Physician-Assisted Suicide: More Than Meets the Eye

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Could right-to-die laws result in people requesting death, even in the face of potentially treatable health problems?

PAIN MANAGEMENT

Several years ago there was an Academy Award–winning documentary about climate change: An Inconvenient Truth. The purpose of the movie was to demonstrate that those who denied the reality of climate change did so only by ignoring the scientific evidence to the contrary. The title of the movie often comes to mind when I hear advocates of legalization of physician-assisted suicide, also known as right-to-die laws (RTD), present their case.

Proponents often cite religious values—especially those of the Catholic Church—as the basis for concerns about legalization or opposition to RTD laws. Non-proponents are generally thought to be those who toe the Church line on abortion rights and who oppose same-sex marriage.

I am not a Catholic nor do I have any particularly strong religious beliefs. I am strongly pro–abortion rights and believe that adults should be able to marry whomever they wish regardless of gender. I also believe that it is highly unethical for physicians to impose their religious or political views on their patients and allow these to affect how they care for them. However, I do have major concerns about the RTD laws.

My concerns are based on science, not religion. As a pain medicine specialist and psychiatrist, I believe that the already existing laws and those that have been proposed have major holes that could result in people requesting death because of potentially treatable health problems.

With the recent passage of an RTD law in California, there are now 4 states that have similar laws (Oregon, Washington, and Vermont are the others). Several other states, including New York, are considering such legislation.

There are obviously many areas of concern apart from untreated pain. The Affordable Care Act has provided health insurance to millions who didn't previously have it, but there are still millions of uninsured people in our country who have limited access to anything other than emergency care. Psychiatrists have proper concerns about making sure that no patient who requests death is allowed to die if the request is the result of a treatable mental illness such as depression. All the RTD laws seek to prevent this: they require that if the attending physicians believe a mental disorder is a potential factor in the request, they need to make a referral to a mental health specialist, usually defined in the laws as a psychiatrist or licensed psychologist.

Any psychiatrist who has been involved in consultation/liaison psychiatry can readily recognize inherent problems in the laws. Most non-psychiatrist physicians have limited training in mental illness, so relying on them to identify such illness is a chancy proposition.

Furthermore, when it comes to terminally ill patients, there is a widespread perception that depression is normal and that there is no need to address it. The executive editor of the New England Journal of Medicine once wrote, “Dying patients who request assisted suicide and seem depressed should certainly be strongly encouraged to accept psychiatric treatment, but I do not believe that competent patients should be required to accept it as a condition of receiving assistance with suicide.”¹ Some physicians fear that referring patients to psychiatrists and psychologists is an insult to the patients by indicating it is felt that they are considered “crazy.” A study from Oregon found that of those who died under its RTD law in 2014, fewer than 3% were referred for a mental...
The RTD laws also acknowledge the possibility that untreated pain can be a major factor in requests for death and seek to ensure that pain will be addressed. Again, how the laws deal with the issue is troubling. For example, the California law requires that the patient’s attending physician present “feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control” [italics added]. This all sounds fine. The problem is that every study of which I am aware has shown that pain is often poorly managed, including in terminally ill patients.

It has bothered me that many proponents of RTD laws choose to overlook this, preferring to leave the impression that this isn’t a problem and that every terminally ill person receives expert palliative care. When confronted with the evidence of the reality of deficiencies in pain management, they acknowledge it is a problem that needs to be corrected but that it shouldn’t stop the passage of RTD laws.

Another complicating factor is that not only has pain itself been associated with increased risk of suicide, but so have some of the most commonly used analgesic medications for severe pain, including opioids and antiepileptic drugs. Untreated pain or fear of it is far from the only reason for suicide requests but—along with a desire not to be a burden to others, fears about loss of autonomy, and depression and hopelessness—it is one of the most common.

One of the ironies is that those who suffer from irreversible illnesses that can completely deprive them of their independence, such as Alzheimer disease and other illnesses that cause significant impairment in cognitive functioning, are not covered by the RTD laws because patients cannot actively request or participate in the taking of the medications to end their lives.

National Pain Strategy

Pain is a widespread problem in this country. A recent study by the National Center for Complementary and Integrative Health found that over 25 million American adults reported having daily pain for at least the previous 3 months and that over 40 million experienced severe or very severe pain during that time. Another federal government initiative that has resulted from the Affordable Care Act includes provisions to improve pain care, research, and education. A draft of this National Pain Strategy (NPS), the result of 5 years of work, was released this spring. The NPS notes the often deficient pain management many patients receive and the reasons for it. Among those it identifies are:

• Inadequate education many health care professionals, including physicians, receive in pain management
• Differences in quality of pain management patients receive due to financial, ethnic, and racial factors
• Reimbursement issues that may inhibit primary care physicians from spending needed time with patients to adequately discuss treatment options

The draft offers a number of proposals for changing these things. However, I fear that however good these proposals may be, they will be ignored like so many similar previous ones—especially regarding inadequate education. And I fear that many people—including the terminally ill—will still have their pain poorly managed.

I recently attended a debate on RTD laws, and during the question period I brought up the issue of inadequate pain management. The participants on both the pro and con sides agreed this needed to be improved, and at the end of the debate the moderator, a medical ethicist, said that this seemed to be the one thing all could agree on. Left unsaid was why states aren’t passing laws to ensure this.

References:


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