Physician-Assisted Suicide: The Influence of Psychosocial Issues

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Introduction

Palliative care and quality-of-life issues in patients with advanced cancer and AIDS have become an important area of clinical care and investigation. Significant progress has been made in extending a palliative care/quality of life research agenda to the clinical problems of patients with cancer, including efforts that focus on such mental health-related issues as neuropsychiatric syndromes and psychologic symptoms in patients with advanced cancer and AIDS. The most compelling and clinically relevant mental health issues in palliative care today, however, concern the desire for death and physician-assisted suicide (PAS) and their relationship to depression.

Desire for death has been postulated as a construct that is central to a number of related issues or phenomena, including suicide and suicidal ideation, interest in PAS/euthanasia, and requests for PAS/euthanasia. This construct, which was initially proposed by Brown and colleagues and further developed by Chochinov et al focuses on the degree to which an individual wishes his or her life could end sooner rather than later. The ends of this hypothetical continuum, therefore, reflect acute suicidal intent (i.e., a desire to end one's life immediately) and a complete absence of any desire to die.

Jerzy Kosinski, the Polish novelist and Holocaust survivor, committed suicide in May 1991. Like other individuals suffering with chronic medical illnesses, he chose suicide as a means of controlling the course of his disease and the circumstances of his death. "I am not a suicide freak, but I want to be free," Kosinski told an interviewer in 1979. "If I ever have an accident or a terminal disease that would affect my mind or body, I will end it." Twelve years later, he did so. Similar sentiments are shared by a significant proportion of Americans. Advocates demanding autonomy for patients regarding how and when they die have been increasingly vocal during recent years, sparked by the highly publicized cases of Drs Jack Kevorkian and Timothy Quill. These cases have centered on the plight of dying patients with terminal illnesses.

What has often been overlooked, however, in the political and legal machinations, has been the importance of medical, social and psychologic factors (eg, depression) that may influence suicidal ideation, desire for hastened death, or requests for PAS. In addition, a discussion of health care provider obligations and responses that are appropriate to such patient verbalizations is offered in order to respond in a manner that is both ethical and hopefully therapeutic.

Definition of Euthanasia and PAS

Euthanasia is defined as the administration of lethal medications to a patient, by a physician, with the intention of ending the patient’s life. Typically, the physician’s motive is merciful and is intended to end suffering. PAS, on the other hand, involves a physician providing medications or advice to enable the patient to end his or her own life. While theoretical and/or ethical distinctions between euthanasia and PAS may be subtle to some, the practical distinctions may be significant. Many terminally ill patients have access to potentially lethal medications, at times even upon request from their physicians, yet do not use these medications to end their own lives (despite the widespread sale of publications such as Final Exit that describe how to use such techniques).

Both euthanasia and PAS have been distinguished, legally and ethically, from the administration of high-dose pain medication meant to relieve a patient’s pain that may hasten death (often referred to as the rule of double effect) or even the withdrawal of life support. The distinction between euthanasia/PAS and the administration of high-dose pain medications that may hasten death is premised on the intent behind the act. In euthanasia/PAS, the intent is to end the patient’s life, while in the administration of pain medications that may also hasten death, the intent is to relieve suffering.

Distinctions between withdrawal of life support and euthanasia/PAS are, in many ways, considerably clearer. Long-standing civil case law has supported the rights of patients to refuse any unwanted treatment, even though such treatment refusals may cause death. On the other hand, patients have not had the converse right to demand treatments or interventions that they desire. This distinction has had the effect of allowing a patient on life support the ability to end his or her life on request, yet a patient who is not dependent on life support does not have such a right. In fact, this difference in perceived “rights” formed the basis of the arguments made to the Supreme Court in Washington v Glucksberg and Quill v Vacco, in which it was argued that this distinction violated the due process clause of the 14th Amendment (the Supreme Court unanimously rejected this argument). Nevertheless, the Court’s decision suggested that while laws prohibiting PAS were not unconstitutional, neither were laws permitting PAS. As such, legal and ethical debates regarding the legalization of PAS continue, despite the limited body of research in support of these arguments.

Legalization of PAS and Euthanasia

Arguments Supporting Legalization of PAS/Euthanasia
The arguments supporting legalization of euthanasia/PAS are substantial. Proponents perceive PAS as an act of humanity toward the terminally ill patient. They believe patient and family should not be forced to suffer through a long and painful death, even if the only way to alleviate the suffering is through suicide. To the advocate for PAS, legalization of PAS is a natural extension of patient autonomy and the right to determine what treatments are accepted or refused. Since patients are allowed to refuse life-sustaining medical interventions (eg, life support, artificial nutrition, and hydration), they are effectively permitted to commit suicide by treatment refusal. Despite the refutation of this argument by the US Supreme Court, advocates of legalization argue that no ethical difference exists between terminating life-sustaining care and administering lethal medication for the terminally ill patient. In both cases, the primary goal of the physician can be seen as the prevention of suffering at the end of life through hastening an inevitable death.

Arguments in favor of legalization of PAS are typically premised on the assumption that requests for PAS are a “rational” decision, given the circumstances of the minimal illness, suffering, and prognosis of a patient (ie, severe, disabling, and fears of becoming physically or mentally dependent) are a burden to family and friends. Given the potential for symptoms and circumstances that may not be relieved, even with aggressive palliative care and social services, the decision to hasten one’s death may seem rational. Moreover, the desire to include one’s physician in carrying out a decision to end one’s life can be viewed as an extension of the natural reliance of terminally ill patients on their physicians for help with most aspects of their illness, as well as a reasonable mechanism to ensure that they do not become even more disabled and burdensome to their family or friends by attempting suicide unsuccessfully (causing a persistent vegetative state or increased disability).

Another argument raised by proponents of legalization is that merely knowing that one can control the timing and manner of death serves as a form of “psychologic insurance” for dying patients. In other words, knowing there will be an escape from the suffering of illness may alleviate some of the stress associated with the dying process. It may be (as argued by some proponents of PAS) that many individuals with a terminal illness desire the option to end their lives if certain possible conditions arise, even though the likelihood that they will utilize this option is small.

**Arguments Opposing Legalization of PAS/Euthanasia**

Opposition to legalization of PAS and/or euthanasia has come from numerous different perspectives. As frequently noted in the editorial pages of various medical journals, the medical profession is guided by a desire to heal and extend life. This guideline is best exemplified in the Hippocratic Oath, which states: “I will never subscribe to the regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice that may cause his death.” Thus, the possibility that a physician may directly hasten the death of a patient — one whom the physician has been presumably treating in an effort to extend and improve life — contradicts the central tenet of the medical profession.

From a mental health perspective, professional psychiatric and psychologic training reinforces the view that suicide is a manifestation of psychologic disturbance.1–3 As such, mental health clinicians typically view suicide, regardless of the context, as an outcome that should be prevented at all costs. Several studies have supported this connection between mental disorder (eg, depression and interest in PAS, suggesting that suicidal ideation in terminally ill patients is a manifestation of undiagnosed, untreated mental illness).3,4,12 Consequently, physicians may incorrectly interpret a patient’s request for PAS. Physicians or other health care providers may recommend PAS as an option because the alternative — providing adequate palliative care — is too expensive or difficult to obtain. Thus, patients with poor health insurance or limited financial resources may be “coerced” into requesting PAS by poor management or untreated physical and psychologic symptoms, perceiving their only options to be either continued suffering or death. Several studies have demonstrated inadequate recognition and treatment of both psychologic and physical symptoms.13 with symptoms such as depression and anxiety going largely unrecognized in many terminally ill patients. Moreover, even if such symptoms are observed, undertreatment of symptoms such as pain is common.14 According to a recent review of palliative care in Canada, only 5% of dying patients in Canada receive adequate palliative care.15 These and related studies are often cited by opponents of legalization for PAS/euthanasia as evidence that legalization is premature until all dying patients and their families have access to skilled and effective palliative care services.

In response to these concerns, legislators proposing guidelines for PAS have incorporated several mechanisms to minimize the risk that PAS, if legalized, will be misused. These guidelines include (1) a voluntary request for assistance in dying on the part of the patient, (2) evidence of a terminal illness, and (3) documentation by the primary physician of the reason for the request and efforts made to optimize the patient’s care. Opponents, however, suggest that these limitations are more arbitrary than scientific, and in the past the legal and medical communities have eventually ended up on a “slippery slope,” where euthanasia is ultimately legalized as acceptable practice for a wider patient population, including nonterminal, nonvoluntary patients.17 Opponents point to a similar evolution of euthanasia use in The Netherlands (discussed below) where regulations regarding PAS have gradually weakened over the 13 years since this practice was decriminalized. For example, in 1994 the Dutch Supreme Court accepted the argument that a chronic disease is an acceptable basis for euthanasia, even if not terminal, and more recent cases have extended this “right” even to patients without a physical illness.

### Attitudes Towards Hastened Death and PAS: Importance of Psychiatric Issues

Public interest has been spurred by media attention devoted to Drs Kevorkian, Quill, and others, as well as legal decisions, state referenda, and the growing availability of life-sustaining medical interventions. While the public and the medical community have openly debated ethical issues relating to end-of-life options, similar questions have received little attention from either the public or the medical community. As recently as the 1980s, the US Supreme Court upheld the rights of individual states to prohibit PAS, its decision simultaneously opened the door for states to “experiment” with legalization of PAS. Furthermore, a study by Ganzini et al17 indicated that only 6% of Oregon psychiatrists felt “confident” in their ability to assess whether a psychiatric disorder was impairing the judgment of a patient requesting PAS, despite overwhelming support from psychiatrists for legalization. Similarly, in a recent survey conducted by the American Society of Clinical Oncology Task Force on End of Life Care, oncologists estimated that 40% of their terminally ill cancer patients had untreated depression (M. Meyer, MD, written communication, August 1998).

### Table 1. — Proposed Clinical Criteria for Physician-Assisted Suicide

<table>
<thead>
<tr>
<th>Condition Associated with Severe and Unending Suffering</th>
<th>Request and suffering not results of inadequate comfort care.</th>
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<tbody>
<tr>
<td>Incurable condition associated with severe and unending suffering</td>
<td>Request and suffering not results of inadequate comfort care.</td>
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<tr>
<td>Clear, repeated requests of patient’s own free will and initiative</td>
<td>Patient's judgment not distorted. Psychiatric consultation if necessary.</td>
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Euthanasia and PAS in Clinical Practice

A number of surveys have been published documenting the practice of euthanasia and PAS among health care professionals. For example, an anonymous survey of Washington physicians conducted in 1995 found that 26% of responding physicians had received at least one request for PAS, and two thirds of those physicians had granted such requests. Thus, roughly one in six Washington physicians acknowledged having granted a patient’s request for PAS or euthanasia. Of course, because of the survey nature of this study, it is not possible to determine whether responding physicians were an accurate representation of all Washington physicians (eg, physicians less interested in or more opposed to PAS may have been more likely to refuse to return the surveys), let alone for the larger United States, yet these statistics suggest that PAS is not a rare event, despite the illegal status. (It is also possible that, despite the anonymous nature of the survey, some physicians who had in fact carried out these requests were unwilling to acknowledge their actions for fear of repercussions.)

Even more striking results were reported in a survey of San Francisco area AIDS physicians. Slome et al found that 98% of respondents had received requests for PAS and that more than half of all responding physicians reported having granted at least one patient’s request for PAS. The average number of times that responding physicians had granted requests for PAS was 4.2, with some physicians fulfilling dozens of such requests. Moreover, in response to a hypothetical vignette, nearly half of the sample (48%) indicated that they would be likely to grant a hypothetical patient’s initial request for PAS.

A more recent national survey by Meier and colleagues sampled nearly 2,000 physicians from those disciplines most likely to receive requests for PAS or euthanasia. They found that more than 18% of responding physicians reported having received at least one request for PAS and more than 11% had received requests for “lethal injection” (the author’s definition of euthanasia). Only 6.4% of the total sample, however, reported having acceded to a request for hastened death (3.3% reported having prescribed medications to be used for this purpose and 4.7% reported having provided lethal injection), roughly one fourth of those who reported having received one. The most common reasons for these requests for hastened death, according to physicians, included discomfort other than pain (present in 79% of cases), loss of dignity (53% of cases), fear of uncontrolable symptoms (52% of cases), pain (50% of cases) and loss of meaning in their lives (47% of cases). Although most physicians responded to requests for hastened death with either more aggressive palliative care (ie, increased analgesic medications) or less aggressive life-prolonging treatments, 25% of physicians reported having prescribed antidepressant medications. Despite this seeming acknowledgment of the possible role of depression in patient requests for hastened death, only 2% of physicians reported having sought psychiatric consultation for their patients who requested assistance in dying.

Perhaps the most striking research to date regarding the use of PAS and euthanasia was a study of critical care nurses conducted by Asch. This study, based on the results of an anonymous survey, found that 17% of respondents reported having received at least one request for PAS and 11% had granted such a request. Approximately 5% of responding nurses acknowledged having hastened a patient’s death at the request of the physician, but without the request of the patient or the family (termed “nonvoluntary euthanasia” by some writers). Moreover, 4.7% of the sample indicated that they had hastened a patient’s death without the knowledge of or request by the physician. Respondents described having stopped oxygen therapy or increased pain medication in order to hasten death. Asch suggested that based on the reports of respondent nurses, these actions were done in order to ease the suffering of the patients. The traditional role of nursing in palliative care was cited as the basis for these results. It should also be noted that Asch’s controversial study generated considerable response, including many suggestions that methodological issues such as vague wording of questions may make these data unreliable. Nevertheless, while these data may not accurately indicate the true prevalence of PAS or euthanasia in the United States, requests for assistance in dying are clearly not rare events, and physicians occasionally grant such requests despite legal prohibitions. Furthermore, because legal restrictions limit the ability of physicians to consult with colleagues regarding how to react to a request for PAS, the appropriateness of patient requests and physician responses is unknown.

In The Netherlands, however, where PAS and euthanasia have been practiced regularly for more than 10 years, data are available regarding the frequency of requests for assistance in dying and the proportion of terminally ill patients whose lives end in this manner. Euthanasia was granted its current status in 1984 after a Dutch Supreme Court decision authorized this practice, provided a number of conditions were met. Specifically, the patient’s request for PAS must be considered free, conscious, explicit, and persistent. Both the physician and patient must agree that the patient’s suffering is intolerable, and other measures for relief must have been exhausted. A second physician must be consulted and must concur with the decision to assist in ending the patient’s life. Finally, all of these conditions must be adequately documented and reported to the governmental body supervising the practice of euthanasia. Because of the availability of such records, several studies have documented the proportion of deaths in The Netherlands in which euthanasia/PAS is implicated (these estimates were adjusted to account for underreporting of euthanasia acknowledged by many Dutch physicians). In reporting on euthanasia and PAS practices in The Netherlands from 1990 to 1995, van der Maas et al incorporated both official reports of euthanasia as well as responses to anonymous surveys to estimate the rates of euthanasia and PAS. They concluded that euthanasia and PAS were involved in roughly 4.7% of all deaths in The Netherlands during 1995, a substantial increase over the 2.7% of deaths involving medical assistance reported in a 1991 study.

Supporters of PAS point to data from The Netherlands as evidence that legalization has not led to widespread abuse or overuse of euthanasia or PAS. However, critics suggest that the 75% increase in deaths involving euthanasia or PAS (from 2.7% to 4.7%) demonstrates a growing tendency towards their more frequent use and thus a greater number of potentially inappropriate cases of euthanasia. Such concerns are clearly reflected in a 1994 Dutch Supreme Court decision in which the right to euthanasia/PAS was extended to include patients suffering from chronic illnesses that are not terminal, including mental disorders such as depression, provided the illness is refractory to treatment and causes intolerable suffering. Although the vast majority of requests for PAS from mentally ill individuals have been denied, isolated cases have occurred in which mentally ill Dutch adults have been allowed to receive PAS or euthanasia as a result of this court ruling. This experience has been identified as evidence of the “slippery slope” argument, in which legalization of PAS is presumed to lead to a gradual widening of the group of patients eligible for this “intervention,” many of whom may not be appropriate (eg, physically healthy but clinically depressed individuals).

Reasons for Seeking Hastened Death/PAS

A growing body of literature has emerged indicating the types of physical and psychologic concerns that may give rise to a desire for hastened death and requests for PAS. Although this literature has not always been consistent, a growing consensus has supported many of the assumptions put forth by the initial advocates and opponents of legalization. Specifically, the issues that have received the broadest empirical support are pain, depression, social support, and cognitive dysfunction. Table 2 lists the most common psychologic, biomedical, and social factors suggested in the literature to influence suicide, desire for death, and interest in PAS.
Pain: The relationship between pain and the desire for death is often described as a relatively straightforward one: intractable or severe pain is thought to lead to a desire for hastened death and particularly to thoughts of suicide. While some research has supported this presumption, most studies have suggested that this relationship may be considerably more complex. For example, our studies of ambulatory patients with AIDS found that while the presence and severity of pain appeared to heighten psychologic distress and depression, there was no direct relationship between pain and interest in PAS. Interest in PAS appeared to be more a function of psychologic and social factors (eg, depression, social support, fears of becoming a burden to one’s friends, etc) than physical factors (eg, pain, symptom distress, disease status). In their sample of cancer patients, Emanuel et al found similar results with regard to the relationship of pain to the desire for death. They found that patients who were in pain at the time of the survey were less likely to consider euthanasia appropriate than were patients without pain, even in response to a hypothetical vignette describing a patient with unremitting pain. These studies, however, are limited by several factors, including indirect measures of desire for hastened death (eg, willingness to consider PAS as an option or approval of euthanasia as a legitimate alternative) and a focus on the presence of pain rather than pain intensity or physical symptom distress more generally.

Studies that have employed more thorough measures of desire for death and pain, on the other hand, have generally supported the hypothesis that severe pain can result in a heightened desire for death. In their study of terminally ill cancer patients, Chochinov et al found that 76% of patients with moderate to severe pain had a “significant” desire for hastened death compared to only 46% of patients with mild or no pain. More recently, Rosenfeld and colleagues found that pain intensity contributed significantly to the prediction of desire for death (even after including measures of depression and social support) for patients who had pain. When the presence or absence of pain was included as a variable in these analyses, no such relationship was observed. Thus, the presence of severe pain is likely to add significantly to a patient’s desire for a hastened death; however, this relationship may be masked when pain is studied as a dichotomous (present/absent) variable.

Depression: Although the relationship between depression and suicidal ideation or attempts is well known, research has only recently begun to focus on the possible role of depression in requests for PAS among medically ill patients. Several studies have demonstrated that suicidal ideation and attempts are also related to depression in patients with cancer and AIDS. However, these studies have not addressed patients’ desire for death more generally or requests for PAS in particular. Only a small number of studies to date have focused specifically on desire for death or interest in PAS. These studies, although preliminary and often with significant methodological limitations, have suggested a significant relationship between depression and the desire for death or the interest in PAS.

In an early study of desire for death among palliative care patients, Brown et al evaluated 44 terminally ill patients in an inpatient palliative care unit. Of those patients interviewed, only 10 acknowledged any suicidal ideation or desire for hastened death, and all 10 of these patients were diagnosed by a psychiatrist as suffering from a major depressive disorder (based on DSM-III criteria). Interestingly, Brown et al reported that treatment for depression resulted in resolution of patients’ desire for death. Chochinov et al also reported a high prevalence of depression among terminally ill cancer patients acknowledging a desire for hastened death. The authors found that 17 (8.5%) of 200 subjects expressed a significant desire for hastened death and 44.5% had at least occasional wishes that death would come sooner. Of the patients with significant desire for death, 10 (58.8%) of 17 met Research Diagnostic Criteria for major depression. Desire for hastened death was also only modestly correlated with pain intensity and was negatively correlated with functional impairment. Social support was also significantly associated with desire for death in this sample. Of note, the authors found that the desire for hastened death decreased over time in several patients studied; however, this information was available in only 6 of the 17 patients.

In a study of 378 ambulatory HIV-infected patients, more than half acknowledged considering PAS as an option for themselves. The strongest predictors of interest in PAS were levels of depressive symptoms, hopelessness, overall psychologic distress, and current suicidal ideation. Other strong predictors included social support, experience with the death of a family member or friend, race, and religious practice. Interest in PAS was not related to the presence or severity of pain, physical symptoms, or extent of HIV disease. More recently, Emanuel et al applied a hypothetical vignette method to study attitudes toward euthanasia among oncologists, a subset of their patients (all receiving follow-up or ambulatory care at the time of the study), and a random sample of nonpatients. These authors, in a telephone interview, inquired about attitudes toward euthanasia (whether or not it would be “acceptable” to respond to a patient’s request for euthanasia) under a series of different conditions (eg, intractable pain, physical deterioration and disability, emotional suffering). They found no difference between cancer patients and nonpatients with regard to their overall acceptance of euthanasia as an option in any of the four vignettes, and they reported that roughly two thirds of all nonphysician respondents found euthanasia to be an “acceptable” alternative. Oncologists, on the other hand, were significantly less likely to approve of euthanasia under any of the hypothetical vignette scenarios. Not surprisingly, patients who acknowledged some psychologic distress were more likely to have discussed PAS/euthanasia with their physician, to have “hoarded” medications for possible future use, and to have read Final Exit, a book describing methods to end one’s life. Interestingly, however, patients who reported the presence of pain were less likely to consider euthanasia acceptable, even in the vignette describing intractable pain. Fairclough et al interviewed terminally ill cancer patients and inquired as to whether patients had thoughts of suicide, PAS, or euthanasia. In their sample of 523 cancer patients, 11.6% had thought of either ending their life or asking their physician to help them end their life, and 3.7% had discussed this issue with another party. Although age, race, caregiver burden, and duration of illness were all significant predictors of “interest in euthanasia or PAS,” depression was the strongest predictor of interest in dying.

Two studies have addressed the role of depression in medically ill geriatric patients’ decision to refuse or terminate life-sustaining medical treatments. Both studies suggested that the presence of a depressive disorder influenced patients’ decisions to refuse or terminate life-sustaining treatments. Furthermore, treatment for depression resulted in changes in patients decision making, with many patients no longer wanting to refuse or terminate life-sustaining treatments. Because of the apparent role of depression in decision making, Ganzini and colleagues suggested that patients with severe levels of depression should be encouraged to postpone decisions about end-of-life care options until after treatment for depression.

Social Support: Although social factors were ignored from much of the early research on desire for death, a growing body of research has demonstrated an important relationship between social support and desire for death. The importance of social factors in determining patient requests for PAS or euthanasia was first evident in the results of a Dutch study described by van der Maas and colleagues, in which they found that social and psychologic factors (eg, concern regarding a loss of dignity, fears of becoming a burden to others) comprised four of the five most frequently cited reasons for euthanasia requests. For example, Chochinov et al found a significant correlation between social support and the desire for death among their sample of terminally ill cancer patients; patients with lower levels of social support had more desire for hastened death than patients with higher levels of social support. Similarly, we found a significant relationship between the quality of social support and the interest in PAS. In addition, a number of other social variables (eg, fear of becoming a burden to family and friends, experience with the death of a friend or family member due to AIDS) were significant predictors of interest in PAS among ambulatory patients with AIDS. More recently, Rosendal et al found that social support provided an independent contribution to the prediction of desire for death even after controlling for the impact of depression, pain, and symptom distress. Thus, despite the methodological differences between these studies, the role of social support has consistently arisen (when studied) as a factor in understanding patient requests for PAS.
Measuring Desire for Death

One of the limitations of research investigating the role of depression, pain, and other physical symptoms or psychosocial determinants of the desire for death among patients with advanced disease has been the lack of valid research measures for assessing desire for hastened death. In their study of 200 terminally ill cancer patients, Chochinov et al developed a brief, unvalidated tool. The Desire for Death Rating Scale allows for clinician ratings of desire for death on a single scale of 0 to 6. Scores on this global clinician-rated scale are based on responses to questions such as “Do you ever wish you had the choice of dying?” Chochinov and colleagues dichotomized the patients in their study into those with “significant desire for death” (scores of 4 to 6) and those without, rather than analyzing desire for death as a continuous variable. Several limitations are apparent in an ordinal rating scale such as the Desire for Death Rating Scale, including reliance on clinician rating, difficulty achieving inter-rater reliability, and the limited range of possible scores. Recently, Rosenfeld et al published a valid, reliable, and brief self-report measure of desire for death called the Schedule of Attitudes Toward Hastened Death (SAHD). The SAHD is a 20-item measure validated in a sample of approximately 200 AIDS patients, a subsample of whom were terminally ill. The SAHD uses a true/false format and encompasses several aspects of desire for death, including concerns regarding future quality of life (eg, fear of pain or anticipated emotional suffering), social or personal factors that may influence desire for death (eg, religion, family obligations), and direct thoughts about or steps taken towards facilitating one’s death. The SAHD has several advantages over a global clinician rating including more varied measurement of the continuum of desire for death and the fact that a self-report measure can be more easily standardized across study settings. The development of research tools to measure desire for death will allow for more sophisticated and potentially more informative studies of this issue in the future.

Suicide Among the Medically Ill

Not all patients who seek a hastened death request assistance from their physicians. Rates of suicide among medically ill populations have been a topic of clinical concern and empirical research for many years prior to the emergence of the PAS debate. This research has generally concluded that depression and suicide among patients with medical illnesses are not particularly common but rather occur more often than in physically healthy populations. Table 3 lists the factors that, as supported by empirical research, appear to be contributors to the risk of suicide in cancer and AIDS patients. These suicide vulnerability factors in cancer and AIDS patients include poor prognosis and advanced disease, depression, hopelessness, loss of control, a sense of helplessness, delirium, fatigue and exhaustion of resources, pre-existing psychopathology, and previous suicide attempts. The role of psychiatric and psychosocial assessment and intervention has been well accepted as a critically important aspect of the care of patients with advanced cancer or AIDS. What is striking is that research on the desire for death and the interest in PAS is revealing that many of these same issues are important risk factors for the desire for death or the interest in PAS.

| Table 3. — Suicide Vulnerability Factors in Patients With Advanced Disease |
|---------------------------------|---------------------------------|
| Pain, suffering aspects         | Advanced illness, poor prognosis |
| Depression, hopelessness        | Delirium, disorientation         |
| Control, helplessness           | Preexisting psychopathology      |
| Substance/alcohol abuse         | Suicide history, family history  |
| Fatigue, exhaustion             | Lack of social support; social isolation |

Early studies of suicide among cancer patients offered conflicting findings, with some studies indicating that the incidence was comparable to that of suicide among the general population and other studies suggesting an incidence of suicide as much as 10 times greater than in the general public. These studies, however, were typically based on small and nonrepresentative samples. More recently, large-scale epidemiologic studies of the incidence of suicide among cancer patients have revealed more modest (but substantial) differences. For example, a Finnish national study found that women diagnosed with cancer were 1.3 times more likely to commit suicide than the general public, while similarly diagnosed men were 1.9 times more likely. Fox et al also reported a higher rate of suicide among Connecticut men diagnosed with cancer (2.3 times) compared with the general population; however, there was no difference in rates of suicide for women with and without a cancer diagnosis. In a review of the literature on suicide and cancer, risk factors for suicide in patients with cancer included advanced disease or poor prognosis, pain, depression or other mental disorders (eg, delirium).

Much more striking rates of suicide marked early epidemiologic research on HIV-infected individuals. An early report of suicide among this population in New York City based on records from the Office of the Medical Examiner found that men with AIDS were 36 times more likely to commit suicide than were age-equivalent men in the general population. Other studies have revealed smaller but nevertheless striking differences in the rates of suicide among HIV-infected individuals. In a study of the AIDS population in Texas, Plott et al reported that the rate of suicide was 16 times greater for people with AIDS compared to the general public. Similarly, Kizer et al reported a rate of suicide among Californians with AIDS to be 17 times greater than that of the general public.

Despite these alarming results, these early studies have been criticized on several statistical and methodological grounds. First, the comparison of patients with AIDS, many of whom have comorbid psychiatric disorders (eg, substance abuse), to the general public obscures ample differences that may increase the likelihood of depression and/or suicide. For example, several studies have found no difference in the rate of depression or suicidal ideation when comparing patients with AIDS and homosexual men to those with a history of injection drug use who do not have HIV/AIDS, both being populations with elevated rates of suicide compared to the general public. Thus, the increased rate of suicide among patients with AIDS may in part reflect the presence of other risk factors for suicide aside from HIV infection itself. In addition, the studies of suicide in HIV-infected individuals have included very few actual cases of suicide. The New York sample described by Marzuk et al in 1988 included only 12 suicides of AIDS patients, while the Texas and California samples included 5 and 13 AIDS-patient suicides, respectively. Thus, the standard error for these estimates of suicide rates would likely be quite large, leading to inaccurate estimates of the risk of suicide. In addition, the issue of relative risk rations has been criticized in these analyses as resulting in exaggerated estimates of the risk of suicide. Nevertheless, the high rates of suicide reported in these early studies of HIV disease have fueled the assisted-suicide movement despite more recent evidence that suicide is relatively uncommon among patients with terminal illness.

Clinical Response to Suicidal Ideation, Desire for Hastened Death, or Requests for PAS

The response of the clinician to a patient’s expression of suicidal ideation or request for PAS has obvious ramifications for the patient’s quality of life as he or she approaches death. Several issues emerge in clinical settings when patients express a desire for hastened death, either with or without the assistance of the physician. These issues, and appropriate clinical responses, are discussed along with a synopsis of legal and ethical issues that exist in such situations.

As with any individual who expresses a desire for death, a terminally ill patient’s expression of suicidal ideation or a request for PAS must be addressed both rapidly and thoughtfully. Perhaps the single most important reason that clinicians can offer to their patients is a willingness to engage in this discussion. Clinician should not only allow...
Many experienced clinicians, however, are uncomfortable discussing suicide or death with their patients, and several fears often arise from these situations. Among these fears is the thought that by allowing a patient to discuss his or her desire for a hastened death, the physician may become a party to an illegal act, face moral or ethical objections, or suggest that death may be more acceptable than life. These fears may cause the patient to avoid discussing these issues in a nonjudgmental manner, the clinician conveys a willingness to keep such topics open, often providing a significant relief to the patient. For these reasons, many clinicians are reluctant to discuss suicidal thoughts or desire for hastened death curtails an important avenue for physicians to gain a more complete understanding of a patient’s mental and physical state. Many patients also find discussions of suicidal thoughts therapeutic, at times even relieving some of the urge to act on such thoughts. Even physicians who are opposed to suicide or PAS on moral, ethical, or religious grounds should be capable of engaging in a discussion of these thoughts or feelings without conveying either a willingness to carry out such actions or a judgment of the appropriateness of such feelings.

Once an open dialogue has been established, the next essential step involves a discussion of the patient’s understanding of his or her illness and the presence and severity of current symptoms. This type of discussion can enable the physician to assess the degree to which the patient’s beliefs or thoughts are rational, as well as the extent to which untreated symptoms are driving their desire for a hastened death. The disclosure of untreated or undertreated physical and psychologic symptoms can facilitate more effective treatment to address symptoms that may be resolvable with improved palliative care. The vulnerability factors influencing suicide, the desire for death, and PAS (Tables 2–3) should be used to guide evaluation and management. Once the setting has been made secure, assessment of the relevant mental status and adequacy of pain control can begin. Analgesics, neuroleptics, or antidepressant drugs should be used when appropriate to treat agitation, psychosis, major depression, or pain. Underlying causes of delirium or pain should be addressed specifically when possible. Initiation of a crisis intervention-oriented psychotherapeutic approach, mobilizing as much of the patient’s support system as possible, is important. A close family member or friend should be involved in order to support the patient, provide information, and assist in treatment planning. Psychiatric hospitalization can sometimes be helpful but usually is not desirable in the terminally ill patient. Thus, the medical hospital or home is the setting in which management most often takes place. While it is appropriate to intervene when medical or psychiatric factors are clearly the driving force in a patient who expresses suicidal plans or requests PAS, there are circumstances when usurping control from the patient and family with overly aggressive intervention may be less helpful. This is most evident in those with advanced illness where comfort and symptom control are the primary concerns.

Another aspect of patient decision making that can be addressed once an open dialogue has been established is the extent of depression present in the patient. Not all terminally ill patients become severely depressed, nor are all terminally ill patients who desire a hastened death suffering from a major depression. On the other hand, many terminally ill patients are likely to be experiencing a depression that may be both treatable as well as temporary. Identifying when severe symptoms of depression exist and providing a referral to a trained psychologist or psychiatrist, preferably one with experience treating patients with terminal illnesses, can be crucial in optimizing the quality of life of these patients. Of course, even when a severe depression exists, a patient’s ability to make rational treatment decisions is not always impaired as a result of this disorder. Thus, a referral to a mental health professional should likely also include an evaluation of the patient’s decision-making competence.

Whenever potentially treatable disorders appear to underlie a patient’s desire for hastened death, aggressive treatment for these symptoms or conditions is necessary. Many patients may be reluctant to pursue such treatments, particularly if the patient believes that treatment will be futile and/or painful. Therefore, clinicians should assure their patient that treatment does not imply a lack of willingness to continue to discuss other options (eg, PAS) but rather merely fulfills a desire to exhaust all possible options to improve their existing quality of life. Therefore, clinicians should seek expert assistance in addressing whatever symptoms or problems have been identified, whether psychologic (eg, depression or despair), physical (eg, pain or fatigue), or social (eg, concern regarding becoming a burden to one’s social supports).

Because PAS and euthanasia (as well as suicide more broadly) are illegal in the United States (with the exception of Oregon), any clinician learning of a patient’s desire for assistance in dying is presented with several ethical and legal dilemmas in addition to the clinical issues that arise. These dilemmas are lessened somewhat by the determination that theoretically resolvable symptoms exist that may be resolved or substantially reduced by available interventions. If the patient’s desire for hastened death does not appear related to potentially resolvable problems, and if the patient has specifically requested assistance in committing suicide (or has expressed a specific intent to kill themselves), the clinician is faced with the uncomfortable burden of deciding how to respond to their patient’s statements. This decision will no doubt rest on a number of factors, including the physicians personal beliefs regarding the appropriateness of suicide and PAS. Although consultation with a colleague is hindered by the illegal nature of PAS, such consultation is nevertheless advisable whenever a patient’s request for PAS is being seriously considered. Consultation with a peer, even if done in a confidential and discreet manner, is important as the clinician that his or her perception of the situation and condition of the patient is accurate, but also provides a second opinion regarding the potential for, and availability of, possible interventions. Unfortunately, we have no easy answer for facilitating clinical decision making in these difficult situations other than to suggest that with adequate interventions and clinical response, such requests will hopefully be relatively infrequent.

Depression, Pain, Social Support, and Suicide/Desire for Death/PAS

The Figure illustrates a proposed model for understanding the influences on suicide, the desire for death, and the interest in PAS as developed by the work of Chochinov et al and Breitbart et al. This model is an integration of two independent research groups that came to startling degrees of agreement on the relationships between the various psychologic, social, and medical issues. Essentially, the model suggests several basic concepts: (1) The desire for death is a central common element in both interest in PAS and suicidal ideation/suicide, but these constructs are overlapping rather than identical or a single construct. (2) The central driving force, the most powerful predictor of desire for death, suicide, or interest in requests for PAS is depression (ie, Major Depressive Syndrome, a treatable disorder). (3) Hopelessness is the most important link/mediator between depression and desire for death/suicide/PAS. (4) Pain, social support, physical debilitation, other psychologic symptoms, and social issues have their most powerful influence on desire for death/suicide/PAS through their influence on depression and their ability to intensify depression as an entity.

This proposed model points to one unavoidable conclusion: the central psychiatric issue in desire for death/suicide/PAS is the recognition and treatment of depression (see below).

Depression in Cancer

Prevalence rates for major depressive syndromes in cancer patients are estimated to range from 4.5% to 58%, based on psychiatric consultation database studies and research-based prevalence studies. Only a limited number of these studies examined prevalence of depression in cancer patients with far advanced disease and these suggest that depression is more common in the later stages of cancer, ranging in prevalence from 23% to 58%.
Depression in cancer patients with advanced disease is optimally managed using a combination of supportive psychotherapy, cognitive-behavioral techniques, and antidepressant medications. Psychotherapy and cognitive behavioral techniques are useful in the management of psychologic distress in cancer patients and have been applied to the treatment of depressive and anxious symptoms related to cancer and cancer pain. Psychotherapeutic interventions, either in the form of individual or group counseling, can effectively reduce psychologic distress and depressive symptoms in cancer patients. Cognitive behavioral interventions such as relaxation and distraction with pleasant imagery have also been shown to decrease depressive symptoms in patients with mild to moderate levels of depression. However, psychopharmacologic interventions (ie, antidepressant medications) are the mainstay of management in the treatment of cancer patients with severe depressive symptoms who meet criteria for a major depressive episode. The efficacy of antidepressants in the treatment of depression in cancer patients has been well established.

### Pharmacologic Treatment of Depression in the Terminally Ill

Any treatment for major depression in the terminally ill will be less effective if given in a context devoid of psychotherapeutic support. Although both psychotherapy and cognitive behavioral therapy are effective in reducing psychologic distress and mild to moderate depressive symptomatology in the cancer setting, pharmacotherapy is the mainstay for treating terminally ill patients who meet diagnosis criteria for major depression. Factors such as prognosis and the time-frame for treatment may play important roles in determining the type of pharmacotherapy for depression. A depressed patient with several months of life expectancy can afford to wait the two to four weeks that may be required to respond to a tricyclic antidepressant. The depressed dying patient with less than three weeks to live may do best with a rapid acting psychostimulant.

### Management of Depression in the Terminally Ill

Depression in cancer patients with advanced disease is optimally managed using a combination of supportive psychotherapy, cognitive-behavioral techniques, and antidepressant medications. Psychotherapy and cognitive behavioral techniques are useful in the management of psychologic distress in cancer patients and have been applied to the treatment of depressive and anxious symptoms related to cancer and cancer pain. Psychotherapeutic interventions, either in the form of individual or group counseling, can effectively reduce psychologic distress and depressive symptoms in cancer patients. Cognitive behavioral interventions such as relaxation and distraction with pleasant imagery have also been shown to decrease depressive symptoms in patients with mild to moderate levels of depression. However, psychopharmacologic interventions (ie, antidepressant medications) are the mainstay of management in the treatment of cancer patients with severe depressive symptoms who meet criteria for a major depressive episode. The efficacy of antidepressants in the treatment of depression in cancer patients has been well established.

### Table 4. — Antidepressant Medications Used in Patients With Advanced Disease


<table>
<thead>
<tr>
<th>Medication</th>
<th>Start/Daily Dose (mg)</th>
<th>Primary Side Effects/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tricyclics (TCAs):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline (Elavil)</td>
<td>10-25/50-100</td>
<td>Sedation; anticholinergic; orthostasis</td>
</tr>
<tr>
<td>Imipramine (Tofranil)</td>
<td>10-25/50-150</td>
<td>Intermediate sedation; anticholinergic; orthostasis</td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>25-75-150</td>
<td>Little sedation or orthostasis; moderate anticholinergic</td>
</tr>
<tr>
<td>Nortriptyline (Pamelor)</td>
<td>10-25/75-150</td>
<td>Little anticholinergic or orthostasis; intermediate sedation; therapeutic window</td>
</tr>
<tr>
<td>Doxepin (Sinequain)</td>
<td>25/75-150</td>
<td>Very sedating; orthostatic hypotension; intermediate anticholinergic effects; potent antihistamine</td>
</tr>
<tr>
<td><strong>Second Generation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buproprion (Wellbutrin)</td>
<td>75/200-450</td>
<td>May cause seizures in those with low seizure threshold/brain tumors; initially activating; available in sustained-release formula</td>
</tr>
<tr>
<td>Trazodone (Desyrel)</td>
<td>50/150-200</td>
<td>Sedating; not anticholinergic; risk of priapism</td>
</tr>
<tr>
<td><strong>Serotonin-Specific Reuptake Inhibitors (SSRIs):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>10/20-40</td>
<td>Headache, nausea, anxiety, insomnia; has very long half-life, may be even longer in debilitated patients</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>10-20/50</td>
<td>Nausea, somnolence, asthenia; no active metabolites</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10/20-60</td>
<td>Nausea, diarrhea, minimal drug interactions (cytochrome p450 system)</td>
</tr>
<tr>
<td><strong>Psychostimulants:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d-Amphetamine (Dexedrine)</td>
<td>2.5/5-30</td>
<td>Should be given in two divided doses at 8 AM and noon; can be used as analgesic adjuvant and to counter sedation of opiates</td>
</tr>
<tr>
<td>Methylphenidate (Ritalin)</td>
<td>2.5/5-30</td>
<td>Follow liver tests</td>
</tr>
<tr>
<td>Pemoline (Cylert)</td>
<td>10-25/50-100</td>
<td></td>
</tr>
<tr>
<td>Metoclopramide (Reglan)</td>
<td>10-25/50-100</td>
<td></td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine (Effexor)</td>
<td>75/225-375</td>
<td>Inhibits reuptake of both serotonin and norepinephrine; achieves steady state in 3 days; may increase blood pressure; available in sustained-release formula</td>
</tr>
<tr>
<td>Nelfazone (Serzone)</td>
<td>100/200-500</td>
<td>Affects serotonin, 5HT, and norepinephrine; sedating; decreased cardiotoxicity; less reported sexual dysfunction than SSRIs</td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>15/5-45</td>
<td>Useful as sedative in low doses; less reported sexual dysfunction</td>
</tr>
</tbody>
</table>

**Pharmacologic Treatment of Depression in the Terminally Ill**

Any treatment for major depression in the terminally ill will be less effective if given in a context devoid of psychotherapeutic support. Although both psychotherapy and cognitive behavioral therapy are effective in reducing psychologic distress and mild to moderate depressive symptomatology in the cancer setting, pharmacotherapy is the mainstay for treating terminally ill patients who meet diagnosis criteria for major depression. Factors such as prognosis and the time-frame for treatment may play important roles in determining the type of pharmacotherapy for depression. A depressed patient with several months of life expectancy can afford to wait the two to four weeks that may be required to respond to a tricyclic antidepressant. The depressed dying patient with less than three weeks to live may do best with a rapid acting psychostimulant. Patients who are within hours to days of death and in distress are likely to benefit most from the use of sedatives or narcotic analgesic infusions.

Antidepressants are prescribed for the treatment of depression in only 1% to 3% of hospitalized cancer patients and only 5% of terminally ill cancer patients. There are a
References


18. Oregon State Supreme Court. ORS127-685, 4.01


Nonpharmacologic Treatment of Depression in Terminally Ill Patients

A number of psychotherapy intervention trials for the treatment of psychologic distress and depression have been conducted with cancer patients, but few if any have included patients with far advanced disease.77,86,90-109

Supportive psychotherapy is a useful treatment approach to depression in the terminally ill patient. Psychotherapy with the dying patient consists of active listening with supportive verbal interventions and the occasional interpretation.110 Despite the seriousness of the patient’s plight, it is not necessary for the psychiatrist or psychologist to appear overly solemn or emotionally restrained. Often it is only the psychotherapist, of all the patient’s caregivers, who is comfortable enough to converse lightheartedly and allow the patient to talk about his or her life and experiences rather than focus solely on impending death. The dying patient who wishes to talk or ask questions about death should be allowed to do so freely, with the therapist maintaining an interested, interactive stance. It is not uncommon for the dying patient to benefit from pastoral counseling. If a chaplaincy service is available, it should be offered to the patient and family.
100. Farash J. Effect of counseling on resolution of loss of body image disturbances following mastectomy. Diss Abst Int. 1979:39:334027.

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