Correspondence

Call for Correspondence

JNCCN is committed to providing a forum to enhance collaboration between academic medicine and the community physician. We welcome comments about the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines), articles published in the journal, or any other topic relating to cancer prevention, detection, treatment, supportive care, or survivorship.

Please submit correspondence to JNCCN.edmgr.com or to JNCCN@nccn.org.

Letters should be no more than 400 words, with no more than 5 references if included. Please include the full names, degrees, and affiliations of all letter authors and a phone number or e-mail address for contact.

Letters are considered for publication as space allows. NCCN reserves the right not to publish correspondence for any reason it deems appropriate. All letters are subject to editing and/or abridgment.

Re: “Putting an End to It!”

To the Editor: End-of-life decision-making and care remain challenging areas for physicians and patients. Dr. Tempero's recent editorial, “Putting an End to It!” brings attention to an important contemporary controversy, the role of the physician in physician-assisted suicide.1

California recently joined Oregon, Washington, and Vermont as the fourth state to provide a process for early self-termination of life. The Montana Supreme Court has ruled that prescribing lethal doses of medications at patient request is not against public policy. This practice has multiple names, including “physician-assisted suicide,” “death with dignity” (the official name given to the legislative acts), and “aid in dying.” It is not “euthanasia,” which is the direct administration of lethal medication by physicians and is still not legally permissible in any state.

The processes of patients requesting lethal doses in the 4 states that allow it are similar. They include patient verbal and written requests and confirmation, physician evaluation of appropriateness, consultant evaluation and concurrence, and written prescription if all criteria are met. Patients choose when and if to take the medication and do so independently. Physician involvement can end with writing the prescription and completing required forms. No treatment or subsequent personal contact is required.

Data from Oregon and Washington are available and support Dr. Tempero’s belief that the impetus for early self-termination is autonomy and control.2,3 Both Oregon and Washington require the physician to identify, from a list of 7 concerns, the major reasons for the patient’s decision. Concerns over loss of autonomy, inability to engage in activities that make life enjoyable, and loss of dignity were the most common reasons given—and in the same order—in both states. Next were losing bodily function and being a burden, although in different order. Concern regarding pain was the sixth most frequent, followed only by financial burden of disease.

Although these concerns clearly impact quality of life, most do not reflect physical suffering. What should a physician’s response be to interpersonal, existential, or spiritual suffering? The American College of Physicians’ (ACP) position paper directs that in this setting, the physician should not only stay involved but also enlist the assistance of other professionals, family, and friends.4

Who is prescribing medications for self-termination? Although yearly statistics do not identify medical specialty, the Oregon 10-year summary identified oncologists as 20.2% of 109 physicians who wrote these prescriptions from 2001 through 2007, although approximately 80% of the patients requesting them had cancer.5 Family practice and internal medicine physicians represented more than 68%. The number of prescriptions written by oncologists was not cited, but 3 individual physicians wrote more than 22% of all prescriptions as of the end of 2007. The duration of patient-physician relationship at time of death has been short, with a median of 13 weeks—including a median of 47 days between first request and death. Although we do know that 87% of patients were enrolled in hospice with an additional 3.7% unknown, no information on how many prescribing physicians worked in hospice programs is available. The only qualification a physician has to meet is to be licensed in the state.

I share Dr. Tempero’s concern about the appropriate physician role in this process. The AMA Code of Medical Ethics calls physician assistance in this process “fundamentally incompatible with the physician’s role as healer.”6 The ACP has taken a similar position.4,7

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intentionally prescribe lethal doses of medication, but we should provide our patients with accurate information about their prognosis and options for therapy, including antineoplastic treatments and supportive care. In the states where physician-assisted suicide is legal, that discussion should include death with dignity, although no physician can or should be required to participate. We should also listen to patients, not just to the voices the media chooses to promote. In 2007, only 280 patients with cancer elected to use Oregon’s Death with Dignity Act, while another 66,255 did not.  

We also need to identify the appropriate physician role. Diagnosing illness and giving prognosis is essential to our profession. But should the death with dignity procedure be modified so that, beyond confirmation of disease, competency, and prognosis, the physician role is that of the compassionate caregiver only? Should there be the option for the state or a third party to provide the medication without physician prescription? Should there be required physician involvement and follow-up? It is my opinion that these aspects all need to be part of the process or at least part of the discussion.

Medical and societal issues will continue to arise. We should not ignore them because they do not affect our individual practice, but should discuss and debate them openly, offering modifications and solutions. Dr. Tempero has opened the door for the discussion and we should all participate.

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References