Euthanasia

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Assisted dying and euthanasia

There are three objectives in this workshop:

a) To present a brief overview of current end-of-life/euthanasia practices.

c) To examine the main issues associated with assisted dying/euthanasia.

d) To review research about what health related professionals think about these issues.

This presentation is intended to encourage hospice based nurses and doctors to reflect on their own position on the difficult but ever present topic of assisted dying and euthanasia.

Practices – what's happening now…

As of June 2016, human euthanasia is legal in the Netherlands, Belgium, Colombia, and Luxembourg.

Assisted suicide is legal in Switzerland, Germany, Japan, Canada, and in the US states of Washington, Oregon, Colorado, Vermont, Montana, Washington DC, and California.

In Belgium in particular…

- Despite last-minute pleas for a rethink…the Belgian parliament agreed that with children should have the same right as an adult to ask to die with dignity and lawmakers passed a bill in 2014 allowing euthanasia in very rare cases of terminally ill children.

http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/

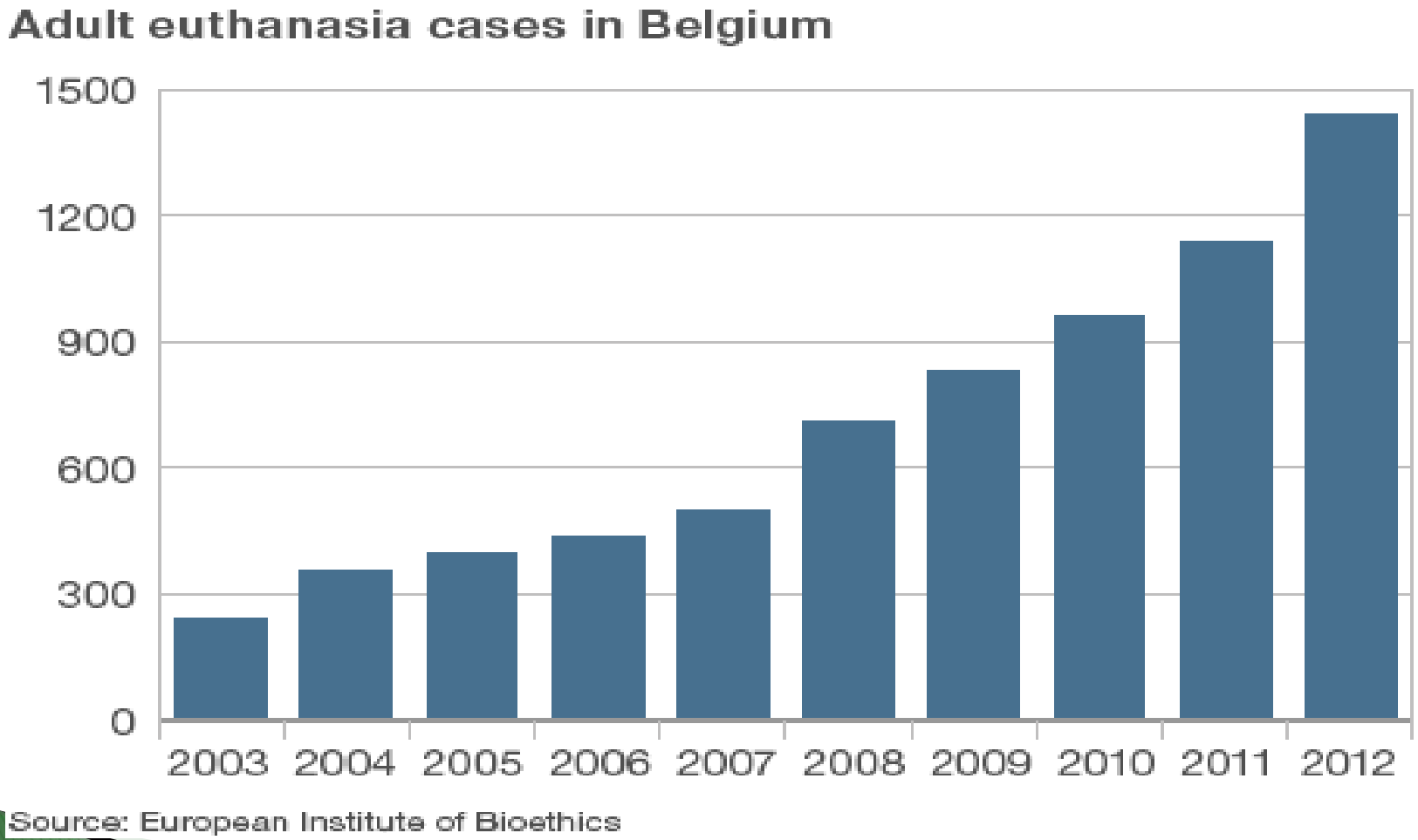
- In the Netherlands, the patient's suffering must be unbearable, with no prospect of improvement. The suffering need not be related to a terminal illness and is not limited to physical suffering such as pain. It can include, for example, the prospect of loss of personal dignity or increasing personal deterioration, or the fear of suffocation.

- The Belgian law is similar. The patient's suffering must be constant and unbearable, resulting from a serious and incurable disorder. There is no requirement that the patient be diagnosed with a terminal illness, although additional checks are imposed if the patient is not terminally ill.

- In Canada, patients will qualify for assistance if they have a grievous and irremediable medical condition that causes enduring and intolerable suffering.

- The five US states permit assisted dying only, so the patient must be terminally ill. There is no additional requirement relating to the patient's experience of the disease or any minimum level of suffering.

What statistics tell us



Source: European Institute of Bioethics

Main issues:
1. Language issues

- Euthanasia
- Suicide
- Assisted suicide
- Physician assisted suicide

- Assisted dying
- Physician aided dying
- Physician-assisted death or physician-assisted dying
- physician aid in dying, or medical aid-in-dying

- "aid-in dying“
- "dying with dignity“
- "right to die"
- “compassionate dying."

Defining the end of life stage

For the purposes of this guidance, patients are 'approaching the end of life' when they are likely to die within the next 12 months.

This includes patients whose death is imminent (expected within a few hours or days) and those with:

(a) advanced, progressive, incurable conditions

(b) general frailty and co-existing conditions that mean they are expected to die within 12 months

(c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition

(d) life-threatening acute conditions caused by sudden catastrophic events

(General Medical Council, 2010, p. 8).

Defining euthanasia

Euthanasia is an act where a third party, usually implied to be a physician, terminates the life of a person—either passively or actively.

In part, it has become a highly topical issue because the use of modern medical technologies can keep patients alive who are:

a) living in a situation that they consider to be worse than death,

b) are in a protracted coma

or

c) are in a persistent vegetative state (PVS).

(Center for Bioethics University of Minnesota, 2005).

Defining 'assisted death'

A form of euthanasia in which an individual expressing a wish to die prematurely is helped to accomplish that goal by another person either by counseling and/or by providing a poison or other lethal instrument.

The assisted death may be regarded as a homicide or suicide by local authorities, and the person giving assistance may be held responsible for the death.

See also **assisted suicide**.

(Mosby's Medical Dictionary, 8th ed. 2009, Elsevier)

2. Physician Assisted Suicide/dying (PAS/D)

- With physician assisted suicide, a doctor provides a patient with a prescription for drugs that a patient could use to end his or her life.
- The main distinction between physician assisted suicide and active euthanasia is that the doctor is not the person physically administering the drugs.
- Physician assisted suicide is only contemplated by—and would only be considered as an option for—patients who are conscious and capable of making their own decisions.

Justification of PAS

- The primary ethical arguments offered to justify physician assisted suicide are that it:
- Allows autonomy and self-empowerment of the patient.
- Shows compassion and mercy.
- Provides freedom from suffering.

Legal alternatives to active euthanasia/PAS

- **Refusal of interventions**

Patients have the legal right to consent to, decline, or withdraw any intervention (e.g., surgery, chemotherapy, pacemakers, ventilators, medications including antibiotics, IV fluids) or settings of care.

- **Refusal of food or oral fluid**

Patients with advanced disease often lose appetite and/or thirst. This is based on the principle of bodily integrity, i.e. force-feeding is not acceptable.

- **Palliative sedation**

For those with unbearable and unmanageable pain or other intractable symptoms who is approaching the last hours or days of his or her life, the induction and maintenance of a state of sedation may be a legally acceptable. This approach has an ethical basis that derives from the importance of intended effect over possible secondary and unintended consequences (argument of 'double effect').

(N.B. See also Timmon, K. (2013). *Nurses Perceptions of Palliative Sedation*. Unpublished research report. Massey University).

3. Legal manoeuvres: Death with Dignity/End of life choice

The concept of “death with dignity” or allowing a person to retain dignity as they die is a popular argument among those who support active euthanasia.

The idea stems from the notion that prolonged death in a medical setting is unnatural and undignified.

Therefore, encouraging death with dignity supports people who wish to cease non-beneficial or unwanted treatment for themselves or a loved one.

Main contents of the draft Bill

The draft Bill claims safeguards for those involved;

- i.e. people who wanted to opt for euthanasia would need to be mentally competent and signed off by two doctors (who would testify that it was actually a clear choice, and that the individual concerned understood the consequences).
- The requesting individual would also need to suffer from a terminal illness which was likely to cause death within 12 months, or from an irreversible physical or mental condition that, in the person's view, rendered his or her life unbearable.

In the draft Bill

The person

- Makes a verbal request to doctor
- Not required to discuss with friends and family
- Reflects for minimum 7 days
- Completes a written, signed or marked request
- May nominate a person other than the medical practitioner to carry out or assist in the act
- Must state absence of coercion

- May choose the procedure
- May choose who is to be present at the procedure
- May choose where the procedure will take place
- May delay or cancel the procedure
- Medical practitioner not required to be present
- If the person unable to self-administer, a medical practitioner must administer.

The certifying medical practitioner

- Receives a request
- Encourages the person to discuss with others
- Observes wait of minimum 7 days
- Completes a certificate
- Arranges for a second doctor to also complete a certificate
- Carries out procedure or provides means for the person
- Is protected from civil or criminal liability
- Registers the death

Note: Refusing a request must result in referring to another doctor who will agree.

<u>…and the nurse?</u>

- The certifying doctor may delegate to another nominated by the person
- The assistance or task can be delegated only with the agreement of the dying person who has made the request
- The delegated person may be a health professional or a lay person who may refuse the request.

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Current legal and moral arguments

- Euthanasia always requires the act of another party.
- When more than one person is involved in a sequence of actions that results in death, then that death is termed a suicide when the last person who acts in the sequence is the one who dies.
- If the last "actor" is someone other than the one who dies, the death is termed a homicide (one human being killing another), even if the person who dies agreed to it.
- The term "euthanasia" implies a "good" death, and therefore any such act should meet commonly agreed criteria for "goodness."
- In the case of euthanasia, the motive is usually noted as one of mercy, and the core value supporting that motive must be altruistic.
- Such criteria may be that it is swift, relatively painless, and causes minimal if any psychological suffering, such as fear, anguish or deep regret.

4. Ethical issues cont…

SANCTITY OF LIFE	QUALITY OF LIFE
Theological concept	Philosophical concept
Associated with duty	Associated with values
Generally understood	Difficult to define
May be objective	Largely subjective
Singular or common meaning	Multiple meanings
Dependent on traditional expectations	Dependent on self-concept: body, interpersonal, self-identification
Principle based	Concept based
Descriptive (morally neutral)	Evaluative (value laden)
Generally clear, unambiguous	Generally unclear, very ambiguous
Easier to follow as a rule	Difficult to follow as a rule

The euthanasia debate and public opinion

- In recent years the softening of legal opinion towards interpretations of acts of euthanasia has been matched – if opinion polls are to be believed – by a softening of public opinion.
- Previous surveys have shown a gradual but ever growing trend towards this preference.
- It remains to note that some of the last bastions of possible resistance to the legislation of euthanasia seem to be members of various national bodies (which include physicians and nurses), and various religious organisations, but interestingly not all.

The main arguments

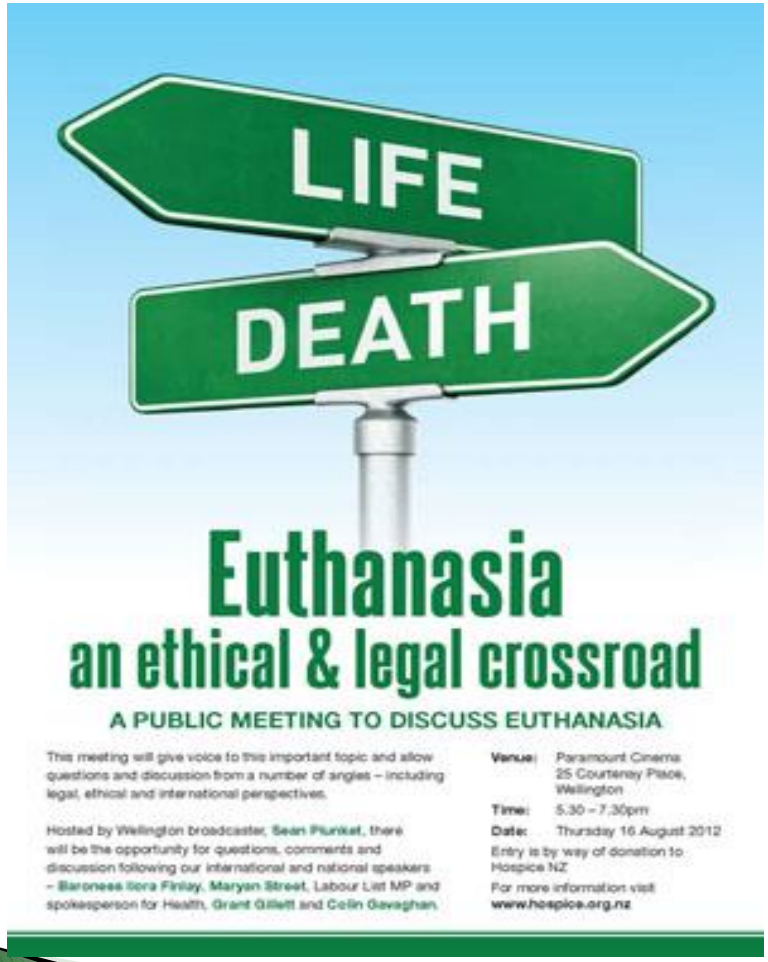
- One of the main arguments for euthanasia remains focused around “a change to the law to allow terminally ill patients, or those whose quality of life has diminished to an unacceptable extent, the right to a peaceful death with dignity at a time of their own choosing” (Voluntary Euthanasia Society, n.d.[http://www.ves.org.nz/]).

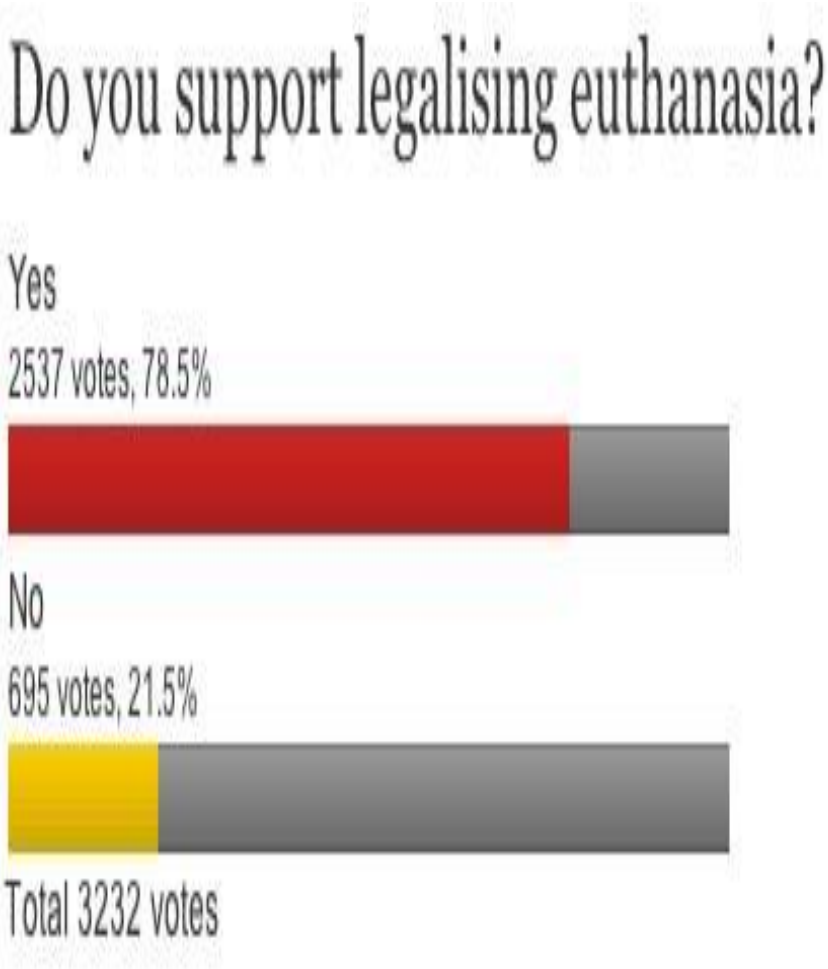
- And one of the main argument against is: “Even if it is done for what seems a good reason, (e.g. to prevent suffering), and even if it is done with the patient’s consent, it is still killing” (New Zealand Catholic Bishops,19/10/2011).

The two camps…

- As a result, the small nation of just over four million individuals that is New Zealand still seems divided into two main camps, i.e.
  - those who argue that the main motivations and consequences for acts of euthanasia are both well-reasoned and more than adequately supported by ethical considerations; and
  - others who are less convinced, arguing that there remains a distinct lack of consideration of the moral principles and pscho-social circumstances pertaining to deaths that are "assisted by others".

What research tells us – public opinion





(Stuff poll 23 Aug, 2012)

However…
The findings of the Select Committee

- The Health Select Committee received a record 21,533 submissions on the issue, indicating intense public interest.
- **77% of submissions to Parliament's Health Select Committee are opposed to changing the law on assisted suicide and euthanasia, an analysis found.**
- "When New Zealanders are given the opportunity to engage with the issue, as opposed to merely responding to a single poll question, most support the current legislation. This is certainly our experience when interacting with people all over the country.
- "The public are understandably concerned that the legalisation of assisted suicide and voluntary euthanasia poses risks to vulnerable people, which is why advocates propose safeguards. However, these safeguards are unenforceable in practice.
- "Polls often elicit a knee-jerk reaction, especially when the questions are emotive or leading, such as referring to a painful condition. In reality nowadays, terminally ill Kiwis do not need to die in pain. A poll question about euthanasia for pain is inappropriate.

(http://www.scoop.co.nz/stories/PO1705/S00077/submissions-against-euthanasia-shatter-assumptions.htm)

…and elsewhere?

- In the Netherlands, a cross sectional survey (n=3996) with 83 interviews showed that there is ample support among nurses, physicians and the public for the euthanasia and physician-assisted suicide law after eight years of legislation.
- The public show greater support for euthanasia for advanced dementia than health professionals.

(Kouwenhoven et al., 2012).

And in Belgium

- A small Belgian study examined the perspectives of eighteen nurses who had been involved in the legal euthanasia process.
- This study identified two predominant perspectives:
- a procedural, action-focused perspective- giving rise to good organisation of care,

  and
- an existential-interpretative perspective – giving rise to a thorough understanding of the patient's request and relying on effective communication.

  (Denier, de Casterle, De Bal, Gastmans, 2009).

And in New Zealand?

Oliver, P., Wilson, M. & Malpas, P. (2017).

- While only 37% of doctors supported legalising AD in New Zealand, 67% of nurses were supportive. Of those respondents who were willing in principle to provide AD services, large majorities identified a range of practical and ethical professional supports as essential to safe practitioner engagement. Those respondents overwhelmingly saw the provision of most of those supports as the responsibility of the medical and nursing professional bodies.
- N.B. The authors of this study have admitted, "the item in our study included the terms 'painful', 'incurable disease' and 'request', which may have influenced participants to express increased support for euthanasia'."

And hospice based nurses in New Zealand?

Unpublished pilot study at 3 hospices in New Zealand
Woods, M., Rook, H. & Popoola, T. (2017).

Selected indicative findings:

- 100% do not perceive the use of large doses of opioids to be a form of euthanasia.
- 80% have been asked by a patient or relative to supply medication to cause premature death.
- 30% support changes to the law to allow acts of euthanasia under certain circumstances.
- 16% would be willing to take part in legalised euthanasia.
- 11% perceive participation in acts of euthanasia to be an acceptable part of the palliative nurse's role, but only 3% consider such acts to be part of any nurse's role.
- 9% have performed an act that they perceive to be an act of euthanasia.

But what do organisations representing doctors and nurses think?

Opposing any changes in the law

- Hospice NZ
- The Palliative Care Council
- Palliative Care Nurses New Zealand (PCNNZ)
- The Australian & New Zealand Society of Palliative Medicine (ANZSPM)
- The Health Professional Association (HPNZ)
- The New Zealand Medical Association (NZMA).

Remaining 'neutral'

- The New Zealand Nurses Organisation
- National Nurses Organisation
- College of Nurses (NZ)

Responding – with or without changes to the law

BOX 1

Factors influencing requests for hastened death in terminally ill people

- Depression or hopelessness (negative expectations about the future).
- Intractable pain and other symptoms.
- Lack of dignity.
- Fear of the future.
- Fears about the dying process and death.
- Loss of control and autonomy.
- Lack of social support.
- Spiritual distress.
- Feeling a burden on carers.

(Seale and Addington-Hall 1994, Chochinov *et al* 1995, Breitbart *et al* 2000, Wilson *et al* 2000, Meyer *et al* 2003, O'Mahony *et al* 2005, Hudson *et al* 2006a, Rodin *et al* 2009)

BOX 3

Responding to patients' desire for hastened death

- Adopt a conversational approach to explore the patient's thoughts and feelings.
- Be empathetic and acknowledge the patient's distress.
- If the nurse feels comfortable enough to pursue an in-depth conversation, he or she should attempt to explore why the patient is asking for help to die.
- During exploratory conversations, the nurse should inform the patient about the legal position in the UK.
- It is important to probe gently for more details about the person's understanding of his or her diagnosis, prognosis, death and dying. Patients may have fears regarding their future, physical changes, cognitive and functional capacity, dependence and vulnerability.
- Support or expert help must be offered to the patient. A useful first step may be to set up a meeting with the patient's doctor.
- The patient must be informed that it is not possible to keep requests, such as wanting assistance to die, private and confidential. For example, the nurse will need to inform the patient's doctor or other members of the multidisciplinary team. The aim of such disclosure is to seek support for the patient and not to report wrongdoing.
- It needs to be identified what the patient perceives would be helpful in terms of improving quality of life, including practical, social and emotional support, and symptom management.
- In view of the association between depression and desire for hastened death, it is essential to ensure that mental capacity is assessed and screening carried out for psychological distress.

(Adapted from Royal College of Nursing 2011)

Robinson, V. & Scott, H. (2012) Why assisted suicide must remain illegal in the UK. *Nursing Standard. 26*, 18, 40-48.

END

References - New Zealand research

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