Euthanasia and physician-assisted death

A D (Sandy) Macleod

Abstract

Medical practitioners do not have the knowledge and expertise to participate competently and reliably in selecting those fit to be offered euthanasia and assisted suicide. Issues relating to the clinically assessment of such requests by the terminally ill, diagnostic errors, prognosis, competency, and mental health status are, as yet, not adequately scientifically resolved.

Maryan Street’s proposed End of Life Choice Bill has reignited discussion about euthanasia and physician assisted suicide (PAS). There are philosophical, religious, financial, moral and legal components to this debate. There are also medical ones.

Having practised medicine at the bedside of the dying for over three decades and having recently reviewed the medical aspects of assisted death legislations and practices in those jurisdictions with liberalised law, it is apparent that, as yet, the discipline of medicine is not in a position to be supportive of a law change.¹

Euthanasia is the deliberate ending of another person’s life at his or her request. A doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at the person’s voluntary and competent request, is PAS. Withholding and withdrawing futile treatments and palliative (deep) sedation are not considered euthanasia.² These allow natural death.

Street’s proposed Bill would allow mentally competent adults suffering a terminal disease with a prognosis of less than 12 months, or those with an irreversible physical or mental medical condition rendering his or her life unbearable, to request from a volunteering medical practitioner life-ending medications to be delivered orally, per gastric tube or by injection.

Another doctor would be required to certify capacity for this self-determining end of life decision, which would need to be confirmed within 7 days. The consultation of family and the seeking of professional counselling would be encouraged.

The attending medical practitioner may delegate his or her functions to another person and the cause of death must be recorded as the underlying disease and not as medicinal killing.

Assisted death discussions in the developed world have been stimulated by the technical ability to artificially sustain life in those mortally traumatised or severely ill, the effectiveness of oncological treatments to extend quantity of life in cancer sufferers, and the prevailing philosophy of self-autonomy in a youth and health valuing society. Modern medicine’s skills have allowed the accumulation of multiorgan pathologies, particularly affectations affecting the brain and mind, to complicate the dying process.³
Dying of malignant disease, now generally a chronic condition, is potentially a more protracted and difficult event in the modern world. The fear of dying badly (*dysthanasia*), rather than the fear of death itself is a recent concern.

The estimated shortening of life for those *euthanased* in the Netherlands is less than 4 weeks. Unattended the process of dying may be unendurable, but few in this country have the misfortune of not being able to access palliative care services and receive symptomatic relief.

The intent of palliative care is to kill distressing symptoms, not the patient. Good end of life care allows persons to live longer well and die well. But modern palliative care is not perfect, and is not always equal to the complex challenges it faces.

Diagnostic errors will always occur in clinical medicine, which is an ‘art of probabilities’ rather than a science. Post mortem studies reveal an incorrect or missed diagnosis in 5% of hospital deaths. Estimating prognosis in the severely ill remains an imprecise impression. It does become more accurate as death approaches but even in the last days of life, let alone the remaining weeks, some still defy the sincere prognostications of health professions.

Most die earlier than predicted, but a few surprise us. Determining the lethality of a cancer is difficult but considerably easier than it is for a neurodegenerative disorder or a psychiatric illness. Diagnostic and prognostic uncertainties trouble doctors as they do their patients.

It is well established that ‘desire for a hastened death’ ideations fluctuate wildly, by the hour and by the day, in the terminally ill. They constitute a medical emergency and in practice are usually alleviated by attention to pain, distress or whatever discomfort befalls the dying.

Thirteen percent of Dutch requesters have a change of mind about assisted death once the formal process is initiated and a third of Oregonians provided a lethal prescription opt to die naturally. This change of mind may represent the insurance of knowing if desperate and trapped one has a way out or perhaps the acquisition of an acceptance of living until death occurs.

Samuel Johnson quipped thus “Depend upon it, Sir, when a man knows he is about to be hanged in a fortnight, it concentrates the mind wonderfully”. But whatever the reasons, a figure of 10–15%, whilst small, would be considered an unacceptably high operating mortality rate in surgical practice.

Sick people feel a burden and are a burden. Suffering influenza or breaking a leg also renders us burdensome. Whilst modern society resents the dependency of the frail or vulnerable, few if any of us, complete life exclusively as a free and independent being. Most requests for assisted death concern non-physical issues rather than symptoms such as pain.

Loss of control, dignity, and independence and concerns about an uncertain future tend to encourage such requests. However there are rewards for caring for others and being cared for is not necessarily entirely a recipient state. Terminal illness can stimulate psychological growth and heal families—it is never too late.
A doctor’s attitude can profoundly influence their patient’s subsequent decision-making. There exists a knowledge and power inequity between patient and doctor. Sick persons are forced to trust their medical attendants.

Tired, ‘burnt out’ clinicians may more easily agree with the seemingly hopeless terminally ill person. Alternatively the naïve and overly optimistic doctor may more readily direct their patient towards yet another futile treatment option. The bedside is dangerous territory with respect to communication—bodily gestures, transference, and linguistic oddities easily corrupt this dialogue.

Trust between patient and doctor, a vital ingredient of medical practice, would be sorely tested by Street’s Bill. That the doctor would be obliged to lie as to cause of death on the death certificate would profoundly undermine the ethics of medical practice.

The essential clinical criteria allowing a request for hastened death to proceed—and only about 20–30% of those requesting this do so in the Netherlands and 50% in Oregon—is whether the patient is enduring “continuous unbearable suffering”. There is no recorded definition of ‘unbearable suffering’.

Ultimately its definition depends on the subjective impressions of two medical practitioners. Their views will be influenced by their nationality, religion, medical experience, medical specialty, empathy or sympathy towards the patient, the availability of their time to assess the request, and a multitude of other contaminants. That the wish of the applicant is respected depends entirely upon the medical profession.

It is an illusion that persons have the ability to request and be granted a hastened death in any legalised assisted death legislation. It could be argued that in these jurisdictions it is not patients exerting autonomy, but doctors exercising power.

The assessment of mental competency or capacity is a difficult clinical process. The more complex the decision, the ‘bigger’ the capacity required. Depression, dementia, fatigue, and delirium all may adversely impact upon decision-making. The cognitive abilities reasonably required to make a rational decision about suicide have never been established. Opining as to whether or not undue influence of others influences is largely impressionistic on the part of the examiner.

The so-called “disability paradox”—that views and ideas alter (and often mellow) during the course of an illness—makes the accepting of advance directives contentious. The proximity of the death bed taints opinion for both patient and doctor. Watching an aftershock on television is not the same experience as being in an earthquake.

Diagnosing depressive disorder, particularly in the medically frail, can be challenging. Depression encourages ‘desire for hastened death’ thoughts, but effective treatment of this disorder may abolish such ideations.

Depression is a painful and nasty disease yet generally can be eased by psychological and pharmacological interventions. Demoralised mental states can potentially be managed by psychotherapeutic interventions. Very few of those who request early death in Oregon and the Netherlands are psychologically or psychiatrically examined.
despite a prevalence of major depression of 15–20%, and the inevitability of delirious states as organs fail towards the end of life.

Suicide is legal in our community. The rate of suicide in cancer patients is approximately twice that of the general population. The most likely cause of suicide, including in those terminally ill, is a depressive episode. The risk periods for suicide are those soon after diagnosis and in the advanced phase of the illness.

Legalising PAS would ‘normalise’ suicide. Supporting assisted suicide in one particular section of society but not in another (such as youth) is likely to convey a rather conflicting public health message. A few dying persons are so debilitated that they are unable to enact suicide, even if provided the means.

Every clinician knows of an exceptional case in which euthanasia might be a humane option. But it has been clearly shown that though a majority of those with for example high level spinal injuries acutely consider death as a preferred option, most soon change their mind.12 Palliative psychotherapies can be helpful in these dire clinical circumstances, at least in anecdotal experience.

The complexities associated with requests for assisted death from those who are “weary with life” or suffer dreadful psychiatric, brain injury and neurodegenerative disorders, an emerging trend in the Netherlands, are immense.3 Some may ‘give up’ before treatments have had an adequate opportunity to be helpful, some insist on living on (and enjoying opportunities) despite what dispassionate outsiders (and relatives) may view as an appalling quality of life.

Though the numbers requesting assisted death in those jurisdiction where PAS or euthanasia are legal are not clearly rising, reporting vagaries make this somewhat uncertain, particularly in Belgium. The ‘slippery slope’ concerns have not necessarily eventuated. In these jurisdictions the funding and provision of resources for palliative care have been actually stimulated by the law changes.

Good palliative care services certainly reduce, but do not extinguish, requests for assisted death. The available option of legalised euthanasia encourages ‘death talks’ and planning for death.13 This is a clear benefit for developed countries facing an aging and ‘death denying’ population bulge.

Deep sedation at the end of life for intractable symptoms such as the confusion of irreversible delirium, unrelieved (neuropathic) pain, or dyspnoea enhances the longevity of remaining life, rather than abbreviating it.14 These persons die of disease but not dehydration and starvation. This vigil can be difficult for surviving relatives yet may also provide an opportunity for family cohesion and the resolution of rifts.

The administration of a fatal cocktail of medication is a task doctors would find a particularly difficult undertaking. Indeed nursing staff are increasingly being delegated this role, the doctors in the Netherlands increasingly attempting to avoid such clinical predicaments.

Therapeutically titrating dangerous pharmaceuticals to lessen suffering, but not to kill, particularly in the very sick, is a delicate skill. Probably delivering a fatal overdose is not. It certainly does not require the skills of a medical practitioner. There is no technical necessity for doctors to be involved in the act of killing the terminally ill.
The quality of remaining life deserves and requires as much research investment as is directed at prolonging the quantity of life. If so, maybe some of the above quandaries would have already been resolved. Orchestrating the timing of death and sanitising the process of dying is fraught with medical concerns.

Presently medical practitioners do not possess the professional competency to participate in Street’s Member’s Bill. We do not have the knowledge to competently and confidently select those fit to be medically killed.

Until the above concerns are resolved by scientific endeavour the medical community are unlikely to agree to legal euthanasia and physician assisted suicide.

**Author information:** A D (Sandy) Macleod, Adjunct Associate Professor, Palliative Medicine Specialist and Psychiatrist, Health Sciences Centre, University of Canterbury, Private Bag 4800, Christchurch.

**Correspondence:** Associate Professor A D (Sandy) Macleod, Health Sciences Centre, University of Canterbury, Private Bag 4800, Christchurch. Fax: +64 (0)3 3836868; email: ad.macleod@cdhb.health.nz

**References:**