Euthanasia and Physician-Assisted Suicide

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Euthanasia and physician-assisted suicide are defined in Table 11-8. Terminating life-sustaining care and providing opioid medications to manage symptoms have long been considered ethical by the medical profession and legal by courts and should not be confused with euthanasia or physician-assisted suicide.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Legal Status</th>
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</thead>
<tbody>
<tr>
<td>Voluntary active euthanasia</td>
<td>Intentionally administering medications or other interventions to cause the patient's death with the patient's informed consent</td>
<td>Netherlands</td>
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<tr>
<td>Involuntary active euthanasia</td>
<td>Intentionally administering medications or other interventions to cause the patient's death when the patient was competent to consent but did not—e.g., the patient may not have been asked</td>
<td>Nowhere</td>
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<tr>
<td>Passive euthanasia</td>
<td>Withholding or withdrawing life-sustaining medical treatments from a patient to let him or her die (terminating life-sustaining treatments)</td>
<td>Everywhere</td>
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<tr>
<td>Physician-assisted suicide</td>
<td>A physician provides medications or other interventions to a patient with the understanding that the patient can use them to commit suicide</td>
<td>Oregon</td>
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</tbody>
</table>

Netherlands
Euthanasia

Belgium

Switzerland

Legal Aspects

Euthanasia is legal in the Netherlands and Belgium. Euthanasia was legalized in the Northern Territory of Australia but then repealed. Euthanasia is not legal in any state in the United States. Physician-assisted suicide is legal in Oregon but only if multiple criteria are met and then only after a process that includes a 15-day waiting period. In Switzerland, a layperson can legally assist suicide. In all other countries and all other states in the United States, physician-assisted suicide and euthanasia are illegal explicitly or by common law.

Practices

Fewer than 10–20% of terminally ill patients actually consider euthanasia and/or
Euthanasia

physician-assisted suicide for themselves. In the Netherlands and Oregon, >70% of patients utilizing these interventions are dying of cancer; <5% of deaths by euthanasia or physician-assisted suicide involve patients with AIDS or amyotrophic lateral sclerosis. In the Netherlands, if all legal and illegal acts are grouped, euthanasia and physician-assisted suicide account for 3.5% of all deaths. In Oregon, ~0.1% of patients die by physician-assisted suicide, although this may be an underestimate.

Pain is not a primary motivator for patients' requests for or interest in euthanasia and/or physician-assisted suicide. Among the first patients to receive physician-assisted suicide in Oregon, only 1 patient of 15 had inadequate pain control compared to 15 of 43 patients in a control group experiencing inadequate pain relief. Depression, hopelessness, and, more profoundly, concerns about loss of dignity or autonomy or being a burden on family members, appear to be primary factors motivating a desire for euthanasia or physician-assisted suicide. A study from the Netherlands showed that depressed terminally ill cancer patients were four times more likely to request euthanasia, and confirmed that uncontrolled pain was not associated with greater interest in euthanasia.

Euthanasia and physician-assisted suicide are no guarantee of a painless, quick death. Data from the Netherlands indicate that in as many as 20% of cases technical and other problems arose, including patients waking from coma, not becoming comatose, regurgitating medications, and a prolonged time to death. Problems were significantly more common in physician-assisted suicide, sometimes requiring the physician to intervene and provide euthanasia.

Whether practicing in a setting where euthanasia is legal or not, over a career, between 12 and 54% of physicians will receive a request for euthanasia or physician-assisted suicide from a patient. Competency in dealing with such a request is crucial. While challenging, such a request can also be a chance to address intense suffering. After receiving a request for euthanasia and/or physician-assisted suicide, health care providers should carefully clarify the request with
empathic, open-ended questions to help elucidate the underlying cause for the request such as: "What makes you want to consider this option?" Endorsing either moral opposition or moral support for the act tends to be counterproductive, either lending an impression of being judgmental or of endorsing the idea that the patient's life is worthless. Health care providers must reassure the patient of continued care and commitment. The patient should be educated about alternative, less controversial options, such as symptom management and withdrawing any unwanted treatments; the reality of euthanasia and/or physician-assisted suicide, since the patient may have misconceptions about their effectiveness; and also the legal implications of the choice. Depression, hopelessness, and other symptoms of psychological distress as well as physical suffering and economic burdens are likely factors motivating the request, and such factors should be assessed and treated aggressively. After these interventions and clarification of options, most patients proceed with another approach, declining life-sustaining interventions, possibly including refusal of nutrition and hydration.