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Euthanasia: do we know it and do we need it?

Published online: 25 April 2002
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Abstract Thinking about euthanasia is confused and controversial. It is hoped that improvements in both clinical and psychosocial/spiritual palliative and supportive care will lead to decreasing desire for hastened death among patients.

Keywords Euthanasia · Physician-assisted suicide · Survey

This issue includes three articles on euthanasia and end-of-life care [1, 2, 3]. This editorial attempts to put them in a broader perspective based on recently published medical experience. The term ‘euthanasia’ derives from the ancient Greek word *euthanatos*, meaning ‘easy death,’ which combines *eu* ‘good’ and *thanatos* ‘death.’ In Webster’s dictionary euthanasia is defined as “the act or practice of killing or permitting the death of hopelessly sick or injured individuals (persons or domestic animals) in a relatively painless way for reasons of mercy.” While euthanasia is generally accepted for domestic animals, it is illegal for humans in most countries. Akin to the issue of abortion, euthanasia has become a very controversial political topic. A “national debate on euthanasia” is in progress in many developed countries.

In The Netherlands euthanasia and physician-assisted suicide started to be practiced with increased openness in the 1990s, and euthanasia was legalized there in 2001. A large majority of Dutch physicians consider it an exceptional but accepted part of medical practice [4]. Similarly, the Oregon Death with Dignity Act legalized physician-assisted suicide in the US state of Oregon in 1997 following a public vote. While in Holland no legal difference is made between euthanasia and assisted suicide, Oregon physicians are only allowed to *prescribe* a dose of lethal medication and not to *administer* it [5]. Both in The Netherlands and in Oregon, physicians must report

their cases to the legal authorities. In a period of 18 months a total of 221 requests for prescription of a lethal medication were made in Oregon (population 3,420,000). Based on 165 informative cases only 1 in 6 requests were granted, and only 1 in 10 resulted in suicide [5]. In most patients requesting prescriptions of lethal medications physicians reacted by recommending such interventions as control of pain or other physical symptoms, advice from a colleague, further referral, mental health consultation, or antidepressant medication. In 40 of 140 patients these interventions altered the patient’s desire for a prescription for a lethal medication.

In Holland (population 15,800,000) explicit requests for euthanasia numbered 8,900 in the study of the year 1990 and 9,700 in the study of 1995 [4]. In each of these studies a sample of 405 physicians was interviewed, each for an average of 2.5 h, in order to gather clinical information. A total of 649 cases (114 of physician-assisted suicide, 535 of euthanasia) were carefully analyzed [6]. The mean age of the patients concerned was 63.9 (range 21–96), and 55% of them were men. Cancer was the diagnosis in 75%. Technical problems with the performance of euthanasia were reported in 5%, complications in 4%, problems with completion in 7% (usually a longer interval than expected between the administration of medications and death). In 21 of 114 cases in which the intention had been to provide assistance with

suicide, the physician ultimately administered the lethal drug. The developments in Oregon and The Netherlands are vigorously opposed by many religious and political authorities and groups. Whatever one's beliefs, the situations in The Netherlands and in Oregon have the distinct advantage of legality, clarity, and publicity. In other parts of the world the situation is confused and complicated by the lack of regulations and the lack of data. Therefore, attempts to elucidate issues related to euthanasia, such as those published in this issue of *Supportive Care in Cancer*, are most welcome.

The first paper, by Bittel et al., is a survey conducted by the Swiss Association for Palliative Care (SAPC) on the issue of euthanasia. A questionnaire was sent to 726 members of the Society. The 404 (55.6%) questionnaires returned that were evaluable came from 90 physicians, 286 nurses, and 28 others. Support for the legalization of physician-assisted suicide (PAS) (44%), direct active euthanasia (DAE) (31%), and life-terminating act without explicit request (LAWER) (10%) was low. Surprisingly, attitudes in the case of respondents' own hypothetical illness were less reluctant, with 45% wanting access to PAS and/or DAE. The willingness to practice PAS or DAE was also low, 38% for PAS and 19% for DAE, respectively. Not surprisingly, almost half of the SAPC members expect their Board to reject euthanasia. In its position paper the SAPC has issued the following statement: "The SAPC demands that PAS and DAE should not be offered unless every patient in need has access to quality controlled palliative care." This is a very valid argument. In Switzerland and elsewhere, palliative medicine is being developed rapidly. Concerns about euthanasia may prove to be one of the shortcomings that fuel this development.

In Switzerland, assisted suicide is not carried out by physicians, but by members of a "right-to-die" society (EXIT) founded in 1982. Assisted suicide is not prosecuted if it is not performed for selfish motives. The medical analysis of 43 such cases of the years 1992–1997 in the Basel region showed a diagnosis of cancer in 20 cases, but in 11 cases (=26%) no medical condition so serious as

to explain the patient's death wish was apparent from the medical file [7]. This is an alarming figure, and the authors of the study concluded that "psychiatric or social factors are not an obstacle for EXIT to assist with suicide." Considering the deplorable fact that assisted suicide is performed by self-appointed lay-persons with no knowledge of palliative care, legal regulations are highly desirable and urgently needed in Switzerland. A parliamentary working group unanimously recommended in 1999 that such regulations be elaborated and enforced.

The second paper, by Virik and Glare, analyses requests for euthanasia to a referral teaching hospital in Sidney, Australia, in the year 2000. In Australia, euthanasia is neither lawful nor openly practiced. Among 490 patients referred, there were 6 requests for euthanasia (1.6%), 4 of whom had a diagnosis of cancer. These 6 requests were issued late in the trajectory of disease, a median of 13 days (4–29) before death. They were more frequently associated with psychological and existential issues (burden/dependency in 6, hopelessness in 3) than with physical symptoms (constipation in 2, shortness of breath in 2). The authors argue that improvements in palliative care and earlier referral might have allowed even these rare cases of requests for euthanasia to be avoided.

The third paper, by Breitbart, is an interesting review on "spirituality and meaning in supportive care." The author reviews a large body of literature on various concepts and approaches applied to the psychological and spiritual situation at the end of life. Based on Victor Frankl's theory of man's will to meaning, he has initiated an intervention program called "Meaning-centered Group Psychotherapy" at Memorial Sloan-Kettering Cancer Center.

Common to these three papers is the hope that with the development of palliative care requests for euthanasia may be avoided. The latter two papers make it apparent that attention not only to physical needs, but more importantly to psychosocial and spiritual-existential needs, may help the patient live through the last phases of his or her life without despair. This ambitious goal should motivate us to develop patient-centered palliative care. While we should know euthanasia, we hope we do not need it.

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