

Editor's comment

End-of-life practices in the Netherlands



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The euthanasia act came into effect in the Netherlands in 2002 and was initially followed by a slight decrease in the frequency of euthanasia. A recent article in *The Lancet* assessed the frequency and characteristics of euthanasia, physician-assisted suicide and other end-of-life practices in 2010 and the trends since 1990.

Nationwide studies of a stratified sample from the death registry of Statistics Netherlands were carried out in 1990, 1995, 2001 and 2010. The authors also sent questionnaires to the physicians attending these deaths.

In 2010, 2.8% of all deaths in the Netherlands (475 of 6 861) were as a result of euthanasia, higher than the 1.7% in 2005 but comparable with those in 2001 and 1995. In 2010, 77% of all the euthanasia deaths or physician-assisted suicide were reported to a review committee. Ending of life without an explicit patient request occurred less often in 2010 than in 2005, 2001, 1995 and 1990. Continuous deep sedation until death occurred more often in 2010 than in 2005. Of all deaths in 2010, 0.4% were the result of the patient's decision to stop eating and drinking to end life – in half of these cases the patient had asked for euthanasia and it was not provided.

The authors conclude that this study provides insight into the consequences of regulating euthanasia and physician-assisted suicide within the context of end-of-life practices, which has, in the Netherlands, resulted in a relatively transparent practice.

A linked commentary notes that the frequency of physician-assisted suicide has

been stable and that abuse had not been widespread, nor is there apparent disproportionate use in vulnerable populations. Nor is it apparent that doctors substitute hastening death for good palliative care, rather concentrating on alleviating symptoms. In fact, the alleviation of symptoms is increasing more than any increase in euthanasia. In addition, doctors grant fewer than half of euthanasia requests from patients.

However, this same commentary raises other pertinent issues. First, doctors have a professional responsibility to improve the quality of the treatment they provide and this includes end-of-life care – something that is not always apparent to all in the profession. Improvement in end-of-life care in general will benefit far more patients than those who request euthanasia. The line between euthanasia and the less controversial, but far more common, practice of palliative sedation is often blurred in clinical practice, particularly where euthanasia is illegal. Good end-of-life care should involve proportionate palliative sedation – using the least sedation needed to control refractory symptoms. Under the Dutch definition of euthanasia or physician-assisted suicide intention to hasten death is crucial. If a doctor increases the dose of opioids in an unresponsive patient who is not showing signs of distress, such as restlessness, grimacing and so on, this can be interpreted as intention to hasten death.

Second, decisions around end-of-life care, particularly palliative sedation, should be discussed with patients and/or their families. Ethically, the trade-off is between consciousness and comfort. Without

asking a patient, doctors do not know their preferences. In the Netherlands study, in around 41% of cases classified as intensified alleviation of symptoms, the doctor had not discussed the decision with the patients, relatives or another doctor. Knowing why such discussions did not occur, especially in cases of palliative or terminal sedation, would be an important first step towards facilitating and improving these important conversations.

The study highlighted ethically problematic cases, such as cases of euthanasia without the explicit request of the patient – contrary to Dutch law. Although the frequency of this practice decreased over time, these cases point to a need for further information from in-depth interviews on ethically problematic cases. The questions that the author of the commentary asked were: how do doctors think through these difficult situations? What key concepts are uncertain, misunderstood or might need modification? How do doctors talk with patients and their families about these practices and are there missed opportunities to improve such discussions? It is answering these questions that will improve the quality of care for dying patients and their families, irrespective of any views on euthanasia and physician-assisted suicide.

Onwuteaka-Philipsen BD, Brinkman-Stoppelenburg A, Penning C, de Jong-Krul GJF, van Delden JJM, van der Heide A. Trends in end-of life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet* 2012. Published online 11 July 2012. [http://dx.doi.org/10.1016/S0140-6736(12)61034-4]

Lo B. Euthanasia in the Netherlands: what lessons for elsewhere? *Lancet* 2012, Early Online Publication, 11 July 2012. [http://dx.doi.org/10.1016/S0140-6736(12)61128-3]

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