Assisted Suicide for Dementia or Those 'Tired of Living'?

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End-of-Life Care: 40 Years of Incremental Progress

No Change in Dutch Euthanasia Rates After Legalization

A minority of Dutch physicians, about one in three, would consider granting a request for euthanasia and physician-assisted suicide (EAS) for a patient with early dementia or psychiatric disease, or one who is just "tired of living" (without severe illness), a new survey hints.

"The Dutch Euthanasia Act is not restricted to patients with physical suffering," Eva Bolt, EMGO Institute for Health and Care Research, VU

University Medical Center, Amsterdam, The Netherlands, told *Medscape Medical News*. "But most physicians who would consider euthanasia in a patient suffering unbearably from cancer or another physical disease would not consider this in a patient who is suffering from psychiatric disease, dementia or in patients who suffer from 'being tired of living.'"

Granting a request for EAS can have "great emotional impact," she added, "and a physician's decision on whether or not to grant a euthanasia request is an individual decision; and this decision is based on legal boundaries as well as on personal values."

The survey was published online February 18 in the *Journal of Medical Ethics*.

In The Netherlands, EAS for patients whose suffering is psychiatric/psychological in nature is legally permissible, but it represents a fraction of the numbers of patients who are helped to die in this way, the researchers note in their article. Patients do not have a right to EAS, and a physician's "freedom to refuse" a request has recently become a topic of debate in The Netherlands. The media have reported on patients whose requests for EAS seem to have been denied on the basis of the physicians' personal opposition instead of legal objections. These patients had psychiatric disease or dementia or were "tired of living" in the absence of severe morbidity.

"The main question," Bolt and colleagues say, "is whether EAS is legally and ethically acceptable in patients with these conditions and, if so, whether physicians should be willing to provide it."

Cause of Suffering a Factor

To find out what Dutch doctors think, they mailed a survey to a random sample of 2269 family doctors and specialists in the fields of elder care, cardiology, respiratory medicine, intensive care, neurology, and internal medicine between October 2011 and June 2012.

The survey asked whether they had ever helped, or could conceive of helping, a patient with cancer or other physical disease, mental illness, early or advanced dementia, or someone without any severe physical ailments, but who was tired of living, to die.

Altogether, 1456 physicians (64%) responded to the survey. Overall, 77% had been asked at least once for EAS during their career: 93% of family physicians, 71% of elder care physicians, and 53% of specialists.
Most physicians (86%) said they would consider helping a patient die, and 60% of respondents said they had helped a patient to die.
But physician attitudes about EAS varied by condition; most said they would consider granting a request for EAS to a patient with cancer (85%) or another physical illness (82%), but less than half would do so for a patient with a psychiatric illness (34%), early-stage dementia (40%), advanced dementia (29% without comorbidities and 33% with comorbidities) or merely tired of living without severe disease (27%).

Only 7% of the physicians had actually helped a patient who did not have cancer or another severe physical illness to die.
"These findings are in line with previous studies in which physicians were found to be more accepting of EAS in case of physical suffering than in case of non-physical suffering," the investigators note in their article.

"Some patients might not fully realize that a decision on euthanasia is a personal decision of the physician, and many physicians have objections to performing euthanasia in case of nonphysical suffering," Bolt told *Medscape Medical News*. "When these patients request euthanasia and their request is denied, this can result in disappointment and disagreement. Therefore, it is important that a physician is clear about their standpoint as early as possible."

Reached for comment, James A. Colbert, MD, from Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts, said the survey results are "not that surprising."
He cited the recent poll he and his colleagues did through the *New England Journal of Medicine*, which found that approximately two of three of US physicians were opposed to physician-assisted suicide.

"Very few states in the US allow physicians to prescribe medications that would actively end a patient's life, so most US doctors are not spending a whole lot of time thinking about the issue," Dr Colbert pointed out. "Furthermore, the number of patients who would actually choose to end their life is quite small."

Dr Colbert thinks a "much more important issue to focus our attention on is: how do we make sure that all patients are comfortable and well cared for at the end of life? Palliative care is such an essential component of medical care, yet very few patients will see a palliative care practitioner. Studies have shown that patients with cancer who see a palliative care practitioner have better quality of life and in some cases even live longer than other cancer patients who are only treated by oncologists," Dr Colbert said.
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