seek TCM approaches to unblock the meridians and repair the imbalance. Some patients may regard Western pain interventions as a means for temporary pain suppression, but not an effective long-term strategy for treating the underlying cause. Further exploration of these preferences and the effects of various CAM approaches require investigation and should be assessed by health care providers treating this population.

This study had limitations. This was an exploratory analysis and several factors, such as active treatment status and global symptom distress, had large effect estimates for the odds of CAM use but lacked statistical significance. It is possible that a larger sample size would better detect such an association. Future studies should clarify the risks and benefits of various CAM approaches for pain, especially herbal medicine, and improve access to interventions for patients who may be undertreated. The acceptability of Western approaches for symptom control requires exploration in this and other immigrant populations. This information may guide the development of evidence-based, culturally relevant interventions for symptom control in Chinese-American communities and facilitate more open discussions between patients and providers.

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Attitudes Among Patients With Advanced Cancer Toward Euthanasia and Living Wills

To the Editor:

Euthanasia has been invariably discussed throughout Europe. In some countries, euthanasia has been legalized under specific conditions that must be fulfilled. These include a properly reported request to be considered carefully, unbearable suffering, no other reasonable alternatives, and a consultation with an independent physician.[1]

A living will, also called an advance directive, is a written document that allows a patient to give explicit instructions about medical treatments to be administered when the patient is terminally ill and unable to communicate. In Italy, euthanasia remains illegal, and living wills are not used. These issues have been the subject of

constant debate.[2] Such discussions, however, seem to take relatively little account of patients' knowledge, views, and attitudes. The aim of this study was to investigate the knowledge and attitudes of patients with advanced cancer toward euthanasia and living wills.

Methods

A consecutive sample of patients with advanced cancer admitted to an acute palliative care unit of a comprehensive cancer center was surveyed for a period of three months. Institutional approval was obtained for this study. A research physician checked patients' background information; subjects were approached, and the purpose and procedure of the study were fully explained. Written consent was sought from each patient to ensure that they were participating in the study on a voluntary basis. They also were assured of anonymity, confidentiality of personal data, and were given the right to withdraw from the interview at any time (the interview lasted approximately five minutes). Patients who agreed to participate completed a demographic data sheet supplying their age, gender, education level, and diagnosis, and the Edmonton Symptom Assessment System, and Memorial Delirium Assessment Scale (MDAS). Patients were eligible to participate if they had an MDAS score less than 13.

Eligible patients then completed a questionnaire to identify their knowledge about euthanasia and living wills. The definition provided by patients was considered correct, partially correct, or wrong, according to broadly accepted definitions. Euthanasia was considered as an intentional ending of a life by the administration of medication by a physician at the explicit request of a patient.[3] A living will, also called an advance directive, refers to a written document that allows a patient to give explicit instructions about medical treatments to be administered when the patient is terminally ill or permanently unconscious.[4] Once patients were informed about the correct definitions, they were asked about their attitudes toward euthanasia and living wills.

Results

One hundred twenty consecutive patients were surveyed over a three-month period. Epidemiological data are presented in Table 1. A total of 14.2% of patients survived less than one month, 23.3% survived one to three months, 46.7% survived three to six months, and 15.8% survived more than six months. Thirty-three percent of patients were receiving anticancer treatment, 37% were off therapy, and in 29% of patients, the decision was yet to be established. Educational level was no schooling (10.8%), primary (35%), secondary (39.2%), upper school (7.5%), and degree (7.5%). Regarding religious persuasion, 90.8% were Catholic (45% were practicing), 0.8% were Protestant, and 8.3% were atheists. Diagnosis was well known to 39.2% of patients, partially known in 53.3%, and unknown in 7.5%. Edmonton Symptom Assessment System and MDAS scores (mean and SD) are presented in Table 1. Of the 120 patients, 32 could not be interviewed because of cognitive deficits. Of the remaining 88 patients, 62 agreed with the interview.

Table 1
Mean Edmonton Symptom Assessment System Values and Memorial Delirium Assessment Scale Score

Edmonton Symptom Assessment System	
Symptom	Mean (SD)
Pain	4.56 (2.22)
Weakness	4.47 (1.96)
Drowsiness	4.46 (1.95)
Nausea	3.45 (1.64)
Appetite	4.21 (2.0)
Dyspnea	3.46 (1.78)
Depression	4.02 (1.7)
Anxiety	3.81 (1.76)
Well-being	5.64 (1.62)
MDAS	8.02 (7.32)

MDAS = Memorial Delirium Assessment Scale.

Thirty-six patients (58%) affirmed that they knew the meaning of the term "euthanasia," whereas 26 patients (42%) had no knowledge of it. Of the patients stating that they knew the meaning of the term, 14 (39%), 13 (36%), and nine (25%) patients used an appropriate definition, a partially appropriate definition, and a wrong definition, respectively. After being informed about the correct definition, 25 (40.3%) and 37 (59.7%) patients were in favor of or disagreed with euthanasia, respectively. Nineteen patients reported that euthanasia is justified to reduce suffering, four patients to avoid aggressive treatment, and two patients for unspecified reasons. Patients who were in favor of euthanasia had a higher Karnofsky score ($P < 0.05$). No other variables taken into consideration provided any relationship.

When asked about living wills, 21 (33.9%) responded that they knew the meaning and 41 patients (66.1%) did not. The definition was correct, partially correct, or wrong for seven (33.3%), nine (42.9%), six patients (23.8%). After being informed about the correct definition of living will, 44 (71%) and 18 patients (29%) were in favor or disagreed, respectively. The reasons (multiple choice) for possibly signing a living will are reported in Table 2.

Table 2
Reasons Patients Would Consider Signing a Living Will

Natural death	21
Avoiding aggressive treatment	13
Avoiding suffering	12
Other	1

Choices of reasons were multiple choice.