THE ETHICAL WAY

Dr. Death and the Meaning of Life

Over the last 10 years or so, all has been relatively quiet on the so-called "physician-assisted suicide" front. This time period more or less coincides with the jailing of Dr. Jack Kevorkian, convicted of second-degree homicide for injecting lethal drugs to a man suffering from amyotrophic lateral sclerosis (ALS).

Dr. Kervorkian was released from jail June 1 on the condition that he not repeat his crime, and he promised not to. This milestone marks a good time to reassess the implications of what Dr. Kervorkian stood for and did.

BY H. STEVEN MOFFIC, M.D.

I probably paid more attention to his release than most because it happened soon after the death of my 94-year-old father-in-law, who also happened to be a physician. Now, my father-in-law probably was on the other end of the spectrum of those whom Dr. Kevorkian had "helped."

Over the last few months, my father-in-law clung fiercely to life, while raging like King Lear about his apparent fate. Still, his life seemed important to many in the family, and my wife did everything possible to keep him alive. Although I never asked him about it, physician-assisted suicide likely would have been the last thing he would have wanted.

I visited with him almost weekly, on Wednesdays after work, but my father-in-law and I also never talked much about death or the meaning of life—certainly not anywhere close to the exploration of life's meanings described in Mitch Albom's best-selling book, "Tuesdays With Morrie" (New York: Random House, 1997).

In that book, as those who read it may recall, the sportswriter's old college professor provides lessons on what was really important in his life, right up to his death. Morrie was able to examine these issues despite losing control over his body, coincidentally, also from ALS.

All of this made me wonder about the possible meanings and connections. Was it only a coincidence that "Tuesdays With Morrie" came out shortly before Dr. Kevorkian's conviction? How do we best prepare for death? What are the roles and ethics of physicians? Of psychiatrists ? Can we do better? How would I like to die? How would you? How would Dr. Kevorkian himself like to die? The last question is an especially poignant one, because Dr. Kervorkian is reportedly terminally ill with hepatitis C and suffers from other ailments.

The Life of Dr. Death

Dr. Kevorkian was trained as a pathologist, and he apparently got into trouble during his residency for advocating consensual experiments on convicts during their executions. His nickname, "Dr. Death," probably partly referred to the many autopsies he performed as a pathologist.

In 1987, at a time when advertising by physicians was more controversial than it is now, he began to advertise in Detroit newspapers as a physician who could be contacted for "death counseling."

Some time after that, until 1998, using his own home equipment, Dr. Kervorkian reportedly assisted in the deaths of at least 100 people. His activities led to the loss of his Michigan medical license in 1991.

There is no indication that Dr. Kervorkian tried to do any sort of standard medical evaluations before responding to people's requests. Therefore, in a technical, ethical, and legal sense, he was not truly a physician, and the people with whom he worked were not his patients.

His activities provoked much ethical debate, particularly in light of the Hippocratic Oath, which in the copy visible on my wall states, in part: "To please no one will I give a deadly drug, nor advice which may cause his death."

Nevertheless, it is well known that many other physicians at that time, before, and after have hastened the death of their patients. Freud himself, who suffered from mouth cancer, prevailed upon his doctor to hasten his death because of worsening pain and a feeling that he had no further reason to live.

Currently, the state of Oregon and various countries do legally allow physician-assisted suicide under certain criteria. Occasionally, the patient's illness can actually be a psychiatric one, and the psychiatrist can be the primary assistant in dying.

Psychiatry and Palliative Care

The psychiatrist's main role in such cases seems to be to diagnose and treat any clinical depression that might be causing the patient's desire to die.

In recent times, psychiatrists have begun to add a new layer of sophistication to care of the dying. Spurred by the work of Dr. William S. Breitbart with terminal cancer patients, emphasis is increasing on helping patients find meaning in their suffering and in their lives (Revue Francophone de Psycho-Oncologie 2005;237-40).

Not only do such searches for meaning relate to the biblical story of Job, but also to the life and story of psychiatrist Victor Frankl, who has written of the need to find meaning even in the Holocaust concentration camps, and after.

Dr. Breitbart looked at these issues in one study for which an eight-session "meaning-centered" psychotherapy group was developed. In it, the participants attempted to address the "loss of meaning" that accounted for about 50% of the requests for assistance in dying (Support Care Cancer 2002;10:272-80). The group successfully focused on four sources of meaning: creativity, rewarding experiences, a positive attitude, and one's perceived historical legacy.

Future History

I began to wonder whether some of the strategies geared to palliative care might have general applicability to the everyday lives of psychiatrists. Beyond our routine taking of history, factoring in the patient's perceived meaning of life and other aspects of spirituality would require us to broaden our inquiries to include the future.

Completing a "Future History" could be enhanced by asking a few questions, such as: What legacy would you like your life to leave? What gives your life the most meaning day by day? What thoughts have you had about death and/or dying? Asking these kinds of questions would allow us to apply to the living a process designed to help the dying. Who knows, maybe such a process would be useful in lowering the risk of suicide and, in turn, preventing it.

When something new comes up for this column, it usually comes up in my patients—sometimes unexpectedly and seemingly unprovoked by me. Take, for example, a patient I recently saw at an outpatient clinic. She's 67; I had been seeing her about once every 3 months for 1 year.

She was depressed and responded better to Doxepin than Lexapro or Celexa. At the last visit, it had taken me about 2 minutes to observe that the medication was working well. Then, to my surprise, possibly knowing that she still had 18 minutes left in the session, the patient asked me whether she should do more for herself. (Her husband has been in assisted living for years.)

When I asked her what would bring meaning to her life, she immediately mentioned doing more traveling. This led to a discussion of the legacy she felt she might leave. She responded by bringing up, for the first time, a family history of sexual abuse. I watched the patient brighten when she thought about what she could do more of, besides travel and despite her guilt. She realized that she could spend more time with her grandchildren and try to break this cycle.

I am now planning to discuss the issue of bringing meaning to life with longtime patients. I have begun giving new patients a homework assignment: Write a brief summary of "what has given your life meaning so far and what you hope will give your life meaning in the future."

Epitaph

Such discussions inevitably lead to thoughts of my own life and death. Family and psychiatry have readily provided the meaning. I have much gratitude for my profession, not only for allowing me to try to help patients for 35 years, but also for the insights the specialty has provided into myself and the world at large.

In the spirit of trying to prepare for death at anytime during life, I've tried to come up with an epitaph. So far, it's "Hey-Hey: He Tried to Stay on the Ethical Way. Always."

"Hey-Hey" is the name my grandchildren call me, and it speaks to the future. The "ethical way" speaks to this column, the influence of my ancestors, and how I've tried to work. "Always" refers to the song I would like to be sung at my funeral. The first line is, "I'll be loving you, always …" For my wife. ■

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Hospital Clinicians Often Override Warnings About Drug Allergies

WASHINGTON — Clinicians ignored more than half of drug allergy warnings generated by computerized physician order entry programs, based on a review of nearly 30,000 medication orders for 2,732 hospitalized patients.

To determine how often computerized allergy warnings for medications were overridden and why, Philip J. Schneider of the Ohio State University, Columbus, and his colleagues analyzed data from four 1-week intervals and one 16-week interval between August 2003 and February 2005. They presented their findings in a poster at a conference sponsored by the National Patient Safety Foundation.

Computerized physician order entry (CPOE) programs allow physicians and other qualified clinicians to enter medication orders directly into a database in order to reduce the ambiguity of handwritten prescriptions. Once a prescription has been entered into the database, the system generates alerts about patient allergies and potential drug-drug interactions.

Clinicians overrode warnings about potential drug allergies in 56% of the orders, and changed the medication in 44% of the orders. When the data were broken down by provider type, physicians were the least likely to override warnings, although more than half of them did so. A total of 54% of physician medication decisions overrode the warnings, compared with decisions by pharmacists (55%) and nurses (61%). The most commonly cited reason for overriding the warnings was that the patient had tolerated the drug in the past. Other reasons included "not a true allergy," "medical reason outweighed risk," and "physician/pharmacist approved."

CPOEs are not yet widely used, but they have the potential to improve patient safety. The results suggest a need for accurate and up-to-date information to make the CPOE allergy alerts more useful for clinicians

—Heidi Splete