

Special Article

PHYSICIAN-ASSISTED SUICIDE AND PATIENTS WITH HUMAN IMMUNODEFICIENCY VIRUS DISEASE

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ABSTRACT

Background Data are limited on the attitudes and practices of physicians regarding assisting the suicide of patients with human immunodeficiency virus (HIV) disease.

Methods Between November 1994 and January 1995, we used an anonymous, self-administered questionnaire to survey all 228 physicians in the Community Consortium, an association of providers of health care to patients infected with HIV in the San Francisco Bay area. The responses were compared with those in a 1990 survey of consortium physicians. Physician-assisted suicide was defined as "a physician providing a sufficient dose of narcotics to enable a patient to kill himself." Respondents were to "assume that the patient is a mentally competent, severely ill individual facing imminent death."

Results One hundred eighteen of the questionnaires were evaluated. Respondents reported a mean of 7.9 "direct" and 13.7 "indirect" requests from patients for assistance. In responses based on a case vignette, 48 percent of the physicians said they would be likely or very likely to grant the request of a patient with the acquired immunodeficiency syndrome (AIDS) for assistance in a suicide, as compared with 28 percent of the respondents in 1990. Asked to estimate the number of times they had granted the request of a patient with AIDS for assistance in committing suicide, 53 percent said they had done so at least once (mean number of times, 4.2; median, 1.0; range, 0 to 100). In a multivariate analysis, factors positively associated with a physician's having, in fact, assisted a suicide were having had a higher number of patients with AIDS who had died; having received a higher number of indirect requests from patients for assistance; having a stated gay, lesbian, or bisexual orientation him- or herself; and having a higher "intention to assist" score (as calculated from the physician's responses to the case vignette).

Conclusions Within a group of physicians caring for patients with HIV disease, the acceptance of assisted suicide increased between 1990 and 1995. A majority of respondents in 1995 said they had granted a request for assisted suicide from a patient with AIDS at least once. (N Engl J Med 1997;336:417-21.)

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WE investigated factors influencing the attitudes and practices of physicians in the San Francisco Bay area regarding physician-assisted suicide for patients with the acquired immunodeficiency syndrome (AIDS). We evaluated whether, and to what extent, physicians are participating — or would be willing to participate — in physician-assisted suicide. Participation was defined as the prescription of a lethal dose of narcotics to a patient who was infected with the human immunodeficiency virus (HIV) or who had AIDS, who requested such a prescription in order to commit suicide. This definition was specified to distinguish physician-assisted suicide from active euthanasia (administering a lethal injection) and passive euthanasia (the withdrawal of life support in response to a patient's advance directive), both of which were outside the scope of our study.

We also assessed whether there have been changes over time in physicians' attitudes and practices regarding assisted suicide. In 1990, we surveyed a similar group of physicians in the same organization,¹ but we did not ask whether or how frequently they had actually participated in assisted suicide. In the present study, we assessed how frequently physicians actually prescribe lethal doses of medications to their patients with AIDS.

METHODS

We surveyed all 228 physician members of the Community Consortium, an association of providers of health care to patients infected with HIV in the San Francisco Bay area. The members include physicians in private practice and those who work at academic medical centers, community hospitals, neighborhood clinics, and health maintenance organizations. The number of members in the Community Consortium has increased since the 1990 survey (from 150 to 250), and there has been some turnover. Because the responses to both surveys were anonymous, it was not possible to identify people who responded to both.

On the basis of the questionnaire used in the 1990 survey, we

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developed a self-administered, anonymous questionnaire that included sections on demographic characteristics, professional and personal experience with AIDS, beliefs and attitudes regarding physician-assisted suicide, and participation in assisted suicide. Respondents were also asked how they would respond to a request from a patient with AIDS for assistance in committing suicide, as described in the following vignette:

Tom is a 30-year-old gay male computer programmer diagnosed with AIDS two years ago. He has severe wasting syndrome and painful oral ulcers, and responded poorly to treatment for his third episode of *Pneumocystis carinii* pneumonia. There is no evidence of neurological impairment, and it is clear that Tom is mentally competent. His mood is mildly depressed, but the depression is not pronounced given the seriousness of his condition. Tom has been in a primary relationship for eight years and worked until several months ago. As his personal physician since his diagnosis, you consider Tom a thoughtful, intelligent patient who does not appear to have any significant psychopathology. During Tom's biweekly clinic visit, he asks you to prescribe a lethal dose of narcotics for possible use at some future date.

Respondents were asked how likely they would be to prescribe a lethal dose of medication for Tom and, if Tom was adamant about obtaining assistance in committing suicide, what course of action they would take.

We defined physician-assisted suicide as "a physician providing a sufficient dose of narcotics to enable a patient to kill himself." Physicians were told to assume that the patient was "a mentally competent, severely ill individual facing imminent death." To determine the frequency with which respondents have participated in assisted suicide, we asked them to estimate the number of times they had granted the request of a patient with AIDS for assistance in committing suicide (e.g., by prescribing a lethal dose of medication). No time frame was specified. We did not obtain data on whether the medication was actually used by the patient to commit suicide. We also asked the physicians to estimate the number of times they had been asked "directly" or "indirectly" by a patient with AIDS to assist him or her in committing suicide. Neither "directly" nor "indirectly" was defined in the survey.

The questionnaire and study procedures were approved by the Committee on Human Research at the University of California, San Francisco. The study was conducted between November 1994 and January 1995. The survey packet included a cover letter, a copy of the questionnaire (including information on informed consent), and a postcard to be returned separately to request a synopsis of the study's findings. Providers who were no longer in clinical practice were asked to indicate this fact on the questionnaire and to return it unanswered.

Statistical Analysis

Fisher's exact test,² the Mantel-Haenszel chi-square test,³ and the normal approximation to the nonparametric Wilcoxon two-sample test⁴ were used to compare the demographic characteristics, attitudes toward assisted suicide, and responses to the case vignette of the 1990 and 1995 survey populations.

A scaled composite variable called "intention to assist" was constructed to aid in the analysis of attitudes toward assisted suicide. An individual score was derived from the responses to two questions about the case vignette. The possible scores ranged from 0 to 4. A response of "very likely" or "likely" to the question as to whether a respondent would prescribe a lethal dose after a patient's initial request contributed 2 points to an individual score; a response of "neither likely nor unlikely" contributed 1 point. To the question regarding an "adamant" request for a lethal dose, granting the request contributed 2 points; referral to the Hemlock Society contributed 1 point.

A forward, stepwise multiple logistic-regression analysis was conducted of the following variables: intention to assist (respondents with a score of 0 were compared with those with a score of 1 to 4), the physician's sexual orientation, the physician's number

of patients with AIDS, the physician's number of acutely ill patients with AIDS, the number of the physician's patients with AIDS who had died, the number of direct and indirect requests from a physician's patients for assistance in committing suicide, the physician's estimate of the likelihood that he or she would consider or actually commit suicide if given a diagnosis of AIDS, and the amount of professional literature about assisted suicide the physician had read. The statistical significance of the coefficients assigned to individual variables was calculated with the Wald chi-square statistic with 1 degree of freedom.

RESULTS

Of the 228 physicians surveyed, 137 (60 percent) responded. Of these 137 respondents, 19 indicated they were no longer in clinical practice, so 118 questionnaires were evaluated. In the 1990 survey, 69 of 150 physicians (46 percent) had responded.

As compared with the respondents in 1990, the respondents in 1995 were a more racially diverse group, more likely to be heterosexual, and more likely to have treated a relatively high number of patients with AIDS (Table 1). Over three quarters of the respondents in 1995 had treated more than 80 patients with AIDS, as compared with 63 percent of the respondents in 1990.

TABLE 1. CHARACTERISTICS OF RESPONDENTS TO THE 1990 AND 1995 SURVEYS.

CHARACTERISTIC	1990	1995
	(N = 69)	(N = 118)
	percent	
Sex		
Male	81	73
Female	19	27
Race or ethnic group*		
White	97	89
Black	0	4
Hispanic	1	3
Asian or Pacific Islander	2	4
Sexual orientation†		
Homosexual or bisexual	55	36
Heterosexual	45	64
Marital status		
Married	33	47
Unmarried but in a relationship	36	32
Unmarried and not in a relationship	30	21
Religion		
Protestant	26	17
Catholic	13	12
Jewish	36	30
Other	25	41
Total no. of patients with AIDS‡		
0	9	0
1-20	4	3
21-40	7	8
41-60	7	4
61-80	9	5
>80	63	78

*P = 0.05 for the comparison of the relative proportions of white and nonwhite respondents in the two surveys.

†P = 0.01 for the comparison between the two surveys.

‡P = 0.01 for the comparison of the distribution of numbers of patients with AIDS between the two surveys. Because of rounding, percentages do not sum to 100.

Respondents to both surveys reported similar numbers of direct requests for assistance in committing suicide from patients with AIDS (for the 1995 survey [n = 116]: mean, 7.9; median, 2; range, 0 to 200; for the 1990 survey [n = 69]: mean, 3.6; median, 1; range, 0 to 50). However, respondents to the 1995 survey reported more indirect requests (1995 [n = 115]: mean, 13.7; median, 8; range, 0 to 100; 1990 [n = 68]: mean, 6.8; median, 3; range, 0 to 100; P = 0.007 for the comparison of indirect requests in the two surveys, by the Wilcoxon test).

In regard to the case vignette, 48 percent of the respondents in 1995 said they would be likely or very likely to grant Tom's initial request for assistance, as compared with 28 percent of the respondents in 1990 (P = 0.005) (Table 2). The physicians were also asked how they would respond if Tom was adamant about getting assistance. Of the respondents in 1995 (n = 110), 51 percent said they would grant Tom's adamant request, as compared with 35 percent of the respondents in 1990 (n = 69) (P = 0.05). The respondents in 1995 were also less likely than those in 1990 to say they would talk Tom out of his request if he were adamant (P = 0.04). If they heard that another physician had offered assistance to Tom in committing suicide, the respondents in 1995 (n = 114) were also less likely to say they would talk to that physician to challenge or condemn his or her action than were the respondents in 1990 (2 percent vs. 14 percent, P < 0.001).

Asked to estimate the number of times they had "granted an AIDS patient's request for assistance in committing suicide," 53 percent of the 117 respondents to the 1995 survey who answered this question reported that they had done so at least once (mean number of times, 4.2; median, 1.0; range, 0 to 100) (Fig. 1). Asked how many times they had consulted with colleagues about helping patients with AIDS to commit suicide, 50 percent of the respondents in 1995 and 49 percent of those in 1990 reported that they had done so at least once (1995 [n = 115]: mean number of times, 2.7; median, 1; range 0 to 20; 1990 [n = 69]: mean, 3.8; median, 0; range, 0 to 50).

In the multivariate analysis, four factors were found to be associated with whether a physician had ever assisted in a patient's suicide: a higher intention-to-assist score, a higher number of the physician's patients with AIDS who had died, a higher number of indirect requests from patients for assistance, and a gay, lesbian, or bisexual orientation on the part of the physician (Table 3).

DISCUSSION

Previous surveys of physician-assisted suicide have reported that 7 to 9 percent of physicians have complied with requests from terminally ill patients for assistance in suicide.^{5,6} We found that about one half

TABLE 2. RESPONSES TO THE CASE VIGNETTE IN 1990 AND 1995.*

QUESTION AND RESPONSE	1990	1995
	no. (%)	
How likely would you be to prescribe a lethal dose of medication for Tom?†		
Very unlikely	20 (29)	18 (16)
Unlikely	20 (29)	19 (17)
Neither likely nor unlikely	9 (13)	22 (19)
Likely	13 (19)	47 (41)
Very likely	6 (9)	8 (7)
If Tom was adamant about getting assistance in committing suicide, what course of action would you take?‡		
Refuse his request	10 (14)	18 (16)
Talk him out of it§	16 (23)	12 (11)
Hospitalize him as danger to himself	2 (3)	1 (1)
Refer him to a mental health professional	41 (59)	50 (45)
Refer him to a suicide-prevention program	4 (6)	5 (5)
Refer him to clergy	11 (16)	17 (15)
Refer him to another physician	1 (1)	8 (7)
Refer him to the Hemlock Society	32 (46)	42 (38)
Grant his request¶	24 (35)	56 (51)

*Only the physicians who responded to questions about the case vignette are included.

†There were 68 respondents in 1990 and 114 in 1995. P = 0.005 for the comparison of the distribution of responses between the two surveys.

‡There were 69 respondents in 1990 and 110 in 1995. More than one response per physician was possible.

§P = 0.04 for the comparison of the distribution of responses between the two surveys.

¶P = 0.05 for the comparison of the distribution of responses between the two surveys.

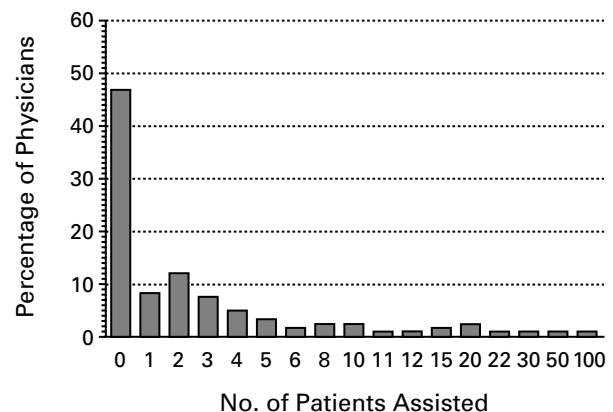


Figure 1. Distribution of the Numbers of Patients Assisted in Suicide, as Reported by 117 Respondents to the 1995 Survey.

TABLE 3. FACTORS ASSOCIATED IN THE MULTIVARIATE ANALYSIS WITH PHYSICIANS' HAVING ASSISTED A PATIENT WITH AIDS TO COMMIT SUICIDE.

FACTOR	ODDS RATIO (95% CONFIDENCE INTERVAL)	P VALUE*
Intention-to-assist score >0†	1.73 (1.25–2.40)	<0.001
Higher no. of patients with AIDS who have died‡	1.36 (1.06–1.74)	0.02
Higher no. of indirect requests from patients for assistance in committing suicide§	1.06 (1.01–1.11)	0.03
Gay, lesbian, or bisexual orientation¶	2.99 (1.07–8.34)	0.04

*P values were derived by the Wald chi-square statistic with 1 degree of freedom.

†See the Methods section for an explanation of the intention-to-assist score.

‡For each additional 20 patients who have died.

§For each additional indirect request.

¶The comparison group was heterosexual respondents.

the physicians we surveyed in 1995 reported assisting at least once in the suicide of a patient with AIDS by prescribing a lethal dose of medication. This is a surprisingly large proportion, given the possible legal and ethical repercussions of such an action. It should be noted that California state law does not limit the amount of narcotics that a physician can prescribe at one time, and the quantity required for a lethal dose is not in excess of what might be obtained in a single prescription; a lethal dose of narcotics would thus not necessarily require multiple prescriptions or the hoarding of prescriptions by patients.

There is increasing support in the United States and elsewhere for so-called right-to-die legislation, euthanasia, and physician-assisted suicide.^{5,7-10} Recent rulings by the Second and the Ninth Circuit Courts of Appeals support the right of terminally ill patients to hasten their death with drugs prescribed by their physicians.^{11,12} Recent data indicate that, in some communities, rates of euthanasia and physician-assisted suicide among patients with AIDS may be higher than in the general population. In a study of 131 homosexual men with AIDS in Amsterdam, 29 (22 percent) died by euthanasia or physician-assisted suicide,¹³ as compared with 5 percent of patients with cancer and 2 percent of the general population.¹⁴ Several studies also suggest that persons with AIDS have a greater relative risk of committing suicide than the general population.¹⁵⁻¹⁷

In our surveys, the change from 28 percent in 1990 to 48 percent in 1995 in the proportion of respondents who reported willingness to assist in a patient's suicide suggests that acceptance by physicians of assisted suicide is increasing over time and that resistance to assisting in suicide appears to be

lessening. The high level of reported assistance in 1995 may be due to the number of patients with AIDS who have died while under the care of physicians, as well as the increase in the number of requests for assistance received. Our respondents' estimates of the number of direct and indirect requests from patients for assistance may have been low in both surveys. In an effort to avoid a difficult issue, physicians may not hear their patients' subtle or disguised requests for assistance and, as a result, may be less attuned to their patients' needs. The physicians who reported a greater number of direct and indirect requests may represent a subgroup who are known in the community to prescribe lethal medications sought by patients with AIDS. The burdensome nature of this role is obvious. We did not study the potential for psychological repercussions among physicians who assist in suicides; however, this activity is likely to have psychological reverberations and to carry a social stigma.

A physician's being gay, lesbian, or bisexual was also positively associated with assisting in a patient's suicide; this may reflect identification with the patient. Identification with patients with AIDS may solidify the alliance between doctor and patient because such physicians may have a greater understanding of the patient's experiences and desires. One could speculate, on the other hand, that a gay, lesbian, or bisexual physician may have difficulty objectively assessing a patient's request for assistance. The physician may assume the patient's request is rational and fail to explore fully the psychological and motivational status of the patient. Ultimately, this could lead physicians who strongly identify with their patients with AIDS to prematurely prescribe potentially lethal medications in a situation in which the patient's request is an indicator of psychological distress rather than of a carefully considered desire to die. Although physicians who were not heterosexual appeared to identify more strongly with their patients and assisted patients in committing suicide to a greater extent than their heterosexual colleagues, sexual orientation was only one of the four factors that were associated with assisting a patient with AIDS to commit suicide.

Some physicians may view prescribing medications in response to a patient's request for assistance in committing suicide as a psychological intervention rather than a means of hastening death. The prescription of medications carries symbolic as well as pragmatic value in that it can increase patients' level of comfort by giving them a sense of control over a disease that tends to rob them of control. It is important to emphasize that although we assessed the frequency with which physicians prescribed a lethal dose of medication, we did not ascertain whether the medication was actually used by the patient to commit suicide.

A major methodologic problem in our study is selection bias, which limits the generalizability of our findings. Physicians who had an interest in or experience with assisted suicide may have been more likely than others to respond to the survey. Although selection bias may have influenced the magnitude of the reported findings, the associations we found are still likely to be genuine. An additional limitation is that the study was conducted in the San Francisco Bay area, where attitudes are generally more liberal and where there is a higher incidence of HIV infection than in other regions of the country. Furthermore, the terms "direct" and "indirect" were not defined in the questionnaire, nor was a time frame specified for the estimate of the number of times requests for assistance had been granted. These limitations notwithstanding, we found substantial evidence that some physicians are making it possible for their patients with HIV infection to commit suicide and that acceptance of this practice in a consortium of physicians who care for many such patients appears to be increasing.

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