abstract

Euthanasia and assisted suicide are attracting increasing public interest. The experiences in the Netherlands and Oregon are explored as well as the topics of terminal sedation and voluntary dehydration. The reasons for requests for euthanasia are broadening beyond medical issues. Reasons for and against are presented. Recommendations are made to improve care of the dying and the frail elderly to decrease the perceived need for euthanasia. If changes are made to legalize euthanasia and/or assisted suicide in Canada, there will be a need to protect conscientious objectors.

Key words: *euthanasia, physician-assisted suicide, terminal sedation, end-of-life care, conscientious objectors*

Euthanasia and Physician-Assisted Suicide: Are They Next?

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On June 15th 2005, Francine Lalonde MP introduced Bill C-407: an Act to amend the Criminal Code (right to die with dignity).[1] If this bill had passed it would have legalized euthanasia and physician-assisted suicide in Canada. In response to a recent case in Quebec, a Globe and Mail editorial was written in support of assisted suicide.[2] Films such as The Barbarian Invasions, Million Dollar Baby, and The Sea Inside have also attracted public attention. It is thus timely to revisit the issue since any legal change will significantly affect clinical practice. A special committee of the Senate last reviewed the matter in 1995 and decided, at that time, that the current laws prohibiting both these practices should remain unchanged.[3]

Definitions

The Special Senate Committee defined euthanasia as a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where the act is the cause of death. Euthanasia may be voluntary, involuntary, or nonvoluntary depending on (a) the competence of the recipient (b) whether or not this is consistent with his or her wishes (if these are known), and (c) whether or not the recipient is aware that euthanasia is to be performed.[4] (In involuntary euthanasia, the patient's views have not been sought or are opposed to euthanasia, in nonvoluntary euthanasia in the patient is not competent to give consent.) Assisted suicide was defined as the act of intentionally killing oneself with the assistance of another who deliberately provides the knowledge, means, or both. In physician-assisted suicide the physician provides the means.[3]

Proponents of euthanasia use another classification, that of passive euthanasia, by which they mean the withdrawal of life-supporting technologies and life-prolonging treatments. On the other hand, opponents of euthanasia regard the withdrawal of burdensome treatments, which are prolonging the dying process, as good palliative care consistent with ethical medical practice.

The Legal Situation

In Canada, the Criminal Code prohibits euthanasia under its homicide provisions, and counselling a person to commit suicide and aiding a suicide are punishable offences. Euthanasia is punishable by life imprisonment and assisted suicide by up to a maximum of 14 years in prison.

Physicians who have been involved in legal proceedings regarding such issues have been dealt with leniently.[5] In the Netherlands, according to a law enacted in April 2002, both euthanasia and physician-assisted suicide will not lead to prosecution if certain requirements of due care are fulfilled by the physician. The physician must hold the conviction that the request by the patient is voluntary, well considered, and lasting; that the patient has been informed of his/her condition and prognosis; that there is no alternative treatment; that the physician has consulted another physician; and that the physician has terminated the patient's life with due medical care. The patient can make a request for euthanasia in writing in advance of becoming incompetent.[6]

Belgium has also followed this same lead, passing a law in May 2002. Assisted suicide is permitted in Switzerland though euthanasia is illegal. Physician-assisted suicide has been legal in Oregon since the Death with Dignity Act was passed in 1997, and it was also legal in the Northern Territory of Australia for a short period of time. A recent attempt to change the law in Hawaii failed but the issue is still under debate in Vermont.

Results

A nation-wide survey of euthanasia was commissioned in 2001 by the Dutch Ministers of Health and Justice. A report was published in the fall of 2003; this was carried out by the same investigators responsible for the surveys on euthanasia in 1990 and 1995. The total number of patients who died by lethal overdose of painkillers was estimated at 28,216. Compared with euthanasia, physician-assisted suicide remains a very infrequent practice. Involuntary euthanasia, described in the report as termination of life without the patient's explicit request, remains at around a 1,000 cases a year. In 100 cases of newborn babies in 2001, physicians administered drugs with the explicitly stated intention of hastening death. Euthanasia at the child's request with consent of the parents was carried out in five cases, and in 17 cases at the request of the parents only. In three cases, euthanasia took place without a request from either child or parents.[7]

A recent report of the Royal Dutch Medical Association recommends that patients should be able to ask for help to die even if they do not have a terminal illness but are "suffering through living." It is claimed that some such cases could be judged unbearable and hopeless and thus fall within the boundaries of the euthanasia law. The report recommends drawing up protocols by which to judge "suffering through living."[8] This challenges a Supreme Court decision that a patient must have a classifiable physical or mental decision. This 2002 ruling upheld a guilty verdict on a physician who helped an 86-year-old patient die even though he did not have a terminal disease.[9]

The Groningen Academic Hospital has proposed guidelines for ending the lives of severely deformed newborn infants. The hospital revealed that it had carried out four such interventions in 2003, which had been reported to the government prosecutors. No legal proceedings were instituted.[10]

The 7th Annual Report on Oregon's Death with Dignity Act looked at the 37 Oregonians who, in 2004, ingested medications under the provisions of the Act. Sixty prescriptions were written in 2004, the first decrease in the annual total of prescriptions since Physician-Assisted Suicide became legal in Oregon. The number had been gradually increasing over the years from 24 in 1998 to 68 in 2003. Thirty-seven patients ingested lethal medications. This was five fewer than in 2003 but the number of patients ingesting lethal medication has increased over the years from 16 in 1998, to 27 in 1999 and again in 2000, down to 21 in 2001, up to 38 in 2002, and to 42 in 2003. The three most common concerns leading to requests for lethal medications were loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and loss of dignity. During 2004, 25 patients (68%) used pentobarbital, and 12 patients (32%) used secobarbital. One-half of the patients became unconscious within five minutes and died within 25 minutes.[11]

In Switzerland, it has been estimated that 125 people, mostly foreigners, have come to Zurich to die with the assistance of Dignitas, a Swiss Right to Die and assisted suicide organization.[12] The practice of this group has attracted a great deal of media attention and concern.[13] A requirement for a period of six months' residency has been recommended.

Terminal Sedation

Exemplary management of symptom control is the hallmark of end-of-life care. Terminal sedation, in which physicians sedate patients until coma develops and withhold artificial nutrition and hydration, is sometimes advocated to address intolerable symptoms refractory to conventional methods.[14] In a survey of experts on sedation for intractable distress in the dying, the definition for terminal sedation emphasized that the goal of therapy was the relief of suffering in an imminently dying patient, without the intention of deliberately accelerating death.[15] Experts responded from eight countries. Eighty-nine percent of these agreed that terminal sedation is sometimes necessary. Ninety percent did not support legalization of euthanasia. Another study has concluded that 10% of deaths in the Netherlands are preceded by terminal sedation.[16] A survey of internists in Connecticut found that 78% of respondents believed that it was ethically appropriate to provide terminal sedation if a terminally ill patient had intractable pain despite aggressive analgesia. Of those who favoured terminal sedation, 38% also agreed that physician-assisted suicide is ethically appropriate in some cases.[17]

One of the major objections to terminal sedation is that its intent may be to kill the patient in order to alleviate symptoms. It has been recommended that there is a need in the United States to control the use of terminal sedation by developing and implementing practice guidelines.[14] In Canada, the Calgary Regional Health Authority has devel-

Optimizing Care for Patients Requesting Termination of Life

In individual patients, a six-step protocol has been proposed to optimize care.

The steps:

- Clarify the reasons for the request to terminate life
- Assess the underlying causes
- Affirm the commitment to care for the patient
- Address the root causes of the request
- Educate the patient and discuss the legal alternatives
- Consult with colleagues

Source: The EPEC Project.[22]

oped such clinical practice guidelines for palliative sedation.[18]

Voluntary Dehydration

Voluntary refusal of food and fluids has been proposed as an alternative to physician-assisted suicide for terminally ill patients who wish to hasten death.[19] To study this concept further, a questionnaire was sent to all nurses employed by hospice programs in Oregon. Nearly twice as many nurses had cared for patients who chose voluntary refusal of food and fluids than had cared for patients who chose physician-assisted suicide. The nurses' descriptions of deaths resulting from voluntary dehydration show that it is usually a peaceful way to die. This accords with the standard teaching in palliative care. Eighty-five percent of patients who voluntarily refused food and fluids died within fifteen days.

Requests for Euthanasia and Physician-Assisted Suicide

Studies of patients in Oregon suggest that loss of autonomy, control, independence, and the ability to pursue pleasurable activities often underlie requests for hastened death.[20] In patients with HIV-1 or AIDS, two main factors were found: disintegration and loss of community. Disintegration was perceived as loss of function, dependency on others, and loss of dignity. Loss of community entailed the progressive diminishment of desire and opportunities to initiate and maintain close personal relationships.[21] In the Netherlands, it has been suggested the data on the reasons for euthanasia present a new image of death and dying with an expansion of suffering as a justification for euthanasia from the somatic suffering of the paradigmatic cancer patient to mental and even spiritual suffering.[6] The Dutch Health Minister herself, during parliamentary debates on euthanasia, suggested that it would be wise for people in the early stages of dementia to draft an advanced directive requesting euthanasia. She also advocated the distribution of suicide pills amongst older adults.

Reasons For and Against

Proponents for euthanasia stress the importance of patient autonomy and control and a need to counterbalance medical power in the overuse of modern technology. They claim that some patients die in uncontrolled pain and in unbearable suffering and they wish to assist their patients in having a good death. They do not perceive a difference between withdrawing life-sustaining treatments, which they term "passive euthanasia," and actively ending life with "active euthanasia." Proponents of euthanasia claim that euthanasia and physician-assisted suicide is taking place clandestinely, and that a change in legislation would bring it into the open and thus promote discussion and regulation.

Opponents argue that society has a responsibility to protect human life and that health care professionals have a duty to care for patients that is not consistent with ending their lives. The introduction of euthanasia and physician-assisted suicide would lead to a major change in the physician-patient relationship. Vulnerable groups such as the frail elderly, the physically disabled, and demented patients would be at risk of coercion or, as has been the case in the Netherlands, of involuntary euthanasia. Guidelines are open to interpretation, and the experiences from the Netherlands show that they can be applied very elastically with ever-broadening parameters.

Recommendations

The focus should be on addressing the underlying causes of the requests for the termination of life. In individual patients, a six-step protocol has been proposed to optimize care (Table 1). The steps are to clarify the reasons for the request, to assess the underlying causes, to affirm the commitment to care for the patient, to address the root causes of the request, to educate the patient and discuss the legal alternatives, and to consult with colleagues.[22] Enhancing the availability of good palliative care to all Canadians should be a goal, as outlined by the Senate Committee. However, the changing nature of the requests for euthanasia in other jurisdictions, focussing on control and dependency, mean that the health system in general needs to concentrate on addressing issues related to the autonomy and functional independence of the frail and the physically and mentally handicapped. This will require an expansion of specialized geriatric services, with a concomitant increase in community resources. The frail elderly need to be assured that they are valued by society and the prevalent ageism must be counteracted. Euthanasia should not be introduced as a means of resolving some of the problems of an under-resourced and overstretched health system.

If further debate leads to changes in the law to permit euthanasia or assisted suicide, there would need to be protection for those health professionals who would strongly oppose such legislation on ethical and religious grounds. Any such change would be extremely controversial and would certainly have a profound effect on the practice of geriatrics and end-of-life care. The issue of medical professionalism and conscientious objection was recently raised and requires further study, particularly with regard to end-of-life issues.[23]

In summary, the debate about euthanasia will continue to be contentious. Experience from the Netherlands and Oregon show that the reasons for requests are broadening beyond the scope of medical practice and, in the Netherlands, pressure is mounting to extend the parameters further. Terminal sedation and voluntary dehydration are being used as a means of hastening death. General availability of good palliative care and general improvements in care and respect for the frail elderly and those suffering from degenerative and disabling diseases are necessary to meet their requirements and decrease the perceived need for euthanasia. If changes are made to legalize euthanasia and/or assisted suicide, there will be a need to protect conscientious objectors.

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