JAMA Internal Medicine: Package of articles on end-of-life, physician-assisted suicide

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JAMA Internal Medicine will publish a package of articles, along with an author interview podcast, focused on end-of-life, euthanasia and physician-assisted suicide. The original investigation, research letter, special communication and commentaries are detailed below.

In the first article, Marianne C. Snijdewind, M.A., of the VU University Medical Center, Amsterdam, and coauthors1 looked at outcomes of requests for euthanasia or physician-assisted suicide received by a clinic founded in 2012 to provide the option of euthanasia or physician-assisted suicide for patients who met all legal requirements but whose regular physicians rejected their request.

The Termination of Life on Request and Assisted Suicide Act went into force in the Netherlands in 2002. In 2012, the group Right to Die NL founded the End-of-Life Clinic, which operates throughout the country with mobile teams consisting of a physician and nurse. The authors examined 645 requests made by patients to the clinic from March 2012 to March 2013.

Of the 645 requests, the authors found that 162 requests (25.1 percent) were granted, 300 requests (46.5 percent) were refused, 124 patients (19.2 percent) died before their request could be assessed and 59 patients (9.1 percent) withdrew their requests.

Patients with a somatic condition (113 of 344 [32.8 percent] i.e., patients who had as their condition cancer, cardiovascular diseases, neurologic

[physical], pulmonary, rheumatoid, other physical discomfort or a combination thereof) or with cognitive decline (21 of 56 [37.5 percent]) had the highest percentage of granted requests. Patients with a psychological condition (i.e. patients whose only medical condition was a psychiatric or psychological condition) had the smallest percentage of granted requests; six (5 percent) of 121 requests from patients with a psychological condition were granted. Also granted were 11 (27.5 percent) of 40 requests from patients who were tired of living.

"Our findings suggest that physicians in the Netherlands have more reservations regarding less common reasons that patients request euthanasia and physician-assisted suicide than the medical staff working for the End-of-Life Clinic. The physicians and nurses employed by the clinic, however, often confirmed the assessment of the physician who previously cared for the patient; they rejected nearly half of the requests for euthanasia and physician-assisted suicide, possibly because the legal due care criteria had not been met," the authors conclude.

In a related research letter, Sigrid Dierickx, M.Sc., of Vrije Universiteit Brussel and Ghent University, Belgium, and coauthors2 conducted a survey in 2013 to examine shifts in euthanasia requests and the reasons physicians granted or denied those requests. Physicians certified a random sample of 6,871 deaths that occurred from January through June 2103 in Flanders, Belgium. The authors compared results to 2007 when a similar survey was conducted. Belgium legalized euthanasia in 2002.

Compared to 2007 results, the 2013 survey (with a response rate of 60.6 percent) found increases in the number of requests (3.4 percent to 5.9 percent) and the proportion of requests granted (from 55.4 percent to 76.7 percent).

Physicians in 2013 reported that the most important reasons for granting a euthanasia request were the patient's request (88.3 percent); physical

and/or mental suffering (87.1 percent); and the lack of prospects for improvement in their condition (77.7 percent).

"Although the prevalence of euthanasia remains highest in patients with cancer, those with a college or university education, and those who die before 80 years of age, there are increasing numbers of requests and granted requests in patients with diseases other than cancer, those who die after 80 years of age, and those who reside in nursing homes," the authors conclude.

In a related commentary, Barron H. Lerner, M.D., Ph.D., and Arthur L. Caplan, Ph.D., of the Langone Medical Center at New York University, write: "The slippery slope is an argument frequently invoked in the world of bioethics. It connotes the notion that a particular course of action will lead inevitably to undesirable and unintended consequences. .... In this issue of *JAMA Internal Medicine*, Snijdewind et al and Dierickx et al report recent findings about physician-assisted suicide and euthanasia from the Netherlands and Belgium, respectively. Although neither article mentions the term slippery slope, both studies report worrisome findings that seem to validate concerns about where these practices might lead. ... Although the euthanasia practices in the Netherlands and Belgium are unlikely to gain a foothold in the United States, a rapidly aging population demanding this type of service should give us pause. Physicians must primarily remain healers. There are numerous groups that are potentially vulnerable to abuses waiting at the end of the slippery slope - the elderly, the disabled, the poor, minorities and people with psychiatric impairments. When a society does poorly in the alleviation of suffering, it should be careful not to slide into trouble. Instead, it should fix its real problems."

Other related content *JAMA Internal Medicine* will publish:

Special Communication: Guardianship and End-of-Life Decision

Making4 by Andrew B. Cohen, M.D., D.Phil., of the Yale School of Medicine, New Haven, Conn., and coauthors, write: "Most state laws do not define the authority of a professional guardian to make decisions about life-sustaining treatment. Because legal uncertainty and variation make these complex decisions even more difficult, ensuring appropriate end-of-life care for patients with professional guardians may require a multidisciplinary effort to develop and disseminate clear standards to guide physicians and guardians in the clinical setting," the authors write.

Commentary: Guiding the Guardians and Other Participants in Shared Decision Making5 by Muriel R. Gillick, M.D., of the Harvard Pilgrim Health Care Institute, Boston, writes: "Making the best possible medical decision near the end of life is crucial, not for reasons of life and death, because the patients in question are all in the final phase of life, but rather because the decisions affect the trajectory of those last hours, days, weeks or perhaps months. Cohen et al perform a service for patients by reminding us how difficult the decision is and how ethicists, lawyers, physicians and others can help facilitate the process. Improving the process would benefit all patients, from the cognitively intact to the incompetent and unbefriended."

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