Original Article

Palliative Treatment Alternatives and Euthanasia Consultations: A Qualitative Interview Study

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Abstract

Context. There is much debate about euthanasia within the context of palliative care. The six criteria of careful practice for lawful euthanasia in The Netherlands aim to safeguard the euthanasia practice against abuse and a disregard of palliative treatment alternatives. Those criteria need to be evaluated by the treating physician as well as an independent euthanasia consultant.

Objectives. To investigate 1) whether and how palliative treatment alternatives come up during or preceding euthanasia consultations and 2) how the availability of possible palliative treatment alternatives are assessed by the independent consultant.

Methods. We interviewed 14 euthanasia consultants and 12 physicians who had requested a euthanasia consultation. We transcribed and analyzed the interviews and held consensus meetings about the interpretation.

Results. Treating physicians generally discuss the whole range of treatment options with the patient *before* the euthanasia consultation. Consultants actively start thinking about and proposing palliative treatment alternatives *after* consultations, when they have concluded that the criteria for careful practice have not been met. *During* the consultation, they take into account various aspects while assessing the criterion concerning the availability of reasonable alternatives, and they clearly distinguish between euthanasia and continuous deep sedation. Most consultants said that it was necessary to verify which forms of palliative care had previously been discussed. Advice concerning palliative care seemed to be related to the timing of the consultation ("early" or "late"). Euthanasia consultants were sometimes unsure whether or not to advise about palliative care, considering it not their task or inappropriate in view of the previous discussions.

Conclusion. Two different roles of a euthanasia consultant were identified: a limited one, restricted to the evaluation of the criteria for careful practice, and

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a broad one, extended to actively providing advice about palliative care. Further medical and ethical debate is needed to determine consultants' most appropriate role. J Pain Symptom Manage 2011;42:32–43.

Key Words
Physician-assisted dying, euthanasia act, end-of-life decision making, palliative care

Introduction

There is much debate about euthanasia and physician-assisted suicide within the context of palliative care. Those who oppose euthanasia often argue that palliative care offers sufficient possibilities to relieve (unbearable) suffering at the end of life.[1] Continuous deep sedation—the administration of sedating drugs until death—can, for instance, be used as an option of last resort.[2,3] In contrast, others believe that euthanasia can be the eventual result of adequate palliative care if unbearable suffering (which can be more than physical suffering alone)[4,5] cannot otherwise be relieved:[6,7] in The Netherlands, alleviating the patient's suffering is the most important principle underlying the Euthanasia Act.[8] Internationally, there have been fears that the acceptance of euthanasia might lead to a disregard of palliative treatment alternatives. The Netherlands has often been criticized for its presumed lack of palliative care, partly because of misunderstandings about the Dutch health care system.[9] However, the quality and accessibility of end-of-life care has improved in the past decade, and physicians can now request expert advice from palliative care consultants in complex medical situations.[10,11] At present an important criticism concerns the practice of continuous deep sedation and its potential overlap with euthanasia in some cases.[12]

In The Netherlands, euthanasia is defined as the deliberate ending of a person's life, at the person's explicit request, by a physician. In physician-assisted suicide, the person self-administers medication that is prescribed by a physician. In 2005, 7% of patients whose death was nonsudden had explicitly requested euthanasia and one-third of these requests had been granted.[13] Physicians who grant a patient's request must comply with six criteria for careful practice (Appendix).[8] Palliative treatment is closely related to one specific criterion, which states that the physician should be convinced that there are no other "reasonable" alternatives available to relieve the patient's suffering.[14] According to parliamentary proceedings, the physician should discuss all the available palliative treatment options with the patient before deciding about euthanasia or physician-assisted suicide. Alternatives comprise treatment options that could either improve the patient's quality of life (e.g., morphine) and/or prolong the patient's life (e.g., palliative chemotherapy or radiotherapy).[15] Although a patient may refuse palliative care, it has been argued that, in certain situations (e.g., not very invasive, few or no side effects), the refusal of palliative options may shed doubts on the "unbearableness" of the patient's suffering, and physicians may, therefore, conclude that euthanasia is not justified.[16–18]

These six criteria, to some degree, overlap, and attention toward palliative care is not only related to the "treatment criterion;" to some extent, palliative care also relates to other criteria. For example, the requirement of no reasonable alternatives also is related to the requirement that the suffering should be hopeless.

Apart from being evaluated by the treating physician, the law establishes that the availability of reasonable treatment alternatives also must be evaluated by an independent physician (Appendix). In The Netherlands, a specialized service (Support and Consultation for Euthanasia in the Netherlands [SCEN])[19] teaches physicians how to give expert advice and how to hold formal and independent consultations as part of the euthanasia review procedure. Their involvement is substantial: they were consulted in 90% of all 2005 euthanasia cases.[16] By visiting the patient, the consultant independently evaluates the criteria. The independent consultation can be an important