Original Article

Palliative Treatment Alternatives and Euthanasia Consultations: A Qualitative Interview Study

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Abstract

Context. There is much debate about euthanasia within the context of palliative care. The six criteria of careful practice for lawful euthanasia in The Netherlands aim to safeguard the euthanasia practice against abuse and a disregard of palliative treatment alternatives. Those criteria need to be evaluated by the treating physician as well as an independent euthanasia consultant.

Objectives. To investigate 1) whether and how palliative treatment alternatives come up during or preceding euthanasia consultations and 2) how the availability of possible palliative treatment alternatives are assessed by the independent consultant.

Methods. We interviewed 14 euthanasia consultants and 12 physicians who had requested a euthanasia consultation. We transcribed and analyzed the interviews and held consensus meetings about the interpretation.

Results. Treating physicians generally discuss the whole range of treatment options with the patient before the euthanasia consultation. We transcribed and analyzed the interviews and held consensus meetings about the interpretation.

Conclusion. Two different roles of a euthanasia consultant were identified: a limited one, restricted to the evaluation of the criteria for careful practice, and
a broad one, extended to actively providing advice about palliative care. Further medical and ethical debate is needed to determine consultants’ most appropriate role. J Pain Symptom Manage 2011;42:32–43. © 2011 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words
Physician-assisted dying, euthanasia act, end-of-life decision making, palliative care

Introduction
There is much debate about euthanasia and physician-assisted suicide within the context of palliative care. Those who oppose euthanasia often argue that palliative care offers sufficient possibilities to relieve (unbearable) suffering at the end of life. Continuous deep sedation—the administration of sedating drugs until death—can, for instance, be used as an option of last resort. In contrast, others believe that euthanasia can be the eventual result of adequate palliative care if unbearable suffering (which can be more than physical suffering alone) cannot otherwise be relieved; in The Netherlands, alleviating the patient’s suffering is the most important principle underlying the Euthanasia Act. Internationally, there have been fears that the acceptance of euthanasia might lead to a disregard of palliative treatment alternatives. The Netherlands has often been criticized for its presumed lack of palliative care, partly because of misunderstandings about the Dutch health care system. However, the quality and accessibility of end-of-life care has improved in the past decade, and physicians can now request expert advice from palliative care consultants in complex medical situations. At present an important criticism concerns the practice of continuous deep sedation and its potential overlap with euthanasia in some cases.

In The Netherlands, euthanasia is defined as the deliberate ending of a person’s life, at the person’s explicit request, by a physician. In physician-assisted suicide, the person self-administers medication that is prescribed by a physician. In 2005, 7% of patients whose death was non-sudden had explicitly requested euthanasia and one-third of these requests had been granted. Physicians who grant a patient’s request must comply with six criteria for careful practice (Appendix). Palliative treatment is closely related to one specific criterion, which states that the physician should be convinced that there are no other “reasonable” alternatives available to relieve the patient’s suffering. According to parliamentary proceedings, the physician should discuss all the available palliative treatment options with the patient before deciding about euthanasia or physician-assisted suicide. Alternatives comprise treatment options that could either improve the patient’s quality of life (e.g., morphine) and/or prolong the patient’s life (e.g., palliative chemotherapy or radiotherapy). Although a patient may refuse palliative care, it has been argued that, in certain situations (e.g., not very invasive, few or no side effects), the refusal of palliative options may shed doubts on the “unbearableness” of the patient’s suffering, and physicians may, therefore, conclude that euthanasia is not justified.

These six criteria, to some degree, overlap, and attention toward palliative care is not only related to the “treatment criterion;” to some extent, palliative care also relates to other criteria. For example, the requirement of no reasonable alternatives also is related to the requirement that the suffering should be hopeless.

Apart from being evaluated by the treating physician, the law establishes that the availability of reasonable treatment alternatives also must be evaluated by an independent physician (Appendix). In The Netherlands, a specialized service (Support and Consultation for Euthanasia in the Netherlands [SCEN]) teaches physicians how to give expert advice and how to hold formal and independent consultations as part of the euthanasia review procedure. Their involvement is substantial: they were consulted in 90% of all 2005 euthanasia cases. By visiting the patient, the consultant independently evaluates the criteria. The independent consultation can be an important
stage in the decision-making process to evaluate the availability of reasonable treatment alternatives—thus abating the above-mentioned fears of disregard for palliative treatment alternatives for euthanasia. By interviewing trained euthanasia consultants and physicians who had requested a euthanasia consultation, we investigated whether and how palliative treatment alternatives come up during or preceding a euthanasia consultation. We further investigated how the criterion that assesses the availability of reasonable treatment alternatives is assessed by the euthanasia consultant.

**Methods**

The study described here is the qualitative component of a larger study that evaluated SCEN. We interviewed euthanasia consultants and physicians who had requested a euthanasia consultation.

**Support and Consultation for Euthanasia in the Netherlands**

A SCEN consultant has at least five years of work experience as a physician; he or she has followed a three-day SCEN training and has to attend SCEN meetings every year. Of the SCEN consultants in 2009, 74% reported to have pursued additional training in palliative care, that is, apart from the SCEN training and their medical training. A SCEN consultant works for a specific SCEN district. When on duty, he or she may be summoned for a euthanasia consultation. The SCEN organization assigns a SCEN consultant to the physician requesting a consultation to guarantee the independence of the consultant.

In preparation for a euthanasia consultation, a SCEN consultant discusses the patient’s situation with the physician requesting the consultation and looks into the patient’s medical files. During the consultation, the SCEN consultant has to speak with the patient alone for a short period of time and assesses the criteria of careful practice by carefully listening to the patient’s story. On the basis of a standard checklist, the SCEN consultant writes a consultation report, which usually concludes with a positive or negative judgment as to whether the criteria for careful practice have been met or not.

**Design and Setting**

**Euthanasia Consultants.** Participants were purposively sampled from this list to represent a range of medical specialties, gender, and type of service (home-based care and inpatient units) to reflect the diversity of possible differences. We recruited consultants from towns and cities in all regions of The Netherlands.

**Physicians Who Had Requested a Euthanasia Consultation.** A snowball technique was then applied. The consultants we contacted were asked to identify physicians who had previously requested a euthanasia consultation. We only recruited general practitioners (GPs) because most euthanasia consultations take place in the home setting where GPs are primarily responsible.

**Data Collection**

Data for this study were collected from March to September 2009 through face-to-face interviews that lasted approximately 50 minutes for the euthanasia consultants and 30 minutes for the physicians who had requested a euthanasia consultation. We approached the participants by telephone, mail, or e-mail, and the study aims and methods were explained to them by the principal investigator (H. M. B.). Furthermore, every (potential) participant received an information sheet. If they were willing to participate, an interview was arranged and they were interviewed in their practice. Within each respondent group, we held interviews until data saturation was reached. The principal investigator conducted a total of 14 interviews with euthanasia consultants and 12 interviews with physicians who had requested a euthanasia consultation. According to Dutch policy, the study did not require review by an ethics committee because the data collection was anonymous with regard to the attending physician and the content of the interviews was not considered to be incriminating in any way.

**Interview Format.** We used semistructured topic lists to conduct the interviews. Each topic list covered several items to answer the various research questions of the SCEN evaluation.
study. For instance, items included the discrimination between support and consultation, the right moment of a SCEN consultation, and the consultants’ experiences with the SCEN meetings every year. The interview guide for consultants consisted of two parts: 1) open-ended questions about their experiences and attitudes toward SCEN and end-of-life care in general and 2) open-ended questions in which they were asked to reflect on two consultations they had held, one which they considered as “good” and one about which they were less satisfied. We were interested in all consultations: consultations that eventually resulted in euthanasia and consultations that did not result in euthanasia. For the present study, we specifically focused on topics raised during the interviews related to end-of-life care and (palliative) treatment alternatives. In the general questions and the case-specific questions, they were asked about the timing of the consultation, the position of other forms of end-of-life care, such as continuous deep sedation, and the way in which the criteria for careful practice were assessed. We also obtained data about the consultant’s background (demographics and work experience).

The interview guide for physicians who had requested a euthanasia consultation had a similar design. Because the treating physicians had less experience with euthanasia consultations, it was not possible in all cases to discuss two different types of consultations. We did not intend to discuss matched consultations; our focus was on consultations with which physicians were satisfied and less satisfied.

Analysis

All interviews were audiotaped and transcribed verbatim. We deleted any information that could lead to identification of the respondent. After the third and sixth interview in each respondent group, the content of the interviews was discussed (H. M. B. and B. D. O.-P.) to determine whether any changes in the topic list were necessary. These discussions resulted in the rephrasing of a few questions that appeared to be unclear for the physicians. We also added some additional questions that triggered the physicians to mention specific aspects concerning the euthanasia consultation.

Data analysis was informed by qualitative methodology, using a constant comparison approach. H. M. B. and B. D. O.-P. read through all the interviews to identify general themes and subsequently specific categories within the themes. We developed these categories further by making comparisons across transcripts. We met several times and reviewed the categories until consensus was reached. We later discussed our findings with the entire project group (H. M. B., B. D. O.-P., H. R. W. P., M. L. R., and D. L. W.) and worked toward consensus about the interpretation, taking possible meanings into consideration. The primary researcher checked these interpretations with the existing data. All data were analyzed with qualitative research software (ATLAS.ti 5.2; ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). A professional translator translated the quotes that we eventually chose to illustrate our results.

Results

Sample Characteristics

We approached 19 euthanasia consultants for an interview. Two declined participation, two were no longer working as a consultant, and one had died. Eventually, we interviewed 14 euthanasia consultants (11 GPs, two medical specialists, and one physician trained in nursing home medicine) (Table 1). The consultant sample comprised physicians with an average age of 51 years, of whom seven were women. Work experience as a consultant varied from one to 10 years. The sample of physicians who had requested a euthanasia consultation were all GPs, and all were willing to participate in the interview study. The average age of the 12 physicians was 52 years, and five were women.

Interview Data

In our data, we identified four domains that are relevant to palliative treatment alternatives within the context of euthanasia consultations: 1) barriers to assess the criteria for careful practice, 2) the way in which consultants and treating physicians bring up palliative care during or preceding the consultation; 3) the tasks of a euthanasia consultant, and 4) the position of continuous deep sedation within the context of euthanasia consultations.
Table 1

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<tr>
<th>Background Characteristics of Study Participants</th>
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SD = standard deviation; NA = not applicable.

The work experience of two euthanasia consultants was unknown.

>150,000 inhabitants.

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Barriers to Assess the Criteria for Careful Practice. Obviously, the moment in the disease trajectory when a euthanasia consultant sees the patient depends on the moment when the patient requests euthanasia as well as when the physician requests a euthanasia consultation. The consultants reported that the treating physicians sometimes (consciously or unconsciously) postponed the request for an independent consultation. As a result, the consultation sometimes seemed to come too late for adequate assessment of the criteria for careful practice, for instance, because it had become impossible to talk to the patient.

However, whereas some of the treating physicians postponed their request for a consultation, others preferred a consultation in an earlier stage of the disease. Such consultations also occurred in situations in which the patient was considering euthanasia but had not yet explicitly requested it. The physicians’ main reasons for such “early” consultations were to set the patient’s mind at rest and to make sure that the criteria could be assessed. However, it was sometimes too early to assess whether the criteria were met.

And that is an awkward point, because I have … in the event of doubt I usually nevertheless go and see. Meaning rather “I will give my opinion now, but I am quite happy to return in three weeks’ time or in a month’s time and then we can look to see whether all the criteria have been met, but in that case you have already spoken to somebody at a stage when it had not yet entirely reached that pass. Euthanasia Consultant 7

I do that in fact already at a reasonably early stage, because I notice that if you discuss the matter carefully with people this makes the situation calmer. So I do not want to have it hanging in the air or to be unclear for any length of time. People must have the idea that “if it is necessary then I can be helped, then I can be given professional help.” Physician Requesting Consultation 4

Apart from establishing an appropriate time for the consultation, another element that appeared to be important for consultants to guarantee an appropriate assessment of the criteria for careful practice was that there was no pressure on the consultation. Pressure could, for instance, occur if the treating physician had already made arrangements for euthanasia.

I certainly do not want a situation to arise that the physician has already made a commitment that it will happen tomorrow and that you just come along to ratify this […] I want to be able to give a free opinion and to take the time for this. Euthanasia Consultant 7

Insufficient information about the patient’s medical situation provided by the treating physician and pressure from the patient or the family were other factors that sometimes hampered adequate assessment and discussion about the criteria for careful practice.

How to Bring Up Palliative Care During Euthanasia Consultations. With regard to discussing palliative care, some of the consultants seemed to be uncertain whether their task was to verify whether palliative care had previously been discussed sufficiently with the patient or whether they should actively suggest certain palliative treatment options themselves.

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care had previously been considered and discussed with the patient; they checked this with the physician (before the consultation) and with the patient (during the consultation). The consultants mentioned that different forms of palliative care had often been discussed extensively between the patient and the treating physician in an earlier stage of the disease. The treating physicians also indicated that they generally discussed the whole range of treatment options with a patient who requests euthanasia.

Yes, in the majority of cases we discuss whether this has been discussed [another form of end-of-life care] and frequently you also hear from the treating physician what has been discussed. Euthanasia Consultant 14

And I do indeed think that it is my responsibility as a physician to explain all kinds of things. And that is why I think up to now that it [euthanasia] has been barely necessary. Very frequently it amounts to some reassurance and the knowledge that at the end-of-life stage there is sufficient care and sufficient attention and that the physician can always be reached. Through this you already remove a great deal of the anxiety. It is usually after all anxiety. Physician Requesting Consultation 12

Some of the consultants, however, appeared to have doubts about whether or not to advise about palliative care. Some of them indicated that occasionally they did not want to propose new treatment alternatives for a patient because they considered it inappropriate in view of the previous discussions about palliative care between the patient and the physician and that they did not want to interfere with the long-standing relationship between the patient and the treating physician. When consultations took place when the patient was in a very severe state of suffering, the consultants sometimes considered it inappropriate to advise about palliative care.

And I find it extremely unpleasant to stir things up, because people are often at the end of their tether, they are stretched to the limit because things are going very badly with a close member of the family, and then some or other independent physician comes along who says “I do not think these pills are any good” or “I do not think that this is any good or that could have been done differently” … It is an extremely difficult situation. Euthanasia Consultant 2

But at that point [very advanced stage of the disease] there is nothing more to do. Yes, an ileus in a woman who has already been wretched for two weeks and who says “I cannot take it anymore,” I can see that you are no longer going to say: “We are going to try this and that and we will look at the situation in a week’s time;” there are no more options. But then it is a pity that it did not go differently earlier on. Euthanasia Consultant 11

Consultants who did have some doubts about suggesting palliative treatment alternatives preferred to discuss these with the physician instead of the patient. One of them said that if he discussed palliative alternatives with patients, it was just to check whether they had been informed and not to offer them new options. Others, however, did mention palliative options but in a hypothetical manner.

Of course, I am not a treating physician [. . .]. And what I do say then is “Suppose you can do something about the pain, or suppose that we could do something about the nausea, would you then prefer . . . would you then look again?” And then I would discuss with the treating physician that I do see options with regard to the symptoms. But of course I am not going to say that to the patient. Euthanasia Consultant 12

The Tasks of a Euthanasia Consultant. Although there appeared to be some doubts with regard to advice about palliative care during euthanasia consultations, the consultants as well as the treating physicians agreed that the primary task of the euthanasia consultant is to evaluate whether the criteria for careful practice are met. The consultants indicated that they assess the “reasonableness” of possible treatment options by looking at all other palliative options that had previously been tried, the side effects of the possible treatment options, the patient’s actual suffering, the time it would take before the treatment that was administered would be really effective, and the patient’s explicit wish with regard to the possible treatment options. The consultants said that hearing the patient’s story and wishes, in combination with the patient’s medical file, was often sufficient to assess the “reasonableness” of possible treatment options and
accordingly—if reasonable—to follow the patient’s refusal of further treatment would be understandable.

Interviewer: But if, as you just indicated, there are options for chemotherapy, is that awkward?

Respondent: Well if the patient makes it clear to me that he or she does not want that … I mean it is not a “must” to grasp at every straw. If people quite deliberately opt not to have chemotherapy, with very little result and so forth … yes, why would you not be allowed to request/receive euthanasia? Because you refused chemotherapy? No, those people are in fact being perfectly consistent, they say “I do not want to prolong my life, I am deteriorating fast.” Yes, no, I am not going to say “First of all try the chemotherapy and then I shall come back.” No.

Interviewer: Yes, and the treatment alternatives?

Respondent: Yes, well from the data that you are given you see everything that has happened. And I rather think that it has to be a reasonable thing. There has to be something of which you know … You frequently still have little time, a very limited amount of time … so it has to be something, if you begin with it today there will be an effect tomorrow, so that as a result possibly … but I have not yet come across that. And if you see all the things that people do before they arrive at that question.

Euthanasia Consultant 5

Interviewer: Yes, all right, and the treatment alternatives [how were these assessed]?

Respondent: Well, it was so obvious that this lady did not want to go on living. For this lady, palliative sedation was no reasonable treatment alternative. In her opinion it was a continuation of her agony, albeit in a comatose situation. But she was so clear in saying “I do not want this anymore,” “I want to bring it to an end,” that there was no reasonable alternative for her.

Euthanasia Consultant 7

One euthanasia consultant also indicated that assessing the availability of treatment alternatives also is the result of assessing other criteria for careful practice such as the assessment as to whether the patient’s suffering could be considered hopeless and unbearable.

Interviewer: How would you assess the criterion of the availability of reasonable treatment options?

Interviewer: That comes actually from the hopelessness [of the suffering]. Are there opportunities to turn the tide and tackle the case? Or to alleviate suffering? And usually the hopelessness, the reasonable treatment alternatives, emerge already in the medical file… and the unbearable suffering, that emerges in conversation with the patient, whether the patient finds it acceptable to step-up symptom alleviation or to go to a hospice or accept all kinds of other alternatives which would alleviate the unbearable suffering. Euthanasia Consultant 3

In situations in which consultants concluded that one or more criteria for careful practice were not met, they were generally willing to advise palliative treatment alternatives.

“But if the judgment is negative, if you say “I do not agree, the criteria for careful practice have not been met,” then you usually nevertheless say something about what you think should happen next at least.

Euthanasia Consultant 9

A substantial number of the treating physicians did not expect any palliative advice from the consultants concerning euthanasia because they considered palliative care as a completely different trajectory. However, some of them said that what they expect is that a euthanasia consultant will prevent physicians from performing euthanasia if other reasonable treatment options are available. Those physicians clearly made a distinction between suggestions for reasonable treatment alternatives, as part of the euthanasia procedure, and palliative (technical) advice.

And I use the palliative consultant more for advice, about palliative techniques, not so much with reference to euthanasia, but the palliative aspect. Physician Requesting Consultation 8

I do think that the consultation should be about euthanasia […]. It does happen that the SCEN physician points out to the treating physician that there are perhaps palliative alternatives that have not yet been exhausted. […]. In that sense I expect the SCEN physician to point this out to me, if we have overlooked certain things. But I do not think that I should receive palliative advice from a SCEN physician, there are palliative consultants for that and that functions well here.

Physician Requesting Consultation 1
The Position of Continuous Deep Sedation Within the Context of Euthanasia Consultation. Because continuous deep sedation may be one of the palliative treatment options for euthanasia, we specifically asked consultants if they brought up the issue of sedation with the physicians or the patients. Consultants made a clear distinction between the practice of continuous deep sedation and the practice of euthanasia. Many of the consultants indicated that sedation was never an alternative for euthanasia. However, in situations in which the patient’s medical condition (extremely ill, no communication possible) really made continuous deep sedation necessary, all consultants were willing to advise it.

In one case I did advise it. But that was indeed because the man was no longer in a fit state, he was already so far advanced, that I discussed that. Along the lines of “euthanasia is no longer a discussable possibility, the situation now is still tenable, but I can imagine that, for example, the matter of sedation will arise.” Euthanasia Consultant 5

Consultants who indicated that continuous deep sedation was never an alternative for euthanasia seemed to identify “alternative” with “euthanasia in disguise” and accordingly seemed to consider it to be (legally) unacceptable. However, they were willing to advise continuous deep sedation in situations in which it appeared that the patient was not well informed, and continuous deep sedation, therefore, could be a “reasonable” alternative to euthanasia.

Yes, but certainly not as an alternative to euthanasia [continuous deep sedation]. I do not think it is. No, it does occasionally crop up when you say “you are not eligible for euthanasia,” or you say “when do you think you would not want euthanasia,” that sometimes serious symptoms emerge and you think, “there may perhaps be another way of doing something about it.” Euthanasia Consultant 9

But yes, I think it is the case that if you have people in a real terminal situation, who have less than a week to live, that terminal sedation is also a solution. I do think that. In the past, terminal sedation existed as well, but it was not so well known among physicians. So then frequently euthanasia was performed in the case of a dying patient, so to speak. Euthanasia Consultant 6

Yet, the consultants also indicated that the decision as to whether continuous deep sedation was a “reasonable” alternative also depended on the patient’s explicit wish concerning euthanasia.

It is usually the GP who brings it up [continuous deep sedation]. And as a SCEN consultant I mentioned it once, because at the time I thought it was a real situation, but otherwise in my opinion it is not something that crops up. […] But some people have long beforehand very explicitly requested “when I get to that stage I want euthanasia.” And then you can refer to other forms of end-of-life care, but then you are also obliged to say that it is not euthanasia and that the course is also different. Euthanasia Consultant 10

In general, just like the consultants, treating physicians clearly distinguished euthanasia from continuous deep sedation. According to the treating physicians, the idea of continuous deep sedation can sometimes abate a patient’s fear of unbearable suffering. Most of the treating physicians said that they preferred to perform continuous deep sedation over euthanasia.

And there is also a follow-up development in palliative sedation which is of course something different to euthanasia, but does allow euthanasia to be avoided. Physician Requesting Consultation 4

Discussion

This study aimed to provide a deeper insight into the attention that is paid to palliative treatment alternatives during or preceding the independent euthanasia consultation, as is required in the Dutch euthanasia procedure. The results show that treating physicians generally discuss the whole range of treatment options with the patient before the euthanasia consultation. They also show that consultants actively start thinking about and proposing palliative treatment alternatives after consultations, when they have concluded that the criteria for careful practice have not been met. During the consultation, they take into account
various aspects while assessing the criterion concerning the availability of reasonable alternatives, and they clearly distinguish between euthanasia and continuous deep sedation. Furthermore, they primarily verify whether the patient has been well informed about palliative care. It sometimes seems to be unclear for consultants whether or not they should advise physicians about palliative care, either because they did not consider it to be one of their tasks or inappropriate in view of the previous discussions that had taken place with the treating physician.

In 2008, consultants judged in 19% of all euthanasia consultations that one or more criteria for careful practice were not met. For many physicians who request a euthanasia consultation, the consultants’ advice (which can be positive or negative) strongly determines whether or not they eventually perform euthanasia; the consultant is, therefore, highly influential in the decision making and considered a moral and legal safeguard for the physician as well as a protection for the patient. This legal verification task is in line with the consultants’ personal opinion about what they consider to be their most important task: to independently assess the criteria for careful practice. By assessing the availability of reasonable alternatives, the consultants consider various aspects, such as the possible side effects of the proposed treatment and the time it would take before the treatment that was administered would be really effective. Together with the patient’s medical history and the patient’s explicit euthanasia wish, consultants often considered potential treatment alternatives to be too burdensome for the patient and, accordingly, sympathized with the patient’s refusal. A previous study about the arguments that Dutch physicians use to substantiate their adherence to the criteria reports similar findings, that is, that treating physicians are generally inclined to accept the patient’s refusal. The annual reports of the euthanasia review committees demonstrate that review committees generally accept a patient’s refusal of palliative treatment alternatives for euthanasia, although they explicitly request additional substantiation from the treating physician about why the treatment is considered to be unreasonable for the patient in question. Treating physicians have been shown to vaguely substantiate the reasonableness of available alternatives in their reports to the review committees. Our study suggests that euthanasia consultants pay specific attention to the “reasonableness” of possible treatment alternatives and seriously consider palliative treatment if reasonable with respect to the patient’s medical situation. This is mainly done by assessing the reasonableness of treatment alternatives but also by evaluating other criteria such as the criterion that assesses the patient’s suffering.

Whereas the consultants’ role with regard to euthanasia seems to be clear, their role with regard to palliative care is less clear-cut. It is plausible that consultants—being physicians also—find it difficult to only verify which forms of palliative care have been discussed and that they are inclined to advise possible treatment options. Therefore, it is understandable that the consultants have problems especially in situations in which the patient’s medical situation is not very far advanced or in situations in which a patient is only considering, but not really requesting, euthanasia. In another part of our SCEN evaluation study, we found that the “Support” function of SCEN also is considered to be important by consultants and that the Support and Consultation functions sometimes go together, especially in “early” consultations. Giving advice to the treating physician is part of the Support function.

In view of the euthanasia review procedure, it can be questioned whether it is necessary for a consultant to go as far as actively giving advice about palliative care. It could be argued that adequately assessing the reasonableness of alternatives should be sufficient. The Royal Dutch Medical Organization has developed a protocol for euthanasia consultations, in which apart from the criterion that assesses the availability of reasonable alternatives, no direct attention is paid to palliative treatment. During the training course for SCEN consultants, one of the four aims is the ability to formulate adequate alternatives to relieve the patient’s suffering. Palliative care is a separate topic within the course, but it receives relatively little attention. Yet, the results of our study showed that treating physicians, as well as consultants, sometimes preferred to consult in an earlier stage of the patient’s disease.
Sometimes, in such consultations, the patient has not yet made an explicit request for euthanasia. Therefore, the consultant not only assesses the availability of reasonable treatment alternatives for euthanasia but also gives advice in how to provide high-quality palliative care. This would imply that the role of the euthanasia consultant is broader in such cases. This role would be more in accordance with the role of independent euthanasia consultants in Belgium, where consultations are not limited to euthanasia but also include other medical end-of-life decisions.

It has been suggested that the increase in continuous deep sedation in The Netherlands (5.6% in 2001 to 7.1% in 2005) is partly because of the fact that it is more often used as a relevant alternative to euthanasia. In a focus group study in 2005, it was found that treating physicians sometimes considered continuous deep sedation in the context of a request for euthanasia. They indicated that the option of continuous deep sedation can comfort patients whose request is mainly rooted in fear of future suffering and that continuous deep sedation could be a relevant and easy-to-perform treatment, compared with euthanasia. Our 2009 findings show that consultants and treating physicians held similar views. The participants in our study further appear to have sufficient knowledge to distinguish between the two, which may partly be related to the release of national guidelines (2005, revised in 2009). This distinction is in accordance with the view of the euthanasia review committees, which stated in their annual report of 2007 that the option of continuous deep sedation does not always revoke the patient’s request for euthanasia, partly because it is not always in accordance with the guideline and partly because some patients explicitly refuse sedation because they want to stay conscious until the end.

Some limitations of our study need to be taken into account. First, we only interviewed consultants who had been trained by SCEN. It is possible that untrained consultants (who also can be asked for a euthanasia consultation in The Netherlands) might have different views and different strategies with regard to how to bring up palliative care during a euthanasia consultation. However, the large majority of physicians who request a euthanasia consultation now ask for a SCEN consultant, and the sample is, therefore, considered to be representative for all euthanasia consultations in The Netherlands. Second, selection bias cannot be excluded. SCEN physicians were asked to identify physicians who had previously requested a euthanasia consultation, and it is possible that they suggested physicians they had good experiences with. However, because the physicians could discuss every euthanasia consultation they had ever had, and because we carefully stressed the anonymity of the study, selection bias and socially desirable answering is probably limited to a great extent. Another form of possible selection bias is that we only interviewed GPs requesting a consultation and did not include medical specialists or nursing home physicians. It could be that different specialties have different views and different strategies with regard to how to bring up palliative care. However, the large majority of euthanasia (>90%) is performed by GPs. Finally, as part of our results concerned the physician’s behavior, an observational study could have had additional value. However, observing consultations in such a sensitive research area is ethically difficult.

Conclusions and Suggestions for Policy

Two different roles of a euthanasia consultant, with regard to palliative treatment alternatives, were identified in this study: a limited role, which was restricted to evaluation of the criteria of careful practice, and a broad role, which included actively giving advice about palliative care. The most appropriate role during a euthanasia consultation was not altogether clear for all physicians. Both roles seem to have their own benefits, depending on the timing of the consultation. With the legal verification task as their most important task, the different criteria for careful practice receive much attention. Accordingly, our results do not support the sometimes expressed fear that the acceptance of euthanasia might lead to a disregard of palliative treatment. In addition, continuous deep sedation was clearly distinguished from euthanasia. However, further medical and ethical debate about the most appropriate role for euthanasia consultants should clear up the problems that some
of the euthanasia consultants currently experience. The Royal Dutch Medical Organization, responsible for teaching the consultants, should stimulate further discussions among consultants and develop guidelines for their role in discussing palliative care during euthanasia consultations. Our study further showed that euthanasia consultants do have a separate role from that of palliative care consultants but that knowledge about state-of-the-art palliative care is essential to assess whether certain criteria for careful practice are met. This is especially important because the medical and ethical debate about where to draw the line between acceptable and unacceptable forms of euthanasia remains an important topic of discussion in the medical, ethical, and political arena. It is, therefore, recommended to motivate euthanasia consultants—and treating physicians as well—to be adequately informed about palliative care.

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Appendix

**Dutch Criteria of Careful Practice for Euthanasia and Physician-Assisted Suicide As Laid Down in the Act**

1. The patient’s request should be voluntary and well-considered.
2. The patient’s suffering should be unbearable and without prospect of improvement.
3. The patient should be informed about his situation and prospects.
4. There are no reasonable alternatives.
5. Another independent physician should be consulted.
6. The termination of life should be performed with due medical care and attention.