

Ethical issues

- Respect for autonomy (self-determination)
- Beneficence (do good)
- Non-maleficence (do no harm)
- Justice (fairness)

The exploration of ethical issues that arise at the end of life is inherent to the work of palliative care. This is because the process of dying and death raises profound ethical questions about the meaning and value of human life. These questions are negotiated every day by the individuals who are dying, by their loved ones and by those who are caring for them. With good communication and trust in the patient/professional relationship, patients' attitudes and concerns can be discussed sensitively, confusion unravelled and fears dispelled. For example, in practice, when some patients ask for euthanasia there may be areas of 'unfinished business', fear, guilt or other issues that need to be explored. After sensitive and open communication, most patients feel a sense of relief and their need to press for a deliberate ending of their life diminishes.

We live in a world which has become increasingly complex. Ethical issues that arise towards the end of life are often fraught with difficulty in an increasingly technological age in which the process of dying may be prolonged. In many healthcare situations, it is often difficult, sometimes impossible, to be certain about what is the right thing to do; at best we try to reach a consensus that is based on sound and sensitive ethical reasoning and evidence. The most widely used ethical framework in health-care decision-making in the West obliges health professionals to respect four basic principles:

- **Autonomy** (respect patients' values and inform and involve them in decision-making)
- **Beneficence** (do good)
- **Non-maleficence** (do no harm)
- **Justice** (treat patients fairly and balance the needs of individuals with those of society)

In the abstract, these principles can seem straightforward; in the heat of a clinical situation their application can be anything but clear. It is, however, very useful to have a framework with which to deal with ethical crises.

The following clinical scenarios are examples which occur commonly. Applying the principles of ethics in order to reach a balanced compromise can help provide a path through uncertainty.

Example 1: 'My father is not drinking adequately. Why are you not giving him extra fluids?'

Ethical issues

- **Beneficence:** Will artificial fluids help the patient?
- **Non-maleficence:** Will giving or not giving artificial fluids cause the patient harm?
- **Autonomy:** Does the patient want a drip?

It is instilled in all of us, from childhood years onwards, that food and drink are essential for life. There are clinical situations in palliative care when extra systemic fluids might be useful, for instance in hypercalcaemia or profuse diarrhoea and vomiting. These may be salvageable clinical situations where we are expecting the patient to return to his 'normal', albeit generally deteriorating, state of health.

Artificial hydration

- A blanket policy of artificial hydration, or of no artificial hydration, is ethically indefensible
- If dehydration is thought to be due to a potentially correctable cause, the option of artificial hydration should be considered
- The appropriateness of artificial hydration should be weighed up in terms of harm and benefit on a day-to-day basis

When someone is considered to be dying irreversibly, however, the routine of giving systemic fluids may not be in the patient's best interests.

Background information

A few studies address this issue, but there is no proof that either the giving or withholding of fluids interferes with the length of remaining life or affects comfort.

- Biochemical parameters show that only 50% of patients have any evidence of dehydration within the final 48h of life and, even then, only in mild to moderate degree
- There is no evidence that thirst or dry mouth (particularly) improve with artificial hydration
- The extensive experience of nurses working in hospices suggests that systemic fluids, at best, make no difference and, at worst, may actually contribute to suffering at the end of life
- The more fluid available, the more likely it is that it will gather in the lungs and dependent parts of the body, particularly in the presence of hypoalbuminaemia, which is common in advanced malignancy
- Artificially increasing fluids at the end of life, when the body physiology is winding down, may lead to worsening respiratory secretions, increased vomiting, increase in volume of ascites, raised intracranial pressure in the presence of intracerebral disease and an uncomfortable urinary output

- Families can spend precious time worrying about intravenous infusions running out or plastic cannulae being displaced and causing discomfort, instead of concentrating on quality time with the patient.

Discussion

Withholding systemic fluids is inevitably a very emotive issue signifying finally and clearly, perhaps for the first time to the family, that their loved one is now entering the final stage of his/her life. In practice, patients are often able to take small amounts of fluids until shortly before death. It should be explained to families that the body is gradually shutting down and is unable to handle an extra fluid load. They need to be aware that the patient will not be allowed to suffer from pain or other discomfort and they will need explanations of the measures that will be taken to avoid discomfort. These will include medication where necessary and, most importantly, meticulous mouthcare to prevent the common symptom of a dry mouth.

Palliative care is neither about shortening life nor prolonging the dying period.

Occasionally, families cannot bring themselves to accept the inevitability of death and insist on artificial hydration. Although healthcare professionals must act only in the best interests of the patient, it would be unwise to ignore the views of the family, who have to go on surviving with vivid memories of the dying phase. On occasion, if it is felt that extra fluids will not adversely affect comfort, it is sometimes helpful to have a contract with the family for a relatively small volume of fluid to be used subcutaneously or intravenously for a defined short period, on the understanding that it would be discontinued at any time if it was thought to be causing the patient distress.

As in most ethical crises, a balance has to be made—in this situation, between the harm caused by withholding or giving artificial hydration:

- Acknowledge family distress
- Explore concerns
- Discuss the above points
- Reassure the family that the patient will be looked after and kept comfortable whether or not fluids are given artificially

Example 2: 'How long have I got left?'

Ethical issue

- **Autonomy:** Is every attempt being made to inform the patient adequately?

This type of question usually relates to prognosis. As ever, however, it is always important to make sure that the question has been entirely understood, since to enter into a conversation about how long a patient has to live when all they want to know is when they are leaving hospital can cause unnecessary distress.¹

When it is certain that the patient is talking about prognosis, first find out what they already know, how they see the situation, why they are asking the question and how much they really want to know.

The following questions can be useful:

- 'What have the doctors told you so far?'
- 'What has prompted you to ask this question now?'
- 'How do you see the situation?'
- 'Are there other specific issues, related to how long there is left, on your mind that you would like to talk about?'
- 'Are you the kind of person who likes to know everything?'

In practice, patients often say they have not been told anything by the doctors: this may be true, or they may have inadvertently used denial mechanisms to 'forget' the bad news. The patient may also deny knowledge in an attempt to find out more information. It is important to explore what they understand accurately thus far. Patients often want to achieve goals such as writing a will, attending a family wedding, reaching a wedding anniversary, being reunited with old friends and family who they have not seen for a long time or seeing their religious adviser. Some patients like to consider writing a formal Advance Directive or 'living will', which should give a more formative, clearly defined record of their wishes in order to facilitate more informed decision-making. Patients may not find it easy to discuss these issues, even with close family members, and may need help to facilitate discussions. They may need help in setting realistic and achievable goals while planning their limited future.

¹ Launer J. (2005) Breaking the news. *Quarterly Journal of Medicine*, **98**: 385–6.

Before addressing prognosis directly, it is important to be aware of the full medical history and to build up a picture of the pace of clinical deterioration. Comments such as 'I believe you have not been feeling so well recently' or 'the doctors/your medical notes tell me that you feel that life has become more difficult over the past few weeks' open up these issues, giving you and the patient a chance to estimate prognosis. Remember that studies show that health professionals tend to overestimate prognosis.

Centuries of systematic insensitive deception cannot be instantly remedied by a new routine of systematic insensitive truth telling.

Buckman

Background

Literature on determining prognosis is available, especially for patients with cancer. For a population presenting with a defined stage, grade, cancer type and histology, five-year survival rates are available and often quoted to families. Many other factors have been studied singly and in combination in an attempt to categorize patients into prognostic groups, and this can be helpful in broad terms. In practice, however, it is not possible to predict prognosis for an individual accurately, because there are so many different influencing factors—including psychosocial, emotional and existential issues—all of which defy measurement of any kind.

- Make sure that you are answering what the patient wants to know
- Stress that you are not evading the question but that it is difficult to answer
- Find out specific issues that should be addressed, e.g. weddings, wills, etc.
- Do not be specific, but use days/weeks or weeks/months, etc.

Despite all these pitfalls, it is still important to answer the patient's question. It is still relatively common for a precise prognosis, for example 'six months', to be given and this is invariably inaccurate. If the patient dies before the due date, the family feel cheated of time that they would otherwise have spent differently had they known that time was so short. If the patient survives longer than the due date, both patient and family may feel proud that they have defeated the odds and take comfort from this; on the other hand, if the family have altered their lifestyles including giving up work (and salary) to look after a patient who has not significantly deteriorated by the due date, family tensions inevitably build up alongside all the normal feelings of guilt and anger.

It is not helpful to give a precise date, which patients and families often take literally, but to talk in terms of days/weeks, weeks/months and months/years. It is also important to say that even within these broad terms we may still be inaccurate.

It is also useful to talk about the pace of deterioration and to say that the pace may continue at the same rate but it may also either stabilize for a while or accelerate.

Example 3: ‘Don’t tell my mother the diagnosis. I know her better than you.’

Ethical issues

- **Autonomy:** Does this patient not need to be told regardless of what the family think?
- **Beneficence:** Would it help this patient to know her diagnosis?
- **Non-maleficence:** Would it harm this patient to know her diagnosis?

It is common to be caught in the hospital or health practice corridor by anxious relatives who (possibly wrongly) have been told that their relative has cancer, before this information has been given to the patient. There is increasing evidence that patients want to know what is wrong with them and to be involved in decisions. Generally speaking, we have moved away from a paternalistic approach in truth-telling whereby doctors often avoided telling patients they had cancer, to a more open approach, respecting the principle of autonomy.

However, family members have known the patient over many years and are aware of how he/she has responded to bad news in the past. They may feel that there is no point in discussing the diagnosis, particularly if the patient is very elderly and there is no available treatment.

- For understandable reasons the family want to protect the patient from bad news, but very often they want to protect themselves from further hurt and the reality that the patient may now be entering the last stages of life
- It needs to be acknowledged with the family that this is a difficult area but that the patient may have important things to say or do (financial, wills, gifts, etc.) or opinions to voice (regarding both medical and after-death decisions)
- The family also need to know that patients pick up non-verbal clues from professionals and relatives; they are often aware of the diagnosis and are not unduly surprised if it is confirmed
- Patients often want to protect the family, by denying that they know anything
- The family need to be aware that patients are often comforted by a ‘label’ to their illness, even if it is cancer, because it explains why they have been feeling so unwell. This gives them a genuine reason for feeling so wretched
- Families need to know that it becomes more difficult to conceal the truth from the patient as time goes on and as more professionals, family members and friends share the secret. There are increasing opportunities for the truth to slip out and for the patient to lose trust in and be angry with the family for not having been more honest in the first place
- Families also need to know that patients are not always frightened of death but of the process leading up to it, over which they may want some control
- It is very important not to lie to the patient as this breaks all communication, confidence and trust

- Acknowledge family anxiety
- Inform family of the issues as above
- Stress that it is important for neither professionals nor family to lie if the patient starts asking direct questions

If there are no particular decisions to be made, the patient has dealt with his or her affairs and is living with the family, there may be no pressing need to try to discuss the issue and invite family disquiet. However, if the patient begins to ask direct questions, the family should be advised not to lie. The family also needs to be aware that family tensions reduce considerably when there are open discussions about diagnosis.

The professional is able to override family views if it is clearly in the interests of the patient to do so, but it is also always advisable and prudent to listen to and take account of the views of the family. If it is felt important to discuss the diagnosis with the patient, it is usually acceptable to families to say that we will try to find out what the patient understands by their illness and whether or not they would like more information.

Example 4: 'I want full resuscitation if my heart or lungs fail.'²

Ethical issues

- **Autonomy:** Does the patient have the right to demand treatments from nursing and medical staff?
- **Beneficence:** Would it be in the patient's best interests to initiate resuscitation?
- **Non-maleficence:** Would it do the patient any harm to initiate resuscitation?
- **Justice:** Would it be an appropriate use of resources to initiate resuscitation measures and allocate a bed in an intensive care unit?

Background

Patients and families are increasingly aware of the many ethical issues surrounding cardiopulmonary resuscitation. These have been highlighted recently with 'DNR' (Do Not Resuscitate) notices being recorded in patients' notes without the patients being aware that they had been thus assigned. This has caused much concern, particularly among the weakest and most vulnerable sections of the community.

The issues have caused marked unease within hospices where, until very recently, resuscitation was regarded as an unacceptable practice. Patients with non-malignant disease and patients with cancer in the early stages, who may have a less predictable and possibly more favourable prognosis however, are increasingly requiring specialist palliative care. Such patients may feel very strongly that, in the event of a sudden cardiac or respiratory collapse, they want full resuscitation.

Litigation anxiety can cause a dilemma and increase the strain on staff to make the right decision. The need to document the resuscitation status of patients, following full discussion, can of itself lead to increased anxiety for all involved in handling what can be a very distressing issue.

- Patients have the right to ask for whatever treatment they choose. Medical and nursing staff are not obliged to comply with such expressed wishes if:
 - they feel it would not be in the patient's best interests
 - the intervention is deemed to be futile

² Willard C. (2000) Cardiopulmonary resuscitation for palliative care patients: a discussion of ethical issues. *Palliative Medicine*, **14**: 308–12.

Good practice would dictate that such matters are addressed by the whole multiprofessional team, although the senior doctor has ultimate responsibility for the decision.³

Approximate achievement of success from CPR in any setting:

In hospital	15%
In community	5%
In hospices	1%

A king, a doctor, and a convenient death

Lord Dawson of Penn was the most admired and respected doctor of his generation. The skill with which he managed King George V's respiratory illness in 1928 undoubtedly saved the King's life and made Dawson a national celebrity. He was also respected within the medical profession. He was president of the Royal College of Physicians, elected twice president of the BMA, and honoured with a viscounty.

His reputation would have been considerably diminished, however, had it been known that when the King was suffering from cardiorespiratory failure in January 1936 he administered a lethal combination of morphine and cocaine at a time when the King was already comatose and close to death. His action remained a well kept secret and the truth came to light only 50 years later when his private diary was opened, Dawson having died in 1945.

The King had been in failing health for several weeks when Queen Mary summoned Dawson to Sandringham on 17 January. Contemporary accounts of the King's last days given by the Archbishop of Canterbury and others tell of days that were tranquil and pain free with the King sitting in an armchair before a log fire for much of the time but becoming steadily weaker and with consciousness gradually slipping away.

At 9:25 pm on 20 January Dawson issued the memorable bulletin stating that the King's life was moving peacefully towards its close. The action which he took one and a half hours later is described in his diary thus:

'At about 11 o'clock it was evident that the last stage might endure for many hours, unknown to the patient but little comporting with the dignity and serenity which he so richly merited and which demanded a brief final scene. Hours of waiting just for the mechanical end when all that is really life has departed only exhausts the onlookers and keeps them so strained that they cannot avail themselves of the solace of

³ National Council for Palliative Care. (2002) *Ethical Decision-Making in Palliative Care. Cardiopulmonary Resuscitation (CPR) for people who are terminally ill*. London: NCPC. See also: Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2001). *Journal of Medical Ethics*, **27**: 310–16.

thought, communion or prayer. I therefore decided to determine the end and injected (myself) morphia gr.3/4 and shortly afterwards cocaine gr. 1 into the distended jugular vein.⁷

Dawson did not consult the other two doctors in the case, and his diary indicated that he was acting entirely on his own. To her credit, Sister Catherine Black of the London Hospital, who was present and who had nursed the King since the 1928 illness, refused to give the lethal injection, which is why Dawson had to give it himself. Nevertheless, faced with conflicting loyalties, she kept quiet about what had been done and her autobiography published in 1939 made no mention of what must have been the most poignant and unforgettable episode in her long and distinguished career.

The reason for his action, which Dawson frankly admits in his diary, was to ensure that the announcement of the King's death should appear first in the morning edition of *The Times* and not in some lesser publication later in the day. To make doubly sure that this would happen Dawson telephoned his wife in London asking her to let *The Times* know when the announcement was imminent.

Nevertheless, it was surely special pleading to claim that he also acted to reduce the strain on the royal family. Apart from the Prince of Wales, who was unhappy at being separated from his mistress Mrs Wallis Simpson, there was no evidence of such strain and in particular, as Dawson noted in his diary, Queen Mary remained calm and kindly throughout. The earlier death suited Dawson. Having issued his famous bulletin he had a vested interest in ensuring that death occurred sooner rather than later. At the same time it allowed him to get back to his busy private practice in London.

Although Dawson spoke against euthanasia when it was debated in the House of Lords in December 1936, he clearly felt that it or something similar might sometimes be appropriate for his own patients and there is no reason to think that King George V was the only patient he treated in this way. He described his management of the King's final illness as 'a facet of euthanasia or so called mercy killing.' But even the most ardent supporter of euthanasia would hesitate to describe the killing of an unconscious patient, without the patient's prior knowledge or consent, as mercy killing. Indeed, when examined closely this and almost all similar cases turn out in the end to be examples, not of mercy killing but of convenience killing. This was so in this case and the person most inconvenienced was Dawson.

The ethical line which separates acceptable from unacceptable conduct is sometimes a narrow one. What caused Dawson to stray across the line is a matter of speculation but the likely answer is that he was guilty of the besetting sin of doctors and that is of arrogance. Although in daily contact with the great and good of the land, including the Archbishop of Canterbury who was living at Sandringham at the time, he arrogantly assumed that he, and he alone, had the special insight to appreciate the importance of the timing of the King's death. It was also unfeeling of

Dawson to involve Sister Black in his plan and arrogant to assume that her conscience was as elastic as his own.

This whole episode seems a piece of pointless folly which Dawson was wise to conceal at the time. The emergence of the truth 50 years later did nothing to enhance his reputation nor did his half-hearted espousal of euthanasia do anything to diminish the opprobrium which rightly attaches to doctors who break the sixth commandment.

J H R Ramsay

British Medical Journal (1994); **308**: 1445, with permission from the BMJ Publishing Group.

Consent and competence

A patient is able to give *valid consent* to a procedure if he is *informed, uncoerced and competent*.

'Informed' means that a patient has all the relevant information, given in an appropriate form, with which to make a decision.

'Uncoerced' means that the person is free to make decisions without any undue influence or pressure from any other person.

To be considered 'competent' (the medical term) or to be deemed to have 'capacity' (the legal term) the patient must be able to:

- 1 Understand the issue in question
- 2 Retain the information in memory for long enough to use it in making a decision
- 3 Believe the information given
- 4 Weigh the information in the balance and evaluate arguments for and against in order to reach a decision
- 5 Express the decision in some form

The requirement for the consent of individuals for treatment protects patients from harm (non-maleficence); benefits them (beneficence); and respects their autonomy.

- **Non-maleficence:** This is viewed as a means of respecting a patient's privacy and dignity and protecting him/her from bodily invasion, assault, deception or coercion
- **Beneficence:** Therapeutic benefit ensues because it encourages patients' adherence with treatment and care procedures, and enables them to communicate a more complete picture of their concerns in relation to proposed treatments
- **Autonomy:** Having information about the potential advantages and disadvantages of any proposed treatment enables patients to reflect and deliberate on whether or not to accept or refuse the treatment that is offered. In consenting to the treatment that a health professional plans for them, they make the aims and objectives of the health professional part of their own

If a patient is not competent to be involved in discussions regarding medical care, in the UK a medical decision should be taken in the 'best interests' of the patient. It is best practice for the multidisciplinary team and the family to be involved in these discussions. The family cannot make decisions for incompetent patients in the absence of appropriate legal documentation but, where possible, they should be consulted to find out what the patient would have wanted. It often focuses the minds of a distressed family to ask questions such as 'What do you think your mother would want, given this situation?'

Points to consider:

- It is perfectly in order to provide all measures to enhance competence by managing the environment, e.g. optimize the senses (glasses/hearing aids), ensure a comfortable familiar environment with good lighting and heating, bring an advocate to the meeting, provide writing materials, and an interpreter, etc.

- Patients are entitled to make seemingly illogical decisions provided they are made with competence
- Patients may be competent even if they are mentally ill
- Patients may have lucid intervals

Specific situations

In palliative medicine we may be asked to assess competence in order that a patient can, for instance, make a will, change a codicil to a will, execute a Lasting Power of Attorney or document Advance Decisions to refuse treatment. All the above points apply.

Making a will

Clinical staff members are generally advised not to witness the signing of a will for fear of legal complications. In palliative care, however, we are endeavouring to support patients and their families through a very difficult time and it may be helpful for us to assist. In this situation, a senior doctor, if witnessing a signature, would be advised to do this only if they have assessed competency. The competency then needs to be documented.

Lasting Power of Attorney

As above, doctors witnessing the signing of these documents should ensure and document that the patient is fully competent. (📖 See also Chapter 19A.)

Advance Decisions to refuse treatment

Again, doctors need to assess and document competency. (📖 See also Chapter 19A.)⁴

⁴ Perkins H.S. (2007) Controlling death: the false promise of advance directives. *Annals of Internal Medicine*, **147**(1): 51–9.

Euthanasia

He jests at scars, that never felt a wound.

Shakespeare, *Romeo and Juliet*

Etymologically, the term 'euthanasia' derives from the ancient Greek, 'eu', meaning good and 'thanatos', meaning death, thus a 'good death'. Today, the term 'euthanasia' refers to the administration of death, the active intentional ending of life. It is a final and irreversible step and the subject of great debate engendering, on the one hand, strong feelings about the right to demand death and, on the other, strong feelings that life is so precious that we have a duty to preserve it at all costs. It must not be forgotten that patients are often making decisions regarding euthanasia on the basis of inadequate prognostic information, since medical advances will never be able to identify accurately when an individual patient will die naturally.

Proponents of euthanasia feel that:

Euthanasia is the only alternative to avoiding a painful death

Comment: Although the control of pain is not perfect, patients can usually achieve a degree of relief acceptable to them. Public education has started to erode the myth that all patients with cancer inevitably die in considerable pain, although this fear is still held strongly by some.

In practice, even patients with distressing symptoms and an apparent high level of suffering rarely request euthanasia consistently.

Euthanasia is the only answer to the fear of being kept alive at all costs

Comment: Extraordinary advances in medicine over the last few centuries have pushed forward the frontiers, extending the quantity of life and potentially, therefore, the extension of an 'unacceptable' poor quality of life. Medical ethics, however, has also advanced, allowing competent patients to refuse treatment and supporting the concept that burdensome, futile treatment is bad medicine. Assuming that healthcare professionals act with multidisciplinary support within an ethical framework, the fear of being kept alive at all costs should be minimized.

Euthanasia is the only way to die with dignity

Comment: Families are torn between not wanting to see their loved ones deteriorate and wanting them to survive as long as possible to nurture precious time. A natural death and all the potential healing and strengthening of family unity that so often occurs during the final days is often worthwhile and dignified, a sentiment supported by most healthcare professionals experienced in the care of the dying. Furthermore, the efficacy of drugs used to carry out euthanasia is unpredictable. There are literature reports of failure to achieve coma and patients re-wakening in considerable discomfort, which cannot be described as dignified.

'My dear Schur, you remember our first talk. You promised to help me when I could no longer carry on. It is only torture now, and it has no longer any sense'.

Sigmund Freud

(After years of suffering from cancer of the jaw, Freud convinced his personal physician to give him several large doses of morphine, for the pain. He fell into a coma and died the next day.)

Euthanasia should be legalized to uphold the principle of autonomy

Comment: In the West, individual rights are viewed as key to a democratic society, implying that the individual has the right to control his/her own destiny.

In society, however, others also have rights and the concept of a healthcare professional delivering euthanasia as a technical act may not be in the best interests of individuals or society.

Euthanasia, if carried out, should rightly occur only when the patient is fully competent and consistently requests it. However, patients who are ill, often bed-bound, unable to care for themselves and wholly reliant on others for care may feel a burden and under pressure to acquiesce.

A diagnosis of a reversible clinical depression may be missed if families and healthcare professionals are slow to recognize it. The concept of the 'slippery slope' argument, in which patients may be subjected to euthanasia without their expressed consent and within a short time of having had the discussions, has already been reported in the literature.

Whatever the arguments, the fundamental principles are that life is infinitely precious and that the vulnerable deserve protection. We should always consider the views of our competent patients and act in the best interests of those who are unable to give consent.

It is also fundamentally important to recognize what is *not* euthanasia, which includes the following, where the primary intention is to prevent suffering:

Euthanasia is not

- Withholding or withdrawing futile, burdensome treatment including nutrition and hydration if the patient is dying and is unable to swallow
- Giving opioids, or any other medications, to control symptoms including pain, fear and overwhelming distress
- Sedating a patient in the terminal stages if all other practical methods of controlling symptoms have failed
- Issuing a *Do Not Resuscitate* order

The Royal Dutch Medical Association has formulated five requirements that must be fulfilled for euthanasia to be acceptable or legally excusable. These are:

- 1 There is voluntary, competent and durable request on the part of the patient
- 2 The request is based on full information
- 3 The patient is in a situation of intolerable and hopeless suffering (physical or mental)

- 4 There are no acceptable alternatives
- 5 The physician has consulted another physician before performing euthanasia

The physician has to notify the local medical examiner and complete an extensive questionnaire. It is then reported to the public prosecutor who decides if prosecution is necessary. This notification procedure has formal legal status and also covers cases involving euthanasia without the patient's explicit request.

In some American states, physicians are allowed to prescribe medication to hasten death in terminally ill adults.

Further reading

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