Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey.

BACKGROUND: In 2002, the euthanasia act came into effect in the Netherlands, which was followed by a slight decrease in the euthanasia frequency. We assessed frequency and characteristics of euthanasia, physician-assisted suicide, and other end-of-life practices in 2010, and assessed trends since 1990.

METHODS: In 1990, 1995, 2001, 2005, and 2010 we did nationwide studies of a stratified sample from the death registry of Statistics Netherlands, to which all deaths and causes were reported. We mailed questionnaires to physicians attending these deaths (2010: n=8496 deaths). All cases were weighted to adjust for the stratification procedure and for differences in response rates in relation to the age, sex, marital status, region of residence, and cause and place of death.

FINDINGS: In 2010, of all deaths in the Netherlands, 2.8% (95% CI 2.5-3.2; 475 of 6861) were the result of euthanasia. This rate is higher than the 1.7% (1.5-1.8; 294 of 9965) in 2005, but comparable with those in 2001 and 1995. Distribution of sex, age, and diagnosis was stable between 1990 and 2010. In 2010, 77% (3136 of 4050) of all cases of euthanasia or physician-assisted suicide were reported to a review committee (80% [1933 of 2425] in 2005). Ending of life without an explicit patient request in 2010 occurred less often (0.2%; 95% CI 0.1-0.3; 13 of 6861) than in 2005, 2001, 1995, and 1990 (0.8%; 0.6-1.1; 45 of 5197). Continuous deep sedation until death occurred more frequently in 2010 (12.3% [11.6-13.1; 789 of 6861]) than in 2005 (8.2% [7.8-8.6; 521 of 9965]). Of all deaths in 2010, 0.4% (0.3-0.6; 18 of 6861) were the result of the patient's decision to stop eating and drinking to end life; in half of these cases the patient had made a euthanasia request that was not granted.

INTERPRETATION: Our study provides insight in consequences of regulating euthanasia and physician-assisted suicide within the broader context of end-of-life practices. In the Netherlands the euthanasia law resulted in a relatively transparent practice. Although translating these results to other countries is not straightforward, they can inform the debate on legalisation of assisted dying in other countries.

JOW Comment: This is another hallmark paper on end-of-life practices in the Netherlands. Again it provides evidence of a consistent level of various practices and not a ‘slippery slope’. The macabre practice (in my view) of continuous terminal sedation appears to be on the increase, a bad type of death in many respects. Sadly, though rarely, some individuals still seem to have to starve themselves to death.
**Euthanasia and physician-assisted suicide: Knowledge, attitudes and experiences of nurses in Andalusia (Spain).**

Tamayo-Velázquez MI, Simón-Lorda P, Cruz-Piqueras M.


The aim of this study is to assess the knowledge, attitudes and experiences of Spanish nurses in relation to euthanasia and physician-assisted suicide. In an online questionnaire completed by 390 nurses from Andalusia, 59.1% adequately identified a euthanasia situation and 64.1% a situation involving physician-assisted suicide. Around 69% were aware that both practices were illegal in Spain, while 21.4% had received requests for euthanasia and a further 7.8% for assisted suicide. A total of 22.6% believed that cases of euthanasia had occurred in Spain and 11.4% believed the same for assisted suicide. There was greater support (70%) for legalisation of euthanasia than for assisted suicide (65%), combined with a greater predisposition towards carrying out euthanasia (54%), if it were to be legalised, than participating in assisted suicide (47.3%). Nurses in Andalusia should be offered more education about issues pertaining to the end of life, and extensive research into this area should be undertaken.

**JOW Comment:** This is published evidence from a 70% Catholic country that euthanasia/physician-assisted suicide is carried out – as one would expect. It is curious that assisted-suicide gets a worse press than euthanasia – maybe explicable in the light of Spanish society’s Catholic (suicide is a sin) background.

**Physicians’ and nurses’ experiences of end-of-life decision-making in geriatric settings.**


**Background and aims:** In Italy there is a paucity of empirical data on practices concerning end-of-life decisions (ELDs) in geriatrics. We aimed to investigate the frequency and characteristics of ELDs made by Italian physicians and nurses in the geriatric setting.

**Methods:** In 2009, an anonymous questionnaire was sent to 54 geriatric units, 21 hospices, and 382 nursing homes in the Veneto and Trentino Alto Adige regions, and to professionals in the area who are members of the Italian Gerontology and Geriatrics Association.

**Results:** This paper reports the results of 552 questionnaires answered by 171 physicians, 368 nurses and 13 professionals who did not state their profession. Death was preceded by decisions to start or continue treatments likely to prolong the patients' life in 51.3% of cases. The proportion of deaths preceded by a decision to end life (DEL) was 20.8%; 18% of DELs concerned non-treatment decisions. There were 9 cases of ending of life without patient’s explicit request. No cases of doctor-assisted suicide were reported, while there were 2 cases of euthanasia, one reported by a physician and one by a nurse. **Conclusion:** In
geriatrics, DELs often precede the deaths of terminally-ill Italian patients. Nurses report making DELs more often than physicians, especially in incompetent patients. Continuous deep sedation was adopted by 39.5% of the Italian physicians for deaths not occurring suddenly and unexpectedly. Our report on physicians' and nurses' experiences of end-of-life decision-making in geriatric settings can offer a valuable contribution to the current debate on end-of-life treatment, an issue that goes beyond national borders.

**JOW Comment:** This is published evidence from another (85%) Catholic country that euthanasia/physician-assisted suicide is sometimes carried out. Continuous deep sedation features prominently – unsurprisingly in view of the illegality of VE.

**To end life or not to prolong life: The effect of message framing on attitudes toward euthanasia.**

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Gamliel E.

People ascribe "euthanasia" different values and view it differently. This study hypothesized that a different framing of objectively the same euthanasia situations would affect people's attitudes toward it. Indeed, "positive" framing of euthanasia as not prolonging life resulted in more support for both passive and active euthanasia relative to "negative" framing of the objectively same situations as ending life. Two experiments replicated this pattern using either continuous measures of attitude or dichotomous measures of choice. The article offers two theoretical explanations for the effect of message framing on attitudes toward euthanasia, discusses implications of this effect, and suggests future research.

**JOW Comment:** An interesting paper highlighting the differences context makes in presenting arguments one way or another. In brief, people in support of VE should use the term 'not prolonging life' rather than 'ending life' and vice versa!

"I wouldn't want to become a nuisance under any circumstances"--a qualitative study of the reasons some healthy older individuals support medical practices that hasten death.

Malpas PJ, Mitchell K, Johnson MH.

AIM: To explore the reasons some healthy older New Zealanders support medical practices that hasten death.

METHODS: Recruitment was from the Voluntary Euthanasia Society of New Zealand (VESNZ), an organisation that supports legal medical assistance in dying. All participants were members of VESNZ. 106 individuals returned signed consent forms. All interviews took place in the
participant's home. After 11 interviews, saturation of information was reached and interviewing was stopped.
RESULTS: An important finding of this study indicates that healthy, older individuals who support medical practices that hasten death have serious concerns about their (perceived) future incapacities and dependency on others, as well as their fears around becoming a burden. The study also found that fear of future pain was not a dominant reason to support medical assistance to die.
CONCLUSION: Our study provides confirmation that the fear of being a burden on others is not only felt by those facing their imminent mortality, but also by older individuals who are currently healthy and living independently in the community. We also conclude that for some older people their prior experiences with health care and dying may be a strong factor in influencing and supporting medical practices that hasten death at the end of life. We believe it is crucial to understand the reasons why people support medical practices that hasten death well in advance of such practices ever becoming legally available.

JOW Comment: A useful exercise conducted by our NZ colleagues addressing a reasonable question often avoided in the VE debate. 'Not wanting to be a burden’ is something those against VE frequently regard as counting for little. I quote from US Catholic.org: " If bearing the burdens of our children’s lives has given blessed meaning to ours, why oughtn’t bearing the burdens of our age and infirmity and eventual deaths give meaning and purpose and its special tuition to them?” Against this, breaking the cycle of burden appeals to me.