MEDICAL DECISIONS AT THE END OF LIFE THAT HASTEN DEATH

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ABSTRACT

Medical decisions at the end of life (MDELs) that have the potential to hasten death are increasingly prevalent in medical practice given (a) an aging population and (b) the increase in medical technology that allows life to be sustained beyond what it could be in the past and sometimes beyond what may be comfortable for the patient. When a decision is made to introduce life-sustaining interventions this may imply a later decision to halt these. Attitudes towards medical decisions that hasten death were explored among Greypower members, 55+ years (N = 595), Psychology students, 29 years and under (N = 205) and General Practitioners, 70 years and under (N = 120) in Auckland, New Zealand. Vignette scenarios were used related to withdrawing and withholding life support and nutrition and hydration, denying dialysis to a requesting patient, increasing medication to address pain at the risk of hastening death, physician supplying information, drugs, physician assisting patient to take drugs and physician giving a lethal injection to a terminally ill patient with intractable pain, on request and physician providing assisted death to a requesting tetraplegic patient. The effect of age of patient and consent on decision-making was also explored. Greypower members and Doctors had similar attitudes towards MDELs that are legal in New Zealand but over three-quarters of the Greypower members judged physician-assisted death for a terminally ill patient as justified compared to only one third of the Doctors. Psychology students were more conservative than either the Greypower members or the Doctors for all judgments related to the justifiability of MDELs. There appear to be underlying philosophical differences in the approaches to end of life decision-making by the three groups with Psychology students favouring a Sanctity of Life position and General Practitioners favouring the Status Quo. Greypower members appear to have a pragmatic approach to end of life care that does not favour one position over another.

A second study adapted the questionnaire used in Holland in 1990 by the Remmelink Commission of Inquiry exploring the incidence of MDELs among general practitioners in New Zealand (N = 1255). Results indicate that 63% of general practitioners had made an MDEL for the last patient who died in their practice in the previous twelve months. Practitioners could select more than one action for this patient and taking into account the probability that the end of life would be hastened, 37.2% had withheld treatment, 28.8% had withdrawn treatment and 84.9% had increased medication to relieve pain. Medication to relieve pain or other symptoms was increased in part with the intention of hastening the end of life by 24.8% of practitioners.

Actions were taken with the explicit purpose of not prolonging life or hastening the end of life and death was caused by withholding treatment 18.7%, withdrawing treatment 10.2% and prescribing, supplying or administering a drug 5.6%. In 54.8% cases, there was no discussion with the patient prior to the action taken, although in some of these cases a wish had been expressed by the patient at a previous time to have death hastened. Of the 39 cases where a drug was supplied or administered with the explicit intention of hastening death and death occurred, the drug was administered by a nurse alone in 15 cases (under physician orders, implied in the question) and the physician alone in 13 cases. In two cases the patient self-administered the drug.

In order to assess the impact of euthanasia (arguably at the extreme end of the MDEL continuum) on practitioners, a qualitative study was conducted to explore the accounts of ten Dutch doctors who had cared for dying patients, five who had performed euthanasia and five who had not. Themes were compared and contrasted to expose similarities and differences in the approaches of the two groups to patient care. Both groups endorsed palliative care as the preferred approach to the care of the dying patient. Those who had not performed euthanasia expressed their commitment to the patient in continued exploration of palliative options and a stated commitment of non-abandonment of the patient. Those who had performed euthanasia portrayed this action as the "ultimate commitment" to the patient, no other option being seen as meeting patient need. The effect on the doctor of performing euthanasia was intense. Other medical decisions at the end of life that hasten death such as terminal sedation or withdrawing nutrition and hydration were posited by the doctors who had performed euthanasia to be analogous to euthanasia, and the psychological effect on the doctor was similar. Those who had not performed euthanasia stated that these actions were not the same as euthanasia. Dissonance theory was used to explore why the two groups may portray their actions that hasten death in different ways.

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DEDICATION

This thesis is dedicated with love to the memory of Mary Shane Goodall
August 5 – December 13, 1947

There is only one child in the world
and the name of the child is All Children
Carl Sandburg

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