Euthanasia and physician-assisted dying: editorial comment and reply to the Waikato GP survey findings by Dr Havill

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The Roman Emperor, Augustus, prayed for euthanasia, a good, easy and painless death. He did achieve this in his old age. His fear was an early death by violent assassination. In contrast, General Franco’s death in 1975 stands for the most horrible medical death, a death that only doctors could devise.¹

Heroic interventions and life support systems can delay death. The Greek myth of Tithonus tells of the pain of prolonged life in loathsome old age. Begging for death to overcome him, his pleas were ignored. Modern euthanasia advocates rile against the violent death made possible by modern medicine’s ability to sustain life.

A fear of dying badly (dysthanasia), rather than the fear of death itself, whilst not new, is more prevalent and probably more likely an eventuality in modern Western societies.² Multiorgan failure, including brain failure, and the elongation of dying, can be the cost of a few weeks or months granted by chemotherapy.

Science has driven medical progress but the art of sensible caring is at risk of being lost. How and when we die has always been a concern of mankind. It is encouraging that our profession is beginning to more openly discuss the issues of euthanasia, actively killing patients, and physician-assisted suicide (PAS).

The letter of Dr Havill (in this issue of the Journal) does relatively little to further our knowledge.³ The response rate was poor and it is likely that it was only those GPs with firm views, supportive or otherwise, who bothered to reply. But nonetheless, that about 40 Waikato GPs would be willing to hasten the deaths of their patients, even if they are mentally incompetent, is noteworthy.

Certainly there has been a thawing of the trenchant opposition by Medical Governing bodies over recent decades, implying an invitation to consider the issues in a reasoned and reasonable fashion. However there are many ethical, philosophical, legal, fiscal, religious and political influences to ponder, let alone the medical ones.⁴

One of the surprises emerging from the Netherlands, Belgium and Oregon, legislations in which medicinal killings are allowed, is that it is not unrelieved physical symptoms or the inadequacy of palliative care services that stimulate euthanasia requests, but fears of loss of control and being a burden on others. It is for psychosocial and existential reasons that most request hastened death.⁵

The stability of request is a critical factor. Thirteen percent of Dutch requesters changed their minds and up to a third of Oregonians provided a lethal prescription opted to die naturally.⁶,⁷ Medically estimating prognosis is notoriously imprecise. A definition of “unbearable suffering” has yet to be determined. The accurate assessment of competency and mood in those seriously ill is by no means well established. These medical tasks are difficult and as yet, uncertain. I doubt our bedside skills are as yet sufficient to competently assess medical fitness for physician-assisted dying.

In those with neurodegenerative disorders, such as the dementias, it is even more challenging. Neurology and psychiatry are the specialties likely to be most affected by liberalised euthanasia legislation and the early reports of euthanasia requests by Belgium psychiatric patients are likely to catapult discussion into further controversy (unpublished correspondence). A difficulty of caring for dementia, which is a terminal disease, is often the mismatch between the patient’s perception of quality of life and that of the relatives (and maybe the attending staff).
Paradoxically with fading cognitions the determination to live is usually enhanced. This, a variant of the disability paradox, is a challenge to the validity of Advance Directives and it also complicates the palliative care of this increasingly common disorder. Thus the answer to a question posed by Havill may depend on when and to whom it is addressed.

The surveys of the general public indicate that the closer one may be to death, the less certain is the ideology to foreclose life. The enthusiastic support for euthanasia fades in oncology outpatient clinics and is virtually dead in hospices. Surveys of medical specialists parallel this trend.6

GP’s may well differ from specialists and indeed it is GPs who field the majority of requests. The incidence of medicinally hastened death is poorly researched. Not uncommonly an alteration of opioid dose is attributed for a community death that was imminent anyway, so medicinal killing is assumed, but probably did not occur. Prompt relief of “unbearable” suffering is the persuasive argument in favour of euthanasia (though the medicolegal processes may take considerable time).

Relatives may be the beneficiaries of the hastened death of their love one. The grief of surviving relatives may be eased by a prescribed death.5 Appropriate analgesia and palliative sedation has been shown to prolong remaining life in those terminally ill rather than abbreviating it, thus potentially adding psychological burden to relatives (and perhaps staff). However there are medical problems to overcome in legalised euthanasia jurisdictions.

Allowing requests to be sanctioned is fraught with as yet uncertain method and practitioner idiosyncrasies. US states, in which capital punishment is practised, struggle to medicinally execute humanely, with speed and precision. And Dutch doctors are increasing hesitant to practise euthanasia and are deferring to nurses to administer the fatal drug.8

A solution to ‘unbearable’ suffering toward the end of life is, as proposed by Havill, physician-assisted dying (PAD). By removing “suicide” from the term, presumably to counter the concerns of suicide prevention educators, moves the proposed practice toward euthanasia, the deliberate ending of another person’s life at his or her request. Alternatives to PAD include regaining the art of good clinical judgement and decision-making, diagnosing dying and allowing natural death, and skilful palliative sedation if intractable symptoms (most frequently delirium) can’t be managed in other ways. Yet every clinician knows of cases in which mercy killing might appeal.

But the broader risks of prescribing death remain uncertain. The Dutch, Belgians and Oregonians are accumulating experience and opinion and they are deserving of admiration for these efforts. But the slippery slope has happened before in history, and legal protections are not always full-proof (and invariably very expensive).

A ‘peaceful’ death is desirable and Augustus was lucky in this regard. King George V was euthanised by his doctor in 1936. Maybe the King was lucky for he was enduring an undoubtedly terminal delirium caused by respiratory failure. Dr Dawson acted, he stated, to preserve the King’s dignity, to prevent further strain on his family, and to ensure that the announcement could be made in the following morning’s newspaper. I am not sure Dawson’s rationale was proper.

We certainly need to manage the dying better. We need good research, wise expert opinion and fair legislation. We lack these. Dying is not invariably easy, and clumsy medicine can aggravate it. But is it best to give up and terminate life by the violence of non-physiological pharmacology?

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References


