


 CHAPTER 21

Euthanasia and Physician-Assisted Suicide

Bert Broeckaert

KEY POINTS

- It is best to limit use of the term *euthanasia* to those cases in which the life of the patient is terminated actively (i.e., by lethal medication) and directly (intentionally).
- Voluntary euthanasia is legalized in two countries, The Netherlands and Belgium. Physician-assisted suicide is allowed in The Netherlands, in Switzerland, and in the U.S. state of Oregon.
- The attitude of world religions toward euthanasia and physician-assisted suicide is predominantly negative.
- There is a sharp distinction between euthanasia and physician-assisted suicide on the one hand and pain control and palliative sedation on the other.
- Requests for euthanasia should always be taken seriously and should cause a thorough evaluation and optimization of the care offered.

The essential ethical dimension of the challenges with which physicians are confronted in care for the terminally ill cannot be ignored. Even though many other ethical questions and problems in palliative care practice are more frequent, euthanasia and physician-assisted suicide are often seen as the foremost ethical problems. This issue provokes much emotion on all sides and can cause major controversy. It is impossible to describe the many facets of the euthanasia debate in just a few pages, so a few important topics are discussed briefly.

DEFINING EUTHANASIA

A meaningful ethical discussion on euthanasia is possible only if we first agree on the terminology. This affects the rest of the discussion. It is of major importance to define euthanasia and physician-assisted suicide in a way that is both sufficiently inclusive and specific but simultaneously links to the language of daily life. Euthanasia literally means “good or mild” (*eu*) “death” (*thanatos*); in the original sense, euthanasia had nothing to do with the actions or interventions of physicians, certainly not in terminating or shortening life. Euthanasia was simply the gentle and natural death almost every human being wanted and wants. When this old term was revisited in the 16th century, the focus shifted to the doctor, even though, at that time, shortening or ending a person’s life was not implied. The term referred to what the physician could do to facilitate a gentle death. Euthanasia, thus defined, seems to coincide with what is now called palliative care.

Samuel D. Williams (1870) and Lionel Tollemache (1873), originators of the pro-euthanasia movement, were the first to use the word *euthanasia* in its modern meaning of “mercy killing.”¹ From the fierce debate sparked by their ideas, various types of euthanasia were distinguished, and euthanasia became an umbrella term referring to all medical actions or omissions intended to shorten life and/or having a life-shortening effect. Voluntary was distinguished from nonvoluntary euthanasia, active (doing) from passive (withholding or withdrawing), and direct (intentional) from indirect (death accepted but not intended).

Many cling to this broad concept of euthanasia. In contrast, a strict definition of euthanasia has been in use in The Netherlands since 1985, and in Belgium since 1997.^{2,3} In these countries, *euthanasia* is defined as “intentionally terminating life by someone other than the person concerned, at the latter’s request.” Euthanasia is active, direct, and voluntary by definition.

The term *passive euthanasia* does not appear to be expedient. First, it is counterintuitive. Belgium and The Netherlands are said to be the only countries to have legalized euthanasia, but passive euthanasia—*withholding or withdrawing life-sustaining treatment*—is possible and legal in virtually all countries. Second and most important, it is wrong to imply or suggest that, as a rule, withholding or withdrawing a life-sustaining treatment has a life-shortening effect and implies a life-shortening intention. Therefore, it is best to stop talking about passive euthanasia and assume that euthanasia is active by definition. Many authors share this opinion.⁴

As far as the distinction between *direct* and *indirect euthanasia* is concerned, the same rationale can be followed. First, what is called “indirect euthanasia” is allowed in most countries, so this term also appears to be counterintuitive. Second, when indirect euthanasia refers to pain control with a life-shortening effect, it is (completely erroneously) postulated that pain treatment has an intrinsic life-shortening effect.⁵ Moreover, the intention of pain control and direct euthanasia are so different that they cannot be placed under the same heading (euthanasia).

The last of the major classic distinctions is that between *voluntary* and *nonvoluntary* euthanasia. I believe that there are more fundamental similarities than differences between voluntary and nonvoluntary euthanasia, so it is appropriate to maintain this dichotomy. In both cases, the same unusual and controversial act is meant—to actively and directly terminate a life, as painlessly as possible—and for the same reason (i.e., to spare further suffering). Nonvoluntary euthanasia does occur. Even though it is viewed very negatively and often equated with murder, this does not remove the need for a clear terminology.

In conclusion, what is needed is a definition that makes clear (1) that death is the result, not of withholding or withdrawing life-sustaining treatment, but of an active intervention; (2) that there is not only a life-terminating effect but also a life-terminating intention; (3) that the objective is to have a gentle, mild death; and (4) that life-terminating action is undertaken because the patient’s incurable condition is considered unbearable. Taking these points into account, I offer the following definitions:

- *Voluntary euthanasia*: The intentional administration of lethal drugs in order to painlessly terminate the life

of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient's request.

- *Nonvoluntary euthanasia*: The intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable, not at this patient's request.

The main difference between assisted suicide and euthanasia is that, in the case of assisted suicide and physician-assisted suicide, the patient undertakes the killing act. I suggest the following definitions:

- *Assisted suicide*: intentionally assisting a person, at this person's request, to terminate his or her life
- *Physician-assisted suicide*: a physician's intentionally assisting a patient, at this patient's request, to terminate his or her life

Being for or against euthanasia or assisted suicide does not relieve anyone from their duty to reflect thoroughly on the terminology. Accepting a certain terminology does not mean that one deems the practice defined as acceptable, and certainly not in all circumstances.

LEGAL SITUATION

Until now, only two countries, The Netherlands and Belgium, have legalized voluntary euthanasia. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act came into force in The Netherlands on April 1, 2002; in Belgium, the Act Concerning Euthanasia went into effect on September 23 of the same year. From this and the fact that they are neighboring countries that (partly) share the same language, it cannot simply be concluded that similar social processes are the basis of both laws. This is not the case. In The Netherlands, the euthanasia act is the codification of case law from a broad euthanasia debate and a euthanasia practice that started more than 3 decades ago. In contrast, Belgium was a fairly ordinary European country, as far as euthanasia was concerned, until political debate started in 1999; there was no established euthanasia practice.⁶

The two countries' laws show great resemblance (e.g., allowing voluntary euthanasia in the nonterminal and also on the basis of mental suffering and advance directives), but there are also significant differences. The Belgian Act deals exclusively with euthanasia, the Dutch Act with both euthanasia and physician-assisted suicide. The Belgian Act describes the procedure in minute detail, but the concise Dutch Act does not. In Belgium, euthanasia based on an advance directive is possible only if the patient is irreversibly unconscious; the Dutch Act has no such limitation. The Netherlands allow euthanasia in children older than 12 years of age; the Belgian Act imposes a minimum age of 18 years. The Belgian Act explicitly states that "a serious and incurable disorder *caused by illness or accident*" [italics added] should be at the root of the suffering; the Dutch Act does not mention this medical condition (which could lead to broad interpretations of "hopeless and unbearable suffering" that were, however, rejected by the Dutch Supreme Court in December 2002).² In Belgium, 259 euthanasia cases were reported to the national euthanasia commission between September 2002 and Decem-

ber 2003. In 2004 349 cases of euthanasia were reported and in 2005 393 cases.⁷ In The Netherlands, 1815, 1886, 1933, and 1923 cases of euthanasia and physician-assisted suicide were officially reported in 2003, 2004, 2005, and 2006, respectively.⁸ A study commissioned by the Dutch government indicated that, in 2001, 54% of the actual cases of euthanasia and physician-assisted suicide were officially reported.⁹

Apart from Belgium and The Netherlands, the U.S. state of Oregon, Switzerland, and The Northern Territory of Australia need to be mentioned. In The Northern Territory, the Rights of Terminally Ill Act (1995) was in force for a short time. This act allowed for euthanasia and physician-assisted suicide in competent, terminally ill adults but was revoked by the Australian national parliament in 1997. In Switzerland, assisted suicide is not punishable, provided that this assistance is not given from selfish motives. There is, however, no Swiss law regulating this practice. Euthanasia is illegal. Assisted suicide in Switzerland is only rarely physician assisted; involvement of a physician is neither necessary nor implied.¹⁰ Oregon's Death With Dignity Act came into effect in 1997. It allows physician-assisted suicide (but not voluntary euthanasia) in competent, terminally ill adults. In January 2006, the U.S. Supreme Court upheld this act. In 2003, 2004, 2005, and 2006, respectively, 42, 37, 38, and 46 assisted suicide deaths were officially reported in Oregon.¹¹ In many other countries, voluntary euthanasia bills have been submitted and debated (e.g., the Assisted Dying for the Terminally Ill bill in Great Britain during 2004, 2005, and 2006), but so far none has had majority support.

Except for The Netherlands, Belgium, the State of Oregon, and Switzerland (which simply decriminalized assisted suicide), there are no countries or states with a legal framework that allows voluntary euthanasia or physician-assisted suicide. Those who perform voluntary euthanasia outside of Belgium and The Netherlands are acting outside the law and risk legal prosecution. Physicians involved in physician-assisted suicide outside of Oregon, Switzerland, and The Netherlands are either breaking the law or at risk. Nonvoluntary euthanasia is not allowed in any country or state and therefore is prone to prosecution everywhere.

PUBLIC OPINION

Data from the European Values Studies (1981, 1990, and 1999-2000) showed that, in virtually all Western European countries, public acceptance of euthanasia (defined as "terminating the life of the incurably ill") has increased.¹² A similar trend can be noticed in the United States. Public opinion, as shown by U.S. figures, is, however, fluctuating and still fluid.¹³ The changing public opinion is determined not only by factors such as the waning influence of religion, the greater importance given to autonomy or self-determination, and increasing permissiveness, but also by concrete cases and the ways in which these are portrayed in the media by supporters and opponents of euthanasia.

Based on the most recent data on societal attitudes in 33 European countries, from the 1999-2000 European Values Studies, the average acceptance scores in The Netherlands and in Belgium (on a scale of 1 to 10) are not

fundamentally different from those in a number of other European countries. The Netherlands (6.68) does indeed have the highest score, but Denmark (6.61), France (6.16), and Sweden (6.07) all precede Belgium (5.97). The other European countries have scores between 5.63 (Luxembourg) and 2.23 (Malta), with an average European score of 4.71.¹⁴ The reason that Belgium and The Netherlands have euthanasia legislation is clearly not because public opinion in these two countries is significantly different from that in the rest of the world.

Of course, responses to questionnaires on euthanasia and assisted suicide are determined by the ways in which questions are formulated. The image of a terminally ill person, victim to unbearable and indelible physical pain, who requests that his or her life be terminated will find in most Western countries a majority who think that euthanasia not only is morally acceptable but should be legally possible.

FOUR ASSUMPTIONS

Public opinion on euthanasia and physician-assisted suicide is fluid, not rigid. Moreover, it would be a mistake to assume that public opinion on these issues is really *informed*; that is, based on a correct assessment of the actual problems faced by terminally ill patients and the actual possibilities offered by palliative care. Four assumptions are often present in public opinion regarding euthanasia and physician-assisted suicide.

First Assumption: Some People Die an Inhumane Death

Politicians who submit and defend a euthanasia bill often do so from an ethical commitment, a genuine concern for the fate of those who die in inhumane circumstances. Indeed, although great progress has been made in this area, there still are people who are confronted, on their deathbed, with sustained and unbearable suffering. Any family member, friend, acquaintance, or caregiver who has witnessed such dying may, not surprisingly, adopt a positive attitude toward euthanasia and physician-assisted suicide. In any case, the impact of such personal experiences or media stories on attitudes toward euthanasia cannot be overestimated.

Second Assumption: Palliative Care Is Helpless in Such Cases

What is problematic in the reasoning that without euthanasia and physician-assisted suicide some people die an inhumane death is not the fact that incurably ill patients do sometimes end life in degrading circumstances. It is rather the incorrect assumption that they do so because nothing else is possible, because in these tragic cases medicine is powerless and unbearable suffering is simply an unavoidable part of dying. However, even if inhumane deaths do occur, they do not have to.

This assumption underestimates the possibilities offered by specialized and interdisciplinary palliative care. It is almost always possible to allow a humane, dignified death. Pain and other symptoms (e.g., nausea, angst, restlessness) can be handled adequately by specialized palliative

care. In extreme cases, it may seem impossible to bring certain physical or psychological symptoms under sufficient control using medication and still leave the patient fully conscious. Palliative care then offers the possibility, in consultation with the patient and the family, to administer palliative sedation, in which consciousness is reduced to the point that refractory symptoms are adequately suppressed. This second assumption is a serious underestimation of the ability of palliative care to free patients from unbearable suffering and to ensure that the reasons for many euthanasia requests simply disappear.

Third Assumption: The Average Physician Has the Necessary Expertise for Palliative Care

The argument that euthanasia and physician-assisted suicide are needed because some people would otherwise die an inhumane death rests on yet another, equally questionable presupposition. This is the idea that people who die inhumanely do so only after their physicians and caregivers have provided all the palliative care possible so as to spare the patient this bitter end. It is a mistake to believe that the average physician, nursing home, or hospital ward possesses the expertise and means for state-of-the-art palliative care. Lessons from the field of pain control—and effective pain control is absolutely essential in palliative care—reveal that the average medical treatment of the incurably ill often exhibits grave shortcomings. Sadly, expert palliative knowledge is not yet generally available.

Fourth Assumption: The Unbearably Suffering Patient Is Making a Free, Autonomous Choice

A fourth, and again questionable, assumption has to do with the putative autonomy of the unbearably suffering patient. A terminally ill patient who suffers intolerable pain and sees no end to the pain will quickly be driven to ask for euthanasia or assisted suicide. In such a case, the patient is not making a free, autonomous choice. The pressure exerted by the degrading circumstances is so great that the patient's own will and convictions scarcely have any influence. In cases like this, the patient's choice cannot be between palliative care on the one hand and euthanasia or physician-assisted suicide on the other. Palliative care is not some exotic or esoteric therapy available to the incurably ill patient as just one possibility. It is, or rather should be, the active and total standard approach with which medicine and health care respond to the terminally ill. In this sense, it is, or should be, more a self-evident point of departure than a conscious and explicit choice made by the patient.

If one really wants to respect autonomy and freedom of choice, it is of the utmost importance that terminally ill patients be treated according to the principles of palliative care. Otherwise, many people will request (and receive) euthanasia for reasons that have more to do with the shortcomings of the health care system than with autonomous will.

Palliative care cannot resolve or prevent every request for euthanasia or physician-assisted suicide. There will always be people who continue to request euthanasia, even with the best palliative measures, and even when the

physical and psychological symptoms from which they suffer have been controlled. In many cases, these are people who consider their lives no longer meaningful or people who want to stay in control. It is on the basis of these considerations, the level of meaning rather than purely physical or psychological problems, that their request for euthanasia should be understood. However, regular contact with dying people teaches that only a small minority who request euthanasia belong to these categories. With the vast majority of patients requesting euthanasia, the request vanishes after the beneficial effects of good palliative care (including specific attention to the patient's psychological and spiritual needs) are applied. The vast majority of the terminally ill do not *want* euthanasia; they want to live, even in the final months, weeks, and days. Palliative care is not so much about humane *dying* as it is about humane *living* in the face of death.¹⁵

WORLD RELIGIONS AND EUTHANASIA

Only a brief overview of how the major religions view euthanasia (as defined earlier in this chapter) and assisted suicide is presented here. Obviously, this says nothing about the various religions' ideas on pain control, palliative sedation, or withholding or withdrawing life-sustaining treatment. All religious traditions share a positive view of palliative care.

Various studies point to a clear link between religious affiliation and a negative attitude toward euthanasia and physician-assisted suicide.¹⁴ This is not surprising. Those who assume that God determines and controls reality and decides on life and death will be reluctant to take such decisions upon themselves. The view of major religions on euthanasia and assisted suicide is predominantly negative. Almost all Jewish rabbinic authors argue against euthanasia and assisted suicide. Even when a person is a *goses* (a person expected to die within 72 hours), it is not allowed to intentionally speed up the process. For this position, orthodox, conservative, and reformist rabbis all refer back to the *halakhab* (the Jewish religious law, consisting of Torah, Talmud, and other texts).¹⁶ Among the various Christian churches, sanctity of life prevails. Life has been given to us by God and it belongs exclusively to Him. Killing an innocent fellow human, even at his or her own request, goes against the biblical command "Thou shalt not kill" and is a denial of the intrinsic value of each human being, made in God's image. The official position of most Christian churches is very much opposed to euthanasia and assisted suicide. Muslims have a similar attitude. Based on the sanctity of life, the idea that human beings are stewards responsible for their bodies, and the prohibition to go against the divine plan that God has for every person, euthanasia and assisted suicide are unacceptable for the Islamic *ulama* (religious authorities).¹⁷

Euthanasia and assisted suicide violate important Hindu ideals and principles. They clash with the central virtue of *ahimsa* (non-harming) and result in bad *karma* for both the physician (who uses violence) and the patient (who will be faced with suffering again in a next life, because of his or her mistakes in previous lives). On the other hand, it is sometimes argued that helping a patient to die is not a violation of the physician's *dharm*a (duty).¹⁸ The principle of *ahimsa* also plays a central role in Bud-

dhism. The first of the Five Precepts, the five fundamental commands for laymen, forbids killing. Based on the aforementioned *karma* doctrine, most Buddhist religious leaders and authors are reluctant to condone euthanasia and assisted suicide. Others, however, point out the major importance of compassion (*karuna*) in Buddhism and, as a result, advocate some openness to euthanasia and assisted suicide.¹⁹ Sikhism offers its followers a general framework (focused on the sacred scripture of the Sikh, the Guru Granth Sahib), but it does not offer concrete guidelines regarding new ethical dilemmas. Sikhism considers life as a gift of God, and God is the one who decides on life and death. Based on these principles, most Sikh denounce euthanasia and assisted suicide.

SLOW EUTHANASIA?

There is much confusion with regard to pain control and sedation among the general public. Medical practice itself is not always unambiguous. Some studies have investigated the incidence of "intensification of the alleviation of pain and suffering *partly with the intention of hastening the patient's death*" [italics added], categorizing this doubtful but regrettably not uncommon practice, no questions asked, as pain and symptom control.^{20,21} Sedation, in turn, is sometimes accused of being "slow euthanasia."²² In any case, ambiguity and abuse put pain control and sedation in a poor light, making them appear similar to euthanasia, and can cause colleagues, patients, and families to fear heavy pain medication or sedation. Undertreatment of serious pain and inhuman suffering can be the tragic consequence.

To avoid misunderstandings and malpractice, I previously introduced the term *palliative sedation* (to replace the ambiguous *terminal sedation*)²³ and offered precise definitions of both pain control ("the intentional administration of analgesics and/or other drugs in dosages and combinations required to adequately relieve pain") and palliative sedation ("the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms").²³⁻²⁵ Definitions such as these allow a sharp line between pain control and palliative sedation on the one hand and euthanasia on the other. The essence of both pain control and palliative sedation is that they are forms of symptom control. The physician's intention in both cases is to fight a symptom, not to terminate life. All actions taken need to reflect this intention. In a field where dosages and combinations are crucial (i.e., overdosing can, in fact, shorten life), the dosages and combinations administered should be in proportion to the specific suffering the clinician wants to alleviate. Adequacy and proportionality are at the forefront of what is and should be done on an objective level.

There is, then, this important and threefold distinction: the *intention* (symptom control), the *action* (administering only what is necessary to control the symptom), and the *result* (in the vast majority of cases, no life-shortening effect) are totally different in pain control and palliative sedation versus euthanasia²³⁻²⁶ (Table 21-1). A physician who claims to carry out pain control or palliative sedation but in fact knowingly overdoses to shorten a patient's life may be administering "slow euthanasia" but is certainly

TABLE 21-1 Distinctions among Pain Control, Palliative Sedation, and Euthanasia

FACTOR	PAIN CONTROL	PALLIATIVE SEDATION	EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE
Intention	Symptom control	Symptom control	Terminating life
Action	Administering as much medication as needed to control the pain (proportionality)	Administering as much medication as needed to control the symptom (proportionality)	Administering as much medication as needed to terminate life
Result	Shortens life only in very exceptional cases (and may have a life-lengthening effect)	Shortens life only in exceptional cases	Termination of life (by definition)

not performing pain control or palliative sedation. Even more problematic than euthanasia or physician-assisted suicide is euthanasia in disguise.

DEALING WITH REQUESTS FOR EUTHANASIA OR PHYSICIAN-ASSISTED SUICIDE

Caregivers who work with the incurably ill will be confronted with patients who (either in guarded terms or explicitly) ask for euthanasia or assisted suicide or family members who ask to end the suffering of their loved one. Several elements play a pivotal role in an ethically responsible approach to dealing with these questions. Let us assume a legal situation in which both euthanasia and physician-assisted suicide are illegal, although the points discussed are equally important in Belgium, The Netherlands, Oregon, and Switzerland.

Employ Dialogue and Respect

Dialogue and respect are crucial in dealing with requests for euthanasia or assisted suicide. The best chances of a dignified death are through honest dialogue, characterized by openness and respect for the beliefs, emotions, and attitudes of the patient and family as well as those of the physician and other caregivers.

Comply with the Law

In a society in which euthanasia and assisted suicide are prohibited, as a general rule the physician should comply with the law. This principle goes beyond simply avoiding the risk of prosecution and its consequences for the physician and the institution. First of all, physicians are not to put themselves above the law, certainly not in situations of life or death; physicians can and should exert their professional autonomy within the boundaries set by society through its legislative bodies. Second, with illegal euthanasia and assisted suicide, it is likely that procedural safeguards found in euthanasia laws would not be respected; to avoid the risk of prosecution, euthanasia and assisted suicide would be carried out in secret. For this reason, open discussion with the nursing team, with an independent colleague, with the palliative care team, and so forth would not take place. As a result, there is a higher risk that euthanasia or assisted suicide would be performed in cases in which other, much less drastic and problematic measures could have solved the unbearable suffering.

Take the Request Seriously

The fact that what is requested (i.e., euthanasia or physician-assisted suicide) is out of the question, does not imply

that the physician should not take the request of the patient or family very seriously. In an open and continued dialogue with the patient and/or the family, the physician should communicate that, although euthanasia and assisted suicide are not an option, the whole team of caregivers will do whatever they can and propose any appropriate palliative treatment (including, if necessary, palliative sedation) to ease suffering.

Discover the Reasons behind the Request

People do not request euthanasia or assisted suicide out of some morbid death wish or because they have always wanted so much to die, but rather because, at a certain moment in their illness, their suffering, and consequently life itself, becomes unbearable. Moreover, will to live and will to die show substantial fluctuation among the dying.²⁷ Various factors can be decisive in a request for euthanasia or assisted suicide, often in combination; these include fear of what is to come, respiratory difficulties, physical pain, loss of control, increasing weakness and dependence on others, and hopelessness and depression.^{28,29} Behind a request for euthanasia or assisted suicide there is always physical, psychological, social, or spiritual suffering that has caused a decline in quality of life. It is the responsibility of the caregiver who receives a request to discover, through successive open and in-depth discussions, the reasons behind the patient's desire to end his or her life. What is it exactly that makes the patient's life no longer bearable?

Re-evaluate and Optimize the Care Offered

How can caregivers alleviate the physical, psychological, social, or spiritual suffering that lies at the origin of requests for euthanasia or assisted suicide? A request to end one's life, even if vague, must always stimulate a thorough evaluation and optimization of the care offered. What might be done to optimize the care (including psychological and spiritual care) even more precisely to the needs of the patient? Is it really impossible to alleviate the suffering? Have we simply reached the limits of our abilities and therefore require specialized advice?

Take an Interdisciplinary Approach

Because it considers patients in their totality, palliative care is interdisciplinary by definition. For this reason, a physician who receives a request for euthanasia or assisted suicide can never act alone. Dealing with such a request responsibly always involves an interdisciplinary approach.

There are diverse and complex motives that can underlie such a request, and various caregivers can offer their own perspectives. For instance, nurses are often close to their patients, both literally and figuratively, and therefore are often in a good position to know the reasons behind the request. Specialized input from various disciplines is frequently necessary to alleviate the patient's suffering.

Consult the Palliative Support Team

Because of the crucial role played by specialized and interdisciplinary expertise, it is strongly recommended that the local palliative support team be consulted whenever a physician or a nurse is confronted with a request for euthanasia or assisted suicide. It is the role of this team to improve the quality of life of the incurably ill and to alleviate their suffering as much as possible, no matter what its nature. These interdisciplinary teams provide palliative expertise; they do not make decisions in the place of the patient, the physician, or the nurse involved but rather inform them about the various palliative options and offer support, especially in very difficult circumstances.

CONCLUSION: A PALLIATIVE FILTER

Euthanasia and physician-assisted suicide are among the most controversial issues in palliative care. There are many aspects of this delicate ethical problem, only a few of which have been briefly discussed here. Interdisciplinary palliative care certainly cannot prevent or give an adequate answer to each and every euthanasia request. What I have called a *palliative filter*³⁰ can prevent much unbearable suffering as well as the tragedy of euthanasia or physician-assisted suicide associated with false choices resulting from poor palliative care rather than an explicit wish to end one's life.

REFERENCES

1. Emanuel EJ. The history of euthanasia debates in the United States and Britain. *Ann Intern Med* 1994;121:793-802.
2. Adams M, Nys H. Euthanasia in the low countries: Comparative reflections on the Belgian and Dutch euthanasia act. In Schotsmans P, Meulenbergs T (eds). *Euthanasia and Palliative Care in the Low Countries*. Paris, Peeters, 2005, pp 5-33.
3. Belgian Advisory Committee on Bioethics. Advice No 1 of 12, May 1997, concerning the desirability of a legal recognition of euthanasia. Available at https://portal.health.fgov.be/portal/page?_pageid=56,512676&_dad=portal&_schema=PORTAL (accessed January 2008).
4. Roy DJ. Euthanasia and withholding treatment. In Doyle D, Hanks G, Cherny N, Calman K (eds). *Oxford Textbook of Palliative Medicine*, 3rd ed. Oxford: Oxford University Press, 2005, pp 84-97.
5. Bercovitch M, Waller A, Adunsky A. High dose morphine use in the hospice setting: A database survey of patient characteristics and effect on life expectancy. *Cancer* 1999;86:871-877.
6. Broeckaert B. Belgium: Towards a legal recognition of euthanasia. *Eur J Health Law* 2001;8:95-107.
7. Federale Controle en Evaluatiecommissie Euthanasie. Eerste verslag aan de wetgevende kamers (22 September 2002-31 December 2003), 22 November 2004. Available at <http://www.dekamer.be/FLWB/pdf/51/1374/51K1374002.pdf> (accessed September 2007).
8. Regionale toetsingscommissies euthanasie. Available at <http://www.toetsingscommissies euthanasie.nl/Toetsingscommissie/jaarverslag> (accessed January 2008).
9. van der Wal G, van der Heide A, Onwuteaka-Philipsen BD, van der Maas PJ. Medische besluitvorming aan het einde van het leven: De praktijk en de toetsingsprocedure euthanasie. Utrecht: De Tijdstroom, 2003.
10. Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: Allowing a role for non-physicians. *BMJ* 2003;326:271-273.
11. State of Oregon. Death with Dignity Act. Available at <http://www.oregon.gov/DHS/ph/pas> (accessed January 2008).
12. Cohen J, Marcoux I, Bilsen J, et al. Trends in acceptance of euthanasia among the general public in 12 European countries (1981-1999). *Eur J Public Health* 2006;16:663-669. Epub 2006 Apr 26.

13. Duncan OD, Parmelee LF. Trends in public approval of euthanasia and suicide in the US, 1947-2003. *J Med Ethics* 2006;32:266-272.
14. Cohen J, Marcoux I, Bilsen J, et al. European public acceptance of euthanasia: Socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 European countries. *Soc Sci Med* 2006;63:743-756.
15. Cannaearts N, Dierckx de Casterlé B, Grypdonck M. *Palliatieve Zorg: Zorg Voor Het Leven, een Onderzoek Naar de Specifieke Bijdrage van de Residentiële Palliatieve Zorgverlening*. Gent: Academia, 2000.
16. Mackler AL. Introduction to Jewish and Catholic Bio-Ethics: A Comparative Analysis. Washington, DC: Georgetown University Press, 2003, pp 64-84.
17. Brockopp JE. Islamic Ethics of Life: Abortion, War and Euthanasia. (Studies in Comparative Religion.) Columbia: University of South Carolina Press, 2003.
18. Firth S. End-of-life: A Hindu view. *Lancet* 2005;366:682-686.
19. Keown D. *Buddhism and Bioethics*. London: MacMillan, 1995.
20. van der Heide A, Deliens L, Faissst K, et al. End-of-life decision-making in six European countries: Descriptive study. *Lancet* 2003;362:345-350.
21. Seale C. National survey of end-of-life decisions made by UK medical practitioners. *Palliat Med* 2006;20:3-10.
22. Billings JA, Block SD. Slow euthanasia. *J Pall Care* 1996;12(4):21-30.
23. Broeckaert B. Palliative sedation defined or why and when sedation is not euthanasia. *J Pain Symptom Manage* 2000;20:588.
24. Broeckaert B, Núñez Olarte JM. Euthanasia and physician-assisted suicide. In ten Have H, Clark D (eds). *The Ethics of Palliative Care: European Perspectives*. Buckingham, Open University Press, 2002, pp 166-180.
25. Broeckaert B. Palliative sedation: Ethical aspects. In Gastmans C (ed). *Between Technology and Humanity: The Impact of Technology on Health Care Ethics*. Leuven: Leuven University Press, 2002, pp 239-255.
26. Materstvedt IJ, Clark D, Ellershaw J, et al. Euthanasia and physician-assisted suicide: A view from an EAPC Ethics Task Force. *Palliat Med* 2003;17:97-101.
27. Chochinov HM, Tataryn D, Clinch JJ, et al. Will to live in the terminally ill. *Lancet* 1999;354:816-819.
28. Chochinov HM. Dying, dignity, and new horizons in palliative end-of-life care. *CA Cancer J Clin* 2006;56:84-103.
29. van der Lee ML, van der Bom JG, Swarte NB, et al. Euthanasia and depression: A prospective cohort study among terminally ill cancer patients. *J Clin Oncol* 2005;23:6607-6612.
30. Broeckaert B, Janssens R. Palliative care and euthanasia: Belgian and Dutch perspectives. In Schotsmans P, Meulenbergs T (eds). *Euthanasia and Palliative Care in the Low Countries*. Paris, Peeters, 2005, pp 34-62.

SUGGESTED READING

- Lavi SJ. *The Modern Art of Dying: A History of Euthanasia in the United States*. Princeton: Princeton University Press, 2005.
- Schotsmans P, Meulenbergs T (eds). *Euthanasia and Palliative Care in the Low Countries*. Paris: Peeters, 2005.
- ten Have H, Clark D (eds). *The Ethics of Palliative Care: European Perspectives*. Buckingham, Open University Press, 2002.

CHAPTER 22

Research Bioethics

Carmen Paradis and Kathryn L. Weise

KEY POINTS

- Informed consent is essential for research.
- Risks must be balanced by benefits.
- Research must have scientific validity.
- Placebo use must not result in less than standard quality of care.
- Treating physicians may act as researchers, but care must be taken not to confuse the roles.

Is Euthanasia or Physician-Assisted Suicide Legal? Voluntary euthanasia is not legal in most parts of the world. The Netherlands and Belgium are currently the only countries that allow the practice. Involuntary euthanasia is not legal anywhere. Physician-assisted suicide is currently legal in the United States in several states, including Oregon and Washington, and in a handful of other countries. Physician-assisted suicide is only done when a patient has a terminal diagnosis and is suffering, with little or no relief. In such cases, a patient may wish to control when and how they die. A key p Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately caus