Prevalence of formal accusations of murder and euthanasia against physicians.
Goldstein NE, Cohen LM, Arnold RM, Goy E, Arons S, Ganzini L.

BACKGROUND: Little is known about how often physicians are formally accused of hastening patient deaths while practicing palliative care.

METHODS: We conducted an Internet-based survey on a random 50% sample of physician-members of a national hospice and palliative medicine society.

RESULTS: The final sample consisted of 663 physicians (response rate 53%). Over half of the respondents had had at least one experience in the last 5 years in which a patient's family, another physician, or another health care professional had characterized palliative treatments as being euthanasia, murder, or killing. One in four stated that at least one friend or family member, or a patient had similarly characterized their treatments. Respondents rated palliative sedation and stopping artificial hydration/nutrition as treatments most likely to be misconstrued as euthanasia. Overall, 25 physicians (4%) had been formally investigated for hastening a patient's death when that had not been their intention-13 while using opiates for symptom relief and six for using medications while discontinuing mechanical ventilation. In eight (32%) cases, another member of the health care team had initiated the charges. At the time of the survey, none had been found guilty, but they reported experiencing substantial anger and worry.

CONCLUSIONS: Commonly used palliative care practices continue to be misconstrued as euthanasia or murder, despite this not being the intention of the treating physician. Further efforts are needed to explain to the health care community and the public that treatments often used to relieve patient suffering at the end of life are ethical and legal.

JOW comment: Interesting and uncomfortable evidence from the US where, sometimes, even individuals within a team assert a stance against their colleagues' actions in end-of-life management.

Evolution of requests to hasten death among patients managed by palliative care teams in France: a multicentre cross-sectional survey.
Ferrand E, Dreyfus JF, Chastrusse M, Ellien F, Lemaire F, Fischler M.

BACKGROUND: Strongly marked ideological positions on the impact of palliative care and limited hard data plague the debate on physician-assisted death.

METHODS: A national cross-sectional study on the requests to hasten death (RHD) was conducted among 789 French palliative care organisations. Data were collected for all patients with RHD encountered during year 2010. Data on patients’ characteristics, medical, psychological and social context, symptoms, nature of palliative management, patient's
evolution and palliative care team's interpretation of the request were obtained.

**FINDINGS:** A majority of centres responded and 342 teams provided descriptions of 783 RHD, 476 by a patient, 258 by relatives or close friends and 49 by the nursing staff. Cancer was the most frequent pathology (72%) and 68% of the patients had entered terminal stage. Patients rarely appeared with uncontrolled pain (3.7%), but had difficulties with feeding (65%), moving (54%), excretion (49%), or were cachectic (39%); 31% were considered to be anxio-depressive; 79% did not give physical reasons for their request; 37% of RHD were maintained and 24% fluctuated despite provision of regular follow-up by a palliative care team to 83% of all cases; 68% of patients died within a month; the interpretation of RHD by the staff was a wish for relief (69%), patient's inextricable situation (44%), actual desire not to continue living (36%) or to be helped to die (30%).

**INTERPRETATION:** The large number of described cases provides, for the first time, comprehensive hard data on the evolution of RHDs in a country that has not legalised euthanasia. Whatever the way RHD are expressed, they are frequently maintained despite adequate palliative care with suitable control of pain and psychological support by specialists.

*JOW comment:* The authors’ interpretation says it all, more evidence that palliative care is not enough.

**Narratives of ‘terminal sedation’ and the importance of the intention-foresight distinction in palliative care practice.**

Douglas CD, Kerridge IH, Ankeny RA.


The moral importance of the 'intention-foresight' distinction has long been a matter of philosophical controversy, particularly in the context of end-of-life care. Previous empirical research in Australia has suggested that general physicians and surgeons may use analgesic or sedative infusions with ambiguous intentions, their actions sometimes approximating 'slow euthanasia'. In this paper, we report findings from a qualitative study of 18 Australian palliative care medical specialists, using in-depth interviews to address the use of sedation at the end of life.

The majority of subjects were agnostic or atheistic. In contrast to their colleagues in acute medical practice, these Australian palliative care specialists were almost unanimously committed to distinguishing their actions from euthanasia. This commitment appeared to arise principally from the need to maintain a clear professional role, and not obviously from an ideological opposition to euthanasia. While some respondents acknowledged that there are difficult cases that require considered reflection upon one's intention, and where there may be some 'mental gymnastics,' the nearly unanimous view was that it is important, even in these difficult cases, to cultivate an intention that focuses exclusively on the relief of symptoms.

We present four narratives of 'terminal' sedation - cases where sedation was administered in significant doses just before death, and may well have hastened death. Considerable ambiguities of intention were evident
in some instances, but the discussion around these clearly exceptional cases illustrates the importance of intention to palliative care specialists in maintaining their professional roles.

**JOW comment:** This gives one an insight into the thinking of palliative care specialists who persistently oppose choice for voluntary euthanasia, without religious beliefs obscuring the discussion. The answer: they role-play at being palliative care specialists.

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**Senior doctors' opinions of rational suicide.**
Ginn S, Price A, Rayner L, Owen GS, Hayes RD, Hotopf M, Lee W.

CONTEXT: The attitudes of medical professionals towards physician assisted dying have been widely discussed. Less explored is the level of agreement among physicians on the possibility of 'rational suicide'-a considered suicide act made by a sound mind and a precondition of assisted dying legislation.

OBJECTIVE: To assess attitudes towards rational suicide in a representative sample of senior doctors in England and Wales.

METHODS: A postal survey was conducted of 1000 consultants and general practitioners randomly selected from a commercially available database. The main outcome of interest was level of agreement with a statement about rational suicide.

RESULTS: The corrected participation rate was 50%; 363 questionnaires were analysed. Overall 72% of doctors agreed with the possibility of rational suicide, 17% disagreed, and 11% were neutral. Doctors who identified themselves as being more religious were more likely to disagree. Some doctors who disagreed with legalisation of physician assisted suicide nevertheless agreed with the concept of rational suicide.

CONCLUSIONS: Most senior doctors in England and Wales feel that rational suicide is possible. There was no association with specialty. Strong religious belief was associated with disagreement, although levels of agreement were still high in people reporting the strongest religious belief. Most doctors who were opposed to physician assisted suicide believed that rational suicide was possible, suggesting that some medical opposition is best explained by other factors such as concerns of assessment and protection of vulnerable patients.

**JOW comment:** Like the abstract above (Douglas et al.), it is agreed that there can be a rational basis for suicide/VE, this time specifically noting the distorting prism of belief.

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**Medical end-of-life decisions: does its use differ in vulnerable patient groups? A systematic review and meta-analysis.**
Rietjens JA, Deschepper R, Pasman R, Deliens L.
Medical end-of-life decisions, defined as end-of-life practices with a potential or certain life-shortening effect, precede almost 50% of deaths in Western countries, and receive ample medical-ethical attention. This systematic review aims to detect whether there are differences in the prevalence of medical end-of-life decisions in 'vulnerable' patient groups. In 2009, five major databases were scrutinized for publications containing original data on the prevalence of euthanasia/physician-assisted suicide, life-ending without explicit patient request, intensified symptom alleviation, non-treatment decisions and palliative sedation by social factors (eg age, gender and SES). Heterogeneous findings were pooled using a random effects model. We identified 6377 papers of which 51 papers were selected, involving over 1.09 million patients. Most publications reported the prevalence of non-treatment decisions. The most studied social factors were age and gender. Among patients older than eighty years, non-treatment decisions occurred more frequently compared with younger patients, while intensified symptom alleviation, palliative sedation, euthanasia/physician-assisted suicide and life-ending without explicit request were practiced less often. Similar patterns of association, although less strong, were found for female patients compared with males and those with lower levels of education versus more highly-educated patients. We conclude that the administration of medication with a potential or certain life-shortening effect seemed generally to be practiced less often among the elderly, females and less well-educated patients compared with younger, male or more educated patients, while decisions that include the withdrawal or withholding of treatments seem to be more common in these groups. Further studies should focus on investigating whether these differences reflect less than optimal end-of-life care for specific patient groups.

JOW comment: Again we have evidence that vulnerable groups are less likely to access voluntary euthanasia, contrary to the oft-repeated statements of those opposed.

Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed method approach.

BACKGROUND: The practice of euthanasia and physician-assisted suicide (PAS) in the Netherlands has been regulated since 2002 by the Euthanasia Act. In the ongoing debate about the interpretation of this Act, comparative information about the opinions of the different stakeholders is needed.
AIM: To evaluate the opinions of Dutch physicians, nurses and the general public on the legal requirements for euthanasia and PAS.
DESIGN: A cross-sectional survey among Dutch physicians and nurses in primary and secondary care and members of the Dutch general public, followed by qualitative interviews among selected respondents. The
participants were: 793 physicians, 1243 nurses and 1960 members of the general public who completed the questionnaire; 83 were interviewed.

RESULTS: Most respondents agreed with the requirement of a patient request (64-88%) and the absence of a requirement concerning life expectancy (48-71%). PAS was thought acceptable by 24-39% of respondents for patients requesting it because of mental suffering due to loss of control, chronic depression or early dementia. In the case of severe dementia, one third of physicians, 58% of nurses and 77% of the general public agreed with performing euthanasia based on an advance directive. Interviewees illustrated these findings and supported the Act.

CONCLUSIONS: Health care professionals and the general public mostly support the legal requirements for euthanasia and PAS. The law permits euthanasia or PAS for mental suffering but this possibility is not widely endorsed. The general public is more liberal towards euthanasia for advanced dementia than health care professionals. We conclude that there is ample support for the law after eight years of legal euthanasia.

JOW comment: An unsurprising survey from the Netherlands: acceptance and support for the legalization of voluntary euthanasia. Again there is the sour note that persons with dementia have their advance directives discounted by physicians, a problem that we have previously encountered.