

Response to LiPuma and DeMarco's Article on "Hastening Death"

Julia Zenz

Ruhr University Bochum, Germany

Health Services Insights
Volume 10: 1–2
© The Author(s) 2017
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1178632917710017



ABSTRACT: The paper "Palliative care and patient autonomy: moving beyond prohibitions against hastening death" by LiPuma and DeMarco deals with an aspect of end of life care which is the source of considerable disagreement. It is important to emphasize that autonomy is not the unique feature for end of life care. There is always a medical and ethical commitment to care, i.e. beneficence and nonmaleficence. All of these aspects have to be taken into account when treating patients at the very end of life. There is considerable scientific proof indicating that most patients and families can experience a death in dignity when being cared for in palliative care or hospice units.

KEYWORDS: Palliative care, hastening of death, euthanasia, dignity, end of life care

RECEIVED: February 3, 2017. **ACCEPTED:** February 13, 2017.

PEER REVIEW: One peer reviewer contributed to the peer review report. Reviewers' reports totaled 32 words, excluding any confidential comments to the academic editor.

TYPE: Review

FUNDING: The author(s) received no financial support for the research, authorship, and/or publication of this article.

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

CORRESPONDING AUTHOR: Julia Zenz, Ruhr University Bochum, Fallmerayerstr. 32, 80796 München, Germany. Email: juliazenz@mail.de

The paper "Palliative care and patient autonomy: moving beyond prohibitions against hastening death" by LiPuma and DeMarco deals with an aspect of the end of life which is increasingly important and the source of considerable disagreement. More discussion and open debate regarding end-of-life questions is urgently needed, which is why papers covering this topic are to be highly appreciated. However, some thoughts regarding this important issue need to be added to the approach taken by LiPuma and DeMarco.

The authors approach this topic from a philosophical point of view, emphasizing the importance of respect for patient's autonomy. Autonomy is one of the gold standards of bioethical principles, which means that any treatment decision needs to be based on the patient's autonomous wish. However, autonomy cannot stand alone to justify actions. To classify an action as ethically sound one also has to consider the other 3 principles of bioethics: beneficence, nonmaleficence, and justice.¹

Unfortunately, LiPuma and DeMarco focused solely on patient's autonomy, thus failing to mention that there is always a medical and ethical commitment to beneficence and nonmaleficence. All of these aspects have to be taken into account when treating a patient, particularly at the end of life. It is questionable whether focusing on the patient's autonomy alone can justify hastening a patient's death.

Several instances can come to mind that can lead to the wish to die prematurely, and it is not my intention to dismiss any of these reasons. However, unlike the approach suggested by the authors, to assist a person in dying is not the singular right answer to such a wish of a patient. This suggests that the person is a client rather than a patient or sufferer. Palliative care is a holistic concept accompanying patients at the end of life with their medical, psychological, and spiritual needs.² All these aspects need to be taken into account when offering comfort care at the end of life. Failing to hasten a patient's death does not equal disrespecting his

autonomy or abandoning him as suggested in this paper. Palliative care can be a way to understand why patients want to die and offer means to modify the patient's situation according to his or her wishes and needs and respond accordingly.

The authors suggest that under palliative care patient's are "forced to endure symptoms, suffering and undesirable states of consciousness" but fail to mention that palliative care can offer symptom relief—which may affect a patient's wish to die. In addition, they fail to mention that even under the Death with Dignity Act (DWDA), this problem can occur as "the patient must make two oral requests to his or her physician, separated by at least 15 days" and "if either physician [of the required two] believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination."³ This might even extend the period of enduring symptoms until the desired death and impair provision of sound comfort care.

Furthermore, from the aspect of autonomy—the central argument of the authors—it is not logical to exclude and prohibit voluntary active euthanasia. The patient who cannot swallow or drink or move his arms has no alternative to voluntary active euthanasia. Why should that not be "morally sound" in contrast to assisted suicide?

Correctly, LiPuma and DeMarco state that the patients have to be fully informed about treatment and possible effects and side effects. However, they fail to consider anything about alternatives to suicidal ideation by simply ignoring that palliative care is successful in many patients with a wish to die.

In the interest of providing all the necessary information to the patient, it is also important to mention data from the Netherlands and Belgium showing the problems that arise in the practice of hastening a patients' death, ie, ending of life without a proper request or the application of the wrong medication.^{4–7} Although the quality of care within DWDA has



been improved, the time between ingestion of the medication until death ranged up to 34 hours with no mention of the burden for family, patient, and health care provider.⁸ This aspect is also not mentioned by LiPuma and DeMarco.

In addition, the authors labor under some misconceptions. There is no scientific proof for treatment titration causing pain or suffering. Also, administering pain medication does not “likely result in death.”

When speaking about the short time frame in hospice and “having their last days spent attempting to determine the proper pain management protocol,” the same is true for patients applying for a hastened death under the DWDA, where 2 oral requests have to be made separated by at least 15 days.

“Death with dignity” stands in contrast to death with indignity. This raises the question, “Is a ‘natural’ death undignified?” This assumption should never occur among our patients. Dignity can and should be measured.⁹

All patients in hospices and palliative care might feel undignified when reading that dignity in dying is only possible in a couple of US and European countries. However, considerable scientific proof indicates that a death in palliative care is a death with dignity for most of the patients.

Author Contributions

JZ wrote the first draft of the manuscript and approved the final version.

REFERENCES

1. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. Oxford, UK: Oxford University Press; 2012.
2. Blinderman CD, Billings JA. Comfort care for patients dying in the hospital. *N Engl J Med*. 2015;373:2549–2561.
3. Oregon Public Health Division. Oregon death with dignity act. <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/requirements.pdf>. Accessed January 8, 2017.
4. Bilsen J, Robijn L, Chambaere K, Cohen J, Deliens L. Nurses’ involvement in physician-assisted dying under the euthanasia law in Belgium. *Int J Nurs Stud*. 2014;51:1696–1697.
5. Smets T, Bilsen J, Van den Block L, Cohen J, Van Casteren V, Deliens L. Euthanasia in patients dying at home in Belgium: interview study on adherence to legal safeguards. *Br J Gen Pract*. 2010;60:e163–e170.
6. Deyaert J, Chambaere K, Cohen J, Roelands M, Deliens L. Labelling of end-of-life decisions by physicians. *J Med Ethics*. 2014;40:505–507.
7. Inghelbrecht E, Bilsen J, Mortier F, Deliens L. The role of nurses in physician-assisted deaths in Belgium. *Can Med Assoc J*. 2010;182:905–910.
8. Oregon Public Health Division. Oregon death with dignity act: 2015 data summary. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>. Published 2016. Accessed January 8, 2017.
9. Chochinov HM, McClement SE, Hack TF, et al. The Patient Dignity Inventory: applications in the oncology setting. *J Palliat Med*. 2012;15:998–1005.