

## Suicide at Life's End

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▪ slides posted at <http://www.brungardtmd.com/wp-content/uploads/2010/06/Suicide-Lifes-End.pdf>

## 68 yo panc ca – request PAS

- c/o abd pain
- multiple sx issues
- wife supportive but quiet
- pas request – “if I could make it to Oregon I’d go”
- Vietnam Vet
- reticent to share psycho-social-spiritual history

## Suicide at Life's End

- Define Terms and Key Facts
- Euthanasia – Netherlands
- Physician Assisted Suicide – Oregon
- Palliative Sedation
- Clinical Response
- Hope ... Relationships
- Transf/Countertransf ... Ambivalence

## key terms - “desire for hastened death”

- Suicide - the act of intentionally killing oneself
- Euthanasia- the intentional killing of a person who is suffering in order to eliminate that suffering
- Physician Assisted Suicide (PAS) - patient requests lethal dose of medication, physician prescribes, patient takes
- Palliative Sedation - the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is intractable and intolerable

## key dates...

- 1973 Dutch decriminalize euthanasia
- 1998 Oregon legalizes PAS
- 1999 Kevorkian convicted
- 2000 Netherlands legalizes euthanasia
- 2002 Belgium legalizes euthanasia
- 2008 Luxembourg legalizes euthanasia

## key dates ...

- 2007 AAHPM (hospice md's) adopts position of “studied neutrality” re PAS (“physician assisted death”)
- 2008 Washington State legalizes PAS
- Assisting suicide in Switzerland never criminalized...
- (assisting suicide a felony in Kansas)

### 'neither hasten nor prolong'

- traditional main stream hospice philo
- aahpm 'studied neutrality'
- physician assisted 'death'
- pall sedate – existential sx's
- mainstream journals with neutral articles re hastened death
- blog/conversation – hastened death is just the individual's choice/opinion

### Suicide Risk Factors

- (in advanced disease)
- Depression
- Hopelessness
- Loss of Control – helplessness
- Lack of social support – social isolation
- Fatigue - exhaustion

### Suicide Risk Factors (cont)

- Preexisting psychopathology
- Substance/Alcohol abuse
- Suicide history – family history
- Pain – suffering
- Advanced Illness – poor prognosis
- Delirium – disinhibition

### Euthanasia

- Ancient Greeks "good death"
- 18<sup>th</sup> century "help to die well"
- Today euthanasia means the intentional killing of a person who is suffering in order to eliminate that suffering.

### Dutch Euthanasia

- 35 yo female ALS
- single, high school music teacher
- ALS progressed slowly for 2 years ...
- ... then she declined rapidly
- now unable to perform ADL's
- parents are caregivers

### Dutch Euthanasia

- 35 yo female ALS
- admitted for pneumonia
- patient asked not to live 'on a machine' and asked 'not to suffer'
- patient stated she preferred euthanasia to life on a ventilator
- her main fear was 'no air' ... 'not having enough air'

## Dutch Euthanasia

- 35 yo female ALS
- admitted for declining lung function
- patient assented to euthanasia
- case taken to 'terminal care committee'
- request approved
- condition continued to decline
- patient and family decided that 'waiting ... was unbearable'

## Dutch Euthanasia

- 35 yo female ALS
- family said good-bye's and left the room
- md gave 1 gm pentobarbital IV
- then 4 mg curare derivative
- breathing stopped a few seconds later
- death certificate = "sudden respiratory arrest"

## Dutch Euthanasia

- 1973 decriminalized
- 1986 psychological suffering justifies
- 1987 non-voluntary OK if done "attentively"
- 2000 euthanasia legalized
- 2004 Groningen protocol - pediatric euthanasia

## Dutch Euthanasia

- unbearable suffering
- voluntary and persistent request
- competent decision maker
- consultation with one other doctor
- at least 12 years old
  - 16-18 requires parental notification
  - 12-16 requires parental consent
- Groningen Protocol (2004) < 12 yo

## Netherlands

- 1991 Rummelink Report
- Euthanasia 2300 deaths (1.8%)
- Assisted Suicide 400 deaths (0.3%)
- Involuntary Euthanasia 1000 deaths (0.8%)
- other interpretations of the data count as many as 25,306 instances of euthanasia (19.4% of all deaths) with over half of these being involuntary

## Dutch Euthanasia

- 3% of deaths (1.8 + 0.3 + 0.8)
- if 2000 pts/year (local hospice)
- 2000 \* .03 = 60 pts/year
- or more than 1 a week

Table 1. Frequencies of Euthanasia, Assisted Suicide, and Other End-of-Life Practices in the Netherlands, According to Year.<sup>a</sup>

Variable	1990	1995	2001	2005
No. of studied deaths <sup>†</sup>	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)

<sup>a</sup> All percentages were weighted for the sampling fractions, for nonresponse, and for random-sampling deviations. CI denotes confidence interval, and NA not available.  
<sup>†</sup> 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.  
<sup>‡</sup> P<0.05 for comparison with the frequency for 2005.  
<sup>§</sup> Continuous deep sedation may have been provided in conjunction with practices that possibly hastened death.

## Patient Concerns: Netherlands

- Loss of dignity 57%
- unworthy dying 46%
- dependence on others 33%
- tired of life 23%
- pain 10%

## Oregon PAS

- Helen 81 yo lady with breast cancer
- requested assisted suicide
- primary md and consulting md refused both stating she was clinically depressed
- husband called Compassion in Dying whose medical director spoke with Helen
- “frustrated and crying because she felt powerless”

## Oregon PAS

- Helen 81 yo lady with breast cancer
- daily aerobic exercise until 2 weeks ago
- still doing housework
- no pain
- had experienced the lingering death of her husband
- primary concern was anticipated suffering

## Oregon PAS

- Helen 81 yo lady with breast cancer
- Compassion in Dying recommended md
- this md also referred her to specialist and psychiatrist
- lethal prescription supplied and Helen died soon after

## Oregon PAS

- 1994 legalized in referendum
- 1994-1997 legal challenges
- 1997 Oregon Death with Dignity Act implemented
- “Physician Assisted Death”
- 2007 AAHPM adopts “position of studied neutrality”

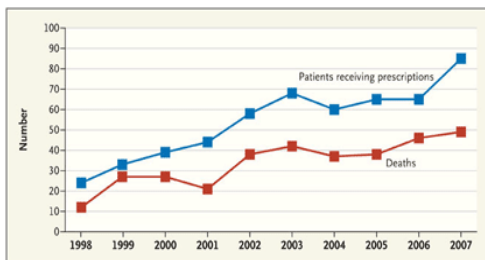
## Oregon PAS

- adult (18 yo) resident of Oregon
- capable of decision making
- terminal illness (< 6mo)
- two oral requests (15 days apart)
- written request signed by 2 witnesses
- prescribing md and consulting md confirm dx and prog and decision making ability

## Oregon PAS Rules

- psych referral not mandatory
  - 1998 Oregon 19% psych refer
  - 2009 Oregon 0/59 deaths
  - 2009 Washington 3/36 deaths
- no requirement re pain & suffering
- very limited data collection and disclosure
- no mechanism to ascertain non-reporting

## Oregon 1998-2007



## Oregon PAS

- > 50% do not receive palliative rx of any kind (pain control, social work assess, hospice referral, trial of anti-depressant)
- 1/2 of the patients for whom any interventions were made changed their minds
- MD's completely immune to any/all potential criminal, civil or professional liability
- divorced 2X married to commit pas

## Patient Concerns: Oregon

- Loss of autonomy 89%
- Less able to engage in activities making life enjoyable 87%
- Loss of dignity 82%
- Losing control of bodily functions 58%
- Burden on family, friends/caregivers 39%
- Inadequate/concern pain control 27%
- Financial implications 3%

## Patient Concerns – Family Point of View: Oregon

- wanting to control circumstances of death
- worry about loss of dignity
- worry about loss of independence
- quality of life
- self-care ability
- (physical symptoms rated very low)
- Ganzini. J Gen Intern Med 23(2):154–7, 2007.

## Clinical Issues – ambivalence

- do we ignore the ambivalence death provokes ... and operate under an illusion of control?
- Burt argues that in our hearts we perceive death as inherently wrong – a logical and moral error
- we have designed systems/laws to suppress/silence this perception ... PAS in Oregon is one example
- [Death is That Man Taking Names](#) – Burt

## Clinical issues – ambivalence

- suffering patient - MD needs to eval ...
- 'in control' patient - MD can prescribe PAS
- re 'streamlined' approach of Oregon ...
- "... this compressed format also serves to abet the denial of ambivalence, both by the requesting patient and by any evaluating physician." (Burt)

## VSED

- voluntary stopping of eating and drinking
- a type of Physician Assisted Suicide
- we suggest it ... normalize ... give them the option
- we have given the means to hasten death
- they carry out

## Palliative Sedation

- [Palliative Sedation](#) - the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is intractable and intolerable
- (NHPCO Kirk JPSM)

## Palliative Care ... or Sedation?

- sedation of the imminently dying
  - while treating intractable pain or other burdensome symptoms
  - side effect of treatment
  - palliative care
- sedation toward death
  - existential symptoms
  - a form of euthanasia, PAS
  - palliative sedation

## Palliative Care: Sedation of the Imminently Dying

- patient is close to death (hours-days)
- refractory symptoms
- aggressive treatment of symptoms...
- has a foreseen/unintended side effect of sedation
- other burdensome therapy may be withdrawn/withheld
- dose titration trials

## Palliative Sedation: Sedation toward death

- patient is not imminently dying
- 'existential' symptoms – autonomy, control, indignity
- patient is sedated to unconsciousness as a means of treating these symptoms
- other life sustaining treatments (including nutrition/hydration) are withdrawn
- no dose titration trials

## Mellar Davis, MD ...

- "...just as one could not intend to kill the physical body to remove physical pain, one cannot kill the social/existential self to remove existential/social suffering ... The 'medicalizing' of existential suffering is problematic ..."

## Clinical Response

- Desire for Hastened Death
- Clinical correlates ...

Depression	Loss of autonomy
Hopelessness	Severe pain
Loss of dignity/meaning	Cognitive dysfunction
Feeling a burden to others	Low social support

- Breitbart et al in Walsh Palliative Medicine p.55 (2009)

## Clinical Issues

- Presentation
- Risk Factors
- Assessment
- Intervention
- (Counter)-transference

## Clinical Issues – presentation

- suicide – hastened death
  - passive wish – fleeting – no active plans (up to 40%)
  - request for assistance (up to 20%)
  - active desire – with plan (up to 5%)
  - completed - < 1%

## Clinical Issues – risk factors

- depression
- hopelessness
  - the capacity to find purpose in living
  - hope – certainty in the future based on the strength of a present reality
- social support
  - feeling like a burden to others
  - loss of autonomy
- pain/symptoms – and how they affect activity

## Clinical Issues – assessment

- validate – normalize these thoughts – feelings
- risk factors?
- thorough assessment
- talk through with patient
- vigilant follow-up

## Clinical Issues – assessment

- ideation?
  - 'many have passing thoughts of suicide ... have you?'
  - have you found yourself thinking you'd be better off dead?
- plan?
- intent?
  - 'do you think you would carry out?'

## Clinical Issues – intervention

- assessment & exploration of feelings, fears and suffering
- evaluate & address risk factors
- empathy – active listening – mgmt of realistic expectations – normalize distress
- Hudson PL et al. Responding to desire to die statements from patients with advanced disease. *Palliative Medicine*. Oct 2006. 20(7): 703-710.

## Clinical Issues – intervention

- **enhance meaning**
  - Breitbart, W., Rosenfeld, B., Gibson, C., et al. (2009). Meaning-centered group psychotherapy for patients with advanced cancer. *Psycho-oncology*, 19, 21–28.
- **conserve dignity**
  - Chochinov, H.M., Hack, T., Hassard, T., et al. (2005). Dignity conserving therapy. *Journal of Clinical Oncology*, 23, 5520–5525.
- **life completion tasks**
  - Steinhilber, K.E., Alexander, S.C., Byock, I.R., et al. (2009). Seriously ill patients' discussions of preparation and life completion. *Palliative and Supportive Care*, 7, 393–404.

## Clinical Issues – (counter)transf

- how do doctors and patients behave toward each other in times of stress & tension?
  - patient – sick & dying
  - doctor – being confronted with 'failure' to cure/fix ... being confronted with death
- countertransference – unconscious responses of clinician to patient...
- transference – ... patient to clinician ...
- ... based upon previous patterns of significant relationships in his/her own life

## Clinical Issues – (counter)transf

- projective identification
  - whose emotion is it?
- countertransference enactment
  - whose (emotional) need is it?



## Clinical Issues – (counter)transf

- challenges of dying patient ...
  - confrontation with the limits of medicine
  - persistent suffering – despite MD efforts
  - stark confrontation with death
- run up against MD attributes ...
  - heightened sense of responsibility
  - tendency to experience guilt
  - high self-criticism & perfectionism
  - need for control

## Clinical Issues- (counter)transf

- ... can lead to MD failure to explore and assess risk factors – depression – hopelessness – etc
- MD falls back on the cultural rhetoric of 'autonomy' and 'right to die' ...
- "the failure to explore the meaning and basis of the patient's request for hastened death is the real violation of the rights of a dying patient." (Muskin. JAMA. 279, 323-8)

## Hope

- the present, even if it is arduous, can be lived and accepted if it leads towards a goal, if we can be sure of this goal, and if this goal is great enough to justify the effort of the journey

Benedict XVI Spe Salvi

## Conclusions ...

- suicide at life's end = request for hastened death is not substantively different than suicide at other times of life
- legally available options for physicians to aid and abet patients in their suicide efforts are growing in the West
- attend to our own countertransference and/or ambivalence issues

## Conclusions ...

- sloppy language blurs reality
- are we willing to walk this journey with our patients and families?
- is mainstream hospice abandoning 'neither hasten nor prolong'?
- suicide at life's end is a loss of opportunity for closure and growth

## Conclusions ... Breitbart

- Do you agree that my life is worthless because I am dying?
- Our participation in PAS as physicians chooses a side of the patients' ambivalence and moves them towards death, when in fact there are very valid reasons to take the other side of the ambivalence towards death and support the meaning, value and dignity of the patient even during the dying process.

## Conclusions ... Breitbart

- ... to assuage concerns of burden, loss of meaning, hopelessness, worthlessness, and loss of dignity. We need to understand this intense complexity of the request for PAS and not feel content to have it go relatively unexplored and feel satisfied that we have a nice set of guidelines for its performance (guidelines that do not require psychiatric assessment or expert palliative care assessment, but rather suggest them).

## 68 yo panc ca – request PAS

- c/o abd pain
- multiple sx issues
- wife supportive but quiet
- pas request – “if I could make it to Oregon I’d go”
- Vietnam Vet
- reticent to share much of any psycho-social-spiritual history

## 68 yo panc ca – request PAS

- repeatedly declined psych-soc-spir interventions (including psych referral)
- no resolution
- died 6 wks later
- ? hx ptsd/Vietnam/atrocities

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