



Physician-Assisted Death — From Oregon to Washington State

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In November, residents of the state of Washington voted 58% to 42% to allow physician-assisted suicide.¹ The Washington Death with Dignity Act is modeled on a similar law that has been in effect in

Oregon since October 1997 and that was upheld in 2006 by the U.S. Supreme Court. The act permits terminally ill state residents, defined as adults with an illness expected to lead to death within 6 months, to request and receive a prescription for a lethal dose of a medication that they may self-administer in order to end their life. Booth Gardner, a former governor of Washington who has Parkinson's disease — which is not considered a terminal disease under the act — filed the initiative, spearheaded the campaign, and was a major financial contributor.

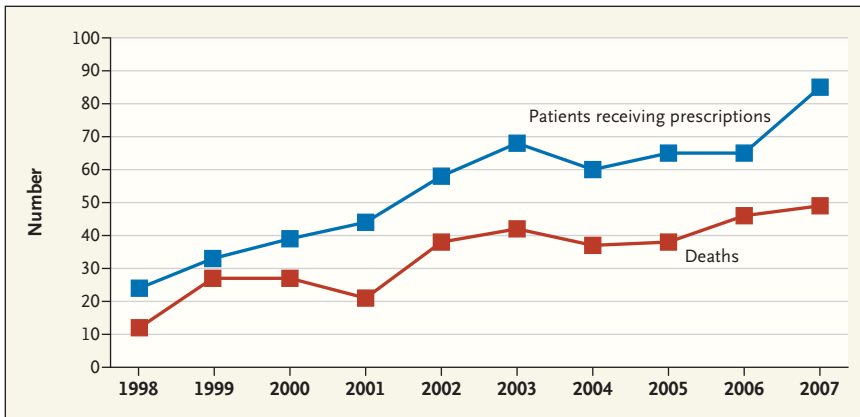
If the Washington act takes effect as scheduled on March 4, 2009, there will be two states in which physician-assisted suicide is

legal; no states permit euthanasia. Physician involvement in hastening death is also legal in Belgium, the Netherlands, and Switzerland — the specifics vary by country — and is an underground practice elsewhere.

The prescription of lethal doses of medication to terminally ill people who want to hasten their own deaths is inherently controversial. The Washington State Medical Association opposed the initiative, and doctors have divergent views on the matter. In 1991, voters in Washington rejected a broader initiative that would have allowed doctors to administer the lethal drugs. The controversy carries over into disagreements over terminology; designations such as

“death with dignity” and “physician-assisted suicide” may be considered emotionally charged and judgmental. Indeed, deaths under the Oregon act are not classified as suicides. Although some prefer terms such as “physician aid in dying” and “physician-assisted death,” physician-assisted suicide remains a frequently used descriptor.

Amid the controversy and debate, the hastening of death by physicians under Oregon's act is uncommon. Between 1998 and 2007, physicians wrote a total of 541 prescriptions for lethal doses of medication (almost always secobarbital or pentobarbital), and 341 people died as a result of taking the medications (see graph). Thirteen patients who had received prescriptions were alive at the end of 2007, and the rest of those who received prescriptions ultimately died of their underlying disease. The group of patients



Number of Patients Receiving Prescriptions for Drugs for Use in Assisted Death and Number of Assisted Deaths under the Oregon Death with Dignity Act, 1998 to 2007.

Data are from the Oregon Department of Human Services (www.oregon.gov/DHS/ph/pas/index.shtml).

who died after ingesting a lethal dose of medication had a median age of 69 years, almost all were white and relatively well-educated, and the group consisted of slightly more men than women, according to data collected by the Oregon Department of Human Services. About 86% were enrolled in hospice programs, and 81.5% had terminal cancers.

The legalization of assisted death has been associated with substantial improvements in palliative care in Oregon, in areas including the appropriate training of physicians, the communication of a patient's wishes regarding life-sustaining treatment, pain management, rates of referral to hospice programs, and the percentage of deaths occurring at home.² Effective palliative care and hospice services may address many of the key reasons why patients request assistance in dying — such as loss of autonomy, dignity, and the ability to care for themselves in a home environment — and lead some to change their minds.³

Because of the nature of their medical practices or personal objections to involvement, most physicians in Oregon have never written a prescription for a lethal dose

of medication; in 2007, 45 physicians wrote the 85 prescriptions issued (with a range of 1 to 10 prescriptions per doctor). If the experience in Washington is similar, however, there will eventually be more prescriptions and deaths because Washington has more people (6.5 million, as compared with 3.7 million in Oregon).

Whereas physicians and health care organizations in Oregon had 3 years to prepare for their state's Death with Dignity Act (there were legal challenges, and ballot measures passed in 1994 and 1997), those in Washington will have only several months. Thus, physicians, hospitals, hospices, and other entities involved in the care of terminally ill patients will need to rapidly become familiar with the initiative and develop appropriate policies and procedures, including those for referrals. Some physicians and institutions will not participate because of religious or moral objections to the law. Of course, Oregon's well-documented experiences are an invaluable resource; a comprehensive guidebook for health care professionals is available online and was recently updated.⁴

As in Oregon, the Washington

initiative requires that an attending physician and a consulting physician independently determine that a patient is qualified to initiate a written request for a prescription for a lethal medication — a determination that includes verification that the person is competent, is acting voluntarily, and has made an informed decision. Medications must not be prescribed to a patient “suffering from a psychiatric or psychological disorder or depression causing impaired judgment.” If such disorders are suspected, the patient must be referred to a psychiatrist or psychologist for counseling, a determination of whether or not the patient's judgment is impaired, and possible treatment.

Although the Oregon law has been successfully implemented, it is concerning that in 2007 none of the 85 patients who received prescriptions for lethal medications were referred for psychiatric evaluations, whereas 12.6% of those who received prescriptions between 1998 and 2006 did receive such referrals. A study conducted between 2004 and 2006 suggested that not all patients in Oregon who request a physician's aid in dying are adequately screened for depression and that “some potentially ineligible patients” may have received a prescription for a lethal drug.⁵

Physicians will continue to disagree about the wisdom of prescribing lethal doses of medication to terminally ill people who want to hasten their own deaths. Nonetheless, the approval of the Washington initiative and the potential for similar legal changes in other states provide the medical profession with an opportunity to evaluate what can be done to continue to improve care at the end of life.

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3. Ganzini L, Goy ER, Dobscha SK. Why Oregon patients request assisted death: family members' views. *J Gen Intern Med* 2008;23:154-7.
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Screening for Prostate Cancer among Men 75 Years of Age or Older

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Prostate-cancer screening with the prostate-specific-antigen (PSA) test remains one of the most controversial issues in modern medicine. The U.S. Preventive Services Task Force (USPSTF), an independent group of experts supported by the Agency for Healthcare Research and Quality under a mandate from Congress, recently revised its recommendations regarding prostate-cancer screening. The USPSTF concluded that “the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years,” but it now “recommends against screening for prostate cancer in men age 75 years or older.”¹ In its 2002 statement, the task force did not recommend for or against screening in either age group. The implication of the new recommendation for medical practice is that clinicians should discuss the potential benefits and known harms of screening with men between 50 and 74 years of age, but not necessarily with older men.

Why change the recommendation for men 75 or older, at least given the continuing dearth of evidence from randomized trials that addresses the tradeoff between the benefits and harms of

prostate-cancer screening in men of any age? The task force believes that at least a moderate amount of evidence now makes it possible to conclude that the known harms of screening outweigh the possible benefits for this age group.

This statement does not imply that prostate cancer is an unimportant problem among men 75 or older; in fact, as the statement acknowledges, 71% of deaths due to prostate cancer — almost 20,000 annually in the United States — occur after the age of 75. Moreover, it does not mean that no men 75 or older could possibly benefit from screening. After all, there are relatively healthy men in their late 70s and even early 80s harboring high-grade cancers that are likely to kill them; early detection and attempted curative treatment might prevent these men from dying from prostate cancer. So why not continue to offer screening after the age of 74?

First, the effectiveness of attempted curative treatment for prostate cancer among men 75 or older appears to be low or negligible. In the only published randomized trial comparing the effect of radical prostatectomy with a strategy of “watchful waiting” for men with clinically localized prostate cancer, the benefit of radical

prostatectomy was statistically significant but small, with an absolute difference of 5.4 percentage points in the rate of death due to prostate cancer at 12 years (which has not widened with continued follow-up). This difference means that about 18 radical prostatectomies would have to be performed to prevent a single death from prostate cancer over a 12-year period.² However, in subgroup analyses at both 10 and 12 years of follow-up, even this level of effectiveness appeared to be confined to men 65 years of age or younger. Men 75 or older were not enrolled, presumably because they were considered less likely to benefit from surgery.

It is important to note that less than 10% of subjects in this Scandinavian trial had their prostate cancer diagnosed through screening. The long average lag time between a detectable increase in the PSA level — 5 to 10 years — and the development of clinical cancer, as well as the possibility of overdiagnosis associated with PSA screening, suggests that an even smaller benefit may be seen in the U.S. Prostate Cancer Intervention versus Observation Trial (PIVOT), in which about three quarters of participants had their cancer diagnosed through PSA screening.