

PROFESSION

Cancer center goes public with assisted-suicide protocol

■ For the first time, a health care organization details how its physicians help terminally ill patients navigate the process of securing lethal prescriptions.

By KEVIN B. O'REILLY ([HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY](http://www.amednews.com/apps/pbcs.dll/personalia?id=koreilly)) amednews staff — Posted April 22, 2013

The physicians who run the Seattle Cancer Care Alliance do their best to treat patients who have cancer. For patients whose disease progression cannot be controlled, the University of Washington-affiliated comprehensive care center offers palliative care and transition to hospice.

And for those who seek physician-assisted suicide under state law, the center is prepared to help them with that, too.

Providing access to doctor-hastened death is an element of top-notch care for terminally ill patients, SCCA's clinical leaders argue in a first-of-its-kind published report to outline an organization's physician-assisted suicide protocols and the results for its patients. The authors wrote in the April 11 issue of *The New England Journal of Medicine* that their program should be “particularly instructive” to other comprehensive cancer centers in states where doctor-assisted suicide is legal or may be legal one day.

Washington voters enacted the state's Death With Dignity Act in 2008, and implementing regulations were issued in 2009. Oregon's similar law took effect in 1998.

“Our goal is still to cure cancer,” said Elizabeth Trice Loggers, MD, PhD, lead author of the *NEJM* article and medical director for palliative medicine at SCCA. “When we, unfortunately, can't cure cancer, our goal is then to relieve suffering, to be doctors caring for all patients and families with cancer. This is simply one of a full range of high-quality, end-of-life options.”

Critics of physician-assisted suicide and proponents of legal access to doctor-aided dying view the *NEJM* article as a sign of the normalization of the practice. From March 2009 to the end of 2011, 24 patients died after taking lethal prescriptions written by physicians at the Seattle Cancer Care Alliance, a consortium of the Fred Hutchinson Cancer Research Center, University of Washington Medicine and Seattle Children's Hospital.

Publishing these results took courage, said Linda Ganzini, MD, MPH, professor of psychiatry and medicine at Oregon Health & Science University School of Medicine in Portland. Dr. Ganzini, the leading independent researcher on Oregon's experience with doctor-assisted suicide, has pushed for more depression screening of terminally ill patients seeking aid in dying and has consulted with SCCA leaders in the formulation of their program.

Discussing protocols and care standards in the peer-reviewed literature will help lead to better implementation of doctor-hastened death, she said.

“It's the same approach to what we're trying to do across medicine — to improve quality, improve outcomes and improve efficiency all at the same time,” she added. “There's nothing to say that those principles couldn't be applied to this situation.”



Elizabeth Trice Loggers, MD, PhD

The *NEJM* article “adds to the literature that is developing a standard of care around aid in dying,” said Barbara Coombs Lee, a former nurse who is president of Compassion and Choices, a Denver-based organization that advocates for legal access to doctor-aided death. “This is how treatments evolve in medicine. They don't usually come from legislatures. They don't usually come from citizens' initiatives. They usually emerge organically from the practice, where the practice itself recognizes a need and responds.”

**DID YOU KNOW:
8 states are considering
bills to allow physician-
assisted suicide.**

Not everyone sees the cancer center's report as a welcome sign.

It's “disastrous,” said William L. Toffler, MD, national director of the Physicians for Compassionate Care Education Foundation, based in Yakima, Wash., which opposes doctor-assisted suicide.

“People who are promoting assisted suicide will cite this article to say, 'See? Everything's going swimmingly,' ” said Dr. Toffler, a professor of family medicine at Oregon Health & Science University. The article represents an attempt to normalize a procedure that is inadequately monitored, could be abused and can prompt some patients to wonder about their physicians' commitment to care, he added.

How assisted-suicide requests are handled

One hundred and fourteen patients being treated for cancer at SCCA inquired about physician-aided death. Nearly 40% of them did not pursue the program after learning about it or were deemed ineligible due to their prognosis, mental competence or mental illness.

Thirty patients started the process but either died before completing it or gave up on the idea. Forty patients got prescriptions for a lethal dose of secobarbital, and about half of these patients were enrolled in hospice at the time.

Twenty-four patients ultimately ingested the medication and died. That figure represents about 10% of Washington doctor-assisted suicide deaths and 0.02% of estimated annual patient deaths at SCCA. One patient who ingested lethal medication did not die until the next day — death usually occurs within an hour — with “the protracted process causing distress on the part of family members and clinicians,” the authors wrote.

All patients seeking doctor-assisted suicide are referred to SCCA's internal Death with Dignity program and are assigned a “patient advocate,” a social worker who helps them navigate the legal requirements and screens them for depression and anxiety disorder by using validating instruments. None of the patients who further pursued doctor-hastened death was referred to a psychiatrist or psychologist or was “deemed to require mental health evaluation for depression or decisional incapacity,” the article said.

In March 2009, SCCA leaders decided to set up the program after considerable debate, then surveyed doctors about their willingness to participate. Twenty-nine of 200 physicians said they would be willing to write lethal prescriptions. That list, which has since grown in number, is consulted to help SCCA patients find doctors to prescribe life-ending medications. There is no penalty for refraining from taking part in hastening patients' deaths. The Death with Dignity program is not advertised or mentioned in signage at the cancer center.

The Seattle Cancer Care Alliance is not the only health care organization with a set of policies and protocols to govern how it helps terminally ill patients secure legal, physician-aided deaths. Oregon Health & Science University Hospitals & Clinics in Portland adopted a policy that served as a model for SCCA shortly after Oregon enacted its Death With Dignity Act in 1997.

Other health systems spurn requests

Many hospitals and clinics in Oregon and Washington have said publicly that they will not help patients pursue doctor-assisted suicide. For example, Renton, Wash.-based Providence Health and Services, a Catholic health care system, has policy barring any participation in doctor-assisted suicide and requires physicians to tell that to patients seeking aid in dying. The health system operates 16 hospitals and hundreds of clinics in Washington and Oregon.

“Providence does not participate in any way in a patient's suicide,” said Colleen Wadden, the health system's director of external communications. “If patients want additional or different information, there are many groups who support aid in dying who are available to provide that information or service.”

Between 1998 and 2012, 673 Oregonians died after taking physician-prescribed lethal drugs. From 2009 to 2011, the most recent year of available data, 241 Washington residents died with doctors' aid. Eight states are considering bills to allow doctor-assisted suicide.

In Montana, the state Supreme Court in 2009 ruled that mentally competent state residents with terminal illnesses had a constitutional right to seek doctor-aided death. However, the state Legislature has not enacted a law to explicitly authorize or regulate the practice. A bill to ban doctor-assisted suicide passed the state House in February but failed on a 23-27 Senate floor vote on April 15.

The American Medical Association adopted policy opposing doctor-aided death in 1993 and has since reaffirmed that position numerous times.

“The AMA continues to adamantly oppose physician-assisted suicide as unethical and fundamentally inconsistent with the pledge physicians make to devote themselves to healing,” said AMA President Jeremy A. Lazarus, MD. “Rather than sanction physician-assisted suicide, the AMA asserts that we should recognize the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all.

“Physicians must be able to respond aggressively to the needs of patients at the end of life with adequate pain management, emotional support, comfort care, respect for patient autonomy and good communication,” Dr. Lazarus added. “With the continuing strides that are being made in the area of palliative care, the patients of America deserve to know that there is an available alternative to physician-assisted suicide.”

Doctor-assisted suicide will continue to inspire spirited arguments, but transparency about how it is practiced is welcome, said Porter Storey, MD, a hospice physician and executive director of the American Academy of Hospice and Palliative Medicine. The organization, which represents about 5,000 hospice and palliative care physicians, describes its position as one of “studied neutrality” on physician-assisted death, noting that “sincere, compassionate, morally conscientious individuals stand on either side of this debate.”

“By bringing it into the daylight, we can look at it and decide for ourselves whether it's a good idea or not,” Dr. Storey said. “I'm really glad someone's writing up what they're doing and putting it out there and talking about it. ... We can all agree that we shouldn't be handing large bottles of lethal pills to people whose problems can be solved with less extreme measures.”

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ADDITIONAL INFORMATION

Who chooses doctor-assisted suicide?

The top reasons for patients to pursue physician-aided death are inability to engage in enjoyable activities, and loss of autonomy and dignity, according to data collected since Oregon's and Washington's aid-in-dying laws took effect in 1998 and 2009, respectively. Other facts about the patients seeking doctor-hastened deaths at Seattle Cancer Care Alliance, and elsewhere in Washington and in Oregon:

Characteristic	Seattle Cancer Care Alliance	Washington	Oregon
Number of patients dispensed lethal medication	40	255	935
Died after ingesting medication	60.0%	65.1%	63.7%
Died at home	83.3%	93.5%	94.3%
Enrolled in hospice*	54.2%	83.0%	89.7%
Minority race or ethnicity	27.5%	4.8%	2.4%

High school diploma or more	97.5%	94.1%	93.2%
Uninsured	10.0%	2.7%	1.7%
Median length of patient-physician relationship	33 weeks	14 weeks	12 weeks
Prescribing physician present at time of death	Unknown	11.5%	23.4%

*The alliance tracked whether patients were in hospice when they initially requested aid in dying. The statewide figures for Washington and Oregon represent whether patients were enrolled in hospice at the time of request or at the time of death.

Source: "Implementing a Death with Dignity program at a comprehensive cancer center," *The New England Journal of Medicine*, April 11 (link)

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EXTERNAL LINKS

Oregon Public Health Division's 2012 report on Oregon's Death With Dignity Act (link: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>)

Washington State Dept. of Health's 2011 report on Washington's Death With Dignity Act (link: <http://www.doh.wa.gov/portals/1/Documents/5300/DWDA2011.pdf>)

"Implementing a Death with Dignity Program at a Comprehensive Cancer Center," *The New England Journal of Medicine*, April 11 (link: <http://www.ncbi.nlm.nih.gov/pubmed/23574120>)

"Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," *BMJ*, Oct. 7, 2008 (link: <http://www.ncbi.nlm.nih.gov/pubmed/18842645>)

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