Original Article

Predictors of Pursuit of Physician-Assisted Death

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Abstract

Context. Physician-assisted death (PAD) was legalized in 1997 by Oregon's Death with Dignity Act. The States of Washington, Montana, Vermont, and New Mexico have since provided legal sanction for PAD. Through 2013, 1173 Oregonians have received a prescription under the Death with Dignity Act and 752 have died after taking the prescribed medication in Oregon.

Objectives. To determine the predictive value of personal and interpersonal variables in the pursuit of PAD.

Methods. Fifty-five Oregonians who either requested PAD or contacted a PAD advocacy organization were compared with 39 individuals with advanced disease who did not pursue PAD. We compared the two groups on responses to standardized measures of depression, hopelessness, spirituality, social support, and pain. We also compared the two groups on style of attachment to intimate others and caregivers as understood through attachment theory.

Results. We found that PAD requesters had higher levels of depression, hopelessness, and dismissive attachment (attachment to others characterized by independence and self-reliance), and lower levels of spirituality. There were moderate correlations among the variables of spirituality, hopelessness, depression, social support, and dismissive attachment. There was a strong correlation between depression and hopelessness. Low spirituality emerged as the strongest predictor of pursuit of PAD in the regression analysis.

Conclusion. Although some factors motivating pursuit of PAD, such as depression, may be ameliorated by medical interventions, other factors, such as style of attachment and sense of spirituality, are long-standing aspects of the individual that should be supported at the end of life. Practitioners must develop respectful awareness and understanding of the interpersonal and spiritual perspectives of their patients to provide such support. J Pain Symptom Manage 2015;49:555–561.
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Key Words

Physician-assisted death, euthanasia, end-of-life care, attachment, spirituality, depression, pain, hopelessness

Introduction

Physician-assisted death (PAD) is now legal in five states: Oregon, Washington, Montana, Vermont, and New Mexico. In addition, PAD is requested and provided in jurisdictions that do not legally sanction the practice.[1–3] To provide meaningful end-of-life interventions, health care providers must understand the factors that motivate individuals to pursue PAD as an end-of-life option.

Previous research supports that domains central to understanding pursuit of PAD include autonomy, spirituality/meaning, and hopelessness or negative expectations of the future.[4,5] Although early discussion and debate regarding PAD focused on the potential role of inadequate symptom control motivating interest in and pursuit of PAD, much research points to a less significant role of physical symptoms. Some of the most salient factors influencing pursuit of PAD may be related to lifelong values and interpersonal qualities, particularly around autonomy, dependence, and a desire to remain in control of the end-of-life process.[4,6–10] Attachment theory provides a framework for understanding how these

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qualities might influence response to end-of-life experiences.

Bartholomew[11] as well as Bartholomew and Horowitz[12] proposed a model of four attachment styles, depicting models of the self and other, organized along the dimensions of avoidance and anxiety. The four attachment styles are labeled secure, preoccupied/anxious, fearful, and dismissing/avoidant and reflect patterns of behavior in intimate and caregiving/care-receiving relationships. According to this theory, attachment behaviors become activated when security is threatened, and individual responses to distressing situations, such as illness, may be understood within the framework of attachment style. Dismissing/avoidant individuals have developed strategies to defend against attachment needs, and close relationships are seen as less important compared with other attachment styles. They place high value on independence and self-reliance and dread being dependent on others.[13]

Hopelessness also has been identified as a potential factor contributing to pursuit of PAD. Hopelessness is typically described as a psychiatric concern, involving negative cognitive schema and negative future expectations,[14] although it also has been described as an existential[15] or spiritual[16–18] concern. In psychiatric populations, hopelessness has been found to be a stronger predictor of suicidal ideation and behavior than depression.[19,20] Findings in the literature generally support the hypothesis that higher levels of hopelessness are correlated with desire for hastened death,[15,18,21,22] and interest in PAD,[23,24] but are mixed regarding pursuit of PAD.[16,25]

The concept of spirituality contains elements related to the desire for meaning and purpose in life, and particularly in the face of terminal illness, a higher purpose beyond current suffering.[26,27] The construct, although distinct, has elements that overlap with religiousness. Spiritual beliefs and practices have been associated with positive coping and identified as important elements of overall quality of life in cancer patients.[28,29]

Research examining the role of these factors has largely been conducted with proxy informants (including physicians, nurses, and family members); thus, it is important to validate understanding by inquiry with patients themselves. This study provides an opportunity to deepen understanding of patients' motives for pursuit of PAD by use of validated instruments measuring attachment, social support, depression, hopelessness, and spirituality; inquiry with patients actually pursuing legal PAD; and by the presence of a comparison group of terminally ill patients by which to better understand the PAD data.

Methods

Terminally ill patients who seriously pursued and/or requested lethal medication under Oregon's Death with Dignity Act (DWDA) were recruited as cases, and patients with advanced disease and no interest in pursuing PAD were recruited for the comparison group. Participants were recruited from a variety of sources, including Compassion and Choices of Oregon, an end-of-life advocacy organization; several large hospices in the Portland area; ethics consultants; and palliative medicine and oncology physicians at large medical centers in the Portland area. Potential participants were excluded if they had cognitive impairment (score of 23 or less on the Folstein McHugh Mini-Mental State Examination or 7 or less on the Short Portable Mental Status Questionnaire).[30–32] Criteria for caseness (serious pursuit and/or requested PAD) included that the patient contacted Compassion and Choices of Oregon for information about accessing PAD or that the patient made an explicit request for PAD to his or her physician. Data on the proportion of terminally ill cases with major depression and severe hopelessness[25] and the cases' ranking of reasons they requested PAD[4] have been previously published. We have neither, however, previously published data on the cases' attachment style and spirituality nor compared the cases to controls. Three PAD requesting participants from the previously published article were excluded from analysis because they had not completed all the measures that are the focus of this article. All participants gave written informed consent to participate, and the institutional review boards of the Portland Veterans Affairs Medical Center and the participating agencies and medical centers approved the study.

Measures

Pain was measured with the severity subscale of the Modified Wisconsin Brief Pain Inventory short form.[33,34] The severity subscale is a four-item instrument to measure frequency and severity of pain on a 0–10 Likert scale. The scores were summed, and the mean was calculated for a composite pain severity score.

Severity of depression was assessed with the depression subscale of the Hospital Anxiety and Depression Scale,[35] a seven-item subscale in which participants rate statements on a 0–3 scale. Scores were summed, with higher scores indicating more severe depression. The Beck Hopelessness Scale (BHS)[14] comprises 20 true-false items designed to measure pessimism and negativity about the future. Responses were summed, with higher scores indicating greater hopelessness. We deleted one item, "I cannot imagine what my life would be like in 10 years," which has been identified as potentially problematic in a study of psychometric properties of the BHS with terminally ill individuals.[36]

The Relationship Scales Questionnaire provides a continuous score for each of four prototype attachment styles.[37] On a five-point scale, participants rate