Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness

The Role of the Psychiatrist

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Psychosocial assessment and treatment are critical elements of care for terminally ill patients who desire hastened death. Most patients, in saying that they want to die, are asking for assistance in living—for help in dealing with depression, anxiety about the future, grief, lack of control, dependence, physical suffering, and spiritual despair. In this article, the authors review current understandings of the psychiatric aspects of requests by terminally ill patients for assisted suicide and euthanasia; describe an approach to the common problems of physical, psychological, social, and spiritual suffering encountered in managing dying patients; and elaborate the functions of the psychiatrist in addressing these problems. (Psychosomatics 1995; 36:445–457)

Psychiatrists have been remarkably absent from the public debate about euthanasia and assisted suicide. While there has been tremendous growth in the literature about the ethics of euthanasia and assisted suicide[1–5] over the past 10 years, very little has been written about the psychiatric aspects of requests by terminally ill patients for accelerated death.[6–8] Nonetheless, psychiatrists have special expertise that can contribute to the dialogue about providing optimal care to these patients and their families.

We outline the major clinical tasks met in working with patients who request assisted suicide or euthanasia, review the psychiatrist's role in evaluating and managing such requests, and describe the psychiatrist's role when the patient persistently requests hastened death and the primary physician seriously contemplates acceding to this request. In a previous article,[9] we have addressed the management in primary care of requests for accelerated dying; here, we enrich this discussion with clinical vignettes and specifically address psychiatry's unique and necessary contribution in such difficult situations. Although recent developments in the care of the terminally ill, such as the growth of hospice services and the increasing use of ad-

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vanced directives, have been aimed at promoting a sense of comfort and control during the dying process, many patients still fear pain and loss of control and distrust the health care system's ability to ease their passage to death.[10–12] Patients may view euthanasia and assisted suicide as the sole alternatives to prolonged suffering.

Case Report

J.A. is a 68-year-old woman with pancreatic cancer who broached the issue of euthanasia with her oncologist after an escalation in symptoms of pain and nausea while receiving chemotherapy. The oncologist asked for a psychiatric consultation. The psychiatrist learned that J.A. had been wanting to stop chemotherapy for some time, but she feared that such a request would alienate her oncologist. She anticipated that her physician would be unable to control her pain and that her suffering would be disregarded. These expectations led her to opt for "an early out." The psychiatrist, struck by the patient's hopelessness and helplessness, suggested that J.A. might benefit from treatment with a psychostimulant and encouraged J.A. to discuss her concerns about stopping chemotherapy and about pain relief with her oncologist. J.A. began treatment with methylphenidate and then negotiated discontinuance of her chemotherapy, entry into a hospice program, and initiation of an aggressive program of pain and symptom control. Her depression improved, and she died comfortably 1 month later.

As this case illustrates, requests for hastened death can be a focal point for a variety of problems that arise in the care of patients with terminal illness: fear about irremediable physical suffering, the effects of depression on the sense of control in terminal illness, difficulties in physician-patient communication, lack of knowledge about care options, and lack of empowerment to express one's wishes. Problems in these areas are cited as frequent contributors to patients' desires for early death.[13] The previous case also demonstrates that appropriate attention to these problems can result in dramatic improvement in patients' quality of life.

BACKGROUND

Little direct information exists about the frequency of requests for hastened death among terminally ill persons. Such requests are described by oncologists and AIDS providers as regular, but infrequent, phenomena. Unpublished data from Chochinov et al. indicate that about 10% of terminally ill patients express a moderate-to-severe desire for early death.[14] In the Netherlands, where euthanasia and physician-assisted suicide under specified conditions are not prosecuted, 2.9% of all deaths are associated with active interventions to end life (1.8% voluntary euthanasia, 0.3% assisted suicide, and 0.8% euthanasia without explicit and persistent patient request).[15]

Multiple sources of additional, but indirect, data about the prevalence of wishes for hastened death add to our understanding of such requests. While about 25% of cancer patients develop depression during their illness, and about 6% meet the criteria for major depression,[16] suicidal thoughts are rather common.[17] In the late stages of illness, the incidences of depression and suicide have been noted to increase significantly.[18–22] Although many patients desire that the options of euthanasia and assisted suicide be available,[12] only a very small proportion, according to the Netherlands data, actually exercise these options. It appears, however, that there has been a progressive increase in suicide risk among cancer patients between 1971 and 1986.[23]

Among AIDS patients, studies demonstrate markedly elevated suicide rates.[24,25] About 35% of medical inpatients with AIDS "wished to die," and 17% had active suicidal wishes.[26] The culture of the gay community has come to see assisted suicide and euthanasia as reasonable alternatives to a "living death" with AIDS.[27]

Practitioners report anecdotally that recent attention to legislative proposals for legalization of euthanasia, the publication of *Final Exit,* and widely reported cases of assisted suicide appear to be associated with increased frequency of such requests. This impressionistic data are reinforced by the evidence of recent

increase in suicide rates among Danish patients[23] and by a study that documented an increase in the frequency of suicide by asphyxiation, as recommended in *Final Exit*, following the book's publication.[28]

THE CARE SETTING

Hospitals and nursing homes are still the major loci of care for the dying,[29,30] although it appears that the number of persons dying in hospice programs is increasing. No studies address how the care setting affects the desire for hastened death, its expression, or how patients and health care workers act on the request. Hospice programs have suggested that provision of palliative care services "treats" the wish to hasten death, but no systematic data are available. We noted persistent requests for hastened death in 2 of 400 consecutive hospice patients (Billings, unpublished data, 1994). We would hypothesize higher rates in settings that do not adequately address the full spectrum of physical, psychosocial, and existential/spiritual concerns and needs of patients.

THE CLINICAL APPROACH TO PATIENT REQUESTS FOR ACCELERATED DEATH

Fleeting thoughts about hastening death occur frequently among terminally ill patients in all settings. However, sustained requests are distinctly unusual, especially when patients are receiving palliative care services. Most dying patients face their illnesses with remarkable equanimity, hanging on to whatever time they have left despite devastating difficulties. Requests to hasten death should be viewed as falling outside the usual spectrum of responses to terminal illness, and require special attention. Full evaluation of patient requests for assistance in dying demands an in-depth psychosocial assessment with an expanded focus on existential or spiritual issues. The psychiatrist's competencies complement those of the primary care physician (and ideally, other interdisciplinary team members) in carrying out a comprehensive evaluation of the clinical issues involved in the patient's desire for accelerated death. The psychiatrist should focus on the following six major areas: 1) physical suffering, 2) psychological suffering, 3) decision-making capacity, 4) social suffering, 5) existential/spiritual suffering, and 6) dysfunction in the physician-patient relationship.

Physical Suffering

Although treatment of physical symptoms is not usually the responsibility of the psychiatrist, physical suffering has such a profound effect on psychological well-being that the psychiatrist may need to advocate for more effective symptom palliation as the first element of an overall treatment plan. Undertreatment of pain is common, attributable to deficiencies in health professionals' education about pain management as well as concerns about addiction among patients, family members, and clinicians.[31–36]

Uncontrolled pain is a major risk factor for suicide among cancer patients.[37,38] Sixty percent to ninety percent of cancer patients have pain during the last year of life; 10% to 20% endure pain that is difficult to control.[39–41] In the Netherlands, an estimated 85% of patients withdraw their requests for hastened death after receiving better symptom palliation.[42] More than 90% of patients with cancer pain respond to simple analgesic measures.[43,44] The remaining 10% of patients, however, may require sophisticated treatment approaches, including additional pharmacologic interventions (antidepressants, anxiolytics, anticonvulsants, antiarrhythmics, corticosteroids), psychotherapy, and cognitive and behavioral strategies, as well as neurosurgical or anesthetic procedures.

Major depression, anxiety disorders, somatoform disorders, and some personality disorders may contribute to intractable symptoms[45,46]; psychiatric expertise is invaluable in diagnosis and management. Psychiatric input may also be useful when substance abuse disorders complicate symptom management in the terminally ill (e.g., when a patient with a history of heroin addiction has difficult-to-manage can-

cer pain). Many common psychopharmacologic agents can be used for symptom control in the terminally ill (benzodiazepines for anxiety and insomnia; tricyclic antidepressants for pain; psychostimulants for depression and sedation; antipsychotics for nausea, anxiety, and agitation; and anticonvulsants for pain). The psychiatrist's familiarity with these agents and their clinical use complements the knowledge of primary physicians and may lead to enhanced effectiveness of pharmacologic interventions. Also, behavioral treatments can be highly effective for commonly encountered symptoms such as anxiety, nausea, and insomnia.

Psychological Suffering

Grief. The terminally ill patient faces an array of losses that commonly give rise to psychological pain severe enough that hastening death may seem desirable. In addition to the anticipated loss of relationships because of death, the patient loses current relationships as illness progressively narrows the person's interpersonal world. Also, often lost are independence, control over one's body, hopes and expectations for the future, social and occupational roles, and sexual desire.[47] The patient's request for hastened death may be a cry for help in feeling valued, a plea for someone to share in the grief, or a protest against unbearable suffering.

Most patients manage to cope with these losses on their own, through relationships with family and friends, and sometimes through relationships with nonpsychiatric clinicians and volunteers. Some patients, however, lack such supports and/or have psychiatric disorders—depression, anxiety, organic mental disorders, and personality disorders—that complicate the process of adapting to dying. These disorders can be difficult for primary physicians to diagnose and are different from normal grieving, and may contribute to a desire for hastened death.[48] Many of these patients may benefit from psychotherapy, which can be done competently by nurses, social workers, and psychologists, as well as by psychiatrists. The psychiatrist, however, often has additional expertise in the diagnosis of psychiatric disorders and of dysfunctional grieving in the setting of serious medical illness.

Depression. Major depression tends to be underrecognized and undertreated, and it is a major source of unnecessary suffering among the terminally ill. Contrary to popular and nonpsychiatric professional opinion, depression is *not* a normal feature of terminal illness.

An array of somatic symptoms that overlap with symptoms of depression—pain, insomnia, fatigue, loss of sexual interest—regularly accompany terminal illness. Medication-induced depressive symptomatology and depression-like symptoms of normal grief also make it difficult to diagnose major depression in advanced terminal illness.[49–53] A high level of clinical skill is required to make clinically important distinctions. Rarely are primary care physicians adequately trained to do this task. Because of the high prevalence of depression in the terminally ill (and especially in terminally ill patients who desire euthanasia or assisted suicide), its treatability, and the difficulty of diagnosis, the psychiatrist should be involved in evaluating all patients who request hastened death. The psychiatrist's role extends through assessment and treatment to a point where either the patient's symptoms have improved or sufficient approaches have been tried to suggest that the depression is not ameliorable.

Case Report

R.T. is a 63-year-old divorced Puerto Rican truck driver with far-advanced esophageal cancer who had a gastrostomy and cervical esophagostomy for palliation. During his 4 months in the hospice program, R.T. has complained of constant abdominal pain that does not respond to high doses of narcotics and has experienced intolerable side effects from multiple medications. He describes continual discomfort and odors from his ostomy which, on multiple inspections, appeared to be functioning well and had no odor. His interactions with the hospice staff are often hostile. He denies depression. He says he considers himself Catholic but wants no contact with the clergy.

Since coming to the United States 40 years ago, R.T. has worked steadily and raised 5 children. He is living with a devoted girlfriend and is often visited by his children and grandchildren. He gets out of bed only to use the bathroom, sleeps most of the time, and refuses to watch the World Series, despite a lifelong love of baseball. His family members attribute his distress to his cancer and effects of his medications.

Hospice staff describe to the psychiatric consultant their frustrations with R.T. They do not feel he is depressed, expressing the view that his disease, the difficulties caused by his ostomy, and his pain sufficiently explain his mental status. The psychiatrist evaluates R.T., determines that he is depressed, and recommends treatment with dextroamphetamine (2.5 mg twice a day). Four days later, R.T. is watching baseball and building a model in the living room with his 9-year-old grandson. His family expresses relief that he seems to be "back to his old self."

Further education of patients, physicians, nurses, and social workers practicing in terminal care settings is needed to counter prevailing beliefs about the normality of depression among patients with terminal illness and its consequent undertreatment. In addition, psychiatrists should promote the appropriate use of antidepressants in the care of depressed terminally ill patients. In informally polling several groups of hospice clinicians, we find that, although they are aggressive in the treatment of physical symptoms, they use antidepressants for the treatment of depression in less than 5% of their patients, a rate that is considerably below reported rates of depression in this population. Inappropriate medication choices are common, including the underutilization of psychostimulants, inappropriate dosing, and the reliance on tertiary amine tricyclics with needlessly high rates of toxicity. Psychostimulants are effective agents in the treatment of depression in the terminally ill because they work quickly and have a lower incidence of side effects than tricyclics among patients with medical illness.[54–56]

Anxiety Disorders. Anxiety commonly accompanies terminal illness, stemming from uncertainty about the future, apprehension about symptoms and their treatments, concerns about caretaking arrangements, and fear about the process of dying and how it will be handled. Anxiety is also frequently amplified by pain, physical symptoms (especially dyspnea), metabolic abnormalities, hormone-secreting tumors, and medications.[57] Anxiety may be manifested as agitation, restlessness, anger, or other psychological responses that are difficult to evaluate. Differentiation among these sources of anxiety often requires psychiatric expertise. The psychiatrist's familiarity with the use of psychotropics, as well as interpersonal and cognitive-behavioral approaches to anxiety reduction, complements the expertise of other professionals involved in the care of the terminally ill.

Organic Mental Disorders. Organic mental disorders frequently cause cognitive disturbances, suspiciousness, anxiety, and impulsivity that can contribute to desires for accelerated death. Especially among AIDS patients, organic mental disorders are risk factors for suicide attempts.[24,58] Even subtle cognitive impairments may contribute to suicidal ideation and requests for accelerated death. Nonpsychiatric physicians frequently fail to recognize, diagnose, and appropriately treat these disorders.[59] All patients who raise the question of hastening death should be evaluated for the presence of organic mental disorders; the psychiatrist is usually the best-equipped professional for this clinical task. Psychiatrists are also needed to educate physicians and other health professionals who care for the dying about the diagnosis of organic mental disorders.

Substance Abuse Disorders. As in nonmedical settings, preexisting substance abuse disorders among cancer patients are associated with increased suicide rates.[19] Among the factors likely to increase suicide risk among substance abusers are impulsivity, inadequate coping skills, intolerance of affect, and depression. In addition, intravenous drug abusers who develop cancer or AIDS-related pain are especially likely to have analgesics withheld[60]; under-

treated physical pain may represent an additional factor that predisposes them to request hastened death. Psychiatrists have an important role in the management of patients with substance abuse disorders—as educators about the pharmacokinetics of opioids in patients with histories of substance abuse, as resources in the management of substance abuse, and as advocates for effective analgesia in this population of stigmatized patients whose needs for analgesia are often minimized and labeled as drug-seeking behavior.

Personality Style and Personality Disorder. Some patients may describe their wishes for euthanasia or assisted suicide as growing out of ideas about self-determination and "death with dignity." Nonpsychiatric clinicians may take such expressions at face value, failing to explore the individual meanings of these abstract ideas. Why is this patient now feeling afraid of losing control and dignity? What is the nature of this patient's suffering such that death is preferable to loss of control and loss of an intact self? Exploration of these questions often identifies and highlights personality characteristics such as self-reliance, perfectionism, self-control, rigidity, and the tendency to respond judgmentally. These defensive styles may have been highly adaptive in many spheres of life. However, in the setting of terminal illness, self-reliance may be expressed as difficulty in trusting others, accepting help, and being dependent; perfectionism as frustration with personal weakness and neediness; self-control as intolerance of the noncontrollable vicissitudes and uncertainties of illness; and the tendency to be judgmental as self-criticism and self-blame over being ill and incapacitated. Giving up control, accepting dependency, and tolerating physical deterioration may be so intolerable that hastening death becomes a way to preserve the self.

Persons with these personality traits may be highly successful professionals who have prided themselves on their accomplishments and ability to control their lives. Often, little is remediable about their experience and feelings, and they make a convincing case for assisted death. Psychiatric intervention may help such patients reframe their experience; alternate expressions of control and of living up to high personal standards of behavior include forbearance in the face of uncertainty and difficulty, the capacity to model grace in confronting impending annihilation, and receiving help as a means of permitting others to master their feelings of loss.

Case Report

A.L. is a 46-year-old former Marine officer in the terminal phase of lung cancer. His wife sought psychiatric assistance after her husband told her that he planned to use a gun from his large collection of military weapons to kill himself. Mr. L. had joined the military at age 18 and had risen through the ranks through "gritting my teeth, shutting up, and doing what had to be done." He said that he found it unbearable to feel weak, and preferred to die before he "stopped being a man." Mr. L. told the psychiatrist that he had discussed his wish for assisted suicide with his physician, who had declined to help him. Following that, Mr. L. felt his only option was to kill himself. Although not in pain, he said he could not bear to watch his wife suffer through his dying. He said that he had not spoken about his feelings about his illness and death with his wife because he felt she could not tolerate them. In a joint meeting, Ms. L. described her increasing isolation from her husband and beseeched him to talk with her. Initially, Mr. L. refused, but gradually came to redefine his task in dying in terms that he found acceptable: "It takes a strong man to look death in the face and talk about it," and "A good man takes care of his wife for as long as he can."

In a more extreme form, self-reliance, perfectionism, self-control, rigidity, and the tendency to be judgmental may be conceptualized as part of a narcissistic or obsessive-compulsive personality disorder. In our experience, these are the most common personality configurations seen in patients whose physical, psychosocial, and spiritual problems are well managed and who persistently seek hastened death. Although the patient's request for accelerated

death may be framed as an issue of "rights" and "autonomy," it also often reflects deep emptiness and conflict over dependency. Clinicians sometimes perceive such patients as cold, ungrateful, demanding, demeaning, or help-rejecting,[61] and may be troubled by the discrepancy between the patient's description of intolerable suffering and the medical realities of the patient's situation.

Case Report

Ms. B. is a 52-year-old woman with metastatic cancer who insists on receiving immediate help in accelerating her death and is referred for psychiatric evaluation at home by her hospice nurse. The psychiatrist is met at the door of the patient's elegant apartment by the patient's two grown sons. They describe their mother's precipitous decline over the past few weeks, and they request that her wishes for help in dying be honored as soon as possible. The patient, seeming impatient about having to speak with another physician, articulates her urgent wish for help in dying. She says that she is physically comfortable, but anticipates future deterioration. She states that she is angry that no one will help her and that she plans to throw herself out of her 47th floor window in the next 2 days if she cannot be helped to die. She is convinced that this may be her last chance to control the end of her life. Having been a successful academic, she finds the prospect of "having my sons wipe my ass" intolerably humiliating. She describes herself as a strong, independent woman who has surmounted considerable adversity in her life, including the loss of a parent when she was 15 and her own divorce. Although she has many supportive and involved family members and friends, she does not want them to have to take care of her. She describes herself as "vain" and "concerned about appearances" and states that several years of intensive psychotherapy have not changed these characteristics. She feels that the losses of bodily functions and attractiveness are unbearable insults to her "core self." As the psychiatrist leaves, Ms. B. demands to know when she can expect help.

As this example indicates, these patients may ask for or demand help in hastening death in a setting and manner that health professionals find difficult to understand or tolerate. By making the patient's behavior comprehensible to members of the health care team, the psychiatrist helps his/her colleagues to remain involved with the patient instead of withdrawing, set limits on the patient's demands when appropriate, tolerate the patient's oscillations between intense dependency and anger, and redefine the goals of treatment to reflect the likelihood that the patient's dysphoria and anger will continue regardless of the team's actions. This "impossible" patient thus becomes manageable, and the team retains its cohesiveness and ability to provide compassionate professional services despite the patient's difficult behavior.

Self-destructive patients with borderline personality disorder may also seek physician-assisted death. Self-destructive patients may be unconsciously seeking a physician to hurt or abuse them to confirm their views of themselves as damaged and unworthy. These patients often have significant associated depressions and impaired decision-making capacity. Such patients can generate great distress within the caregiving team. By helping the team understand the patient's defenses, relationships, vulnerabilities, and personality, the psychiatrist enables care providers to manage the difficulties that arise in providing care and to resist the intense pressures to either accede to the patient's request or abandon the patient.

Decision-Making Capacity

As described before, depression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. Because of the irrevocability of hastening death, decisions about competency must be especially rigorous. Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of

alternative choices.[62–66] Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential.

Social Suffering

Difficulties in interpersonal relationships commonly trigger requests for accelerated death. Dying patients may channel anger, disappointment, and the wish to avoid the pain of a slow separation from loved ones into a request for hastened death. They may also fear that they will overburden their caregivers with the physical tasks of care, deplete financial resources intended for others, or encumber loved ones with painful memories. Decisions about desired care at the end of life are heavily influenced by the desire to avoid burdening others, especially children.[67] Requests for hastened death are sometimes designed to test love and the commitment of family members to providing care. In saying that he or she wants to die, the patient may be asking to be given a reason to live. Psychiatrists' skills in exploring and understanding personal meanings and experience, as well as nuances and tensions in interpersonal relationships, are valuable resources for the primary physician or interdisciplinary team caring for terminally ill patients.

Case Report

M.T., a 62-year-old man with metastatic lung cancer, began speaking of his desire for euthanasia at a time when his symptoms were relatively stable. The physician sought psychiatric consultation to further evaluate the patient's state of mind. The psychiatrist learned that the patient and his wife had been fighting constantly over recent weeks, an intensification of their long-term dysfunctional relationship. Upon further exploration, it became clear the patient viewed accelerating his death as a way of retaliating against his wife, stating "I want her to believe that she made me do this."

Particular attention should be devoted to exploration of meanings of loss of control and dependency, both to the self and in relationships with significant others. Among the common social themes that arise in exploring patients' desires to hasten death are loss (or anticipated loss) of support from a spouse, distrust of family members' ability and willingness to provide care, anger related to perceived disappointments, and inability to relinquish the role of caretaker.

Existential/Spiritual Suffering

Conscious patients who are facing death confront questions of meaning that may give rise to existential/spiritual suffering. Grieving entails a process of life review, remembering, and reckoning with earlier experiences. Clinicians must appreciate that religious and spiritual despair may contribute to desires for hastened death. Common themes that arise are guilt over past actions, anger at God, fear of punishment, and anxiety about lack of meaning. Exploration of the patient's current and past religious and spiritual identity, affiliations, and beliefs are an important first step in understanding such concerns. Further discussion of the patient's feelings about the sources of meaning in life, beliefs about why the patient became ill, and expectations about what happens after death can help identify patients who might benefit from pastoral care or other forms of spiritual counseling.

Dysfunction in the Physician-Patient Relationship

Difficulties in the patient's relationship with the primary physician may also contribute to desires for hastened death. The wish to hasten death often grows out of fears about how death will be handled: Will I be given adequate pain relievers? Will I be alone? Will I be able to express my wishes and be listened to? The patient often feels more in control and more confident in caregivers when the primary physician is able to explore these concerns, reassure the patient about his or her ongoing involvement, and educate the patient about what is likely to

happen and about options for care. However, because of the intense emotions evoked by discussions of death, communication between patient and physician may be problematic. Patients are often unclear about what the implications of their wishes and requests might be, and patients have been shown to misunderstand information they receive about such emotionally loaded issues as cardiopulmonary resuscitation.[68] Also, physicians' concerns about upsetting or frightening patients in the course of discussions of wishes for care at the end of life may lead to euphemistic or incomplete discussions.[69]

Because ambivalence is such a universal aspect of discussions about death, it is all-too-easy for the physician to hear only one side of the patient's feelings, ignoring or minimizing the opposite pole.[70,71] In seeking a quick and painless end to living, a patient may simultaneously be hoping for a cure of the underlying medical disorder, remission of symptoms, lifting of a depression, or alleviation of the social and economic burdens of illness. In expressing a wish to separate from the living, a patient may be searching for a relationship that counters loneliness and frustration.

For many physicians, a dying patient represents a personal failure. Some physicians, in response to this sense of failure, withdraw from their patients as a way of reducing their own distress about the patient's deteriorating condition.[72,73] Sensing the physician's withdrawal, the patient may then become more needy, more withdrawn, or even come to view hastening death as a way to control the feelings of abandonment. The psychiatrist may be a useful consultant in exploring these issues with the patient and physician, and in identifying problematic dynamics in the physician-patient relationship that may impede the patient's ability to express feelings and wishes fully and clearly.

The request to hasten death itself often generates a strong emotional response in the physician. The primary physician may find it painful and difficult to endure a patient's sustained and escalating plea for help and may respond with depression, avoidance, anger, denial, or guilt. These emotional responses must be understood and addressed in developing an optimal care plan for the patient. Unfortunately, few settings legitimize discussions of physicians' emotional reactions to patients and the effects of these responses on care.

Case Report

Dr. M. sought me [S.B.] out at a conference on euthanasia to talk about a patient whose death he had assisted several years ago. Dr. M. described in-depth his longstanding relationship with the patient and his wife, the patient's illness, and the events that led to him administering a lethal dose of barbiturates to the patient. Dr. M. acknowledged that he thought about the case nearly every day, but he had never talked about it with anyone. He described it as the most significant and difficult situation he had encountered in his professional life. He wondered how his own unresolved feelings about this event influenced his care of dying patients in the present.

Clinicians who have encountered requests to hasten death and have allowed themselves to enter into the patient's dilemma often describe such experiences as wrenching and disturbing. Psychiatrists can play an important role in helping to create a nonjudgmental setting for these issues to be discussed, modeling an accepting and inquiring openness to these feelings, and using the physician's emotional response in the service of dealing effectively with the situation.

A physician's refusal to participate in accelerating death often creates a crisis in the physician-patient relationship. The patient may feel rejected, abandoned, criticized, or controlled by the physician's decision. The patient's feelings may cause the physician to respond by withdrawing from the patient, leaving the patient to feel abandoned. The psychiatrist can help the primary physician find a way to maintain connection with the patient, bear the burden of the patient's anger and despair, and tolerate the conflict and guilt engendered by the decision not to participate in hastening death. In this situation, physicians are sometimes tempted to withhold medication that might be needed for symptom control based on fear that the patient

will use it for suicide. Primary physicians must be encouraged to avoid this understandable response and to accept the risk that a patient will use medication prescribed for symptom control to accelerate death.

WORKING WITH THE PATIENT WHO PERSISTENTLY REQUESTS HASTENED DEATH: CLINICAL AND COLLEGIAL ISSUES

On rare occasions, clinicians encounter patients who are receiving excellent symptom palliation; are not depressed or psychologically impaired; have supportive social networks; and have fully and comfortably discussed with their physicians their personal values, priorities, and choices about dying. Yet their suffering remains profound and intractable, and they explicitly request assistance in hastening death.

Case Report

L.T. was a 47-year-old gay psychologist with far-advanced AIDS. Throughout his illness, he had planned to kill himself before the disease "took over," and he had many discussions with a large network of devoted friends and with his physician about his wishes. He had nursed his lover through the end-stages of the disease, which included central nervous system involvement and invasive procedures; that experience had a powerful impact on his own feelings about how he wanted his life to end. He feared loss of control and loss of dignity. L.T. had seen a psychiatrist for psychotherapy at several times during his illness to help him deal with feelings of depression, grief, and loss of control. He had also tried several different antidepressants, because he wondered whether his mood might improve with medication. Medication had not been helpful, but psychotherapy had. His depression improved, although he was still often sad.

Although he was in no pain, L.T. had been experiencing more frequent infections and had lost 40 pounds. He had a taste disturbance that made him aversive to nearly all foods, and he was increasingly confined to his home by fatigue and weakness. As his illness progressed, L.T.'s central focus became his spiritual growth and coming to terms with his death within the framework of his faith. Although he had been raised as a Catholic, in recent years he had become a Buddhist and expected a life after death. As he became sicker, L.T. stopped working because he could no longer concentrate. He felt unburdened by the end of these professional responsibilities, but he also missed his work. Although his relationships with friends remained important, he found himself less eager for their companionship and for the pushes and pulls of human interaction. Small things—an open window that made the room chilly, a visitor who came late—bothered him greatly, and L.T. was disturbed by his disproportionate reactions to these events. Although he did not feel depressed, the constriction of his world and the preoccupation with sickness diminished his sense of meaning and connection. At this point, he asked his physician to assist him in suicide, and a psychiatrist was consulted.

The psychiatrist evaluated the patient and concluded that 1) the patient did not have a major depression; 2) his current thinking was not irrationally distorted by the trauma of his lover's death; 3) he had a full cognitive and affective understanding of his situation and the implications, for himself and his friends, of hastening his death; and 4) he felt a strong and reassuring connection with his primary care physician. In fact, the psychiatrist was impressed by L.T.'s clear understanding of his situation, by his ironic appreciation of both the preciousness and intolerability of his life, and by his personal warmth, vivacity, and connectedness.

The primary care physician and the psychiatrist talked extensively about L.T.'s situation and about what it would mean to the physician to honor or to refuse L.T.'s request. The primary care physician then agreed to help L.T. end his life by prescribing a lethal dose of barbiturates and attending his suicide.

CONCLUSION

Although this last case raises difficult ethical and legal issues that have been extensively discussed in the literature,[23,74,75] we will address here only the psychiatrist's clinical and collegial role. In such situations, the psychiatrist performs several different functions: offering a second opinion on the patient's psychological status, providing a sophisticated evaluation of the patient's decision-making capacity, validating that nothing treatable is being missed, and helping create a setting in which the primary

physician and the team can formulate a thoughtful decision about how to respond. For the primary physician to be comfortable turning to the psychiatrist, the two parties ideally will have a history of working with each other in difficult situations as well as a degree of trust in each others' clinical and moral judgment. Such a relationship develops most readily when the psychiatrist is part of an interdisciplinary team with a shared history and set of values. Although this ideal is not always achievable, it is a goal to strive for in caring for patients with terminal illness. Psychiatrists must continue to define their roles in the settings in which terminally ill patients receive care—general hospitals, cancer centers, oncology units, and nursing homes. In addition, psychiatrists should become much more involved with the hospice and palliative care programs—inpatient, outpatient, and home-based—that are a growing locus of care for the dying.

Both providing and refusing assistance in accelerating dying represents a professional crisis for the primary physician.[9] Although the main responsibility for deciding whether to hasten death rests with the primary physician, both the primary physician and the psychiatrist who evaluates the patient share in the moral responsibility and the emotional burden of the decision. In rare circumstances, we believe that accelerating dying is an appropriate ethical and clinical decision. In such situations, as the primary physician attends the patient in the passage to death, the psychiatrist may support the primary physician through the troubling process of hastening death. We believe, though, that assisted suicide and euthanasia should be options of last resort. To assure this, psychiatrists must advocate for the highest standards of medical, psychosocial, and existential/spiritual care for terminally ill patients and their families.

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