

Dr. David Jeffrey, Chair of the Ethics Committee of the Association for Palliative Care in the United Kingdom and recipient of the 2006 Winston Churchill Fellowship, spent six weeks (fall of 2006) in the Pacific Northwest interviewing researchers, ethicists and healthcare providers. The purpose of his study was to assess the relationship between hospice, palliative care and physician-assisted suicide in Seattle and Portland areas. Dr. Jeffrey was opposed to the legalization of physician-assisted suicide (PAS), however, he traveled on the Fellowship in the hope of having his own views challenged and to study end of life care in the USA. We present a brief summary here, but encourage you to read his entire report:

Dr. Jeffrey's report includes several disturbing case histories and stories about physician-assisted suicide (PAS) in Oregon:

- A young man who moved to Oregon specifically to die from PAS
- A wife who was so disturbed about her husband's PAS death that she attempted to commit suicide herself
- A doctor who has been involved in 23 PAS cases
- A patient who had a PEG tube (a tube placed through the abdominal wall into the stomach) inserted solely for PAS
- A nurse attended a patient, whom she had never met, who was to commit suicide
- A patient who was devastated when informed of his diagnosis of ALS yet at the same time informed by the doctor that the patient should consider PAS.

Dr. Jeffrey's conclusions:

1. Patients in the USA are referred to hospice too late in the course of their disease.
2. Palliative care teams are only involved at the extreme end of the terminal phase of illness and USA hospitals do not value such care, and there is often resistance from attending physicians to involve the palliative care team.
3. The group in Oregon who died from PAS are not suffering terribly, they are not in pain and nor are they depressed, rather they appear to have need for control throughout their lives, have a fundamental lack of trust in the medical health care system, and have no interest in receiving palliative or hospice care.
4. Suicidal thoughts and requests for PAS do not persist for the great majority of patients, and their most prominent concerns were not about pain but about loss of control and dignity.
5. Doctors are not comfortable when addressing existential suffering and patients asking about PAS are looking for more than a prescription; they are seeking a guide through the dying process.
6. There is a lack of understanding of the social consequences of legalizing PAS
7. There is a "gaze aversion" reaction by many Americans to the inevitability of death and dying. There is imbalance in favor of active treatments even in the most futile situations, lack of continuity of care in the USA system and that most hospice programs sit uneasily with PAS.
8. "The primacy for autonomy is carried to an extreme in this region of the USA with less regard to issues of justice in health care".
9. He reports that [Oregonians'] "values and beliefs are different from those of the majority of the UK (United Kingdom)."
10. He concluded by recommending that the UK retain its current legislation prohibiting PAS, and that the "experience in the UK has shown that improvements in palliative care can occur independently of legalization of PAS."