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Commentary

Legitimacy issues aries in Euthanasia

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DESCRIPTION

The idea of euthanasia and physician-assisted suicide has resurfaced as part of a growing emphasis on end-of-life care. The Medical Specialties recently recognized palliative care as a subspecialty, which allows terminally ill patients to request and receive lethal doses of medication from physicians. Perhaps the most attention has been paid to euthanasia. Surprisingly, medical advances that allow for the treatment of many previously fatal illnesses (pneumonia) or the replacement of function of failing organs (dialysis and ventilation) appear to have increased the prevalence of difficult end-of-life situations. There is a wide range of physician actions available that can prevent a long, physically and emotionally painful death. The most basic act is to simply refuse treatment, which is virtually uncontroversial when dealing with extraordinary therapies.

When the treatment is considered routine, such as feeding tubes and intravenous fluids, there is more debate. Withdrawal of existing therapies is more involved, and depending on the patient's wish, begins to cross the line between when physician actions are active and when they are passive. In such cases, group decisions and ethics consultations are frequently used. Induced unconsciousness or terminal sedation is a more recent approach to end-of-life care. In such cases, patients are sedated to the point of near or complete unconsciousness, which lasts until death, which can be sped up by withholding fluids. With assisted suicide, a patient is given a sufficient quantity of drugs to cause death, which they administer themselves, physician participation becomes much more active.

One thing is certain: euthanasia has been and continues to be extremely contentious, capable of igniting passionate debate. The need to treat the dreadful physical and emotional suffering experienced by many terminal illnesses is cited by proponents of euthanasia. Many patients are more concerned about their loss of autonomy and dignity than they are about their pain.

Advocates argue that money spent on futile therapy could be better spent elsewhere, and that the patient's ability to choose to end his or her life should be inherent in the right choice. Finally, proponents see physician-assisted suicide as the final step in a continuing duty to provide pain and suffering relief. Not surprisingly, issues surrounding physician-assisted suicide arise most frequently in patients with terminal cancer or neurologic diseases. Taking care of critically ill patients, on the other hand, exposes us to end-of-life issues in cardiology, albeit less frequently. Despite the fact that our patients are critically ill, their path to recovery or death is usually not prolonged. They are more likely to experience emotional pain than physical pain. The majority of end-of-life issues in cardiology involve withholding or withdrawing therapy and occur in the context of advanced heart failure. Comorbidities are frequently a major factor in how patients with advanced heart disease are treated. The deactivation of implantable cardioverter-defibrillators in terminally ill patients has recently sparked debate about end-of-life care.

CONCLUSION

Like many physicians and non-physicians, this is conflicted about physician-assisted suicide. It is obvious that it is illegal for a physician to administer a lethal that there is a growing recognition among thoughtful individuals that difficult cases exist at the end of life that present difficult decisions. Indeed, our own technological advances are frequently to blame for subjecting patients and their families to prolonged periods of physical and emotional suffering.

As a result, it should be clear that we have a responsibility to avoid any measure that would prolong suffering and to consider ways to keep suffering as short as possible. Given the appropriate conditions (i.e., a mentally competent patient or one with a clear written directive, who is experiencing intractable suffering and loss of independence as a result of 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 many physicians believe 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 on the subject continues.

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