The Oregon Death With Dignity Act legalizes PAS only under certain circumstances and specifically prohibits euthanasia. (Information about Oregon's Death With Dignity Act can be found at: http://www.ohd.hr.state.or.us/chs/pas/pas.htm). Mr G met all of the legal requirements under the Act.

There is no moral or legal obligation for physicians to comply with a patient's request for PAS, even in Oregon. Nor is the physician under any obligation to refer the patient to a physician who would honor the patient's request. If the patient's desire to pursue PAS makes it impossible for the physician to continue caring for the patient, the obligation remains to continue providing care and comfort until arrangements are made for another physician to assume care.[23,37] In Oregon, physicians have been encouraged to con-

sider their own stance on PAS before being asked (guidance is available at: http://www.ohsu.edu/ethics/guide.htm) because patients may ask them about their beliefs and may choose to transfer care to a physician who shares their beliefs.[38]

RESPONDING TO A REQUEST FOR PAS

DR R: *I decided that I would recuse myself from the case. I explained that I wasn't trying to abandon him as a patient, but I couldn't facilitate PAS. I made no judgment about someone else doing it; I just felt that, as a physician, there was a line I couldn't cross.*

MS T: *The nurse and I went out the day after Dr R met with Mr G to see how Mr G felt after speaking with the doctor. He was very distressed. In his own words, he was "terrified." And he wept at what he called his loss of control and his options. He felt like everything was pulled out from under him.*

The Initial Response

Caring for dying patients can be challenging for a physician, frequently evoking thoughts of one's own mortality or thoughts of previous or anticipated deaths of loved ones.[22,39] A request for PAS adds to this emotional situation. The request may conflict with the physician's most deeply held moral beliefs. Other physicians may agree in theory with assisted suicide but may be reluctant to participate due to risks of investigation, censure, and prosecution in most jurisdictions. Physicians may interpret a request for PAS as an indictment of their ability to care compassionately for their patients.[40] However, an immediate refusal of a request for PAS runs the risk of adversely affecting the patient's care, as happened in this case. A definitive acceptance or rejection of the request need not occur until the motivation behind the patient's request has been explored and a deeper understanding is reached.[11,20,41] Should the request for PAS persist, physicians who are unwilling to write a prescription for lethal medication should inform the patient that they will not honor the request. In all cases, the physician should ensure that the patient's need for comfort will continue to be met.

Exploring the Request for PAS

DR R: *My response was to try to direct him toward hospice.*

DR L: *What was beneficial for Mr G was for me to explore with him what was driving him to make that request. I explored his understanding of his options and what he believed awaited him.*

Terminally ill patients have a variety of reasons for considering PAS. In TABLE 2, we present questions to guide a deeper exploration of the patient's concerns, fears, and motivations.

Expectations and Fears. DR R: *His primary fear was suffocating. He didn't want to suffocate on his own secretions.*

MS T: *He felt that the doctors had told him what the end of his life would be like with ALS, and it was very frightening. He was fearful of a lot of pain, of drowning in his own fluids, of terrible burning in his legs, and of perhaps being in a vegetative state for a long time.*

Table 2. Approach to Exploring a Request for Physician-Assisted Suicide (PAS)

Area of Exploration	Potential Motivation in Request for PAS	Follow-up Questions
Expectations and fears	Fears of uncontrolled symptoms Expectation of lingering death Expectation of unrelieved suffering	How do you expect your own death to go? What concerns you most about dying? What are your greatest fears? What's the worst thing that could happen to you as you die? Have other people close to you died? How did their deaths go?
Options for end-of-life care	Lack of knowledge of legally available options Equating PAS and euthanasia Equating PAS and aggressive symptom control (double effect)	What do you understand about your options for end-of-life care? How specifically would you like me to assist you?
Establishing patient goals	Discerning if PAS contemplated now or for future use Identifying sources of meaning for patient	What are your goals for whatever time you have remaining to live? What is the most important thing for you right now? If you were to die now, what would be left undone?
Family or caregivers	Family's beliefs may not be congruent with patient's Patient concern about being a burden on family	What does your family think about this decision? How has your illness affected your family? How will your family react if you proceed with PAS?
Relief of suffering or physical symptoms	Patient's unique perspective on experience of suffering	Are you suffering right now? What is your principal source of suffering? What kind of suffering concerns you most? What is your most troublesome symptom right now?
Sense of meaning and quality of life	Understanding patient values	What is your quality of life right now? What gives your life meaning right now? How bad would your quality of life have to become for your life to have no meaning?
Ruling out depression	Presence of treatable depression Patient capacity to make informed decision	Are you depressed? What things in life still give you pleasure? Have you had a good life? Do you have any regrets?

DR L: *His father had died of colon cancer years before, and he had been witness to that. He felt that his father had died a very protracted, miserable death in the hospital.*

Patients often say that they are not afraid of death but are afraid of the process of dying.[22,42] Many patients fear that dying will be a time to "lie there and suffer." In the past, death was familiar and occurred more frequently in the community. In recent decades, however, death has largely occurred in the hospital, in an environment of significant unrelieved suffering and isolation.[43,44] Many patients' only experience of death may have been the prolonged, painful deaths of loved ones. Some investigators report that such experiences are associated with increased contemplation of PAS.[13] For Mr G, the intense memory of his father's protracted death contributed to his fears. Mr G had vivid perceptions of the physical suffering he believed awaited him as death approached. Dr R had perhaps inadvertently heightened these concerns by highlighting the potential dyspnea, suffocation, and leg pain associated with terminal ALS without stressing the availability and effectiveness of treatments for these symptoms.

Options for End-of-Life Care. MS T: *Mr G felt very sure that Dr R would provide him with the lethal injection that he needed. He used the word "injection."*

Frequently, the request for PAS reflects a patient's misunderstanding about his or her options for end-of-life care. Patients may not realize the breadth of alternative responses available to alleviate suffering (BOX). Not all options will be morally acceptable to all patients or physicians.[45] Patients who ask for PAS may actually be requesting aggressive symptom control should their suffering become intolerable. They may not understand that medications can be increased to whatever levels are required to relieve physical symptoms, such as pain and dyspnea or other physical and emotional suffering. In rare instances, in which even extraordinary doses of analgesics are ineffective, physicians can prescribe barbiturates to sedate patients to relieve symptoms.[46] Even if death is hastened in the process, under the principle of double effect, such actions are morally permissible and legal when the intent of the treatment is to relieve symptoms and not to cause the patient's death.[11,47,48]

Patients often confuse PAS with legally available options to control the time and manner of death. Patients may not understand the option of withdrawal or withholding of life-sustaining treatments. Physicians should reassure patients that all life-prolonging treatments and life-sustaining medications can be refused or discontinued.[46,49,50] Patients may also be unaware that artificial hydration and nutrition can be discontinued or refused, as Mr G had instructed in his advance directive. Mr G may have been unaware that he could also choose voluntarily to stop eating and drinking, and in doing so, prevent a protracted death.[46] Moral questions have been raised about such action in patients who can still swallow.[45]

Mr G appeared to equate PAS and euthanasia (a common source of confusion)[51] in expecting that Dr R would administer an injection. Euthanasia remains illegal in Oregon and Dr R could not have legally administered a lethal injection. Therefore, physicians should ask patients who request lethal medications to specifically describe what they mean by PAS.

Box. Options Available to Terminally Ill Patients for Care and Treatment at the End of Life

Options Physicians May Offer

- Aggressive pain management
- Terminal sedation or palliative sedation
- Withdrawal or withholding of life-sustaining treatments
  - Dialysis
  - Mechanical ventilation
  - Medications such as corticosteroids, insulin, antiarrhythmics
  - Artificial hydration and nutrition

Options Patients May Request

- Voluntarily stopping eating and drinking
- Physician-assisted suicide (Oregon only)

Establishing Patient Goals. DR L: *His goal was to avoid a protracted, lingering death; to make sure that when he reached a point of immobility, the end would come quickly.*

MS T: *In his words, he did not want to suffer at the end.*

Some patients, as in Mr G's case, report that their primary goal is to achieve a safe and comfortable death. Such thoughts may be indicative of patients who have "completed their life's work and said their last good-byes." Desire for or acceptance of death in such a patient may not indicate depression but rather a patient who faces death fully content and fulfilled.[42]

A terminal illness can produce a sense of deep meaning and transcendence as dying patients reflect on their lives and seek stronger connections with loved ones.[42] Physicians can promote and encourage such feelings by asking patients about their goals and tailoring medical options to achieve them. These goals will likely have shifted from medical goals, such as control of disease and prolongation of life, to more personal goals, such as spending time with family or living to see an important milestone.[52]

Relief of Suffering. Suffering is uniquely personal.[53] Physicians should exercise caution in evaluating whether the patient's degree of suffering is sufficient to justify a request for PAS. Each patient will experience a unique degree of suffering, which must be believed and validated.

Physical pain may cause severe distress, but it is the impending disintegration of the person, loss of control, and unresolved spiritual or psychological issues ("total pain")[42,54] that may cause the most intense suffering. Suffering of this nature may be addressed with attention to a patient's spirituality or sense of meaning. Mr G appears to have reached an acceptance of his death and did not appear to be experiencing spiritual suffering.

Sense of Meaning and Quality of Life. MS T: *He had become very close to numerous caregivers at the facility. He was good friends with his military buddies and his room was decorated with pictures of him in the military.*

Dr L: *He was really quite pleasant. He could sit up and maneuver around the nursing home with his electric wheelchair; he still had use of one hand.*

Quality of life is also a uniquely personal, subjective experience.[55] A dying patient's estimation of quality of life is not based solely on functional status and the presence or absence of physical symptoms.[14] Frequently, quality of life centers on the transcendent, existential questions of meaningfulness and worthiness.[42] Many dying patients experience some distressing physical symptoms and most lose functional capabilities as death approaches. Yet, some dying patients find quality of life to be enhanced by a heightened sense of meaning even as physical function diminishes and death approaches. Mr G continued to report good quality of life in spite of his dramatic physical limitations. He had good friends who visited frequently. He had established strong bonds with the nursing home staff and felt valued there.

Ruling Out Depression. DR R: *I sensed that he was starting to get a little bit depressed, and we did a trial of antidepressants, which he only took briefly because they caused nausea. He had a very positive attitude. He knew he was staring down the barrel of a gun. He tried to make light of himself whenever he could. I liked him. He was a personable guy.*

Depression is common in terminal illness (estimates range from 4.5%-53%) and is frequently undiagnosed.[56] The diagnosis of depression in dying patients presents several challenges.[57] Dying patients often experience periods of depressed mood. However, in many patients these depressed moods will represent normal reactive sadness, rather than clinical depression. The physical signs of depression, such as weakness, fatigue, change in appetite, and hypersomnolence are frequently present as a result of the disease itself. The diagnosis of depression in the terminally ill is best made using the cognitive signs of depression: anhedonia, guilt, and loss of self-worth, along with pervasive sadness.[57] Some research has shown that the simple question "Are you depressed?" may be the best diagnostic test for assessing depression in the terminally ill.[58]

Dr R wisely considered the possibility that Mr G might be depressed. However, Dr R's description of Mr G does not suggest a man with serious depression. Mr G appears to have retained his self-worth and remained involved with activities that gave him pleasure. Mr G most likely had periods of understandable sadness as the reality of his death loomed. This sadness is perhaps what Dr R sensed was depression. Importantly, the presence or absence of depression may not be the most important marker for the desire for PAS. Rather, some studies of terminally ill patients suggest that hopelessness may correlate better with the desire for PAS.[14,59]

The Request Withdrawn

MS T: *After Mr G met with Dr L, he felt he no longer needed to pursue PAS. Dr L made him feel very sure that his end would be pain-free and peaceful; that he would not suffer the burning legs and the anguish that he was afraid he would suffer. Dr L would give him whatever amount of pain medication or sedation was necessary so that he would not suffer at the end.*

Mr G fit the common pattern of patients who request PAS. Almost all patients do not persist in their request when their concerns are addressed effectively. In Oregon, 15% of patients requesting PAS under the Oregon Death With Dignity Act ultimately received a prescription.[28] Following Dr L's assurances that his suffering would be controlled, Mr G no longer pursued PAS.

When PAS Is Chosen

Some patients, about 0.1% to 0.2%, will persist in their desire for PAS.[21,31] In Oregon some requests for PAS have endured despite physician interventions, including pain control and control of other symptoms, hospice referral, mental health consultation, or trial of antidepressants.[21] Interviews with surviving families in Oregon suggest that some patients who proceed with PAS have a deeply held desire to control the time and manner of their death.[29] Among patients in Oregon who received lethal prescriptions, approximately one third died of their disease without taking the lethal prescription.[21] For these patients, health department interviews suggest that the possession of a lethal medication may have provided a sufficient sense of control. In other patients, the disease may have advanced so quickly that PAS was unnecessary or impossible.[60]

IMPACT ON THE HEALTH CARE TEAM AND FAMILY

MS T: *Dr R was very angry, saying he had "ordered hospice, not physician-assisted suicide." He was very angry at hospice for allowing the conversation to open up. He felt betrayed by [our] hospice and our advocacy for exploring the patient's wishes. He basically accused me of helping the patient commit suicide.*

DR R: *I was upset. My intention in referring him to hospice was to make sure that he had a comfortable death but not assisted suicide.*

The Health Care Team

Mr G's request for PAS created significant challenges for the team providing his care. The ethical principle of conscientious practice requires that team members not be compelled to provide treatments that violate their own moral values and beliefs.[37,48] However, an attitude of mutual respect for others of differing viewpoints is imperative to optimize patient care. Good interdisciplinary patient care requires excellent and open communication.[42,61] Despite the complex moral and legal issues, a nonjudgmental stance will help diminish conflicts between team members.

Several Oregon institutions and health care systems have policies prohibiting PAS. The moral values and beliefs of organizations also deserve respect.[37] Respect for the opposition of individuals and health care systems is specifically contained in Oregon's law.[62] However, irrespective of their position on PAS, all individuals and systems that provide care for terminally ill patients have a fundamental responsibility to respond aggressively to suffering.

The Family

Family members may hold different views regarding PAS from those of their dying loved one.[37] The same divisions in beliefs of the health care team that complicated Mr G's care may strain family relationships. At times, patients may choose not to pursue their request for PAS out of respect for the beliefs of loved ones.[63] Oregon's law requires physicians to encourage patients to notify their family of their desire for PAS. To our knowledge, there are no comprehensive data on the impact of death by PAS on surviving family members.[37] Some families report coming to respect their loved one's choice for PAS.[27,29] However, the potential for complicated grief would exist if the death occurred in the context of unresolved family conflict.[64]

CONCLUSION

It is not uncommon for patients to consider PAS. Many physicians will receive a specific request for PAS from their patients. When a terminally ill patient asks about PAS, physicians may feel anxious and some may abruptly truncate the conversation. Premature closure of this discussion may contribute to the patient's sense of isolation and also result in missed opportunities to identify suffering that can be ameliorated. Open dialogue about PAS may allow an exploration of patients' expectations and fears, their knowledge of options for care at the end of life, and their sources of suffering. When physicians commit themselves to remain present with patients and to respond to their suffering, in almost all cases, the patient's wishes can be met without PAS.

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> Truth is the secret of eloquence and of virtue, the basis of moral authority; it is the highest summit of art and of life.
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> —Henri-Frédéric Amiel (1821-1881)