Quality of Death and Dying in Patients who Request Physician-Assisted Death.
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**Background**  Physician-assisted death (PAD) was legalized in 1997 by Oregon's Death with Dignity Act (ODDA). Through 2009, 460 Oregonians have died by lethal prescription under the ODDA.

**Objectives**  To determine whether there was a difference in the quality of the dying experience, from the perspective of family members, between 52 Oregonians who received lethal prescriptions, 34 who requested but did not receive lethal prescriptions, and 63 who did not pursue PAD.

**Design**  Cross-sectional survey. Measurements: Family members retrospectively rated the dying experience of their loved one with the 33 item Quality of Death and Dying Questionnaire (QODD).

**Results**  There were differences reported in 9 of the 33 quality item indicators. Few significant differences were noted in items that measured domains of connectedness, transcendence, and overall quality of death. Those receiving PAD prescriptions had higher quality ratings on items measuring symptom control (e.g., control over surroundings and control of bowels/bladder) and higher ratings on items related to preparedness for death (saying goodbye to loved ones, and possession of a means to end life if desired) than those who did not pursue PAD or, in some cases, those who requested but did not receive a lethal prescription.

**Conclusions**  The quality of death experienced by those who received lethal prescriptions is no worse than those not pursuing PAD and, in some areas, it is rated by family members as better.

**Comment (JOW):**
This recent finding is encouraging and is in keeping with what advocates of physician-assisted dying would expect to be the case, namely, access to physician-assisted dying or voluntary euthanasia benefits people. This article addresses the quality of life for families of individuals utilising physician-assisted dying; we hope it would be the same for the individuals.

Should palliative care be a necessity or a luxury during an overwhelming health catastrophe?
Rosoff PM.

**Abstract**  In the event of a widespread health catastrophe in which either or both human and material resources were in critically short supply, rationing must take place, especially if the scarcity will last for some time. There are several tested allocation methods that are routinely used during emergencies. These include triage procedures employed by emergency
departments and the military on the battlefield. The goal is to save the lives of as many as possible.

When it is not possible to save all, or even most, who come for care, what should be done, if anything, with those whose fate is death? The central tenet and goal of medicine is the relief of suffering. If we take this seriously as an axiom of practice, then healthcare providers and the institutions in which they work are duty-bound to provide comfort and relief to all, especially the dying. There are several ways this can be done. One is to prepare by training sufficient individuals to provide what might be called emergency palliative care. These people do not all have to be doctors but could (and should) include people from a range of backgrounds including nursing, allied health, pastoral care, and social work. For them to be able to do their jobs effectively, some basic supplies should be stockpiled so the pain and suffering associated with untreated illness and injury can be relieved.

However, what happens when there is a shortage of, say, opiates, so that relief of air hunger and pain cannot be eased? Then critical decisions must be made. Alternative sources of symptom relief not considered under ordinary circumstances might be used. However, it is possible to imagine a situation when all resources are in critically short supply. Those remaining resources, logically and morally, should be allocated to persons who can survive. In this scenario, what can be offered to the suffering dying? This might depend on the attitude of personnel caring for patients. In desperate circumstances, it is possible the proscription against active euthanasia could be justifiably overridden by concern for ongoing, relentless, and unmitigated suffering. Any justification that could be made for such action would be undermined by arbitrary or capricious administration. Thus, preparation for a catastrophic healthcare emergency should take into account all conceivable outcomes.

Comment (JOW):
This is one of several abstracts I have read to do with health catastrophes and the ethics of managing those who are going to die through the absence of sufficient resources. It broadens the discussion of the involvement of medical teams in diminishing the distress of dying.