Dutch GPs' Views on Good Dying and Euthanasia

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‘Good dying’ study – background

Euthanasia comes from the Greek words ‘Eu’ and ‘Thanatos’, literally meaning ‘a good death’

Not everybody thinks euthanasia is indeed a good way to die

We wanted to know how Dutch GP’s view good dying , and how they see euthanasia in that respect

Background information: In the Netherlands health care is characterized by an strong emphasis on primary care. All citizens have their own general practitioner (GP) and the majority of Dutch people with a non-acute illness die at home, with their GP as a central figure providing and coordinating care. GPs also perform the majority of EAS cases (85%)

‘Good dying’ study – background

The direct cause for wanting to know more about Dutch GPs views on good dying was an earlier study we did, with the following research question: “what considerations play a role in practice when Dutch GPs have to decide on a request for euthanasia or assisted suicide (EAS)?”

K ten Cate, DG van Tol, S van de Vathorst

“Considerations on requests for euthanasia or assisted suicide; a qualitative study with Dutch general practitioners”
Family Practice. 2017 May 9. doi: 10.1093/fampra/cmx041.

‘Good dying’ study – background

Dutch euthanasia law in a nutshell.

6 criteria of due care that doctors must meet to escape criminal charges for violating art. 293 of the Dutch penal code (Euthanasia → ending life on request)

Doctors must:

a. be satisfied that the **patient’s request is voluntary and well-considered**.

b. be satisfied that the **patient’s suffering is hopeless and unbearable** and that there is **no prospect of improvement**;

c. **inform the patient** about his situation and further prognosis;

d. discuss the situation with the patient and come to the conclusion that there is **no reasonable alternative**;

e. **consult at least one other physician** with no connection to the case, who must then see the patient and state in writing that the due care criteria listed in a. to d. above are fulfilled; and

f. **exercise due medical care and attention** in terminating the patient’s life.

‘Good dying’ study – background

- We analyzed 33 in-depth interviews with Dutch GPs
- We distinguished three main categories:
  I. (Perceived) legal criteria
  II. Individual interpretations of the legal criteria
  III. Considerations unrelated to the legal criteria

  - Examples of considerations of the 3rd type are: the family must agree to EAS, the patient’s attitude must reflect resignation, or unresolved (family) issues must be addressed

‘Good dying’ study – background

- One can understand these findings by looking at some essential features of the Dutch euthanasia law:
  - Euthanasia law is a law for doctors, to shield them against criminal charges
  - It is not designed to empower patients. Patients don’t have a right to EAS, and doctors never have a duty to perform EAS.
  - EAS is thought of as an extraordinary action not belonging to normal medical practice, and doctors are free to make their own considerations and to refuse a request at any time and for whatever reason
  - Furthermore, the Dutch legislator used rather open and abstract terms to formulate the legal criteria. That leaves a lot of room for interpretation of the legal criteria

‘Good dying’ study – background

- We hypothesized that these type of personal considerations we found, stem from GPs’ underlying views on ‘good dying’

- So we set up an new interview study

‘Good dying’ study – methods

- Qualitative research
- 20 in-depth interviews
- Dutch GPs
- From various regions in the Netherlands
- Heterogeneous group
- 10 volunteered, 10 through snowball sampling

‘Good dying’ study – background

RQ: ‘What are GPs’ views on good dying? And how do they view euthanasia in this respect?

‘Good dying’ study – background

We studied the literature on good dying.

These normative ideas seem to prevail in the modern Western perception of good dying:

awareness, acceptance, harmony, connection, growth, open and honest communication, autonomy and authenticity

And also a prevailing idea is that medicine, in the form of palliative care, has a prominent role in arriving at such a good death.

‘Good dying’ study – results

- Our respondents seemed to have a rather similar view on ‘good dying’, elements often mentioned were:
  - little physical suffering
  - acceptance and resignation,
  - being supported by loved ones
  - harmony
  - and being at home.

‘Good dying’ study – results

- However, many added to that the good dying is also dying in a way that reflects a patient’s preferences and personality.

“I used to think good dying would mean being at peace with your situation, accepting your death and having completed your life. But now I believe people die in the same way they’ve lived. So that’s different for every person. Some people won’t go harmoniously no, they’ll go angry while still fighting their situation. But you know, those are people who had this attitude all their lives. It doesn’t suite them to go peacefully, but that’s fine. ”(R8)

“You live your own way, you die your own way. As a GP I think it is important to tailor care as much as possible to your patients wishes, especially at the end of life. So what good dying is totally depends on the person you’re asking it.” (R10)

‘Good dying’ study – results

- When those preferences and a patients’ personal ways to deal with the coming death do not match with the GP’s ideal picture of good dying this can cause tension.

- Two situations in particular our GPs had difficulties dealing with; patients who are in denial and patients who are in a ‘fighting mode’.

‘Good dying’ study – results

- The GPs differed in how they deal with such situation. Some (try to) accept a patient’s way to handle their coming death, others tried to make a patient change his views or behaviour, with some GPs being more directive or judgemental in this than others.

“Sometimes people don’t even want to know they are dying, they are in denial. And that’s very hard because how am I supposed to arrange care if they don’t want to talk to me about it. What I do then, is just telling them that. I say: ‘I find it very hard to help you if I can’t talk to you about your condition and the care you want’. And then I just ask them for advice. ‘What can I do better? What do you expect from me, what cán I do for you?’ I absolutely don’t want to give the patient the idea I’m judging him. Of course I have my own ideas on good dying, but those won’t help the patient, and they don’t help me being a good doctor. Because if you’re judging people you’ll lose your ability to help properly.” (R15)

‘Good dying’ study – results

“I called his daughter without asking permission first. But I knew he would have said his children didn’t need to know he was about to die if I would have asked him. I couldn’t let that happen, you need to say good bye.” (R11)

“R: I think it is very important that people come to accept their death. That they don’t fight their situation or stay in denial. I try to convince patients they need to come to terms with their death. I see that as an important task. If I don’t succeed in that, I feel I have failed.
I: You don’t say, this is the way this person has always dealt with difficult things in his life…?
R: O come on! No, that is so banal. People can still learn things on their death bed you know. And yes perhaps he has always dealt with difficult things like this before, but I doubt that was a rational choice. Our ‘choices’ are not that rational most of the time.”(R6)

‘Good dying’ study – results

- Suprisingly, for some GPs EAS fits the ideal picture of a good death perfectly, while for others the opposite counts, although their picture of good dying seem to be rather similar.

“Yes, an arranged death can be good too, sometimes even better than a natural death. I once had a patient with ALS and at a certain moment she decided it was enough. She talked about it with her husband and her children a lot and they were fully supporting her. So in harmony with her family she chose the moment, the place, the time and the way she wanted to die. And that matched very well with who she was and how she had lived. I thought it was a very brave decision. I admire people that choose EAS, it is a tough decision that requires courage and strength. Another aspect that makes EAS a good death in my opinion, is that most of the time it takes a while, it is a trajectory. Sometimes it takes weeks or months to reach that decision. So by that time patients are really ‘ready to die’. And everyone has gotten the time to get used to the idea, to prepare, to find closure, to say goodbye etcetera. It enables a very conscious way of dealing with the coming death.” (R3)

‘Good dying’ study – results

“I don’t think dying will ever be pretty, but we just have to face the fact that it’s part of life. With EAS, especially for people that still have some time left, I always think: it is the emergency exit you take; you can’t handle life so you take this escape. I don’t know, it feels cowardly. I think the possibility of EAS hinders people in their personal growth. People can still learn a lot in the last phase of life. They can grow, in their relationships, in the way they view life. EAS takes that opportunity away from them.” (R8)

‘Good dying’ study – discussion

- Doctors can have a rather similar ideal picture on good dying and still have a opposite view on euthanasia. Seem to be two seperate issues

- However, what holds for both situations, is the tension that may arise between a doctors’ own views on death and dying and a patients’ preferences or ways to deal with their coming death.

- This poses interesting questions from an ethical and professional point of view, such as:

In what way and to what extend should doctors’ personal views on death and dying influence the care they provide? (whether this is EAS or ‘normal’ palliative care) - What is ethically and professionally justifiable?

‘Good dying’ study – discussion

- We don’t have the answers to these questions..

  Yet ;-)

- But we do think it is important that doctors become aware of their own views and norms on death and dying and are encouraged to think about in what way and to what extend they want to let their personal views determine the care they provide at the end of life.

‘Good dying’ study – discussion

What are your thoughts on this area of tension between doctor and patient?

Thank you!!