Study underscores need to consider multiple factors in debate on physician-assisted suicide

Physician-assisted suicide (PAS) is an evolving national issue for both patients and healthcare professionals. The ultimate decision to use this procedure comprises consideration of sociological, psychological, ethical, religious, medical, and pharmacological factors. To explore medical opinion in detail, Kersh and colleagues conducted a state survey and now report their results in "Opinions and reactions of physicians in New Jersey regarding the Oregon Death with Dignity Act," beginning on **page 349.** It is of interest that 59% of the 191 responding physicians agreed that a state law allowing PAS should be approved, but substantially fewer of them—only 47%—believed this to be a proper method for physicians to use in relieving pain and suffering. The latter response is, in my opinion, the more important one because it relates to the direct connection between patient and physician—and less than half of the respondents thought that PAS is an appropriate process to use when treating terminally ill patients.

Other issues of concern include a lack in capability to determine if a patient has less than 6 months to live (42% were not confident that they could do so) and to recognize depression in patients who asked for a lethal prescription (84% of physicians indicated that they could not). Enmeshed in such medical decisions are additional substantive problems such as patients who request PAS to avoid having their families incur a debt for management of the terminal illness (96% of responders agreed that this could occur) and family members who may promote PAS to avoid a caregiving role or prevent financial shrinkage of the estate, or both (almost three fourths of physicians answering the survey recognize this possibility).

Therefore, what Kersh and colleagues have documented is that a majority of New Jersey physicians who answered their survey believe PAS to be inappropriate treatment for terminally ill patients and recognize the strong possibility of having this process requested for nonmedical purposes by both patients and their relatives. These valuable data show that many factors involved in PAS are unsettled, opposed, or not strongly supported by physicians and should be incorporated into the national debate on such a powerful, irreversible medical decision.

Frederick J. Goldstein, PhD, FACP
Professor of Clinical Pharmacology
Director, Clinical Master of Science Program
Philadelphia College of Osteopathic Medicine
Philadelphia, Pennsylvania

Editor's note

The May 1999 issue and the May 2000 issue of *The D.O.* magazine carry related articles on physician-assisted suicide:

- ☐ "**First Do No Harm** Physician-assisted suicide: Compassionate or criminal?" by Jennifer Berger (May 1999)
- ☐ "**Leading the Way?** Oregon breaks new ground with physician-assisted suicide law," by Jennifer Berger (May 1999)
- ☐ "**Criminal Treatment** Kansas legal system condemns innocent DO as double murderer," by Jennifer Berger (May 1999)
- ☐ "Compassion, pain control curb requests for assisted suicide," by Lydia Hodges (May 2000)
- ☐ "Taking the sting out of chronic pain," by Lydia Hodges (May 2000)

The full text of these articles is also accessible on the American Osteopathic Association's Web site: *http://www.aoa.net.org./Publications/DO/domagazine.htm*

(continued)

Consortium publishes guidelines to lessen "headache" of treating migraine

Headache is one of the most common complaints for which patients seek medical attention from their physician. Unfortunately, comparatively little educational time has been devoted to headache and its treatment. Certainly, over the years, the lack of standardization of diagnosis and reliable modes of treatment have contributed to this problem for patients and physicians alike.

In the late 1980s, the International Headache Society produced a classification of criteria for headache. Although complex, this classification has eliminated many of the issues of appropriate diagnosis of headaches, serving as a much-needed first step in improving the recognition of various headache types. The ongoing study of this area and revisions to the classification will allow for more rapid and accurate clinical diagnosis of headache in practice.

The treatment of migraine and other headaches for the average physician, however, was based in many situations on the opinion of various writers and lecturers, with little exposition of the science behind their opinion. In 1998, Duke University's Center for Clinical Health Policy Research completed its work in conjunction with the American Academy of Neurology on a federally funded project by the then Agency for Health Care Policy and Research (now the US Agency for Healthcare Research and Quality) to examine the evidence for various treatments of migraine headache. The US Headache Consortium, a multidisciplinary group, developed this summation of evidence into a series of guidelines on the diagnosis and treatment of migraines. In addition to the American Osteopathic Association, the consortium comprises the American Academy of Neurology, the American Academy of Family Physicians, the American Headache Society, the American College of Emergency Physicians, the American College of Physicians, and the National Headache Foundation.

Working from the evidence gleaned from the published literature on the treatment of migraine headache, physician-members of the consortium developed treatment guidelines relying on the quality of evidence coupled with expert opinion when it was needed to assure clarity and direction for treatment. These guidelines are published in their entirety by mutual agreement of the members of the consortium at the American Academy of Neurology Web site: *http://www.aan.com*. An abbreviated version will be found in a forthcoming issue of *Neurology*.

These guidelines serve as the first exhaustive attempt to provide physicians with evidence from clinical research of the treatment of migraine headache in a standardized and easily accessible source. Not every possible treatment is present; some that are effective clinically, such as osteopathic manipulative treatment (OMT), are not addressed. This omission is not because of a question of efficacy, but because of the lack of well-designed, controlled trials to study the utility of OMT. The consortium recognized the importance of OMT and recommends that it be an area for further study. Plans are currently being developed to study this commonly used, effective but understudied important treatment modality. The holistic principles that have served as a cornerstone of our profession, however, are found replete through the guidelines.

As with diagnosis of migraine, these guidelines are but the first step to improving the ability of physicians to render optimal care for migraine and for patients to benefit from past decades of research. Ongoing revision of the guidelines as new modes of therapy are studied and old ones reinvestigated will enhance their long-term success.

Educational programs to publicize these advances are being developed. The consortium will be releasing brief tools for patients and physicians to acquaint both with the concepts from the guidelines on disease recognition and treatment. These tools became available the week of June 4, National Headache Awareness Week. Coupled with more advanced tools such as those being developed through the newly established Headache Council within the AOA, these guidelines will be made more accessible and more readily applied to patient care. ◆

Frederick G. Freitag, DO
Associate Director
Diamond Headache Clinic
Chicago, Illinois