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Guest Editorial

Assisted Suicide and Euthanasia Should Not Be Practiced in Palliative Care Units

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Introduction

Euthanasia or physician-ssisted suicide (PAS) have been legalized in a small number of jurisdictions. Oregon allows PAS, while in The Netherlands both PAS and euthanasia are legal. Belgium permits euthanasia and Luxembourg may follow suite. Although euthanasia is illegal in Switzerland, assisted suicide is allowed and may be performed by nonphysicians.[1]

In January 2006 the Centre Hospitalier Universitaire Vaudois (CHUV) in Lausanne became the first university hospital in Switzerland to allow, under exceptional circumstances, assisted suicide within its walls.[2] Staff members, however, are not obliged to provide assisted suicide. In such circumstances, external persons, including members of right-to-die societies, are called in. In early 2007, The Hôpitaux Universitaires of Geneva (HUGE), made a similar decision. Other hospitals in the cantons of Vaud and Geneva are considering instituting similar policies. Current and future palliative care units in these hospitals would therefore be placed in a situation of conforming to these institutional directives. We defend the position that assisted suicide (and euthanasia) should not be allowed in palliative care units because it would place many units, their staff and, in some cases, their patients and families, in untenable positions.

Reasons for Not Allowing Assisted Suicide or Euthanasia in Palliative Care Units

Intentionally hastening death is contrary to palliative care philosophy

The World Health Organization's definition states that palliative care does not intentionally hasten death.[3] Most regional, national, and international palliative care organizations and societies have adopted this position.[4] Several reasons are given to justify this stand, amongst which are the beliefs that these practices are intrinsically wrong, violate professional integrity and may endanger the relationship with the patient.[5] Offering assisted suicide (or euthanasia) within palliative care units would therefore mean the endorsement of a policy that runs counter to international norms and standards of palliative care practice.

Sends mixed message to a public that is already poorly informed about palliative care

Many members of the public are unaware of palliative care or misinformed about what it represents.[6,7] Only 30% of the Canadians could explain what it represented in a 1997 study.[6] In a British study, only 18.7% of patients referred to a palliative care service could adequately define the term "palliative care."[7] Allowing assisted suicide and euthanasia within palliative care units, even if the units' staff members are not directly involved in the practices, would send mixed messages to a public that is already misinformed about palliative care.

Source of distress for some patients and families

Not all members of the public endorse assisted suicide or euthanasia.[8] Patients and families who disagree with assisted suicide or euthanasia may decline admissions to palliative care units for fear of being subjected, either directly or indirectly, to these practices. For some patients, the availability of assisted suicide or euthanasia on a palliative care unit may erode their trust in the unit and the treatments it offers.

Source of tension and conflict between palliative care staff

Health care professionals are divided on the issue of assisted suicide and euthanasia. Although the extent of this division varies from country to country, at least a third to a half of physicians or nurses polled express opposition to or support of the practices.[9] Opposition to these practices is particularly strong amongst palliative care professionals; 92% of members of the United Kingdom Association for Palliative Medicine[10] and approximately 72% of physicians of the Swiss Palliative Care Society[11] do not support the legalization of PAS or euthanasia). However, a small minority are open to its legalization (18% in Switzerland).[11] These senti-

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ments may mirror the position of Quill and Battin[12] who contend that while good palliative care should be a standard of care for those who are dying, strong philosophical and ethical principles support access to PAS as a last resort in those rare circumstances where suffering becomes intolerable despite the best palliative care possible.

These contrasting values and views may result in significant tension and conflict between staff members should assisted suicide or euthanasia be allowed on a palliative care unit if not all team members are of the same opinion. Wilkes and colleagues,[13] for example, have described how varying views in a palliative care team towards these practices resulted in unresolved tensions that affected their relationship with patients and each other.

Source of personal distress for some staff members

Staff members with strong or even ambivalent views towards assisted suicide or euthanasia may find themselves in a dilemma.[14,15] Hospice nurses and social workers in an Oregon-based study reported conflict between their personal beliefs against PAS and their advocacy for patient autonomy.[15] The biggest dilemma arose from the conflict between two important hospice values: honoring patient autonomy versus promoting a death experience in which personal and spiritual transformation are possible. They reported other sources of distress, including a sense of "failure" if their patients ultimately chose to hasten death by PAS, conflicts over whether helping patients redefine quality of life impinges on their autonomy, and conflicts over whether to advocate for the patient when the family is against it. Several subjects felt that they had been drawn into an assisted suicide to a greater extent than they would have liked.

Stevens[16] has highlighted the adverse psychological and emotional effects on some physicians who have participated in euthanasia and/or PAS. Caring for terminally ill patients on a daily basis can, at times, be emotionally taxing. The emotional effects of participating directly or indirectly in assisted suicide, particularly when it runs against ones values, may add additional burden. Professionals who do not support the practice may feel torn between nonabandonment and complicity if patients ask them to be present during the final act.

Places palliative care teams in the position of gatekeepers

Allowing assisted suicide or euthanasia on palliative care units could place the team in a position of gatekeepers for assisted suicide. The team, for example, may be drawn into mediating between a patient who has requested assisted suicide and a family that disagrees with the request.[14]

Dynamics of care altered once decision made to proceed with assisted suicide or euthanasia

The reasons that prompt patients to request hastening of death are often complex. The wish to hasten death may also fluctuate.[17,18] Responding to these underlying problems requires a combination of time, the appropriate interprofessional expertise, and therapeutic relationships between caregivers and patients. A decision to proceed with assisted suicide or euthanasia may halt attempts at addressing the underling problems. Anecdotal evidence suggests that the dynamics of care may change once patients make a final decision to proceed with assisted suicide or euthanasia.[19] The focus changes to making practical preparations for receiving assisted suicide or euthanasia. This can derail the team's efforts to ameliorate the sources of distress.

Palliative care units may become "dumping sites" for assisted suicide (or euthanasia)

Access to a palliative care unit that allows assisted suicide or euthanasia may prompt some hospital teams to transfer patients with such requests to the palliative care unit rather than be burdened with having to deal with the requests themselves.

Negative Repercussions of a Policy that Excludes Assisted Suicide or Euthanasia in Palliative Care Units

It would be important to consider the possible negative consequences of disallowing assisted suicide or euthanasia in palliative care units. The specialized interprofessional competencies that these units provide is often the very expertise that is required to address the reasons underlying patients' requests for assisted suicide. A policy that excludes assisted suicide in these units may prevent some of these patients from being admitted and receiving care that could result in them rescinding their original requests. Patients whose wishes for assisted suicide (or euthanasia) despite palliative care will have to be transferred out of the unit again. This may be perceived as abandonment by patients and families.[20] Professionals in the units patients are transferred to may feel unfairly burdened. One strategy to address this potential problem would be to inform patients early on in the relationship that the team does not provide assisted suicide or euthanasia. This would allow them to decide whether or not to continue the relationship or to seek other kinds of support.

Conclusions

Allowing assisted suicide or euthanasia in palliative care units or hospices is associated with considerable risks. Notwithstanding the respective strengths of the arguments for and against assisted suicide or euthanasia, not including these practices as part of palliative care would seem the most prudent approach at this time. This should not however stop an ongoing constructive and mutually respectful discourse between those against assisted suicide and euthanasia and those in favour of these practices. In jurisdictions that allow assisted suicide or euthanasia, palliative care units should be exempted from allowing assisted suicide and euthanasia. As long as the moral permissibility of assisted suicide or euthanasia remain open questions, palliative care units must be permitted to stand outside of the debate, where they can focus on providing care and comfort for patients approaching death. This stand has recently been supported by the CHUV's administration.

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