Assisted suicide and cancer

For more than a decade, euthanasia and physician-assisted suicide have been intensely debated in the Western world. Many of the moral arguments are old; indeed, almost all of today’s ethical claims and counter claims are simply reformulations of arguments first put forward in the 1870s in England, following Samuel Williams’ proposal to the Birmingham Speculative Club to legalise euthanasia. However, thanks to the many careful empirical studies over the last 10 years, a large amount of information about the practices of euthanasia and physician-assisted suicide (PAS) has emerged. The data raise questions about the importance and relevance of euthanasia and PAS for dying patients today.

Many of these studies have highlighted the importance of euthanasia and PAS for cancer patients. Despite the discussions surrounding the use of these techniques for patients with amyotrophic lateral sclerosis, HIV/AIDS, or other terminal illnesses, the data show that euthanasia and PAS are primarily interventions for patients with malignancies. In Australia, there have been seven cases of legal assistance in death in the Northern Territory; all of the patients suffered from cancer. In Oregon, reports of the legal cases of PAS show that over 70% of PAS patients had cancer.1 According to the studies by van der Maas, van der Wal, and their colleagues in the Netherlands, about 80% of patients who die by euthanasia or PAS are cancer patients.2 Indeed, in the Netherlands, nearly one in six cancer patients dies by euthanasia or PAS.

These statistics indicate that interventions are primarily a concern for oncologists and other physicians who care for patients with cancer. Data from the USA show fairly clearly that oncologists both receive more requests for, and have performed euthanasia and PAS more frequently than other physicians. For instance, a survey by Meier et al. showed that 25% of oncologists had received requests for PAS (a low number compared to other surveys of oncologists in the USA that report 50% or more of oncologists receiving such requests) while 18% of all physicians had received such requests. Despite this, oncologists are more likely to be opposed to such intervention. It may be that with more experience with dying patients and requests for euthanasia and PAS than other physicians, oncologists are more likely to consider these measures unnecessary and undesirable.4

The combination of significant opposition to euthanasia and a relatively high demand, means that delicate situations often arise, which oncologists need to be able to manage sensitively. They must not let their personal view stand in the way of a proper exploration of the patient’s motives for considering euthanasia or PAS; to care for dying patients properly requires knowing what ails and troubles them.

There has been much debate comparing and contrasting euthanasia and PAS. Ethicists and other commentators have made much of the difference between having a physician inject the patient to end his or her life and having a patient commit the final act. Physicians also make much of the distinction, on the whole supporting PAS over euthanasia. Interestingly, this distinction is of no ethical importance to patients or the public. They support euthanasia and PAS at the same rate.

While Oregon has legalised only PAS, there is some suggestion that these interventions cannot be so easily separated. Reports from the first 2 years’ experience of legalised PAS describe no cases of PAS that failed either because the patient did not die or because the dying process took too long. These reports – along with the very low level of PAS – have raised suspicions about the accuracy and comprehensiveness of the Oregon data and imply that not all cases are being reported. These suspicions are reinforced by other data, which indicate a 15–20% failure rate with PAS.5 For instance, the Dutch recently reported problems with proper implementation of PAS, including cases where patients did not go into coma, awoke from coma after taking the PAS medications, could not take all the necessary oral medications, or felt that the time between taking the medications, or felt that the time between taking the
medication and dying was too long. Ultimately, in 20% of Dutch PAS cases, physicians found it necessary to resort to active euthanasia. These data suggest that if one out of every five PAS episodes does not end in death, it may be impractical to legalise only PAS without having active euthanasia as a ‘back-up’. If euthanasia is not a legal back-up to PAS, then many cases will be conducted illegally and go unreported. Therefore, whatever the ethical distinction between PAS and euthanasia, in the real world of physicians and patients no such distinction can be sustained.

Recent studies have shown that the proportion of deaths that are the result of euthanasia or PAS in Oregon, USA as a whole, and The Netherlands, are 0.09%, 0.4%, and 3.4%, respectively. What these numbers mean is that even in the Netherlands, where these interventions have been socially accepted and permitted — although not legalised — for over 20 years, very few deaths actually occur by these methods. Even including those who consider or inquire about euthanasia or PAS, it is still only an issue for 10% of terminally ill patients. To put it another way, for 90% or more of dying patients, euthanasia and PAS play no role whatsoever in their dying process. Therefore, these interventions cannot play a critical role in improving the care of dying patients since, for the vast majority of patients, they are irrelevant. To improve end-of-life care, we must disregard them and concentrate on issues such as better management of physical, mental, and psychological symptoms, more attention to assistance for care needs, and spiritual and existential fulfillment.

In 1926, JAMA noted that, “like a recurring decimal, euthanasia becomes a subject of controversy periodically”. This still holds true today, but the debate that has raged over the last decade or so is diminishing. The rationale behind the debate was that euthanasia and PAS would be instrumental interventions to ensure that all patients receive optimal end-of-life care. However, the data that has been amassed over the last decade make this motivation untenable. Ultimately, euthanasia and PAS are sideshows that raise their own problems and concerns. While oncologists and other physicians will continue to face this issue on a regular basis, we must refocus our efforts away from these interventions and concentrate on end-of-life care more generally. It is probably for this reason that the Dutch government has recently established and funded five centres for research and the provision of palliative care, with the overall aim of improving end-of-life care. This is a positive precedent that should be followed and encouraged throughout the world.


In my opinion, PAS and voluntary euthanasia (VE) are a matter of human rights and personal choice. Having the option of VE and PAS is extremely important for many individuals and must not be disregarded as a minority issue. Opinion polls show that a very large majority of people support the legalisation of VE and PAS and there is evidence that the option of VE and PAS can make the idea of palliative care more acceptable to many dying patients. Palliative care has improved in Oregon in recent years. Furthermore, of those receiving prescriptions for a lethal medication in 1999, five of the 33 recipients chose to die of their underlying disease (of these, 21 were in a hospice at the time of their deaths).

It is also important, when considering VE and PAS, to discuss the practice of ‘terminal sedation’ or ‘slow euthanasia’, which is knowingly performed in hospitals, nursing homes, hospices, and private homes, throughout the world. This is carried out under the doctrine loosely described as the ‘double effect’, by which a physician may lawfully administer increasing doses of regular analgesic and sedative drugs that can hasten someone’s death, as long as the declared intention is to ease pain and suffering. Of course, the key word here is ‘intention’. Physicians may, without publicly declaring the true purpose of their action, respond to a terminally ill patient’s request and speed up the dying process in this way. From surveys in The Netherlands, in Australia and in Belgium, we know that ‘the alleviation of pain and symptoms with opioids in doses with a potential life-shortening effect’ caused 19%, 31% and 19% of all deaths in these countries, respectively. However, if we acknowledge the existence of voluntary slow euthanasia, it becomes clear that at least some of these deaths (perhaps at least a quarter, according to the Belgian figures) should rightly have been included with the relatively low figures for PAS and euthanasia quoted by Dr Emanuel in his Introduction above. Also, it should be noted that in 1995, the euthanasia figure for Australia was at least 5.3%, and for Belgium in 1998 it was 4.4% – in both countries, PAS is illegal; in The Netherlands the figure was 3.3%.

If it is acceptable to perform terminal sedation/slow euthanasia over several days, one begins to question the objections against producing immediate death for a terminally ill patient by a single lethal dose. Surely the difference is not in fact an ethical or legal issue, but an emotional matter for the attending physicians and nurses?

I would also dispute Dr Emanuel’s statement that “in 20% of Dutch PAS cases, physicians found it necessary to...
resort to active euthanasia”, which casts doubt on the recent Oregon figures showing “no cases of PAS that failed.” I believe that since 1996 this is no longer true in The Netherlands. Only last September, Dr Pieter Admiraal (a pioneer of VE in The Netherlands, who emphasises “no euthanasia without palliative care”) said that Dutch physicians generally now prescribe 9 g of barbiturate for PAS and that “there has been no report that anyone has survived this lethal amount” – the great majority (53 of the last 60 cases on which he had details) died within 2 h.

Some physicians still believe that requests for VE are the same as demands for suicide because they cannot imagine that a terminally-ill patient might want to hasten his own death. And, another difficulty with PAS, especially for the layman, is the word ‘suicide’.

Perhaps it is useful to remind ourselves that disapproval of suicide dates from the fourth century (nothing in the Bible, which describes eleven suicides, condemns this practice) when the Christian Church became concerned because it had become popular among its adherents – a religion which preaches that life on earth is a prelude to a better afterlife runs into problems unless it can delay its supporters departing for paradise, so declaring suicide a mortal sin was the solution. It is from these times that much of our attitude to suicide stems. Today, hopefully, there is a growing realisation that ‘rational suicide’ (for instance, when someone is terminally ill) is different from a wish for suicide when an individual is, say, depressed.

From a survey by the BMA News Review in 1996, we know that British physicians are split about 50:50 over the legalisation of VE. Those like myself who want to see the law changed to allow for PAS and VE in the UK want a constant review on what is happening in Oregon and The Netherlands (and to a lesser extent in Switzerland, where PAS is decriminalised and is quietly practised). If any mistakes should happen in Oregon (there have been none to our knowledge at the time of writing) or, in future, in The Netherlands, where VE and PAS will be legalised in 2001, then the anti-choice opposition will broadcast them from the rooftops. Meanwhile terminally-ill Dutch adults, who already enjoy universal palliative care provision are empowered by having the additional choice of PAS or VE, subject of course to strict safeguards.

As physicians, what might we want for ourselves and our family members when we are terminally ill? We are familiar with the different scenarios which are possible at the end of life, especially for cancer patients, in which, even with the best palliative care, distressing symptoms and a prolonged dying process can easily occur. If we should find ourselves in situations resembling some of our terminally ill patients, would we like to have, within the context of good palliative care, the option of PAS or VE from a compassionate medical colleague? If the answer is “yes”, then surely we should extend this privilege to our patients?


Doctors are powerful people – they can decide on life or death. The only protection the patient has is the certainty that his or her doctor has promised not to end any patient’s life deliberately. Once a doctor has ended one patient’s life, that protection is no longer complete. That is why the ancient Greek doctor Hippocrates, who lived around the year 400 before Christ, made every doctor swear, that he would never use his skill to kill a patient, either before or after birth. This Hippocratic oath was modernised by the World Medical Association in 1948 and, from then on, has been known as the Declaration of Geneva. However, since 1948 this declaration has been compromised by a series of challenges, including recent attempts to legalise euthanasia.

Several arguments have been put forward to support the killing of patients as part of the doctor’s practice. The threat of overpopulation creates fear in the minds of many, but the problem is not lack of space or food, but a fair distribution of food and water. There are those who want to create a healthy society by eliminating people with an unacceptably low quality of life and those who are carriers of hereditary disease. This would reduce medicine to veterinary surgery and is an unacceptable infringement of basic human rights. There are economic arguments as well; as diseases strike the elderly, in particular, an ever-increasing elderly population is being supported by fewer and fewer younger taxpayers. Finally, some people are simply afraid of dying and prefer to organise their own ‘death before death’ by asking for euthanasia.

By far the most cases of euthanasia are motivated by honest compassion for a severely suffering patient, as is often the case with cancer. But whether a patient suffers or not depends a great deal on the skill of the treating doctor. The UK has been very fortunate in the quality of the specialists in palliative care, but in The Netherlands the situation is different. For example, morphine is often prescribed on a ‘if necessary’ basis. When the pain returns, the patient has to suffer during the time it takes to call the nurse and wait for the next dose. Better palliative care would mean that a sufficient dose of morphine is given at regular intervals, before the pain comes back, thus increasing the chance that the patient will remain free from pain until the day he or she dies.

Good palliative care should involve finding the best way to deal with all the physical, mental, and social aspects of cancer. If patients are helped to feel as happy and comfortable as possible, the question of euthanasia should never arise, and they should be able to live out the last stretch of their lives with peace of mind. Before we abandon the 2400-year-old medical tradition of respecting human life in all its phases, we should ask ourselves what the future will be like if we start accepting the deliberate killing of patients as part of medical practice?

In The Netherlands, a bill has been passed that decriminalises euthanasia as long as there is an explicit request by the patient him- or herself. The doctor involved must consult an independent colleague and write a report,
declaring that all conditions have been met. This is sent to a committee, that decides whether or not the doctor has acted correctly. However, the committee’s decision is based on the report written by the doctor. Is this really a foolproof method of preventing abuse of this procedure? Article 2 of the European Convention for the Protection of Human Rights states: “Everyone’s right to life shall be protected by law”. The law regarding euthanasia is a violation of human rights.

In 1990 and 1995, research was conducted into the extent of euthanasia in The Netherlands, defined as “intentional life-ending treatment at the patient’s request”.

In addition to those instances which fall under this heading, there are many other cases of intentional life-ending treatment, with or without the patient’s consent. The practices of increasing pain-relieving treatment, with the intention of shortening life, and refraining from further treatment, again with the intention of ending life, are both classified as ‘normal medical treatment’ and not euthanasia.

If all cases in which a patient died after a decision by the doctor to hasten the end of life are counted together, we find the numbers look very different. There were almost 20,000 cases (amounting to over 15% of all deaths) in The Netherlands in 1990, only 2.1% of which were termed euthanasia. Of over 26,000 cases, almost 20% of all deaths were recorded in 1995, whereas a euthanasia figure of 2.7% was reported. Extrapolation from these figures suggests that in 1995 one in five deaths was preceded by a decision to hasten the end of the patient’s life. These figures are highly thought provoking. The Netherlands is very proud to be the first country in the world to legalise voluntary euthanasia, but it seems to be creating a society where the doctors are given the power to decide who should be allowed to live and who should die. The Netherlands has become a model for the world, but in the wrong direction.

Personally, I don’t believe that other countries will follow the Dutch example. There is too much evidence that it is impossible to allow the killing of patients who want to die without taking away the protection of patients who don’t.

That is too high a price to pay for the luxury of choice, a luxury that is no longer wanted, even by cancer patients, when sufficient palliative care is provided.

1. G van der Wal, PJ van der Maas. Euthanasie en andere medische beslissingen rond het levenseinde. SDU, den Haag, 1996

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**Timothy E Quill**  
Professor of Medicine, Psychiatry and Medical Humanities, USA

Too frequently in Western culture, we are forced into ‘either/or’ choices when what is needed is a ‘both/and’ approach. I strongly support improvements in palliative care as a cornerstone of treatment for all seriously ill patients and I also support open access to a physician-assisted death for those few patients for whom palliative care fails to adequately relieve suffering. The fact that relatively few dying patients will need the latter type of assistance if they receive adequate palliative care does not diminish its importance if we are committed to caring for all of our dying patients through to their deaths. Potential access to a physician-assisted death is not ‘irrelevant’ to patients whose terminal suffering becomes unacceptable to them and their families, nor is it ‘irrelevant’ to those who have witnessed severe end-of-life suffering and fear a similar end might befall themselves or their loved ones.

Inquiries about the possibility of a physician-assisted death are much more frequent than acts. According to the first Remmelink Report, which systematically studied end-of-life practices in the Netherlands, there were 25,000 inquiries and 9,000 genuine requests for every 3,000 acts. Although a study by Emanuel et al. did not address inquiries per se, over 50% of patients defined as terminally ill by their physicians supported legalisation of physician-assisted suicide, whereas only 10% ever explored the issue in earnest and only a few ultimately received such assistance in illegal environments. In Oregon, where physician-assisted suicide is legal, there are six genuine requests for every prescription, and ten genuine requests for every act. The knowledge that there could be an escape is extremely important to many patients, especially those who have witnessed harsh death, even if they never need such assistance. Those who have this reassurance are then free to spend their precious energy and time addressing other issues that are more meaningful and important.

There is wide agreement that the formal patient request for a physician-assisted death should initiate a broad inquiry, including a careful evaluation for depression, unrecognised symptoms, and social or spiritual crises. However, physicians must also be open to the possibility that a patient might be suffering intolerably, thinking clearly, and genuinely ready to die. To take the ‘political noise’ out of this evaluation, consider how we evaluate competent patients who want to stop life-sustaining therapy. Such acts are subject to similar pitfalls, and result in a patient’s death, yet we have learned to evaluate these requests in a forthright and non-judgmental way. Because the ethics and legalities of assisting such patients are agreed upon, we are able to listen carefully and respond to what the patient is really saying. Psychiatric and ethics consultations can be obtained if needed and we can carefully document what we are doing.

The expansion of potentially acceptable ‘last resort’ methods of assistance has been an area of real progress in the care of terminally ill patients. Instead of devaluing the patient’s request, this approach focuses on potential options that might be utilised after the patient is carefully evaluated (Table 1). The possibilities of accepting sedation that may come with increasing doses of analgesia and/or of stopping all potentially life-sustaining therapy have wide public, professional, and legal acceptance. Two new ‘last resort’ options, voluntarily stopping eating and drinking and/or terminal sedation, give choices to those who need an escape, but are not in pain and have no life supports to stop. These two possibilities are probably legal and their ethical and professional status is now under discussion. They may be morally acceptable to patients and/or
Table 1: Palliative options of last resort

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<th>Option</th>
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<td>Accepting increasing sedation from opioids</td>
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<tr>
<td>Stopping life-sustaining therapy</td>
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<tr>
<td>Voluntarily stopping eating and drinking</td>
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<tr>
<td>Terminal sedation</td>
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<td>Physician-assisted suicide</td>
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<td>Voluntary active euthanasia</td>
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physicians who find physician-assisted suicide unacceptable. Finally, physician-assisted suicide remains ethically controversial, and illegal outside Oregon, but is unlikely to be successfully prosecuted if discovered. Voluntary active euthanasia is illegal everywhere in the US and is much more likely to be successfully prosecuted.

In his introduction, Dr Emanuel suggests that physician-assisted suicide is also ‘untenable’ because the failures (as high as 10–15%, according to Dutch data)
would inevitably require euthanasia. Although the number of failures is likely to be very small in an open process, once the proper dose and technique have been determined (none have been reported after 2 years in Oregon), a small number of ‘unsuccessful’ cases will inevitably emerge. Instead of resorting to voluntary active euthanasia, such patients could be maintained in an unconscious state using terminal sedation (an effort to help them escape intolerable suffering) until they die. Whether terminal sedation involves ‘slow euthanasia’, or a morally distinct practice as suggested by many American commentators, begs the question, but terminal sedation is legal and could be seen as a back-up response to these tragic cases, without resorting to euthanasia.

As a clinician, I have the duty to care for 100% of my patients who are terminally ill, or who may become so in the future. All such patients welcome the promise of palliative care and we must work together to improve access and delivery. Yet the potential to satisfactorily relieve most suffering for most people for most of the dying process is not sufficiently reassuring to all. Many still want to know that there could be an escape if suffering becomes unacceptable, while others find the level of disability and dependence potentially required by a prolonged terminal illness to be undignified and untenable. All hope they will never need a physician-assisted death, but some need reassurance that they could find an escape if their suffering becomes intolerable in the future. For an unfortunate few, despite providing excellent palliative care, we must eventually consider potentially life-ending interventions. The methods needed require a sophisticated evaluation of the patient’s clinical circumstances and personal values, as well as the values of the physician if the act requires his or her participation. Most of these difficult cases can be resolved with the four currently legally acceptable options of last resort, but very infrequently physician-assisted suicide is the least harmful option for a given patient. In my opinion, the challenges raised by all these methods are more similar than different and the method chosen should be the most humane, given the patient’s circumstances and values.

4 Quill TE. Doctor, I want to die. Will you help me? JAMA 1993; 270: 870–73.

Peter Saunders
General Secretary of Christian Medical Fellowship, UK

The Hippocratic Oath instructs that doctors ‘give no deadly medicine to anyone if asked, nor suggest such counsel’. In maintaining this time-honoured tradition, the World Medical Association, in its 1992 Statement of Marbella, affirmed that ‘physician assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession’.

In March 2000, a British Medical Association (BMA) consensus conference upheld this position by rejecting moves to change the law on physician-assisted suicide in Britain; but at the London annual representative meeting which followed, delegates rejected calls for this to be ‘the settled opinion of the BMA for the foreseeable future’. BMA ethics committee chairman, Michael Wilks, said that in order to ‘lead the debate’ the association should not be ‘tied to any position’. Coincident with the removal of legal sanctions against PAS in the Netherlands and in Oregon, it seems that an increasing number of doctors are now unsure about whether it is wrong to help patients take their own lives.

The euthanasia lobby is currently losing the battle for lethal injection euthanasia worldwide; and we are seeing a shift in tactics towards the softer target of legalising PAS. Ethically, however, there is no significant difference between the two. If a doctor prescribes medication with the intention of ending a patient’s life, it does not matter whether the doctor or the patient (or anyone else) physically administers the drug. The doctor’s intention to kill is the factor that separates unethical and ethical end-of-life decisions, and underlies the well-accepted principle of double-effect.

Medical technology and palliative care have now advanced to a level where most people in the developed
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The European Association for Palliative Care, in affirming its strong opposition to the legalisation of euthanasia, noted that euthanasia requests are very uncommon when care is focused on relieving physical, psychosocial, and spiritual suffering. The problem is that even when we allow for the treatment of depression (which is common in terminally ill patients and often contributes to their wish to die), many of the symptoms prompting the request for PAS are psychosocial and spiritual rather than physical. It is therefore inappropriate that doctors trained in physical-symptom control should be using lethal drugs to treat fears about loss of dignity or control over death. We must not medicalise existential angst.

Patients’ anxieties about overzealous and inappropriate medical intervention need to be recognised and reassurance given. As doctors, we must recognise that life has a natural end and that our own denials of its inevitability lead at times to inappropriate interventions where burden outweighs therapeutic benefit. In the same way we need to affirm that even life-saving treatment should not be given forcibly to competent patients who refuse it. But this does not mean that doctors should accede to all patients’ demands.

The law is a blunt instrument, and there will always be individual cases, often those we have failed to manage optimally, which raise questions about PAS. But hard cases make bad laws and bad laws change the public conscience and lead to problems. Any law which allows PAS would threaten the trust necessary for the doctor–patient relationship to function, place pressure on patients (whether real or imagined) to request early death, and introduce a slippery slope to voluntary and involuntary euthanasia. Such legislation would also be impossible to police (because the key witness would be dead), might well undermine the development of palliative-care services, and could lead to patients being incited to request suicide for economic reasons by family, carers, or society at large. The difficulties involved in ‘completion’, leading the doctor to resort to active euthanasia, have also been recently highlighted.

Although these empirical considerations are important, it is ideology rather than evidence-based medicine which is driving this debate. Our Western cultural inheritance, which has opposed both euthanasia and suicide, is part Hellenic and part Judeo-Christian. The Pythagoreans, who were instrumental in formulating the Hippocratic Oath, were opposed to all forms of suicide, as were Socrates, Plato, and Aristotle – for a variety of economic, political, and religious reasons. In early Jewish and Christian tradition, human life was seen as God’s possession, and not ours to do with as we choose. The subsequent cultural shift in the Western world can be traced over recent centuries in the thought of humanistic writers such as Donne, Hume, Voltaire, Goethe, and Hemingway. In their work, and that of other authors, we see a progressive loss of belief in any afterlife and a growing conviction that everyone should have free disposal of their own body. In this way, suicide has come to be seen as the virtuous choice of an autonomous being rather than a self-centred or depression-induced retreat from responsibility or dependence on others.

The debate is therefore as much philosophical as medical and fundamental worldview questions need to take a central role in the discussion. Doctors have a responsibility to provide appropriate treatment, palliation, and support to patients who are suffering from distressing symptoms, whether in the context of terminal illness or not. Despite the many changes in medicine, the ancient wisdom of the Hippocratic Oath and the Judeo-Christian tradition should be reaffirmed by the profession.

1 www.wma.net/e/policy/17-pp_e.html
2 BMA Consensus Statement on Physician Assisted Suicide. web.hma.org.uk/public/pubother.nsf/webdocsvw/PASConf
3 Physician Assisted Suicide: consensus reached on key issues. BMJ 2000; 320: 946 (1 April)
4 Saunders P. Physician Assisted Suicide. Triple Helix 2000; 12: 3 (Summer)
9 See for example Jeremiah 10:23 and Ezekiel 18:4
10 Such as: Does God exist? What is man? Is there life after death? Are there absolute moral values?