• Attitudes towards, and wishes for, euthanasia in advanced cancer patients

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Euthanasia

“A doctor intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request”


‘In the Netherlands, euthanasia is defined as the administering of lethal drugs by a physician with the explicit intention to end a patient's life on the patient's explicit request’  (Onwuteaka-Philipsen et al. 2012)
Physician-Assisted Suicide (PAS)

"A doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person’s voluntary and competent request"

*Materstvedt et al. 2003.*
Where “assisted dying” is legal

**Euthanasia:**
- Netherlands; Belgium; Luxembourg

**Physician-assisted suicide (PAS):**
- BeNeLux countries; Oregon; Washington; Montana; Vermont

**Assisted suicide:**
- Switzerland
  - (Germany?)
Euthanasia is a much more common occurrence than physician-assisted suicide in the Netherlands. In 2005, for example, there were 2,297 cases of euthanasia, compared to 113 cases of physician-assisted suicide (van der Heide et al. 2007). This yields a ratio of 20 to 1.

31% of the Dutch cases of assisted dying are found in the age group 40-59, while the majority (53%) are found in the 60-79 age bracket. In Belgium, the corresponding figures are 26% and 52%, respectively (Rurup et al. 2012).

The data on reported cases of assisted death in the Netherlands in 2010 shows that general practitioners were involved in 92.5 % of the cases, and that 83.1% of the diseased suffered from cancer, making it the predominant illness among those who were registered in the assisted dying statistics (Onwuteaka-Philipsen et al. 2012).
Changing motives to request PAS or euthanasia in the Netherlands 1977-2001


35 research studies

- Great variation in the methodology used
- Most are surveys that utilize self report questionnaires
- **Qualitative studies constitute a minority**
- Both questionnaires and in-depth, semi-structured interviews are hugely different in their design and ask different questions
Norwegian patients
Trondheim University Hospital,
Palliative Medicine Unit, Cancer Dept.

Johansen S, Hølen JC, Kaasa S, Loge JH, Materstvedt LJ

Attitudes towards, and wishes for, euthanasia in advanced cancer patients at a palliative medicine unit

Palliative Medicine 2005; Volume 19, Issue 6

- Short life-expectancy (less than 9 months)
- In-patients at PMU (12 bed unit)
- Qualitative, semi-structured interviews (max 45 min)
- 18 cancer patients (8 women; 10 men) between 38 and 83 yrs (mean: 63)
https://kreftforeningen.no/en

NORWEGIAN CANCER SOCIETY
Cover-Story

Keywords: palliative care, Supportive care, endocrine agent, end of life care, multidisciplinary care, cachexia, quality of life, overtreatment.

Stein Kaasa: Let me show you what integrated palliative care can do

According to Kaasa, head of the Cancer Clinic at Trondheim University Hospital, patients are falling through gaps in care provision because palliative care is seen as an add-on rather than integral to care plans.

by Marc Beishon
Full text article:  
http://folk.ntnu.no/larsmat/SLB_study_PM.pdf

Interview (2000):  
http://folk.ntnu.no/larsmat/SLB_study_english_version_questions.pdf

Written Information & Informed Consent Form (2000):  
http://folk.ntnu.no/larsmat/SLB_study_written_information_and_informed_consent_form.pdf
Diagnoses:

- lung cancer (n/2);
- prostate cancer (n/5);
- gastrointestinal cancer (n/5);
- breast cancer (n/2);
- head and neck cancer (n/2);
- unknown primary cancer (n/2)
Time of interview –> time of death

- Varied between 3 days and 9 months
  - (9 months was also maximum life expectancy for inclusion)
  - (First patient to be interview died the day before the interview was scheduled to take place)
Inclusion criteria & how patients were approached:

- cognitively intact
- fully aware of disease and prognosis
- patients with known previous or present psychiatric diagnosis excluded
- attending physician responsible for determining which patients to approach for participation:
  - initially, oral orientation about study
  - later presented with written informed consent form
- estimated sample size 25 patients; stopped at 18
Structure of interview:

12.1. The patient's comprehension of the expression (the concept of) "active help in dying" – and the public debate concerning active help in dying

12.2. Life at present/right now

12.3. Life as ill up until this point/this moment

12.4. Life before you fell ill – and at the time you became ill

12.5. Active help in dying in relation to health care personnel – and in relation to other patients

12.6. Active help in dying in relation to family/next-of-kin

12.7. Life henceforward/ahead

12.8. The patient's experience of being interviewed about active help in dying

12.9. Closure
Questions about E/PAS:
(words “killing” and “suicide” omitted)

- **Euthanasia:**
  - “Have you ever wished for a physician to release you from life/end your life by lethal injection?”

- **PAS:**
  - “Have you ever wished for a physician to help you take your own life, for instance by prescribing a sufficiently large dose of medication which you could have used for that particular purpose?”
Attitudes:

- Fear of future pain, and/or poor quality of life, most commonly cited arguments for positive attitude towards E/PAS

- The right to self-determination was an argument for E/PAS

- Mostly religious and ethical arguments were given among those against E/PAS
  - e.g., the wrongdoing of taking life
Wishes:

- Frequent finding: patients uttered the possibility of wishing E/PAS
- These wishes were always future-oriented, as a hypothetical possibility
- No one expressed a wish for euthanasia/PAS at time of interview
Some wishes were fluctuating and ambivalent:

**Patient (P):** ‘There are big ups and downs. Some days, I just want to disappear. There have been several times that I have felt I wanted help to do that. But at other times, all this changes’.

**Interviewer (I):** ‘Have you ever thought about taking your own life?’

**Patient (P):** ‘Never’.

**I:** ‘You have never had any concrete wishes to get help from a doctor?’

**P:** ‘Yes, I have, but you know, when you arrive at the situation and face the reality, I don’t think I would have done it anyway. You want to postpone’ (No. 6).
Distinctive aspect of data material: concern about pain

- “... it is the pain that I am most afraid of, because I don’t want to live with pain. My only hope is to have no pain” (No. 11).

- “The way I feel today, I am not considering requesting [E/PAS]. But if I get pain and become really ill, I could consider it” (No. 3).

  (experienced as a life without meaning and worth)
Findings:

- “An important finding is that fear of future pain, rather than actual, perceived pain, was the predominant motivation for a possible future wish for euthanasia/PAS.”
Findings:

- “The fact that a seriously ill patient is in favour of euthanasia/PAS does not, according to our results, signify that the person wants to request it, has personal wishes for it, or wants it legalized.”
Findings:

“An interesting and, to our knowledge, new documentation is the clear discrepancy between attitudes, wishes and requests, and what seems to be the characteristics and nature of wishing E/PAS, i.e., ambivalent, fluctuating and hypothetical.”
Findings:

“Furthermore, [such wishes] may represent a kind of emergency plan, a possible future ‘solution’ or way out. ... [and] may thus have a positive psychological impact in the sense that they create a feeling of control and consolation. The hypothesis that such wishes may actually represent a coping strategy should be further explored in future research.”
Clinical relevance:

“An important learning process took place in these patients when they experienced that intense pain could be alleviated. Many patients knew little about modern pain treatment prior to hospitalisation at the Palliative Medicine Unit.”
Clinical relevance:

“Given the many possible meanings of a wish for E/PAS ... The obvious and most dangerous scenario is the doctor who responds to patients’ wishes for E/PAS as if they were actual requests.”
Clinical relevance:

“Alternatively, responding to such wishes as merely expressions of depression might lead to inadequate interventions (e.g., with antidepressants) and possibly further reinforce the patients’ feelings of hopelessness. The patient may also see such a response in the doctor as a violation of his autonomy – or as a lack of respect for his decision-making capacities.”
Clinical relevance & major conclusion:

“Because of the irrevocable nature of euthanasia/PAS, it is of great importance that health care workers are aware of the apparent ambivalent nature of wishes for E/PAS. A wish for E/PAS may be something completely different from a request for it.”
Euthansia in a palliative care setting


NEW chap. In 5th ed. 2014: "Euthanasia and palliative care"
WHO Definition of Palliative Care

- www.who.int/cancer/palliative/definition/en/
- intends neither to hasten or postpone death;

[= E/PAS or overtreatment]

World Health Organization
The United Kingdom:

- Currently, a PAS bill – another in a row of several previous bills – is before the House of Lords for the period 2013-2014.
    - http://services.parliament.uk/bills/2013-14/assisteddying.html
Mary Warnock: “A duty to die?” (2008)
http://fagbokforlaget.no/filarkiv/Mary.Warnock.pdf

Moral philosopher:

“... the strong feeling that remaining alive in a perhaps painful and certainly pleasureless and purposeless life is an **appalling waste of resources**, whether her own, her family’s or those of the State.”

“The duty to die, then, should not be thought of as something dire and horrible, ... It may rather regain the place of honour it held in ancient Rome.”
BMJ News, 5 October 2010:

New doctors’ group challenges medical bodies’ opposition to assisted dying

www.bmj.com/content/341/bmj.c5498.full
"He won the right to die without dignity."