




Redefining Physicians' Role in Assisted Dying

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Terminally ill patients spend their final months making serious decisions about medical care and the disposition of their assets after death. Increasingly, they are also choosing to make

decisions about the manner and timing of their death, and many are completing advance directives to withhold life-sustaining treatment. A controversial facet of this trend toward a more self-directed dying process is the question of assisted dying — whether patients should have the option of acquiring a lethal dose of medication with the explicit intention of ending their own life.

This practice is generally illegal, but there is a movement toward greater social and legal acceptance. The Netherlands had a long history of court-regulated

 An audio interview with Dr. Lehmann is available at NEJM.org

assisted dying before official legislative recognition, and

some Western European countries have followed its lead. Oregon became the first U.S. state to legalize assisted dying when it passed the Death with Dignity Act (DWDA) through a voter referendum in 1997. Since 2008, six states have considered the issue legislatively or judicially; although legalization efforts failed in New Hampshire, Hawaii, New York, and Connecticut, they succeeded in Washington State (through a referendum) and Montana (through a court ruling). Measures based on the DWDA are up for consideration in Pennsylvania and Vermont, and Massachusetts supporters are working toward a ballot measure. Independent governmental commissions in Cana-

da and Britain have recommended legalization, and the Supreme Court of British Columbia recently struck down a national ban on physician-assisted suicide.

Data from places with legal assisted dying have helped allay concerns about potential abuses and patient safety, but a lingering challenge comes from the medical establishment. Many medical professionals are uncomfortable with the idea of physicians playing an active role in ending patients' lives,¹ and the American Medical Association (AMA) and various state medical groups oppose legalization. This position is not an insurmountable barrier, however; we propose a system that would remove the physician from direct involvement in the process.

Advances in palliative medicine have produced effective strategies for managing and relieving pain for most terminally

ill patients, including the possibility of palliative sedation. Inadequate pain control therefore ranks among the least common reasons that patients in Oregon request lethal medication. Most say that they are motivated by a loss of autonomy and dignity and an inability to engage in activities that give their life meaning.² Patients in the United States may already decline to receive life-sustaining treatment through advance directives, but that is a reactive stance: only when an

families were more prepared for and accepting of their death.^{3,4}

The DWDA outlines a careful, rigorous process for determining eligibility for assisted dying. A terminally ill adult must make two separate requests, at least 15 days apart, to his or her doctor for a lethal dose of medication. Two physicians must independently certify a prognosis of death occurring within 6 months and must refer the patient for a psychiatric evaluation if they suspect mental incompetence or the

assisted dying will disproportionately affect vulnerable groups; the slippery slope — that the practice will be expanded to include patients with nonterminal illness or even nonvoluntary euthanasia (a lethal injection from a physician without an explicit request by the patient); and abuse — that a patient's request for lethal medication may stem from mental illness or coercion by unscrupulous relatives.

These fears have not been borne out in Oregon,^{2,5} where patients choosing assisted dying are overwhelmingly white and, on average, more financially secure and more highly educated than the general population. After 13 years, the number of patients who die from lethal medication has stabilized at 30 to 50 per year, and the state has not attempted to broaden the eligibility requirements or prescription mechanisms. Oregon has reported no cases of coerced requests for lethal medication; indeed, the system's safeguards (waiting periods and psychiatric evaluation) are much more stringent than those for the well-accepted practices of withholding or withdrawing of life-sustaining treatment.

The fifth objection holds that allowing assisted dying undermines the sanctity of life. This is a subjective moral question, commonly framed in terms of absolute preservation of life versus respect for personal autonomy — a divide that often falls along religious lines. There is no clear, objective answer, but as with issues such as abortion or withdrawal of life support, legalization would benefit those who want the option, without affecting care for those who object to the practice.

We envision the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests, dispense medication, and monitor demand and use. Such a mechanism would obviate physician involvement beyond usual care.

acute condition occurs can patients decline intervention, and many patients have no life-sustaining treatments to withdraw. Some terminally ill patients wish to exercise their autonomy and control the timing of their death rather than waiting for it to happen to them.

This perspective is reflected in surveys of relatives of terminally ill patients in Oregon. In two studies comparing deaths from ingesting lethal medication with deaths from terminal illness, relatives gave similar ratings of patients' medical and emotional well-being in the last days of life and of their own feelings about the patients' dying process. The only reported differences were that patients who chose assisted dying had greater control of their symptoms and that they and their

influence of an underlying psychological condition. The patient must be informed of palliative options and can withdraw the request at any time; of course, patients can also receive the medication and not ingest it. Physicians may not administer the medication; patients must ingest it independently.

Critics have voiced six primary objections to legalizing assisted dying, four of which have been largely invalidated by 13 years of data from Oregon. First, opponents fear that permitting patients to take their own life will worsen the quality of palliative care, but in Oregon, overall spending on and patient ratings of palliative care have risen since assisted dying was legalized.⁵

Three concerns center on patient safety: discrimination — that

Finally, there are objections from the medical community. In a 2003 study of AMA members, 69% objected to physician-assisted suicide,¹ a position officially held by various national and state medical associations. Even with allowances for conscientious objection, some physicians believe it's inappropriate or wrong for a physician to play an active role in ending a patient's life. We believe there is a compelling case for legalizing assisted dying, but assisted dying need not be physician-assisted.

Under the DWDA, the patient's physician prescribes lethal medication after confirming the prognosis and elucidating the alternatives for treatment and palliative care. In theory, however, the prescription need not come from the physician. Prognosis and treatment options are part of standard clinical discussions, so if a physician certifies that information in writing, patients could conceivably go to an independent authority to obtain the prescription. We envision the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests, dispense medication, and monitor demand and

use. This process would have to be transparent, with strict oversight. Such a mechanism would not only obviate physician involvement beyond usual care but would also reduce gaps in care coordination: in Oregon and Washington, patients whose doctors don't wish to participate in assisted dying must find another provider to acquire a prescription. Physicians who strongly object to the practice could potentially refuse to provide certification or could even alter their prognosis, but these possibilities yield the same outcome as permitting conscientious objection. Patients could also provide an independent authority with their medical record as proof of their prognosis.

Such a mechanism would make it essential for physicians to offer high-quality palliative care. The availability of assisted suicide in Oregon seems to have galvanized efforts to ensure that it is truly a last resort, and the same should hold true regardless of who writes the prescription. Usual care for terminally ill patients should include a discussion of life-preserving and palliative options so that all patients receive care consistent with their own vision of a good death.

Momentum is building for assisted dying. With an independent dispensation mechanism, terminally ill patients who wished to exercise their autonomy in the dying process would have that option, and physicians would not be required to take actions that aren't already part of their commitment to providing high-quality care.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Cents and Sensitivity — Teaching Physicians to Think about Costs

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Imagine your first medicine rotation. You present a patient admitted overnight with cough, fever, and an infiltrate on chest x-ray. After detailing a history and physical, you conclude, "This is a 70-year-old man with community-acquired pneumonia."

Dead silence.

"Perhaps," the attending finally says. "But what else could this be?"

Your face reddens. "Pulmonary embolism," you say. The resident nods. "Heart failure." Now you're talking. "Churg–Strauss," you add.

"The patient does have a history of asthma."

The attending smiles. "How might you investigate these other possibilities?" he asks. Next thing you know, the patient's lined up for a chest CT, lower extremity Dopplers, echo, and a