

April 24, 2023

To whom it may concern:

I remain opposed to SB239. Section 27 requires the involvement of psychiatry. There's no need to involve a psychiatrist if two independent physicians already know the person asking for assistance lacks medical decision making capacity. The process should stop immediately. Requiring a psychiatrist weigh in accomplishes nothing.

At end of life delirium is expected and serves as a marker for imminent death. Unless the physicians caring for someone asking for assistance can resolve the underlying cause for delirium, the patient will die. For those with known dementia, it is not appropriate to consider assisting their demise. As for others with neurodegenerative illnesses, they may not be capable of making rational decisions.

Psychiatry has a shameful past. We, the psychiatrists of Nazi Germany, created what became the holocaust by first killing the mentally ill and mentally retarded. That was the best German psychiatrists could offer in the 1930s, never knowing that those with mental illness might one day respond to medications. Never let psychiatrist guard the "gate." We already failed the test once. As for psychologists, or mental health specializing nurse practitioners, why would they do any better? It was psychologists who willingly participated in state sponsored torture by the US military and clandestine branches of government (eg, Abu Ghraib Prison, black ops sites, and Gitmo).

Finally, do we not understand that anyone enrolled in a hospice program already has lethal quantities of drug onsite? None of this is new, physicians have debated about assisted suicide for more than 2500 years. I wrote about "what we could do besides killing people" more than 20 years ago. Nothing I wrote then isn't still timely today. Sadly, even the stats from OR demonstrated that the first to take advantage of assistance with dying were white men, living alone, without support systems, and still functional, but were afraid they would become incapacitated and have no help. How sad, that in a nation like the US we still lack a comprehensive health care system that guaranteed every person in our country quality palliative and end-of-life care. How about we improve our overall healthcare system before we help people kill themselves in desperation?

Barry Eliot Cole

What We Should Do Besides Killing People

Barry Eliot Cole, MD, MPA

Administrator, National Pain Data Bank and Pain Program Accreditation

American Academy of Pain Management

Sonora, CA

I must not get it!

Since when is killing someone who might be nearing the end of life appropriate? Why is killing someone who is suffering from a serious medical illness or even a terminal condition the best that we can offer? What about all of the wonderful technology that now exists? What about all of the new medications that keep coming out on the market? What about the changes in state laws that make strong pain relieving medications more available and lessen the risk for physicians prescribing them?

What has happened to our society and to us that we would enthusiastically look to euthanasia and physician-assisted suicide as the best solutions for the medically ill? With all of the wonderful techniques, skills and medications available for relieving pain, physical symptoms and suffering, the increasing interest in and provision of hospice care, and a desire by most people to put an end to violence, how ironic that we would even consider euthanasia as the best option.

One of the core principles of the Judeo-Christian tradition deals directly with murder. According to these teachings and beliefs we shall not commit murder. "Shall not" is the same as "no," and "do not do this." What part of "no" is not clear? Murdering people is wrong and euthanasia is just another form of murder. Deliberately taking any life is murder regardless of the underlying motivations. To clean up the fact that murder is somehow not wrong when we perform acts of euthanasia we rationalize what is being done by claiming that "merciful killing" is beneficial. Merciful killing is beneficial for whom? Is it beneficial for the people suffering from unpleasant illnesses or for those who watch loved ones suffering?

I am not naive. As a psychiatrist for two decades it is clear to me that those wanting to die do not need my help in any way. They are perfectly able to jump from high places, cut their wrists, put guns in their mouths, hang themselves, drive their cars into immovable objects and take any number of different household poisons. Physicians have little to offer those bound on self-destruction considering the wide range of readily available means that are highly effective in the community. Physicians and other health care professionals are only able to help those who are ambivalent about dying and desire help. Practitioners cannot be everywhere and importantly cannot be all things to all people all of the time.

Are there other options for the potentially terminally ill beyond killing them? I believe that there are many options available and none of them involve the deliberate taking of life. What drives the desire for an early demise may be the fear that the system is not able to deal with end-of-life care? That when we become too ill we will be abandoned by our loved ones and caregivers, left with broken bodies and in terrible pain that cannot be relieved. Are these the reasons that leave so many people sadly believing that suicide and euthanasia are their best and only options?

Lessons from the Education for Physicians on End-of-life Care (EPEC) Curriculum

The Institute for Ethics of the American Medical Association developed the Education for Physicians on End-of-life Care (EPEC) curriculum in 1999 with a grant from the Robert Wood Johnson Foundation to educate 750,000 American physicians about palliative care for the terminally ill. While not the only curriculum dealing with the care needs of the terminally ill, the EPEC curriculum has become the most widely publicized and universally distributed program. Many of my ideas come from the EPEC curriculum.

Physician-assisted suicide and euthanasia are ancient medical issues. We have not just stumbled on to these topics in recent times. Physician-assisted suicide involves the aiding or causing of a suffering person's death whereby the physician provides the means to commit suicide, but the patient performs the act of self-destruction. Euthanasia involves the physician performing the life ending intervention, with or without the permission of the patient. It is thought that most physicians receive requests for assistance with dying and such requests are usually signs of patient crises.

For practitioners there are serious legal and ethical concerns about assisting people to commit suicide or actively taking their lives. Practitioners have an obligation to relieve pain and suffering, and to respect decisions to forgo life-sustaining treatment. Rather than rushing to extinguish life, the EPEC curriculum provides a logical approach for responding to requests for assistance with suicide.

Although the United States Supreme Court has recognized that there is no fundamental right to assistance with suicide it has turned the debate over to the individual states to resolve. While the legal status of physician-assisted suicide can possibly differ from state to state, only Oregon has made such assistance legal as of 1999.

Why do patients ask their health care practitioners for assistance committing suicide?

Some patients suffer a crisis of confidence about the goals of their treatment or the management of their many physical and psychological problems. Others have profound fears about possibly suffering with their conditions and they develop concerns about potentially losing control or becoming burdensome for others. Those who experience depression or high levels of pain may become likely to seek professional assistance in ending their lives. Because of this desperation, professional caregivers must be able to work with seriously ill people and to help them find alternatives other than assisted-suicide.

Many physicians sadly believe that they are not adequately trained to address end-of-life issues. Others are just too busy to provide the comprehensive care necessary to manage patients with serious and life-threatening illnesses. The lack of reimbursement and the need to see large numbers of people in managed care environments causes many physicians to just not address requests for suicide in any way.

What is first needed when practitioners are faced with requests for assistance committing suicide is for these practitioners to clarify what the requesters desire. What are the requesters actually trying

to achieve? Not every request for assistance must be acted upon. Not every requester is actually making a direct request for immediate death. There may be many other issues to resolve.

Requests must be examined carefully and critically to determine the underlying root causes. These requests involve the provision of education about the legal and ethical alternatives for symptom control, the ability to limit the scope and duration of selected treatments, along with promoting greater levels of physical and psychological comfort.

To thoroughly clarify requests for assistance with suicide practitioners must demonstrate their immediate concern and compassion. These are not the “problems” that are adequately explored in the hallway or in five-minute office visits. Practitioners must determine if requesters are motivated to kill themselves because of underlying thoughts (ideation) regarding suicide, direct disease effects, medication toxicity or other issues. For safety reasons practitioners must be able to determine if their patients are imminently prepared to act upon well formulated plans (intent to act) that are likely to be successful. Practitioners must be aware of any personal biases they may have about suicide, about people asking them for help committing suicide, and their potential to respond negatively toward requesters (counter-transference). If practitioners will not address these issues they cannot effectively care for their patients.

To fully determine the underlying causes behind requests for suicide, practitioners should consider four major dimensions of suffering motivating people to end their lives prematurely: physical, psychological, social and spiritual. Practitioners must focus on the fears of requesters about the future and their potential for underlying depression and anxiety. To do this there must always be an assessment made for clinical depression. Serious depression is too often under-diagnosed and under-treated despite the availability of potent and effective medications. Depression may be the single most significant source of suffering and the greatest barrier for sufferers to have a “good death” without having to commit suicide.

While diagnosing depression in the setting of serious medical illnesses may initially appear challenging for practitioners, because physically ill people have overlapping symptoms with those having depression, making the depression diagnosis does not have to be difficult at all. In the absence of physical symptoms, especially in the face of complaints about significant preoccupation with themes of helplessness, hopelessness and worthlessness, the diagnosis is essentially self-evident. There are no special laboratory tests to confirm the diagnosis of depression. Depression is a clinical diagnosis. Failing to make the depression diagnosis condemns patients to early deaths. With the modern and very safe medications available for the treatment of depression there are no valid reasons to withhold these remarkable therapeutic agents.

Often the motivation for life termination involves intense psychosocial suffering related to very practical concerns. The sick may have elements of shame about their underlying illnesses or the circumstances by which they came to have these conditions. Many people may not feel particularly needed or wanted any longer as they develop progressive debilities. They may experience difficulties coping with their duties, responsibilities and activities of living. Some may experience losses of bodily function, self-image, decision-making control and independence. Already difficult and strained relationships become further disrupted because of these and other issues eventually leading to increasing isolation, abandonment and despair. Concerns about who will serve as

caregivers, how domestic chores will be accomplished, and who will care for dependents and cherished pets may all exacerbate the emotional distress of seriously ill people contemplating self-annihilation.

Physical suffering is very difficult for most people to handle under the best of circumstances. The infliction of pain serves as the basis for torture. The sick and their caregivers may both wish for life ending strategies when pain becomes severe. Being in pain is awful for all of us. The sick have to deal with pain and so many other issues. Caregivers feel helpless standing by while loved ones are in agony.

Physical symptoms such as breathlessness from progressive lung disease, wasting from anorexia, progressive weakness and fatigue cause many sick people to consider suicide. Nausea and vomiting, massive swelling (edema), loss of bowel and bladder control (incontinence) producing foul odors in addition to the pain and other physical problems collectively contribute to questions about the meaning, value and purpose of life.

It is not unusual to encounter tragically afflicted people who believe that God has personally abandoned them in their hours of need or that God is punishing them for past their transgressions. Sadly, many believe that only through purification by pain and punishment can they be redeemed. These issues causing spiritual suffering may be more painful and difficult to handle than the physical and psychological aspects of being illness. When these people doubt their own self worth and question their underlying faith traditions it is likely that they will become angry and profoundly depressed with little belief that there are any reasons to seek help. Skillful and experienced clinicians must be able to reach out to these people and bring them back from their suicidal desperation.

People are rather vain. None wants to imagine a future without self-efficacy, decision-making capacity and independence. The aged in our country know best what it is like to survive their cherished friends and family members. They know too well what it is like to become abandoned, forgotten and alone in the world due to their progressive debilitation to the point where they are no longer able to even minimally care for themselves. These are very frightening prospects for most of people, but these are usually resolvable problems and not valid reasons just to kill the ill!

Treatment choices beyond assisted-suicide

As professional caregivers we must affirm our commitment to care for all of our patients. We must learn to listen to what is said and to acknowledge the feelings and fears that our patients bring to their appointments. Practitioners must clarify and expand their role in caring for their seriously ill patients to address the psychosocial needs. Practitioners must become committed to finding solutions, exploring current concerns and addressing the roots causes for suicide requests.

Addressing the root causes necessitates professional competence in withholding and withdrawing medical care, aggressively providing comfort measures, following palliative care principles and utilizing the services of local palliative care programs. Doing these things does much to allay suffering and fear.

Practitioners must carefully treat depression, anxiety and delirium whenever it exists. Without first controlling and relieving these serious problems it is never possible to fully respond to requests for assistance with suicide. Some requesters may benefit from individual or group therapy and have an opportunity to talk about their troubled feelings and worries. Others need assurances about the care of their loved ones. They may be comforted working with a professional to bring their legal affairs to order or to have some ability to determine the scope, location and duration of treatment.

Treatment choices for serious depression, underlying requests made for assistance with suicide, depend upon the time available for therapeutic response. The most rapidly acting medications are not traditional antidepressants but the faster-acting psychostimulants. When time is plentiful and the requester is less fragile more traditional therapeutic agents include the newer selective serotonin reuptake inhibitors (SSRIs), newer atypical molecules and the older tricyclic antidepressants. All have the capacity to relieve depression and to potentially help the suicide requester when motivated out of despair.

How anxiety and depression influence pain intensity is a complicated issue. Anxiety and depression may be the consequences of unrelieved pain. Pain produces considerable distress for patients, causing anxiety, depression, and hostility interfering with the quality of life. Anxious or depressed patients who are in pain should initially be treated with analgesics to reduce their pain. If anxiety and depression persist after their pain is substantially relieved, more traditional mental health interventions are indicated.

Since the late 1980s we have assumed that cancer patients could not participate in rehabilitation programs and so we have provided cancer pain sufferers with a wide range of therapeutic options from high dose opioid analgesics to anesthetic blocks to neuro-destructive lesioning. As long as the patients were determined by their physicians to be terminally ill, with less than a year of life expected, a “no holds barred” approach to controlling their pain was taken. In doing so, a great many Americans died far better in the last decade than in previous modern decades. The addition of hospice to end-of-life care permitted the exploration of the role of anticipatory bereavement, spiritual needs and psychosocial support for the terminally ill and their family members.

To control pain we might initially consider anti-inflammatory agents and opioid analgesics. To take the edge off of any underlying inflammatory process anti-inflammatory agents would prove very useful, whether non-steroidal or steroidal in their composition. The use of these medications would allow us to control the toxic chemical events leading to the sensitization of the nervous system and the further experience of pain in response to disease or illness. Opioid analgesics could then be added upon this base of inflammation control to maximize comfort.

What about opioid analgesics? They can be used in any setting, and their benefits generally outweigh their few significant risks such as sedation, constipation, nausea and vomiting, itching and respiratory depression. Providing opioid analgesics is the standard of care for end-of-life pain management. We must be aware that the optimal analgesic dose varies widely among patients.

The factors that limit our use of these opioid medications usually involve patient and professional barriers. Patients are concerned that they might get “hooked” on the medication, or might appear weak if they cannot handle the pain that others can. Practitioners, especially those who prescribe

opioid analgesics, worry that too much medication could cause respiratory arrest, that controlling the pain might mask emerging problems, or that patients might not want the side effects associated with starting opioid medications. Due to knowledge deficits about opioids there is still an erroneous belief that a very narrow continuum exists between prescribing opioids for pain, obtaining pain relief, inducing sedation, creating respiratory depression and eventually the death of the patient.

Why not focus on pain management near the end of life? Why not utilize every medication available, including opioid analgesics, to reduce or eliminate pain? How many elderly cancer patients do we hear about stealing money from the church collection plates to buy drugs? Where is the runaway drug problem we hear about that allegedly comes from giving prescription medications to people in pain? Why do we ever ration opioid analgesics for terminally ill patients?

Making cancer patients comfortable is not difficult. It is clear that cancer patients are going to eventually die from their underlying disease, not because of the analgesics we offer. Our task with palliative care is not to necessarily prolong life at any cost, but to improve the quality of the days remaining. We are not withdrawing all support, only changing the focus of the care provided. When our intent is the relief of pain and suffering, then we are justified in offering whatever analgesic medications, in whatever doses, are necessary to modify the pain. Giving enough medication to make patients comfortable is not passive euthanasia. Giving enough medication to relieve pain is the physician's duty.

Many physicians believe that they could risk disciplinary action if they use high doses of opioid analgesics or other controlled substances to manage pain. They believe that if they under treat pain they face no risk of professional consequences. They fail to understand that patients have the right to adequate pain medication. Physicians have successfully defended the withholding of pain medication by claiming that no clear guidelines existed about how to provide adequate pain care. With the emergence of national, state and medical board guidelines concerning the relief of pain, physicians cannot make such claims any longer.

We have to do a better job managing pain in America if we want to help our patients to not feel they must die to get pain relief. We must get past any barriers preventing us from making patients comfortable. We must aggressively eliminate physical suffering before we can ever consider assisting any suicide. We must educate our patients and their families to demand adequate pain management services, to utilize these techniques and services without fear, shame or guilt, and work with health care educators and policy makers to set aside the 90-year experiment in unnecessary opioid regulation.

We can control physical symptoms with the assistance of physical and occupational therapies, access to pastoral care services, and adequate amounts of medication to control pain, breathlessness, nausea and vomiting. Without the help of a minister, priest, rabbi or other pastoral representative there can be no exploration of the meaning of the suffering, the purpose of life and the preparatory work to close one's life.

What must be done to help people prepare for a natural death?

It is so unfair to deprive people of their final opportunity for gift giving and establishing a legacy by ending their lives prematurely. The final aspects of life may provide the greatest opportunities for personal growth, the settling of old scores, and the passing on of traditions. If we can make the ill physically and psychologically comfortable why would we need to kill them?

We must address the fears of the seriously ill about their loss of control. We must explore areas of their lives dealing with efficacy, accomplishment and independence. We must accept that patients ultimately have legal rights concerning their own medical care, and as such may accept or refuse any medical intervention, including those intended for life prolongation. Those with serious illnesses who are not wishing to continue life-sustaining therapies may “opt out” at any time by forgoing further treatment (dialysis, intravenous fluids and nutrition, or receiving antibiotics with bouts of serious infections). By doing so, these people may select comfort care over curative care when cure is no longer possible.

To make this outcome likely each of us must select personal advocates and proxies for making health care decisions when we are no longer able to decide for ourselves. We must prepare written advance directives and face the inevitability of our own deaths. We must make a commitment to aid patients and loved ones as much as possible to maintain control. We must control pain and other bothersome symptoms.

Knowledge is power and patients deserve full explanations about their diseases, the techniques used to control bothersome symptoms, and the expected course with or without treatment. Those wishing to be sedated to help manage intractable symptoms may be sedated. Sedation is not the same as euthanasia or passive assisted suicide; it is merely the ability to sleep through difficult periods.

If practitioners commit to managing symptoms and addressing their patients’ fears of being burdensome to caregivers and loved ones, would any prematurely end their lives? If financial problems could be solved would these people still believe themselves to be “burdens” upon their families. Perhaps social workers, lawyers and insurance agents could clarify the reality of these situations and diminish the desire of our patients to die. Allowing the ill to make medical decisions for as long as they are capable, and to not be embarrassed about their illness, would do much to promote the well being needed to avert the suicidal drive. Dignity and control are easily available upon a moment of reflection.

Reassuring patients that we are going to stay with them for the duration does much to address their fears of abandonment. We must provide appropriate assurances that we will continue to be involved in their care regardless of the direction their condition takes. There will be continuity of care for the seriously ill if caregivers commit to its importance. Palliative care is not abandonment. It is not the absence of care. Palliative care is a highly evolved and different type of health care entirely dedicated to the relief of bothersome symptoms and the improvement in the quality of remaining life.

Can we provide legal alternatives for suicide?

We certainly can provide information about the likely outcome and expected course of the disease.

We can assure patients that we will respect their right to refuse any and all treatments. We can honor requests for discontinuation and withdrawal of burdensome therapies. We can elect to not replace declining oral intake with other routes. We can stop feeding people who are dying and we can prevent misguided forced-feedings that only increase misery, but do not change the inevitable outcome. We can redirect caregivers to still feel they are important even when they are prevented from forcing fluids and nutrition. In doing so we can shorten the time to naturally die without actively accelerating the process.

To facilitate the withdrawal of treatment or to manage uncontrollable physical symptoms we may offer sedation. Sedation may be continuous or intermittent. Ultimately, patients die from their underlying diseases, not from the methods routinely used to provide terminal comfort. Analgesics, sedatives and anesthetics all make the final days of life more tolerable.

When faced with difficult situations, health care professionals do not need to panic and reach for poison. They need to talk with their patients. They need to seek support from trusted colleagues. They need to allow consultations with pain control specialists and biomedical ethicists. Together, pain and suffering can be lessened. Together, misery can be resolved and patients can naturally die supported, appreciated and appropriately cared for without resorting to acts of terminal violence.

According to the Institute of Medicine in 1998, palliative care seeks to prevent, relieve, reduce or soothe the symptoms of disease or disorder without achieving a cure. Palliative care is not restricted to only those who are dying or those enrolled in hospice programs. Palliative care attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them. The World Health Organization sees palliative care as the active total care of patients whose disease is not responsive to curative treatment. This includes the control of pain, of other symptoms, and of psychological, social and spiritual problems. The goal of palliative care is achievement of the best quality of life for patients and their families.

To do the best job for the terminally ill we must develop centers of excellence for palliative care. These may be hospice programs, panels of traveling experts or downloadable resources from the Internet. While not every member of the American Academy of Pain Management is an end-of-life care expert, most are predisposed to team work and know how to obtain additional resources for their patients. Information about the American Academy of Pain Management, credentialed pain practitioners, accredited pain management programs, and the EPEC curriculum is available on the Website of the Academy (www.aapainmanage.org).

Care for the terminally ill affirms life and regards dying as one part of the normal life process. Doing the right thing for our patients requires that health care practitioners neither hasten nor postpone death. Practitioners are challenged to provide relief from pain, other symptoms, and to integrate psychological and spiritual care into everyday practice rather than passing out poisons. Using an interdisciplinary team to provide a support system for the entire family does much to diminish the drive for premature demise.