Original Article

When Physicians Report Having Used Medical Drugs to Deliberately End a Patient's Life: Findings of the "End-of-Life in France" Survey

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Abstract

Context. The debate on the decriminalization of active assistance in dying is still a topical issue in many countries where it is regarded as homicide. Despite the prohibition, some physicians say they have used drugs to intentionally end a patient's life.

Objectives. To provide some empirical grounding for the ongoing debate.

Methods. Using data from the *End-of-Life in France* survey (a representative sample of 15,000 deaths that occurred in December 2009, questionnaires completed anonymously by the physicians who had certified the deaths), we selected all the cases where the physician had used one or more drugs to intentionally end a patient's life and compared the decisions and decision-making process with the conditions imposed by the French law for decisions to withhold or withdraw life-supporting treatments and by the Belgian law on euthanasia.

Results. Of the 36 cases analyzed, four situations seemed to be deliberate acts after explicit requests from the patients, and only two seemed to fulfill the eligibility and due care conditions of the Belgian euthanasia law. Decisions made without any discussion with patients were quite common, and we observed inadequate labeling, frequent signs of ambivalence (artificial feeding and hydration not withdrawn, types of drug used), and little interprofessional consultation. Where the patient had requested euthanasia, the emotional burden on the physician was heavy.

Conclusion. These findings underscore the pressing need for a clarification of the concepts involved among health professionals, patients, and society at large, and better training and support for physicians. J Pain Symptom Manage 2015;50:208–215.

Key Words
End of life, France, physician-assisted deaths

Introduction

The first survey on end-of-life conditions in France showed that, in 2010, physicians reported using drugs to intentionally end the patient's life in 0.8% of all deaths.[1] In the Flanders region in Belgium, in surveys using a similar methodology, the corresponding proportions were 4.4% of all deaths in 1998 and 3.8% in 2007[2] (i.e., before and after the practice of euthanasia was partially decriminalized).

The Belgian law imposes stringent conditions for decriminalized euthanasia. To qualify for euthanasia, patients must be conscious and competent; they must have a serious and incurable disease with no hope of improvement and suffer from constant, unbearable, and uncontrollable physical and/or psychological pain. Any physician who accepts a request for euthanasia must first ensure that the request is spontaneous, reasoned, and repeated over time. Moreover, he or she is required to consult a second physician to ensure that the criteria "serious and incurable disease" and "at the patient's request" are satisfied and, if the death is not imminent, to confirm the existence of constant, unbearable, and uncontrollable pain. He or she must also discuss this request with

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the patient's medical care team. Yet even in 2007, in 48% of (anonymously reported) cases where a drug had been administered with the intention of causing death, the patient had not requested it.[2] The French 2005 law[3] condemns unreasonable obstinacy in medical treatment but still prohibits euthanasia. It stipulates that a physician can withhold or withdraw a life-sustaining treatment if a patient so requests and is considered competent. If the patient is not, the decision can only be made by the physician after taking into account advance directives, the testimony of an appointed trusted person, or, if none, the family or close friends. The decision process must also involve the nursing team and another physician. The law also allows the use of sedation to alleviate distress in the terminal phase, even if, in some particular and complex situations, it may hasten death, and clinical guidelines have been issued.[4] The 2010 French survey shows that even in cases of (illegal) assistance in dying (use of drugs to intentionally end life), in two-thirds of cases the patient had made no request for euthanasia.[1]

A thorough analysis of this type of situation has been made in Belgium,[5,6] and Smets et al.[7] explored the ways in which Belgian physicians qualified their end-of-life decisions. These studies show that 10 years after Parliament had decriminalized euthanasia, ambiguities still persisted in the labeling of end-of-life decisions. This has fed into the debate over the decriminalization of active assistance in dying, still topical in many countries where it is regarded as homicide.[8,9] But despite these ambiguities, Quebec recently passed a law, contrary to the federal government's stance, allowing physicians to administer drugs with the intention of causing death.[10]

What was the situation in France five years after enactment of the 2005 law on Patients' Rights and End-of-Life? From physicians' responses to the *End-of-Life in France* survey of 2010, we sought answers to the following questions: When the physicians said they had used drugs to intentionally end a patient's life, to what extent did the clinical situation and the decision-making process fulfill the legal conditions and criteria of due care governing decisions to withhold or withdraw life-supporting treatments in France or for euthanasia in Belgium? Do physicians sometimes find themselves in an insoluble situation, and if so what kind? If they have experienced such a situation, what did they think about it subsequently?

Methods

The method for the *End-of-Life in France* survey[1] was inspired to a large extent by the Eureld surveys[11] and by surveys conducted in Belgium and The Netherlands.[12] It was based on a representative sample of adult deaths; the physicians who had certified the deaths were questioned in retrospect, and the respondents' anonymity was fully guaranteed.

The Belgian 2007 questionnaire was slightly altered to take account of French legislation, in particular the 2005 law (trusted person, advance directives, discussion with patient, family, collegiality of the discussion). Both French and Belgian questionnaires included questions about the decedents' end-of-life conditions, including any palliative care, the decision-making process (whether advance directives had been identified, and, if so, taken into account, and who was involved), with particular attention to any request made by the patient and to their competence (consciousness, level of comprehension, and expression). The physicians were also asked about their medical decisions (Did you "do everything possible to prolong life," "withhold a therapy liable to prolong life," "withdraw a treatment liable to prolong life," "intensify treatment for pain and/or symptoms using one or more drugs," or "use one or more drugs to intentionally end patient's life"?), about whether they had intended to hasten death, and what term they would use to describe their last medical act. The questionnaire is available on the Institut National d'Etudes Démogra-phiques (INED) Web site (http://fdv.site.ined.fr/fichier/s_rubrique/20490/ined.fdv.questionnaire.16x24.fr.pdf).

Of the 14,999 deaths in the initial sample, 4891 questionnaires were filled in and validated. In a telephone survey among a sample of 585 nonresponding physicians, the topic of the survey was rarely mentioned as a reason for not responding (only around 2%). Lack of time and difficulties in accessing patients' files were by far the most common reasons given.

In this article, we consider all the cases in which the physician reported using drugs to intentionally end the patient's life. The internal consistency of the responses of each questionnaire (e.g., between the labeling of the last act and the type of end-of-life decisions made, or reasons given and clinical symptoms) was systematically assessed by one of the authors and reassessed by a palliative care practitioner and an intensive care unit practitioner. Then they were classified according to the existence, or not, of an explicit patient request (for euthanasia or concerning the last act) and according to the labeling of the last medical act by the physician. We described the situations in each category, comparing them with the eligibility and due care criteria in the French and Belgian laws. The detailed case analyses are available from the authors on request.