

LETTER TO THE EDITOR

Added Points of Concern About Caring for Dying Patients

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This correspondence responds to "How Should Physicians Care for Dying Patients With Amyotrophic Lateral Sclerosis?" which appeared in the August 2018 issue of the AMA Journal of Ethics.

If there is any doubt that the legalization of assisted suicide has changed the ethos of medicine, that question should be settled by Craig and Dzung's article, "How Should Physicians Care for Dying Patients with Amyotrophic Lateral Sclerosis?" As psychiatrists and ethicists, we appreciate Craig and Dzung's attempt to highlight some central ethical issues involved in end-of-life care. However, we are deeply troubled by the article's implicit message: namely, that physicians are acting ethically when they help patients kill themselves in such a way as to avoid legal liability. In our view, that self-serving calculation serves physicians' interests—not patients' well-being. We are also troubled by several critical omissions in the fictional Dr S's evaluation and clinical management of "Donald"—a patient with [amyotrophic lateral sclerosis](#) (ALS) and extreme physical limitations who is requesting what the American College of Physicians rightly terms "physician-assisted suicide" (PAS).¹

In the case, Dr S worries that despite these extreme physical limitations, Donald might somehow still be able to kill himself in a protracted or violent way, and he considers a lethal prescription to be an acceptable alternative means of death. Some proponents of assisted suicide assert that patients who seek medically assisted death are so determined to die that they will merely find another method if denied a prescription. Jones and Paton² tested this method-substitution theory and found, on the contrary, that having an assisted suicide law on the books did nothing to reduce the rate of "natural" (ie, nonassisted) suicides. States that offered physician-assisted suicide had no reduction in nonassisted suicides.² Conversely, states without assisted suicide laws had similar increases in nonassisted suicides as states with the laws.² However, having an assisted suicide law on the books does increase total state suicide rates by 11.79% when a range of factors are controlled for.² Indeed, evidence from Oregon suggests there might be a "contagion" effect, owing to highly publicized cases of PAS, such as that of Brittany Maynard.³

Craig and Dzung write that their fictional patient must pass through "rigorous psychological testing" in order to obtain a lethal script. Yet neither Washington State nor Oregon have legislated mandatory psychological evaluation or testing for patients who

request assisted suicide.^{4,5} In reality, only 3.5% of Oregon patients given prescriptions were referred for psychiatric evaluation in 2017.⁴ In *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals*, the Task Force to Improve the Care of Terminally-Ill Oregonians acknowledges that, in practice, the act's statutory safeguards do not adequately protect people with mental illness.⁶ Nor do assisted suicide laws require a voluntary referral for mental health care as part of the informed consent process.

In the fictionalized vignette, Dr S never explores factors in Donald's request that could stem from subtle forms of coercion, such as pressure from family members to end his life. Nor is there any assessment of [cognitive distortions](#) that might be clouding the patient's judgment. Instead, in the case, Donald's apparent motivations are rather credulously accepted at face value. Nor does Dr S offer Donald mental health care and counseling in his discussion of treatment alternatives. This is particularly worrying, given that 35% to 50% of ALS patients have cognitive deficits related to decision-making capacity.⁷

The authors are concerned about the "significant harm" that can come from denying a patient's autonomy and agency, and "the potential harms of refusing to prescribe lethal drugs." Yet they cite no empirical data showing that a physician's refusal to prescribe lethal medication leads to any type of "significant harm." As psychiatrists, we recognize that temporary limitations on patient autonomy and agency—coupled with empathic counseling—can lead to continued life, re-engagement, and a renewed sense of meaning even in the face of a terminal illness.

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