

CONCEPT

REQUESTS FOR *PHYSICIAN-ASSISTED SUICIDE* IN OLDER PERSONS: AN APPROACH

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Physicians caring for seniors may be presented with a patient who requests physician-assisted suicide or passive euthanasia. Often, these requests occur near the end of life in the setting of uncontrolled symptoms or depression. The recognition that mood disorders, under-treated pain, dyspnea, and delirium may play a role in these requests is important. With appropriate intervention, patients' quality of life may improve, with diminution of their desire for death.

Key words: Physician-assisted suicide, euthanasia, palliative care, older persons, quality of life

INTRODUCTION

Few topics in medicine generate as much controversy as euthanasia and *physician-assisted suicide* (PAS). Debates regarding the topics are widely seen on television, read in the newspapers and in medical journals, and occasionally heard in the courts. We therefore review the definitions of euthanasia and PAS. We then outline the situations in which patients may request PAS and an approach for physicians who are confronted with these patients. The discussion will focus on older persons.

Definitions

Voluntary active euthanasia is the intentional termination of life, at the patient's request. Thus, persons performing euthanasia are directly involved in the act of terminating life. PAS is the intentionally aiding of patients in terminating their lives at their request. With PAS, physicians do not have to actively participate in the act of terminating life, but instead just provide the means to do so. The discontinuation or the lack of initiation of inappropriately aggressive therapy that a patient does not wish, is not considered PAS or euthanasia. Therapy

aimed at alleviating unbearable suffering, even if a side-effect is to hasten death, is also generally not considered PAS or euthanasia.¹⁻³ This is the principle of double effect: interventions with the intent of relieving suffering are appropriate even if a known, but unintended, effect is to hasten death. This principle may not be very applicable to clinical practice, as there is little evidence that analgesic use hastens death.^{4,5}

The Clinical Situations in Which PAS Could be Requested?

There are numerous clinical situations where patients may request physician-assisted suicide, commonly in the context of terminal illness. Patients with metastatic cancer, end-stage heart failure and end-stage chronic obstructive pulmonary disease (COPD) may request that their physician intentionally hasten their death. Requests for PAS may also occur in the context of ongoing symptoms, such as distressing pain or dyspnea, even if the patient's condition is not terminal. Patients who are under-treated for pain may seek death as a method of ending their suffering. With adequate analgesia, the wish for early death may diminish. A second situation where requests for PAS occur is with patients who have concomitant depression.⁶ In fact, depression is a very common and under-diagnosed problem in patients with terminal disease.⁷ Importantly, this type of depression often responds to counselling and treatment with an antidepressant medication. It is therefore important to ensure that persons requesting PAS are not depressed. A third common situation where there are requests for PAS is where patients are experiencing delirium, again very frequent in patients in the terminal phases of a disease.⁸⁻¹⁰ Any request for PAS from a delirious patient should be reassessed after the delirium has cleared.

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How Stable are Death Wishes?

There are few longitudinal studies on the stability of death wishes. The evidence available suggests that death wishes are not stable, but may change over time.¹¹ The wish to die prematurely may vary over time, depending on severity of the person's pain, cognitive status, and affect. Thus, requests for PAS from patients should be viewed cautiously, because it may not represent a stable choice. Furthermore, attitudes towards euthanasia among physicians and the general public are presently in flux, with substantial changes of opinion over time.¹²

How Could PAS be Requested?

Physicians may be approached by patients in several ways. Patients may ask them directly to end their life. Occasionally, patients may ask in a very oblique manner. For example, patients may ask physicians for lethal doses of analgesia, ostensibly for treating severe pain, but in reality with the intent of hastening death.¹³ In acute situations where patients continue to complain of uncontrolled pain despite seemingly sufficient doses of analgesics, it is reasonable to inquire about suicidal intentions.

How Do Older Patients Differ From Younger Patients?

Elderly persons have a particular interest in the debate around PAS, because many elderly persons suffer from chronic diseases and functional impairment. Some functionally impaired persons may feel that they are a burden to their families and to society as a whole. In some studies, this may in fact be a major reason for desiring death.¹⁴ These people may feel compelled to hasten their death when confronted with a terminal illness.¹⁵ In extreme situations, elderly persons may feel under pressure from family members or service providers to hasten their death. Despite these concerns, in countries where euthanasia is practiced, there does not appear to be a higher rate of euthanasia in older persons compared with the young.¹⁶⁻¹⁸

Nevertheless, older persons seem to have a conservative view of PAS and euthanasia. Only 41% of older Americans supported euthanasia in a recent poll. This was a lower rate of support than among physicians or the general population.¹⁹

AN APPROACH TO PAS

Since many elderly patients requesting PAS have

potentially remediable problems underlying their request, it is important to rule these out:

Depression: Depression should be excluded. Depression commonly occurs in patients at the end-stage of life.²⁰ Depression at the end of life is not easy to diagnose, and different diagnostic and screening criteria may yield different results. However, it seems that the simple question "are you depressed?" correctly diagnoses a considerable number of depressed persons with terminal illness.²¹ Symptoms of depression could include decreased appetite, increased or decreased sleep, weight loss, decreased energy, and decreased initiative. While such symptoms are not uncommon in dying patients, their presence can also suggest the possibility of a major depression. Treatment of depression at the end of life has been shown to improve a patient's quality of life²² and is an integral part of any palliative care approach. Treatment should begin with supportive counseling and may also include pharmacotherapy.

Pain: It is important to adequately treat pain. Pain commonly accompanies the dying process. Undertreatment of pain is prevalent in many clinical settings, including in palliative care situations. Adequate pain control is essential and usually achievable by following guidelines for pain management. Generally regular, rather than as needed analgesics, give better pain control. Analgesic options include acetaminophen, narcotics, and antidepressant medications, and antiepileptic medications.²³⁻³²

Delirium: Delirium should be excluded in the patient requesting PAS. Delirium is characterized by acute cognitive impairment, accompanied by disorientation, fluctuating level of consciousness, and inattention. Delirium is also commonly seen in end-of-life situations.^{8-10,33,34} Recognition and treatment of terminal delirium may improve quality of life. As well, delirium can clearly impact the ability of terminally ill persons to make informed decisions about euthanasia.

End-Stage Heart Failure or COPD: Patients with end-stage heart failure and/or COPD often complain of very severe dyspnea. Again, this symptom is often remediable. Patients requesting PAS should be assessed for significant objective and subjective shortness of breath which interferes with their quality of life. Treatment should be started with breathing exercises, relaxation techniques, and if necessary, narcotics. Narcotics in low doses act to

reduce air-hunger and improve quality of life. Finally, oxygen often gives very good symptomatic relief of dyspnea.³⁵⁻³⁹

CONCLUSION

Patients often request PAS in the context of treatable symptoms. Many people are afraid not only of death but also of the dying process.⁴⁰ With adequate symptom control, the dying process would be less difficult, with fewer patient requests for PAS and euthanasia. Prompt recognition of the factors leading to suicidal ideation, with appropriate intervention, will reduce suffering in seniors, especially those near the end of life.

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