“Prevalence of Depression in Granted and Refused Requests for Euthanasia and Assisted Suicide: A Systematic Review”
Levene, I.; Parker, M. *Journal of Medical Ethics*, 2011, 37:4, 205-11.

**Findings:** “It is unclear whether depression increases the probability of making a request for euthanasia/PAS, but in the Netherlands most requests in depressed patients are rejected, leaving a depression rate in cases that is similar to the surrounding population. Less evidence is available elsewhere, but some level of depression has been identified in patients undergoing euthanasia/PAS in all the countries studied. Whether the presence of depression is ever compatible with an ethical decision on euthanasia/PAS is discussed.”

“Dignity in End-of-Life Care: Results of a National Survey of U.S. Physicians”

**Abstract:** “Two thousand practicing U.S. physicians, from all specialties, were mailed a survey. Main measures included physicians’ judgments about an end-of-life clinical scenario (criterion variable), attitudes about the concept of dignity (predictors), and their religious characteristics (predictors). Responses were received from 1032 eligible physicians (54%). Nine (90%) of 10 physicians reported that dignity was relevant to their practice. After controlling for age, gender, region, and specialty, physicians who judged that the case patient had either some dignity or full dignity, and who agreed that dignity is given by a creator, were all positively associated with believing that the patient’s life was worth living (odds ratio 10.2, 95% confidence interval …) Respondents who strongly agreed that “all living humans have the same amount of dignity” were also more likely to believe that the patient’s life was worth living ([odds ratio] 1.8, 95% C.I. 1.2-2.7). Religious characteristics also were associated with believing that the case patient’s life was worth living…. U.S. physicians view the concept of dignity as useful. Those views are associated with their judgments about common end-of-life scenarios in which dignity concepts may be relevant.”

“The First Five Years of Euthanasia Legislation in Belgium and the Netherlands: Description and Comparison of Cases”

**Abstract:** “The Netherlands and Belgium legalized euthanasia in 2002. In this study we describe and compare cases of reported euthanasia and physician-assisted suicide in the first five years of legislation. The databases of the cases reported in Belgium and the Netherlands were made
available by the review committees. We compared characteristics of all cases reported between September 2002-December 2007. In the Netherlands 10,319 cases were reported, in Belgium 1,917. Gender and age distributions were similar in both countries. Most patients suffered from cancer (83-87%), but patients more often suffered from diseases of the nervous system in Belgium (8.3% vs. 3.9%). In the Netherlands, reported euthanasia more often occurred at home compared with Belgium (81% vs. 42%), where it occurred more often in hospital (52% vs. 9%). In the Netherlands, all cases were based on the oral request of a competent patient. In Belgium, 2.1% of the reported cases was based on an advance directive. We conclude that countries debating legislation must realise that the rules and procedures for euthanasia they would agree upon and the way they are codified or not into law may influence the practice that develops once the legislation is effected or what part of that practice is reported.”

“Dying Cancer Patients’ Own Opinions on Euthanasia: An Expression of Autonomy? A Qualitative Study”
Karlsson, M.; Milberg, A.; Strang, P. Palliative Medicine, 2012, 26:1, 34-42.

Abstract: “Deliberations on euthanasia are mostly theoretical, and often lack first-hand perspectives of the affected persons. Sixty-six patients suffering from cancer in a palliative phase were interviewed about their perspectives of euthanasia in relation to autonomy. The interviews were transcribed verbatim and analysed using qualitative content analysis with no predetermined categories. The informants expressed different positions on euthanasia, ranging from support to opposition, but the majority were undecided due to the complexity of the problem. The informants’ perspectives on euthanasia in relation to autonomy focused on decision making, being affected by (1) power and (2) trust. Legalization of euthanasia was perceived as either (a) increasing patient autonomy by patient empowerment, or (b) decreasing patient autonomy by increasing the medical power of the health care staff, which could be frightening. The informants experienced dependence on others, and expressed various levels of trust in others’ intentions, ranging from full trust to complete mistrust. Dying cancer patients perceive that they cannot feel completely independent, which affects true autonomous decision making. Further, when considering legalization of euthanasia, the perspectives of patients fearing the effects of legalization should also be taken into account, not only those of patients opting for it.”

“Characteristics of Patients Requesting and Receiving Physician-assisted Death”
Meier, D.E.; Emmons, C.A.; Litke, A; Wallenstein, S; Morrison R.S. Archives of Internal Medicine, July 2003, 14;163(13):1537-42.

Abstract: “Of 1,902 respondents (63% of those surveyed), 379 described 415 instances of their most recent request refused and 80 instances of the most recent request honored. Patients requesting assistance were seriously ill, near death, and had a significant burden of pain and physical discomfort. Nearly half were described as depressed at the time of the request. The majority made the request themselves, along with family. In multivariate analysis, physicians were more likely to honor requests from patients making a specific request who were in severe pain (odds ratio, 2.4; 95% confidence interval, 1.01-5.7) or discomfort (odds ratio, 6.5; 95%
confidence interval, 2.6-16.1), had a life expectancy of less than 1 month (odds ratio, 4.3; 95% confidence interval, 1.7-10.8), and were not believed to be depressed at the time of the request (odds ratio, 0.2; 95% confidence interval, 0.1-0.5). … Persons requesting and receiving assistance in dying are seriously ill with little time to live and a high burden of physical suffering.”

“Content of Health Status Reports of People Seeking Assisted Suicide: A Qualitative Analysis”

Abstract: “Two right-to-die organisations offer assisted suicide in Switzerland. The specific legal situation allows assistance to Swiss and foreign citizens. Both organisations require a report of the person’s health status before considering assistance. This qualitative study explored these reports filed to legal authorities after the deaths of individuals in the area of Zurich. Health status reports in the legal medical dossiers of the deceased were analysed using content analysis and Grounded Theory. From 421 cases of assisted suicide (2001-2004), 350 reports on health status were filed. Many cases contained diagnosis lists only. Other reports had more elaborate reports revealing that some physicians were aware about the patient’s death wish and the intention to solicit assisted suicide. Physicians’ attitudes ranged from neutral to rather depreciative. Few physicians openly referred the patient to the organisations and supported the patient’s request by highlighting a history of suffering as well as reporting understanding and agreement with the patient’s wish to hasten death. In the health status reports five categories could be identified. Some files revealed that physicians were aware of the death wish. The knowledge and recognition of the patient’s death wish varied from no apparent awareness to strongly supportive. This variety might be due to difficulties to discuss the death wish with patients, but might also reflect the challenge to avoid legal prosecution in the country of origin. To require comparable health status reports as requirements for the right-to-die organisations might be difficult to pursue.”

“Is Continuous Sedation at the End of Life an Ethically Preferable Alternative to Physician-Assisted Suicide?”

Abstract: “The relatively new practice of continuous sedation at the end of life (CS) is increasingly being debated in the clinical and ethical literature. This practice received much attention when a U.S. Supreme Court ruling noted that the availability of CS made legalization of physician-assisted suicide (PAS) unnecessary, as CS could alleviate even the most severe suffering. This view has been widely adopted. In this article, we perform an in-depth analysis of four versions of this “argument of preferable alternative.” Our goal is to determine the extent to which CS can be considered to be an alternative to PAS and to identify the grounds, if any, on which CS may be ethically preferable to PAS.”
“Attitudes Towards Euthanasia and Assisted Suicide: A Comparison Between Psychiatrists and Other Physicians”

**Abstract:** “Euthanasia and physician assisted-suicide are terms used to describe the process in which a doctor of a sick or disabled individual engages in an activity which directly or indirectly leads to their death. This behavior is engaged by the healthcare provider based on their humanistic desire to end suffering and pain. The psychiatrist’s involvement may be requested in several distinct situations including evaluation of patient capacity when an appeal for euthanasia is requested on grounds of terminal somatic illness or when the patient is requesting euthanasia due to mental suffering. We compare attitudes of 49 psychiatrists towards euthanasia and assisted suicide with a group of 54 other physicians by means of a questionnaire describing different patients, who either requested physician-assisted suicide or in whom euthanasia as a treatment option was considered, followed by a set of questions relating to euthanasia implementation. When controlled for religious practice, psychiatrists expressed more conservative views regarding euthanasia than did physicians from other medical specialties. Similarly female physicians and orthodox physicians indicated more conservative views. Differences may be due to factors inherent in subspecialty education. We suggest that in light of the unique complexity and context of patient euthanasia requests, based on their training and professional expertise psychiatrists are well suited to take a prominent role in evaluating such requests to die and making a decision as to the relative importance of competing variables.”

“Assisted Suicide: Why Psychiatrists Should Engage in the Debate”

**Abstract:** “There is an increasing appetite for a change in the law to allow assisted suicide. This editorial suggests that psychiatrists should engage in the debate because the issues at stake will affect us, and we are likely to have a significant part to play were the law to be changed. We suggest that there are three main areas where psychiatrists’ expertise may be informative: (a) the extent to which safeguards to limit the availability of assisted dying to target groups can be applied safely and fairly, including to individuals with psychiatric disorders; (b) the complexities inherent in assessing mental capacity; and (c) the degree to which individuals adapt or change their desires, particularly in relation to suicidal behaviours.”

“Legalisation of Euthanasia or Physician-assisted Suicide: Survey of Doctors’ Attitudes”

**Abstract:** “This study reports U.K. doctors’ opinions about legalisation of medically assisted dying (euthanasia and physician-assisted suicide), comparing this with the U.K. general public.
A postal survey of 3,733 U.K. medical practitioners was done. The majority of U.K. doctors are opposed to legalisation, contrasting with the U.K. general public. Palliative medicine specialists are particularly opposed. A strong religious belief is independently associated with opposition to assisted dying. Frequency of treating patients who die is not independently associated with attitudes. Many doctors supporting legalisation also express reservations and advocate safeguards; many doctors opposing legalisation believe and accept that treatment and nontreatment decisions may shorten life. It is hoped that future debates about legalisation can proceed with this evidence in mind.”

“Autonomy-based Arguments against Physician-assisted Suicide and Euthanasia: A Critique”

Abstract: “Respect for autonomy is typically considered a key reason for allowing physician assisted suicide and euthanasia. However, several recent papers have claimed this to be grounded in a misconception of the normative relevance of autonomy. It has been argued that autonomy is properly conceived of as a value, and that this makes assisted suicide as well as euthanasia wrong, since they destroy the autonomy of the patient. This paper evaluates this line of reasoning by investigating the conception of valuable autonomy. Starting off from the current debate in end-of-life care, two different interpretations of how autonomy is valuable is discussed. According to one interpretation, autonomy is a personal prudential value, which may provide a reason why euthanasia and assisted suicide might be against a patient’s best interests. According to a second interpretation, inspired by Kantian ethics, being autonomous is unconditionally valuable, which may imply a duty to preserve autonomy. We argue that both lines of reasoning have limitations when it comes to situations relevant for end of life care. It is concluded that neither way of reasoning can be used to show that assisted suicide or euthanasia always is impermissible.”

“Reporting of Euthanasia and Physician-assisted Suicide in the Netherlands: Descriptive Study”

Findings: “Physicians reported that the patient’s request had been well-considered because the patient was clear-headed (65%) and/or had repeated the request several times (23%). Unbearable suffering was often substantiated with physical symptoms (62%), function loss (33%), dependency (28%) or deterioration (15%). In 35%, physicians reported that there had been alternatives to relieve patients’ suffering which were refused by the majority. The nature of the relationship with the consultant was sometimes unclear: the consultant was reported to have been an unknown colleague (39%), a known colleague (21%), otherwise (25%), or not clearly specified in the report (24%). Review committees relatively often scrutinized the consultation
(41%) and the patient’s (unbearable) suffering (32%); they had few questions about possible alternatives (1%).”

“Trends and Determinants of End-of-life practices in ALS in the Netherlands”

Abstract: “In the Netherlands, the proportion of patients with amyotrophic lateral sclerosis (ALS) who choose the option of euthanasia or physician-assisted suicide (PAS) is relatively high (20%). The objective of this study was to determine which factors influence end-of-life practices in ALS and whether rates are changing over time. In a cohort survey, 204 physicians and 198 informal caregivers (response rates 75% and 80%) of patients with ALS who died between 2000 and 2005 filled out questionnaires of the end-of-life circumstances of the patient. Results were compared with those of a similar study performed during the period 1994-1998. Results: In 2000-2005, 16.8% of the patients decided on euthanasia or PAS compared to 20.2% in 1994-1998. Thirty-one (14.8%) patients died during continuous deep sedation (CDS) in 2000-2005. Euthanasia or PAS, but not CDS, were significantly associated with religion not being important to the patient, being more educated, and dying at home. Euthanasia or PAS were not associated with quality of care items or symptoms of depression. Loss of function was similar in both groups. Informal caregivers of patients who died after euthanasia or PAS more frequently reported fear of choking (p = 0.003), no chance of improvement (p = 0.001), loss of dignity (p = 0.02), being dependent on others (p = 0.002), and fatigue (p = 0.018) as reasons for shortening life. Hopelessness was associated with euthanasia or PAS, as with CDS.”

“To Die, to Sleep: US Physicians’ Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support”

Abstract: “This study analyzes data from a national survey to estimate the proportion of physicians who currently object to physician-assisted suicide (PAS), terminal sedation (TS), and withdrawal of artificial life support (WLS), and to examine associations between such objections and physician ethnicity, religious characteristics, and experience caring for dying patients. Overall, 69% of the US physicians object to PAS, 18% to TS, and 5% to WLS. Highly religious physicians are more likely than those with low religiosity to object to both PAS (84% vs. 55%, P< .001) and TS (25% vs 12%, P < .001). Objection to PAS or TS is also associated with being of Asian ethnicity, of Hindu religious affiliation, and having more experience caring for dying patients. These findings suggest that, with respect to morally contested interventions at the end of life, the medical care patients receive will vary based on their physicians’ religious characteristics, ethnicity, and experience caring for dying patients.”