Euthanasia: Great Heat, Little Light

Recently, the wife of one of my longstanding patients asked me to see him in an outlying facility where he had been admitted for acute decompensated heart failure. It had been only weeks since his discharge from a similar admission, and he had deteriorated over several hours to a state of semi-conscious state. This octogenarian patient had multiorgan comorbidities, a prior stroke, and was beginning to experience cognitive dysfunction. The discussion centered about whether we should transfer him to the university hospital for parenteral medications with the possibility of hemodynamic monitoring, intubation, and resuscitation, or just give him supportive comfort care where he was. I assured the wife that everything that could be done for her husband had been done, and we jointly decided on the latter course of management. He died quietly the next day.

The topic of euthanasia and physician-assisted death has again come center stage as part of an increasing emphasis upon end-of-life care. Palliative care has recently been recognized as a subspecialty by the American Board of Medical Specialties and certified by the Accreditation Council for Graduate Medical Education. In addition, in 2008, Washington joined Oregon as the second state to approve a Death With Dignity Act allowing terminally ill patients to request and receive lethal doses of medication from physicians. Perhaps the greatest focus upon euthanasia has come from discussions regarding proposals for health care reform legislation. Financial support for “end-of-life counseling” was included in some proposals and has sparked speculation and fear that this might be the first step toward elimination of care for terminally ill patients. The tremendous proportion of overall health care spending consumed in the last year of life appears to have cast a shadow over all discussions. Interestingly, medical advances that enable the treatment of many previously lethal illnesses (pneumonia) or the replacement of function of failed organs (dialysis and ventilation) appear to have exacerbated the prevalence of difficult end-of-life situations.

A broad spectrum of physician actions exist that can eliminate a prolonged, physically and emotionally painful course to death. The simplest act is to merely withhold treatment, which is virtually noncontroversial when involving therapies considered extraordinary. Greater debate has been seen when the treatment is considered ordinary, such as feeding tubes and intravenous fluids. The withdrawal of existing therapies is more involved, and depending upon the wishes of the patient, begins to breach the border of when physician actions are active rather than passive. Group decisions and ethics consults are often employed in such situations. A more recent approach to end-of-life treatment is induced unconsciousness or terminal sedation. In such cases, patients are given sufficient sedation to produce a near or complete loss of consciousness that persists until death, which can be accelerated by withholding fluids. Physician participation becomes much more active with assisted suicide, in which a patient is given a sufficient quantity of drugs to cause death that they themselves administer. The process of active euthan-
sia, wherein the physician administers the lethal agent, was taken to its extreme by Dr. Kevorkian and is not legal in the U.S.

One aspect of euthanasia is absolutely certain: it has been and continues to be exceptionally controversial and capable of stimulating passionate debate. The proponents of euthanasia point to the need to treat the dreadful physical and emotional suffering experienced in many terminal illnesses. Many patients fear the loss of autonomy and dignity more than the pain. Advocates declare that money directed to futile therapy could be used more effectively for other purposes, and that the patient’s ability to choose to end his or her life should be inherent in the right to freedom of choice. Finally, proponents see physician-assisted death as the final step of a continuation of duty to provide relief of pain and suffering. Opponents argue that physicians have a duty to preserve life and have taken the Hippocratic oath “to give no deadly medicine to anyone if asked.” They contend that euthanasia devalues life. Importantly, they maintain that assisting death for the desirous terminally ill may lead to a “slippery slope,” whereby euthanasia is extended to the nonterminally ill and perhaps even to those who do not seek it. Who, they ask, should be empowered to decide when a life should be terminated? Despite the intensity of the debate, the two sides generally ascribe appropriate motives to each other.

Not surprisingly, issues regarding physician-assisted death arise most commonly in patients with terminal illnesses due to cancer or neurologic diseases. Nevertheless, taking care of critically ill patients does confront us with end-of-life issues in cardiology as well, although less frequently. Although our patients are critically ill, their course to recovery or death is usually not prolonged. They tend to suffer more emotional than physical pain. Most issues entailing end-of-life care in cardiology involve withholding or withdrawing therapy and occur in the setting of advanced heart failure. Issues involving comorbidities are often the major factor in how patients with advanced heart disease are treated. Deactivation of implantable cardioverter-defibrillators in terminally ill patients has been the source of recent discussions regarding end-of-life treatment.

It seems to me that most end-of-life decisions we have to make in cardiology are dictated by common sense. Like the patient presented at the beginning of this editorial, decisions to withhold therapy are usually fairly obvious and do not require an ethics consult. Although I use ethics consults prior to withdrawing therapy, these cases have engendered little disagreement. Nevertheless, we occasionally do find ourselves in situations where induced unconsciousness is an alternative, or participate in cases of others where end-of-life decisions are complex. Moreover, as members of the House of Medicine, we have an interest in how end-of-life treatment and palliation is practiced in our profession.

Like many physicians and nonphysicians, I am ambivalent with regard to physician-assisted death. It is clear that it is illegal for a physician to administer a lethal dose of a medication, and having spent my career trying to sustain life, I am loath to do anything that will end it. However, I believe that among thoughtful individuals there is an increasing recognition that difficult cases exist at the end of life that present challenging decisions. In fact, our own technical advances have often been responsible for subjecting patients and their families to long periods of constant physical and emotional suffering. It should be clear, therefore, that we have a responsibility both to avoid any measure that would prolong suffering and to consider ways to limit suffering to as short a time as possible. Given the appropriate conditions (i.e., a mentally competent patient or one with a clear written directive, who is undergoing intractable suffering and loss of independence due to a terminal illness [diagnosed by multiple physicians], a patient who [after counseling] himself and with his family seeks an end to the misery by any means), I believe that many physicians feel it is reasonable for the attending physician to assist that patient in ending their misery. While we have not yet precisely defined what constitutes optimal palliative care for terminally ill patients, and passionate debate continues on the matter, at least in individual cases, I think we know it when we see it.