Doctor, can we get this over with?

Are your patients really seeking physician-assisted death? Be aware of what palliative care can offer to help prevent and ease suffering.

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In 2016 physician-assisted death will become legal in Canada. Studies of general public knowledge about refusing or withdrawing life-sustaining therapy[1,2] suggest people may be confused about their right to make life-determining decisions when they are seriously ill, and support for physician-assisted death is enhanced by stories of negative experiences associated with dying—poorly controlled symptoms, patients who feel a lack of dignity, and deaths that are drawn out due to repeated rescue by a medical system that assumes prolonging life is more important than the *quality* of living and dying.

Palliative care arose as a response to patient experiences of poor quality dying. People were dying in hospital surrounded by machines that provided futile treatment rather than being comfortable in a loving and supportive community. Following a long period of evidence building, the benefits of palliative care in improving quality of living and dying are now relatively robust.[3] However, making physicians aware of what palliative care can do for their patients and why it should be incorporated into disease management at an early stage is still an ongoing struggle.[4] The toughest part is convincing physicians and surgeons that if they care for patients who have serious illnesses, they are obliged to have basic skills and knowledge in palliative care.

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Physician-assisted death is not seen as an extension of palliative care. The World Health Organization's 1990 definition of the term states that palliative care "affirms life and regards dying as part of the normal process of living" and that palliative care "neither hastens nor prolongs dying." Current definitions continue the theme of respecting and finding meaning in the process of natural dying. Though palliative care is involved in dying, its aim is to help people live as well as is possible until their natural death. In August 2015 the General Council of the Canadian Medical Association passed a motion recognizing that the practice of assisted death as defined by the Supreme Court of Canada is distinct from the practice of palliative care.[5]

Why people request assisted death

To begin to understand how to respond to a request for physician-assisted death it is important to understand why people make the request. As all physicians know, a statement or question can have multiple triggers and motivations behind it, and a request that results in such a serious consequence must be fully explored. When a patient introduces the subject of physician-assisted death, it is always a good idea to clarify what is really being asked, since euphemisms for death abound and it is a difficult topic for anyone to speak about. It is possible that the patient is simply making a statement rather than a request to die. Realizing that life is coming to an end may compel people to comment "I wish I could die," "I might as well be dead," "I'm a dead man," etc. This may simply be a dawning recognition of what lies ahead rather than a request for hastened death. By exploring what a patient means by such statements and providing information and guidance to the patient, physicians can help make the individual feel heard and supported.

A 2012 systematic review and meta-ethnography of the underlying issues behind a request for hastened death identified six themes:[6]

- A response to total pain (physical, psychological, and spiritual suffering).
- Loss of self (the loss of bodily function and the ability to manage one's own life) leading to perceived loss of dignity and perceived loss of meaning in life.
- Fear of the dying process and imminent death.
- Envisioning death as a way to end the suffering that is due to loss of self and fear.
- An expression of wanting to live, but not in the current way.
- A way of maintaining control over one's life.

A patient's request for hastened death is typically associated with depressive symptoms, severe physical symptoms, hopelessness, and a perceived loss of dignity.[7] For some patients, having knowledge about palliative care can help to reduce their desire for hastened death,[8] and systematically implementing palliative approaches to serious illness may reduce the desire for hastened death in many patients. Hopefully all physicians will feel compelled to learn more about how to prevent and respond to this suffering.

By controlling patients' symptoms—both physical and psychological—physicians can reduce the total burden of suffering and enable patients to find a way to cope with the inevitable losses of function, role, and identity that serious illness brings and, in some cases, turn the losses into opportunities for personal growth.

Determining if your patient is in existential distress

The patient may be defensive or reluctant to discuss spiritual or existential issues with you, but a patient's behavior may offer clues to his or her spiritual or existential distress. Examples of this behavior include:

- Lack of a response to pharmacological or other interventions that usually relieve pain.
- Distress remaining after the pain or dyspnea is controlled.
- An inability to identify a physical source for experienced pain despite multiple investigations.
- Exhibiting total distress (e.g., every possible symptom is rated 10 out of 10).

Integrating palliative approaches into practice

Informing patients about palliative approaches to care and integrating those approaches into their chronic disease management at an early stage can help prevent patients' suffering. Certain key practices can make a significant difference:

- Ensure all therapy options are offered to patients, including the option to manage symptoms but not the disease. Do not assume that every patient who presents for health care desires life extension.
- If patients consent to a treatment, make sure they are aware of the right to refuse or withdraw from the treatment, even if withdrawal should hasten their natural death.
- Revisit the goals of care frequently to ensure patients are getting the treatment that feels right to them. This is particularly essential when sentinel events occur such as frequent hospital admissions, loss of independence, and before any new intervention.[9]
- Discuss prognoses with patients who want to know. This does not remove hope; it enables patients to make better decisions about therapy in advanced illness.[10]

Discussing illness, loss, and dying is not easy. It raises issues with our own mortality, losses, and fears. But it can be learned, and with mastery of the skill comes greater comfort in having the discussion. Saving and prolonging life is professionally very satisfying, but preserving quality of life and ensuring quality of dying were the original goals of medicine since Hippocratic times.

Despite physician-assisted dying being legal in Canada, the vast majority of Canadians will still choose to die naturally and should be able to expect care that helps them live as well as is possible until they die in comfort. By being aware of what palliative care can offer to patients with serious illness, essential patient communication tools, and common existential or spiritual issues in advanced illness, physicians can help prevent and ease suffering—our duty since the beginning of the profession.

The author is currently guest editing a theme issue on palliative care that she hopes to publish in the BCMJ *later this year.*

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