

March

On Physician Assisted Death...

Wow, doesn't this one catch a lot of wind! One of my neighbors asked me about "Physician Assisted Murder" and I was a bit taken aback. So, I gave her some of my thoughts and this had me really think about it and reflect on some of the reading I have done over the past year. Given this powerful topic I think that we as physicians need to discuss, argue and talk about this within our profession and also with our patients and with the general populace. As I said to my neighbor "We need to focus on listening and care as our primary activities". We need to be seen to be a "caring profession". What we do and what we say matters, it matters a lot as we are seen as opinion makers.

Now I bring to you the thought of "dilemma". I think that we what we are up against. Yes, up against. Dilemma comes from the Latin "di" meaning two and "lemma" which stands for "premise". So, you need to make a decision from two, often unpleasant choices. Often in medicine you have some pretty easy choices, like treating an infection, seeing an x-ray with a Colles fracture, things that for the most part have pretty easy diagnoses and treatments. Then there are those choices that have you with two, often equal, options. In anesthesia most people could have a general anesthetic or a regional procedure; probably best determined by the anesthesiologist who asks herself which has the combination of best success and least risk in her hands. Now, with suffering and some knowledge of what is and what is about to come, how do we make the "right choice"?

Then there is the challenge of true risk with some options removed. As an example, in my world, I do provide care for patients of the Jehovah's Witness faith. I was involved with a procedure and in my preop discussion had a full and frank discussion with respect to blood management. During this discussion, I disclosed that I work with a lot of Jehovah's Witness patients (I run an anemia clinic) and that there are many questions to answer. This, I tell them is to make sure I can both provide the care they want and also to not violate their beliefs. Most of the time I do not have to "not do" what I was "trained to do", administer blood and blood products when indicated. For this population, I do ask the patient what they would have me do if I thought they would die without administering blood. Most say "Let me die" and we have a tacit agreement. Thankfully that is a rare occurrence. Yet, we had a nasty, but well understood though uncommon, complication the other day. I knew where things were going to go. I announced to the room what I would and would not do, in accordance with this patient's wishes. Thankfully he died without pain, suffering and indignity.

Then there is the real dilemma. This is uncommon, very uncommon but since it happened to a real live patient it was real, unpleasant but real. Yet, that is part of being a physician, having to deal with things that you would rather not, but it is on your doorstep and your watch, so you get to deal with it. And you need to be thoughtful, professional and with clear direction when these things happen. So, I happened to be in the hospital doing one thing and just before I was about to commence a code was

called. Since it was a Saturday morning, I thought I could help out, or at least show up and leave if all was going well. Well, it was not going well. A middle aged (it keeps getting younger as I age!) gentleman had a witnessed cardiac arrest and the whole team was there attending to him (side bar....CPR when well done can have amazing results....even for over twenty minutes of CPR) with CPR going on. I, as usual at an arrest, said "Hi", asked if they wanted my help and as an invited specialist managed the airway. Then the dilemma happened. This gentleman's eyes opened, and he spoke very clearly "Stop, that hurts". Now, I am telling you this was real and he seemed clear headed. Just then his wife entered the room, her hand went over her mouth as she gasped, her eyes opened and the color drained from her face. Being the most senior person there (soon I will be more senior than anyone!) I took it upon myself to attend to her. I quickly told her what was happening and asked her what her husband would like. She said "He wants everything". So, everything is what we did. The dilemma in my mind was which choice to make? Both were rather unpleasant. To quit meant death and to continue did not mean an assurance of well being and recovery, it could put him on a road to a very ugly and protracted period of suffering and invasiveness.

The easy stuff is easy. For me a lot of anesthetics are very, very safe and effective. The harder stuff just takes more skill, knowledge and risk but we have developed tools and supports to make things turn out well....most of the time. (another sidebar.....a medical student noted to me that "That looks easy" and I noted "I get paid to make this look easy") The problem is when it goes pear shaped. Now you have a real problem on your hands.

People talk about rational thought; inferring that we have well thought out ideas. HA! What bollocks; read "Thinking Fast and Slow" and you will see how irrational we can be. Now, another story to illustrate. I was attending to, yes, another middle aged man who had tried to commit suicide by slashing his wrists. He was on the operating table and told me that he felt so foolish and was so embarrassed that he was taking up our valuable time. So, that called for a bit of a discussion before he went off to sleep. I said to him that first off we were here to help him and we had no, absolutely no thoughts that he was in any way shape or form a bother to us. He needed our care and we were more than happy to help him. Then I said something that connected with him. I said "But you thought it was the right thing to do". His look went from embarrassed to appreciative and then the story came out. Obviously I cannot disclose this patient/physician confidential discussion in all but I can give you the gist of things. A terrible event happened that shook him emotionally and he said "I knew what I had to do and it was the right thing to do, I knew it". He then proceeded to slash his wrists. Thankfully his grown children found him and he is alive and well today. He was thinking "in the moment", which we all do. Physician assisted death should not be a simple "in the moment" thought; and I do not think it will occur in this manner. The dilemma here is that with people suffering, true suffering, no option offers you health and a good life. And, how can we predict suffering will play out in any one individual. Lots to think about.

Now I invoke Toyota! Toyota thinks about the five "then what's" before enacting a major decision or shift in direction. They spend time and think about "and then what", and then

the next “and then what” and then again, and again and again. Well meaning people can make very poor decisions if they do not think where that road is going to lead them. Yet, emotion, or lack thereof, can cloud our minds as to what is the real eventual end to our decisions and actions.

I think this last sentence is where I am leading with this editorial. As I said to my neighbor, I have helped people die. I have not killed them, yet, I have ordered and administered drugs (very high risk anesthetics when you think the only solution for life is going to be high risk surgery...and it works every once in a while...that is the kicker!) in situations where the outcome has been death. Yet, I believe I was thinking about care, compassion and hope. Though hope was thin, almost futile (think of this...I do not give anesthetics to a corpse, that is futile) it was still about care, hope and compassion; the essence of humanity and our profession.

Do we want people to suffer endlessly, I do not think so. Yet, do we advocate for the care that is needed so suffering can be abated? I hope so. There are stories, maybe apocryphal, where people wanted to end their life as they were at the “end of their rope” with respect to providing care for someone else. Would we provide PAD for someone who was recognized as having major depression amenable to treatment? I think not. Yet, would we refuse to offer care to someone suffering? Would we not think about what it is to walk a mile (or kilometer) in their shoes?

I would suggest reading Atul Gawande’s “Being Mortal”. He speaks to the power of care. Often a hospice is thought of as a place to die. He shows how it is a place to live. Studies show that people who enter a good hospice have longer and better qualities of life when compared to those who do not. Now the kicker is the word “good”. We need to provide good care, compassionate care, thoughtful care and listening care. We need to put ourselves in our patient’s position and see how vulnerable they might be. We need to be the best physician we can; to seek to be better and provide better care.

Physician assisted death is more than handing someone a poison chalice. As physicians we do not do that; we can and do so much more. There in lies the challenge; and I know so many of you do that each and every day. Thanks to all of you!

And thanks for taking the time to read and give Laurie and myself the feedback that encourages me to keep on writing!