THE SOCIETY FOR THE RIGHT TO DIE WITH DIGNITY

(AFFILIATED TO THE WORLD FEDERATION OF RIGHT TO DIE SOCIETIES

NEWS LETTER

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Editorial

Oregon's death with dignity act was recently passed in USA after a prolonged debate and litigation. It confers the right to the terminally ill patients to seek a prescription to end life which is considered insufferable. This act however does not mandate every physician in the state to assist in the suicide of terminally ill. Autonomy and choice, which is a cornerstone of any civilized society is thus respected. It has honoured the rights and privileges of both.

Life is a many coloured spectrum so is dying. Suicide raises many ethical, social, emotional and legal issues. There are many who would dislike to know their time of death even in a mind game. There can be relatives of terminally ill patients for whom a physical presence of the patient might bring succor and meaning to their own lives. Death of a person with longstanding illness might bring a great deal of financial and emotional relief. Hence, it is no surprise that Jain philosophy has documented more than 64 types of deaths.

The current newsletter includes articles related to Oregon's death with dignity act and other related issues on advanced directives.

Execution of advanced directives is gaining ground in the west. Writing a living will regarding once own terminal events needs farsight and not courage.

There is a growing perception that doctors do not generally honour the 'Living Will". There is a need for an attitudinal change from doctors as well as relatives of terminally ill patients. Religion and research in terminally ill patients can help considerably in rational promotion of good living.

Dr. Nagraj G. Huilgol

"Loving Relatives are Poor Judges of Wishes of the Incapacitated"

Philadelphia (AP) — Close relatives of terminally ill people can accurately say what treatment their incapacitated loved ones would want only about two-thirds of the time, a study suggests.

Faced with questions such as whether to insert a feeding tube in a comatose patient, or to perform cardiopulmonary resuscitation if a patient's heart stops, the study found, about a third of the spouses, siblings and adult children do not make the choices the patients would want.

That holds true even when patients have a living will.

"Having the piece of paper doesn't make a difference," said Dr. Daniel P. Sulmasy, lead author of the study published today in the Annals of Internal Medicine, Journal of the Philadelphia-based American College of Physicians.

"Talking is the most important thing. Talking about what you want helps the loved one to understand what it is you would want in those circumstances."

In what Sulmasy called "the bioethics version of 'The Newlywed Game,"' researchers interviewed 250 terminally ill people being treated as outpatients at hospitals in Washington and Baltimore. They separately questioned the person likely to act as legal surrogate in the event a patient become unconscious or mentally incapacitated.

Patients were asked about specific treatments they would or would not want under three scenarios: permanent unconsciousness, a coma with less than a 1 percent chance of recovery and an incurable brain disease such as Alzheimer's that would leave them mentally impaired.

On average, the surrogates accurately described the patients' preferences 66 percent of the time.

Their accuracy was better in the permanent coma

scenario than in the hypothetical situations involving severe dementia and coma with a small chance of recovery.

Surrogates also did better at predicting patient choices for procedures such as the use of ventilators and CPR, said Sulmasy, director of Georgetown University's Center for Clinical Bioethics in Washington.

"You live with a person, you know them, but maybe you don't," he said.

Choices matched more often when both patient and surrogate had at least a high school education, when they has spoken about such issues, when the patient expected to die within 10 years, and the sick person had private insurance. In general, relatives who chose incorrectly were no more likely to err on the side of giving treatment than on the side of withholding it.

It soon became clear that each death was as individual as the life that preceded it and that the whole experience of that life was reflected in a patients dying.
-Cicely Saunder

The results could help doctors treating incapacitated patients.

"Our study helps clinicians know when to raise their index of suspicion that a patient's loved one may not be representing the patient's true preferences," the study said. "Under these circumstances, the clinician may wish to take additional steps, such as probing more deeply or involving other relatives."

An expert who was not part of the research team, Dr. Arthur Caplan, director of the University of Pennsylvania's Center for Bioethics, called the findings "very troubling."

"The real world is messy, complicated, and it's likely that the performance is going to be worse than the study found," he said.

Dinah Wisenber Brin
The Associated Press
15.04.98

Book Shelf

Death - writing of Sri Aurbindo and the Mother
Sri Aurbindo Society - Pondichery

Death - The Final Freedom
Satyavati M. Sirsat
L.Periera
Publishers Gujarat Sahitya Prakash
P.O.Box 70 Anand 388001
Book Post

Death - The Final Freedom
A review

This book reaches out to humanity humbly trying to tell us not to torture this self and the body should be free from all pain and fear. Care and love offered by one person to another is also of great importance. It can change pain, suffering and any crucial time in a human life to one of hope and happiness. The dying man needs untold love to be told. Not what wrongs he has counted in his life but that someone is there to hold his hand at the crucial time of his life. We as humans have to speed the message of hope, love and that death is not complicated, it is all available in this precious book.

Nilamani N. Huilgol

A Dutch Experience

Reasons for requesting PAS
Unbearable pain 46-77%
Indignity of terminal illness 40-57%
Possible future indignity 40-46%
Need to be independent 22-33%
Tired of Life 14-23%

Reference :
Van der Mass PJ. Van Delden et.al. Euthanasia & Other Medical Decisions Concerning the End of Life. Amsterdam, Elsevier, 1992
The reasons given by most of the patients in Indian scenario are similar to the one listed above in the table. Suffering is an universal emotion with similar core responses. People in distress always need help.

Quotes

We all labour against our own cure, for death is the cure of all diseases
Thomas Mann - Religion Me

Once you are dead, you are made for life
Fimi Hendrix

I will be
A bridegroom in my death,
Run in to't
As to a lovers bed.
William Shakespeare
'Antony & Cleopatra'

Guide Covers Territory PAS Law

by Sheryl Gay Stolberg

The reality of medical practice, however, is far more complex, raising questions the law does not contemplate. What if the drugs don't work and paramedics come to revive the patient? Do doctors who are opposed to physician-assisted suicide have an obligation to refer patients to other physicians? Do pharmacists have a right to know the reason for the lethal prescription, even if knowing comprises the law's mandate to project patient confidentiality?

Physician-assisted suicide is being approached with caution, as is the new guidebook, which can be purchased for $15 from the Center for Ethics in Health Care at the Oregon Health Sciences University.

"There are so many legal and political shadows cast across physician-assisted suicide," said Dr. Charles Hoffman, president of the Oregon Medical Association, which opposed the Death With Dignity Act. "I don't think people are rushing out to buy this guidebook any more than they are rushing to prescribe the medication."

Following are excerpts from a booklet on how doctors should deal with the Oregon Death With Dignity Act.

Whether or not a health care professional chooses to participate in physician-assisted suicide, he/she has an obligation to openly discuss the patient's concerns, feelings and desires about the dying process.....

Health care professionals need to explore their own perspectives on the meaning of suffering, for, from this introspection, they will develop their own perspective on care of the dying. Some physicians will argue that there is meaning in suffering and some will see suffering as meaningless. Their beliefs will be transferred to their care of patients.

Quotes

Dying is an art, like everything else I do it exceptionally well.
Sylvia Plath
Celebrated author of 'Bell..' who committed suicide

While I thought that I was learning how to live, I have been learning how to die.
Leonardo da Vinci

The attending physician has no responsibility under the act to initiate a discussion about physician-assisted suicide. ...We believe that the attending physician should not initiate the discussion, because if he/she does, the patient may feel pressure even though physician-assisted suicide is a legally available option.

Patients have a right to know any limitations of their health insurance plan with regard to physician-assisted suicide and any potential conflicts of interest that may impact decisions about care.

Some patients seeking a lethal prescription will not want to disclose this wish to relatives .... However, there are good reasons to involve the family.

It is unclear whether the Oregon death With Dignity Act allows an attending physician to prescribe an injectable drug for the patient to self-administer for the purpose of ending life. It is clear that a physician may not end a patient's life by lethal injection. ...

If a health care professional is aware of a physician or other health care provider who is noncompliant with the safeguards as outlined in the act, or otherwise delivers significantly substandard case, he/she must report that individual to the appropriate licensing board.

Quotes

It is the duty of a doctor to prolong life. It is not his duty to prolong the act of dying.
Lord Thomas Horder
Speech - House of Lords, 1936

Why fear death? It is the most beautiful adventure in life
Charles Frohman

The medical certification of death should be completed and signed by the attending physician if the attending physician is satisfied the case is a physician-assisted suicide.....

Physician-assisted suicide obviously involves acts intended to produce fatal consequences. When these acts fail to produce death but do produce injury to the patient, will this exclusion apply? Similarly, in cases where the prescription does produce death, but in a patient later determined not to have been qualified, how will the insurance carrier respond? Will the insurance carrier pay the costs of defending such claims? To ensure coverage for such liabilities, answers to these questions should be obtained and documented.....

Pharmacists Respond to the Law

Pharmacists, still defining their role under Oregon's landmark assisted-suicide law, passed another hurdle last month with a resolution from the American Pharmaceutical Association.

The resolution allows pharmacists to decide whether to participate in assisted suicide. It allows those who oppose suicide to refuse to fill lethal prescriptions, at the same time recognizing the right of patients to get a lethal prescription filled by a pharmacists willing to do so. The association last year decided to support pharmacists' right to make an informed decision on the issue, without adopting a moral stance, said Susan Winckler, director of policy and legislation for the American Pharmaceutical Association in Washington, D.C.

"We're not going to put the entire profession on one side or the other of that line when the line doesn't really exist," Winckler said. "It's supporting more than the autonomy of the pharmacist and not prescribing what it is they must do." The association's stance is in stark contrast to the American Medical Association's policy that "physician-assisted suicide is fundamentally inconsistent with the physician's professional role."

The AMA proposes better medical and psychiatric care for dying patients as well as attention to spiritual and emotional needs. "Requesting for physician-assisted suicide should be a signal to the physician that the patients' need are unmet," the policy says.

The Oregon Medical Association fought passage of the Oregon Death With Dignity Act, but has maintained a neutral stance on the larger issue of assisted suicide, despite the AMA's stand.

Paige Clark, an Oregaon pharmacist who was on the American Pharmaceutical Association committee that drafted this latest resolution, lobbied hard for national recognition of the situation of Oregon pharmacists. "The AMA has sort of left the Oregon Medical Association walking a plank and, I have to say, I'm very very pleased with the American Pharmaceutical Association," Clark said. "We need national language that says we appreciate the fact that this is legal in Oregon and patients need to be able access this service. But individual pharmacists' rights need to be protected as well."

The pharmacists' association, with 50,000 members, is the nation's oldest and largest professional organization of pharmacists. It is viewed among pharmacists as the establishment voice, just as doctors view the AMA.

However, it has gained a reputation for consistently supporting patients' rights to access legal therapies, said Joe Schnabel, a member of the Oregon Board of Pharmacy.

"Patients in Oregon have expressed very clearly their desire to have this option," Schnabel said.

The resolution supports Oregon's system for connecting patients pursing assisted suicide and their doctors with a pharmacist willing to participate. Pharmacists for Death With Dignity formed in January and now has 70 members statewide, about half of whom are licensed to dispense medication.

The group is an offshoot of the Oregon Death With Dignity, Legal Defense and Education Center in Portland. That Organization defended the assisted suicide law in court and is helping medical professionals involved in assisted suicide cases connect with each other.

This message is issued on the nonprofit ERGO! electronic mailing list. To contribute, address your information to <right to die@efn.org> It is a monitored list with over 550 international subscribers. To subscribe (no fees) email to <listproc@efn.org> putting nothing in the subject line and in the message text say only "subscribe right to die Your Name" To leave the list, email to <listproc@efn.org> saying "unsubscribe right to die"

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