TREATMENT LIMITATIONS VS. EUTHANASIA. END STAGE DECISIONS ABOUT MEDICATION, FEEDING AND TERMINAL SEDATION

GUNNAR ECKERDAL, SWEDEN

DOCTOR, TELL ME……

- Patients want from the physician:
- Excellence
  - Normal physiology
  - Pathophysiology
  - Symptom control
  - Normal psychological responses to stress
- Structure
  - Advance care planning
  - Continuity
- Compassion
  - To be a fellow human being. No more, no less.

PALLIATIVE MEDICINE IS NOT DIFFERENT

- Treatment without clinical indication should be stopped.
- Treatment that is not going to give effect should not be started.
- In palliative care every treatment must be re-evaluated regularly.
- It is a question of balance – are the benefits greater than the risks?

PALLIATIVE MEDICINE IS NOT DIFFERENT

- This balancing must be done in dialogue with the patient.
- Symptom control seldom shortens life
- The physician always recommends treatment that reduces suffering.
- The physician never recommends treatment that deliberately shortens life.

WMA DECLARATION OF VENICE ON TERMINAL ILLNESS 13TH OCTOBER 2006

The duty of physicians is to heal, where possible, to relieve suffering and to protect the best interests of their patients. There shall be no exception to this principle even in the case of incurable disease.

LISTEN TO THE PATIENT!

- Sometimes the patient wants the physician to stop important life-supporting treatment.
  - Dialysis
  - Nutrition
  - Life-supporting medication and medication for symptom control
  - Blood transfusion
- The dialogue must be shared with other health professionals. The patient's decision capacity must be evaluated, and depression must be assessed. Dialogue with relatives is often necessary.
- After that the treatment often can be stopped. It is not euthanasia. It is recognizing the patient's right to have power over his own body.

WMA DECLARATION OF VENICE ON TERMINAL ILLNESS 13TH OCTOBER 2006

……The patient's right to autonomy in decision-making must be respected with regard to decisions in the terminal phase of life. **This includes the right to refuse treatment** and to request palliative measures to relieve suffering but which may have the additional effect of accelerating the dying process. However, physicians are ethically prohibited from actively assisting patients in suicide. This includes administering any treatments whose palliative benefits, in the opinion of the physician, do not justify the additional effects……

NUTRITION

- In palliative care the goal is to nourish as much as the metabolism needs.
- If the patient is artificially nourished, there is a risk that too much nutrients will not be used by the patient's metabolism – they do not reach the cell metabolism, but degrade in the body into products that cause nausea and in some cases confusion.
- In the palliative care team this calls for assessment every day.
- Nutrition by mouth is always preferable – very low risk of overfeeding.

TERMINAL SEDATION

PALLIATIVE SEDATION IN SWEDEN

- The indication is always symptom control.
- The treatment is most commonly used intermittently.
- Continuous sedation with doses that makes the patient permanently unconscious is very rare. It is only used when all other treatment has failed.
- Severe delirium is the most common indication.
- It is not an alternative to euthanasia.

Eckerdal G, Birr A, Lundström S. Palliativ sedering är ovanlig inom specialiserad palliativ vård i Sverige. Läkartidningen. 2009 106:1086-8

WHAT ABOUT PROGNOSIS?

Days between writing prescription and death, Oregon DWDA patients, 1998-2015

	Frequency	Percent	Valid Percent	Cumulative Percent
Less than 183 days	1380	92	92,1	92,1
183 days or more	119	7,9	7,9	100
Unknown	1	0,1		
	1500	100		

In Oregon >7,9 % of the estimates of time to death was wrong.

Ref: OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

HOW ABOUT DECISION-MAKING CAPACITY?

SUICIDE - CANCER

”Cancer patients carry an increased risk of suicide. However, this risk peaks with the month following diagnosis. Clinicians should be aware of this increased risk and include assessments of mood state and suicidality at the time of initial diagnosis of the malignancy and be prepared to provide referral to mental health treatment providers.”

Johnson TV, Garlow SJ, Brawley OW, Master VA. Peak window of suicides occurs within the first month of diagnosis: implications for clinical oncology. Psychooncology. 2012 Apr;21(4):351-6

CAN SUICIDE BE A RATIONAL ACT?

Methods

The New Zealand Coronial Services provided records of all older people (age≥65) who died by suicide between July 2007 and December 2012. Socio-demographic and clinical data were extracted from the records. Using the characteristics for defining rational suicide, we determined whether the motives in terminal cancer cases represented rational suicide.

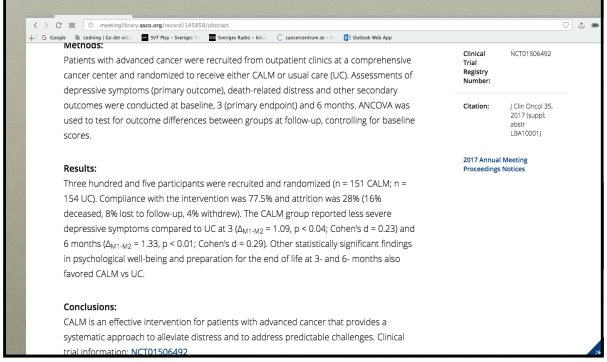
Results

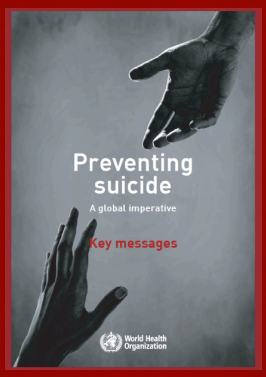
Of the 214 suicide cases, 23 (10.7%) older people were diagnosed with a terminal cancer. Univariate analysis found older people with terminal cancer who died by suicide were less likely to have a diagnosis of depression (8.7% versus 46.6%, p=0.001) or previous contact with mental health services (4.5% versus 35.0%, p=0.004) than those without terminal cancer. 82.6% of the terminal cancer cases had a motivational basis that would be understandable to uninvolved observers.

Conclusions

A high proportion of those with terminal cancer had motives suggestive of rational suicide. Future studies are needed to clarify whether the low rate of depression is secondary to under-diagnosis of depression or people with terminal cancer choosing to end their life as a rational act to alleviate suffering.

DEPRESSION CAN BE TREATED IN PALLIATIVE CARE!





WHO (2014):

Restricting access to the means for suicide works. An effective strategy for preventing suicides and suicide attempts is to restrict access to the most common means, including pesticides, firearms and certain medications.

SECURITY AND EFFICACY

- PAS/euthanasia is not secure
  - Wrong diagnosis
  - Wrong prognosis
  - Underdiagnosed and undertreated depression
- PAS/euthanasia is not efficient
  - The patient´s condition is better addressed with treatment that does not shorten life

CONCLUSION

- In the palliative team we listen to each patient.
- We practice evidensbased medicine as in other specialities.
- A *"No"* to some of the patient´s wishes is necessary….
- …to protect other patients from harm.
- Together we in almost every situation come to an acceptable agreement.

CONCLUSION

- My guess is that 20% of all PAS/euthanasia-actions are made after wrong assessments.
- Can we accept that patients with help from their doctors commit suicide on wrong grounds?
- PAS/euthanasia is not safe!