# Is Medical Assistance In Dying A Platitudinous Medical Treatment?

End-of-life decisions:
*Compassionate use and conscientious objection*

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Vatican 2017

# Is Medical Assistance In Dying A Platitudinous Medical Treatment?

One of the most important factors separating physicians who do or do not accept PAS and E is whether they see their actions as similar or different than other treatments they give their patients

# The main question

Is terminating of life/medical assistance in dying a regular (banal, platitudinous) medical intervention like treatment with antibiotics?

or

*It is something extraordinary demanding different attitude*

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**Physicians, Not Conscripts — Conscientious Objection in Health Care**

Ronit Y. Stahl, Ph.D., and Ezekiel J. Emanuel, M.D., Ph.D.

Health care professionals are not conscripts, and in a freely chosen profession, conscientious objection cannot override patient care.

n engl j med 376;14 April 6, 2017

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Physicians, Not Conscripts — Conscientious Objection in Health Care

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By entering a health care profession, the person assumes a professional obligation… This obligation is not unlimited, but exemptions are reserved for cases in which there are substantial risks of permanent injury or death.

n engl j med 376;14 April 6, 2017

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Physicians, Not Conscripts — Conscientious Objection in Health Care

Ronit Y. Stahl, Ph.D., and Ezekiel J. Emanuel, M.D., Ph.D.

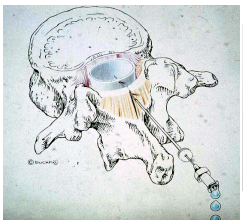
…in most cases, professional associations should resist sanctioning conscientious objection as an acceptable practice. Unlike conscripted soldiers, health care professionals voluntarily choose their roles and thus become obligated to provide, perform, and refer patients for interventions according to the standards of the profession. … collectively, the profession — not politicians, judges, or individual practitioners — sets its contours.

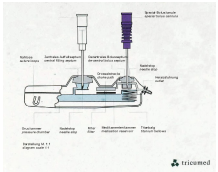
n engl j med 376;14 April 6, 2017

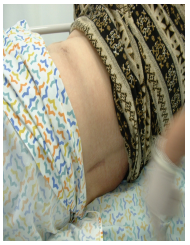
## Pain

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

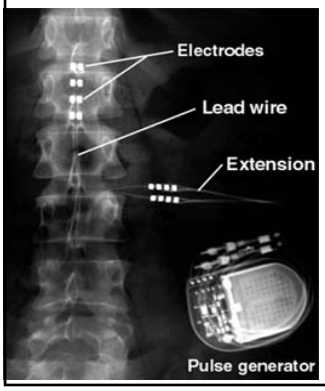
International Association for the Study of Pain (IASP) 1994

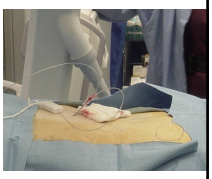






## Spinal cord stimulation



## What causes patients to seek end-of-life?

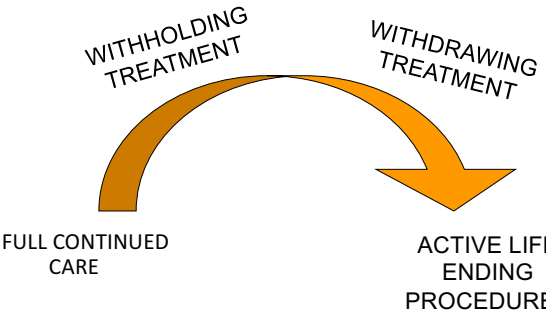
- ✓Pain
- ✓Depression
- ✓Dyspnea
- ✓Nausea and vomiting
- ➢Frailty, fatigue

✓ - treatable

## What causes physicians to seek end-of-life of a patient?

- ❑ Pain
- ❑ Depression
- ❑ Frailty, fatigue
- ❑ Dyspnea
- ❑ Nausea and vomiting
- ❑ Cough
- ❑ Fever
- ❑ Bleeding
- ❑ Agitation/delirium/ terminal anguish/restlessness (e.g. thrashing, plucking, or twitching)
- ❑ Secretions accumulated in the oropharynx and upper airways when patients become too weak to clear their throat
- ➢ Rationing and the allocation of resources

## OPTIONS AT THE END OF LIFE




## End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

In the Netherlands, physician assistance in dying has been legally regulated since 2002:

- physician-assisted suicide
- euthanasia (physician administers lethal medication at the explicit request of a patient)

- Both types of assistance are allowed only for patients who are "suffering unbearably" without any prospect of relief

Agnes van der Heide, et al. (Erasmus MC, Utrecht Univ., Amsterdam)
N Engl J Med 2017; 377:492-494

Table 1. Frequency of Physician Assistance in Dying and Other End-of-Life Practices in the Netherlands (1990–2015).*

| Variable | 1990 | | 1995 | | 2001 | | 2005 | | 2010 | | 2015 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. of Cases | Percent (95% CI) | No. of Cases | Percent (95% CI) | No. of Cases | Percent (95% CI) | No. of Cases | Percent (95% CI) | No. of Cases | Percent (95% CI) | No. of Cases | Percent (95% CI) |
| Total no. of cases studied | 5197 | | 5146 | | 5617 | | 9965 | | 6861 | | 7761 | |
| End-of-life decisions | | | | | | | | | | | | |
| All categories | 2361 | 39.4 (38.1–40.7) | 2604 | 42.6 (41.3–43.9) | 2899 | 43.8 (42.6–45.0) | 2580 | 42.5 (41.3–43.9) | 3685 | 57.8 (56.7–59.0) | 4379 | 58.1 (57.0–59.2) |
| Euthanasia† | 141 | 1.7 (1.4–2.1) | 257 | 2.4 (2.1–2.6) | 310 | 2.6 (2.3–2.8) | 294 | 1.7 (1.5–1.8) | 475 | 2.8 (2.5–3.2) | 829 | 4.5 (4.1–5.0) |
| Physician-assisted suicide | 18 | 0.2 (0.1–0.3) | 25 | 0.2 (0.1–0.3) | 25 | 0.2 (0.1–0.3) | 17 | 0.1 (0.0–0.1) | 21 | 0.1 (0.1–0.2) | 22 | 0.1 (0.1–0.2) |
| Ending of life without explicit patient request | 45 | 0.8 (0.6–1.1) | 64 | 0.7 (0.5–0.9) | 42 | 0.7 (0.5–0.9) | 24 | 0.4 (0.3–0.6) | 13 | 0.2 (0.1–0.3) | 18 | 0.3 (0.2–0.4) |
| Intensified alleviation of symptoms | 1166 | 18.8 (17.9–19.9) | 1161 | 19.1 (18.1–20.1) | 1312 | 20.1 (19.1–21.1) | 1478 | 24.7 (23.5–26.0) | 2202 | 34.4 (33.2–37.6) | 2469 | 35.8 (34.7–36.8) |
| Forgoing of life-prolonging treatment | 991 | 17.9 (17.0–18.9) | 1097 | 20.2 (19.1–21.3) | 1210 | 20.2 (19.1–21.3) | 767 | 15.6 (15.0–16.2) | 974 | 18.2 (17.3–19.1) | 1041 | 17.4 (16.6–18.3) |
| Continuous deep sedation‡ | NA | | NA | | NA | | 521 | 8.2 (8.8–8.6) | 789 | 12.3 (11.6–13.1) | 1288 | 18.3 (17.4–19.2) |

*Absolute numbers are unweighted, but percentages are weighted for sampling fraction, nonresponse, and random-sampling deviations to make them representative for all deaths in the year studied. Therefore, the percentages cannot be derived from the unweighted absolute numbers. CI denotes confidence interval, and NA not available.
†In 2005, 5.2% of all deceased patients had requested euthanasia; this percentage was 6.7% in 2010 and 8.4% in 2015. The number of requests is not available for 1990, 1995, and 2001.
‡The use of continuous deep sedation may overlap with end-of-life decisions. It coincided with intensified alleviation of symptoms in 11% of all deaths and with forgoing life-prolonging treatment in 5%.

Agnes van der Heide, et al. (Erasmus MC, Utrecht Univ., Amsterdam)
N Engl J Med 2017; 377:492-494

About half of all requests for physician assistance in dying were granted in 2015

In 2015 reported 829 cases (4.5%) of euthanasia and *18 cases of ending of life without explicit patient request*

"Such assistance is provided predominantly to patients with severe disease but increasingly involves older patients and those with a life expectancy of more than a month"

Agnes van der Heide, Johannes J.M. van Delden, Bregje D. Onwuteaka-Philipsen
End-of-Life Decisions in the Netherlands over 25 Years. NEJM2017;377:492

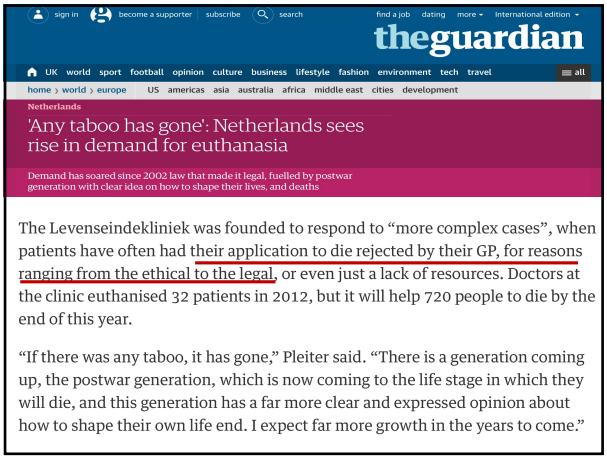
End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

In 2015 had:

- early stage of dementia - 3%
- psychiatric problems - 3%

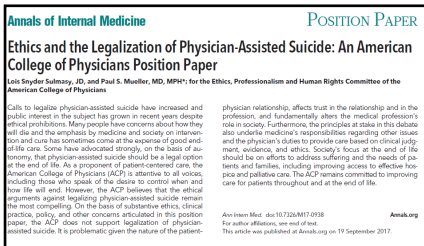
Agnes van der Heide, et al. (Erasmus MC, Utrecht Univ., Amsterdam)
N Engl J Med 2017; 377:492-494






Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases.
T. Smets et al. BMJ 2010;341:c5174

… the incidence of euthanasia was estimated as 1.9% of all deaths (95% CI 1.6% to 2.3%). Approximately half (549/1040 (52.8%, 95% CI 43.9% to 60.5%)) of all estimated cases of euthanasia were reported to the Federal Control and Evaluation Committee



Annals of Internal Medicine POSITION PAPER

Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper

Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH; for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians

Calls to legalize physician-assisted suicide have increased and public interest in the subject has grown in recent years despite ethical prohibitions. Many people have concerns about how they will die and the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Some have advocated strongly, on the basis of autonomy, that physician-assisted suicide should be a legal option at the end of life. As a proponent of patient-centered care, the American College of Physicians (ACP) is attentive to all voices, including those who speak of the desire to control when and how life will end. However, the ACP believes that the ethical arguments against legalizing physician-assisted suicide remain the most compelling. On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient-physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities regarding other issues and the physician's duties to provide care based on clinical judgment, evidence, and ethics. Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. The ACP remains committed to improving care for patients throughout and at the end of life.

Ann Intern Med. doi:10.7326/M17-0938 Annals.org

For author affiliations, see end of text.

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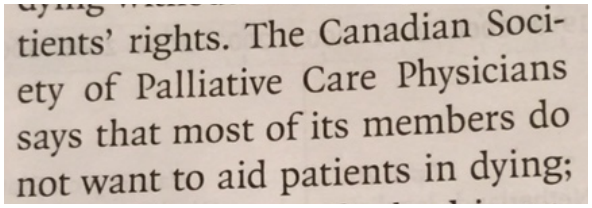

tients' rights. The Canadian Society of Palliative Care Physicians says that most of its members do not want to aid patients in dying;

The American Psychiatric Association (APA) has taken a strong stand against euthanasia. In a **formal position statement** approved by its board of trustees this month, it says:

> *The American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.*

This implies that it is not ethical for a psychiatrist to help a non-terminally ill person to commit suicide, either by providing the means or by direct lethal injection, as is being currently practiced in The Netherlands and Belgium.

Although this binds only APA members, the APA is one of the world's most influential professional bodies. The World Psychiatric Association (WPA) is considering a similar statement.

## Why physicians shouldn't be involved in physician assisted death- euthanasia?

- Many requests disappear with symptom control and psychological support.
- Patients should be sure about medical professionalism: physicians are trying to heal and relieve suffering and they are never intentionally causing harm
- The danger of a slippery slope
  - Administration of lethal drugs without absence of terminal illness, untreated psychiatric diagnoses and patient consent

## Euthanasia and physician assisted suicide

## *Improve palliative care at the end-of-life*

- Patients with severe pain can benefit from better palliative care as almost all patients can be made physically comfortable.

Lorenz K, Lynn J. JAMA 2003;289:2282

## Euthanasia and physician assisted suicide

## *Improve palliative care at the end-of-life*

- Many suicidal individuals do not want to die; they want to escape what they perceive as intolerable suffering. When relief is offered in the form of adequate treatment for depression, better pain management and palliative care, the desire for death wanes.

Kheriaty A. First Things. 2015

Euthanasia and physician assisted suicide

*Improve palliative care at the end-of-life*

- The International Association for Hospice & Palliative Care stated that no country or state should consider the legalization of PAS-E until it ensures universal access to palliative care services and to appropriate medications, including opioids for pain and dyspnea.

De Lima L. J Palliat Med 2017;20:8-14

Alternatives to physician assisted death- euthanasia

- Palliative care
- Social support
- Psychological support

Medical Assistance In Dying Is Not A Platitudinous Medical Treatment?

It is different:

- Physician practicing medicine is constantly trying to heal the patient and never to harm him/her.
- Healing doesn't always mean curing, as palliative care is no longer curing but it is healing suffering.
- The actions of a physician trying to "heal" suffering require us to be WITH our patient and never to abandon him/her
- It's Beneficence, Doing good. VS - euthanasia which is an unwillingness to do this...unwillingness to stay with the person and instead a willingness to eliminate the patient altogether- to make a somebody into a nobody.

(E. Wesley Ely, MD, Vanderbilt University and VA-GRECC- personal communication)

- Causing death means causing absolutely different irreversible state

WORLD MEDICAL ASSOCIATION

WMA DECLARATION OF GENEVA

**The Physician's Pledge**

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

Is Medical Assistance In Dying A Platitudinous Medical Treatment?

PAS and E is different and should not be performed by doctors