Consultation and Discussion with Other Physicians in Cases of Requests for Euthanasia and Assisted Suicide Refused by Family Physicians

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Introduction

In the Netherlands, in 1995 approximately 9700 people explicitly requested euthanasia or assisted suicide (EAS), and EAS was performed approximately 3600 times (2.7% of all deaths).[1] The most important reasons for not performing EAS when requested by a patient were that the patient died before EAS was performed, or that the physician refused the request.[2]

Consultation with another physician is considered to be an important instrument in safeguarding the practice of EAS.[3–8] In Oregon consultation is one of the requirements for assisting in suicide.[8] In the Netherlands it is also one of the procedural requirements for prudent practice. Compliance with these requirements is only examined by the public prosecutor (in the notification procedure) when EAS has been granted. However, these requirements also apply to refused requests for EAS because they concern the decisionmaking process taking place after a patient's explicit request for EAS.

Consultation must be distinguished from discussion with colleagues, which is more informal and in which an important function of the colleague is to be a sounding board for the attending physician.[3] During a consultation, a physician formally confers with an independent and knowledgeable colleague when considering whether to grant a request for euthanasia or assisted suicide. The consultant should assess whether the attending physician is acting in accordance with the requirements for prudent practice, the most important of which are that the patient's request must be voluntary, well considered, and persistent, and that the patient's suffering must be unbearable and hopeless.

Information is only available about consultation in cases of EAS requests that are granted. In 63% of EAS cases consultation takes place. The reason most often mentioned for not consulting was that the attending physician did not intend to report the case. In 85% of cases of EAS in which consultation took place, the attending physician asked one or two of the general questions, Are the requirements for prudent practice met? and Is euthanasia justified in this case? In all cases the consultant agreed with the physician's decision to perform EAS. Of the physicians who had acted as consultant in a case of EAS, 26% had at some time advised against EAS. In such cases, the attending physician

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almost never performed EAS.[9] If consultation is as important for quality assurance in EAS as it is thought to be, consultation should also play a role when requests for EAS are refused. In this study the objective was to obtain more insight into the role of consultation and discussion with colleagues in cases of refused EAS requests. The following research questions were formulated:

1) How often does consultation and discussion with colleagues occur in refused EAS requests?
2) What are the reasons for not consulting or discussing?
3) Which aspects are included in the consultation or discussion?
4) What is the consultant's judgment in cases of refused EAS requests?
5) Are there differences between cases of refused EAS requests in which consultation did take place and cases in which no consultation took place, or between family physicians who did or did not consult a colleague before refusing to grant a request?

Methods

Design

The study is part of the project "Support and Consultation for Family Physicians in Amsterdam in Cases of Euthanasia."[10] In the pretest phase, all family physicians established in Amsterdam (n = 398) received a questionnaire.

Population

Nine of the family physicians did not meet the inclusion criteria (due to prolonged illness or retirement). Of the remaining family physicians, 305 (78%) returned the questionnaire. The nonresponse study provided information concerning 45 of the 84 nonrespondents. The most frequently mentioned reason for nonresponse was "no time available" (34 times), followed by "did not feel like it" (3 times). There were no differences between nonrespondents and respondents with regard to age, working experience, practice size, and (n)ever having performed EAS. Nonrespondents were more frequently men (84% versus 67%) and worked more often in a solo practice (52% versus 35%).

Definitions

Euthanasia was defined as the administration of drugs with the explicit intention of ending a patient's life, at the patient's explicit request. Physician-assisted suicide was defined as the prescription or supply of drugs with the explicit intention of enabling a patient to end his or her own life. Consultation was defined as "consultation of a colleague as stipulated in the notification procedure." All discussions that were not actually consultations (because they were less formal) were considered to be "discussions with colleagues."

Measuring Instruments

An anonymous postal questionnaire with prestructured questions was sent to family physicians in the spring of 1997. The questionnaire contained questions

about background characteristics, the family physician's experience in performing EAS, the last time the family physician had granted a request for EAS after the 1st of January 1994 (if any), the last time the GP had refused a request for EAS after the 1st of January 1994 (if any), the family physician's experience of acting as a consultant, and opinions on consultation. The questions in these sections focused mainly on consultation and discussion with colleagues.

Analysis

To answer the first four research questions, we compared data on the last request that was refused with data on the last request that was granted. Family physicians could have both a last case of a request that was refused and a last case of a request that was granted. The majority of family physicians who described a last case of a refused and/or granted request, had only one last case (99 family physicians had granted a request, 48 had refused, and 72 had both granted and refused a request for euthanasia). To find out to what extent the independence of the groups of most recent granted and most recent refused request would be at stake, we analyzed the data in two ways: one time excluding and one time including the physicians who described a most recent case of both a refused and an acceded request. Because both analyses had similar results, we decided to include the physicians with both a most recent granted and a most recent refused request in our final analyses. We used chi-square tests to compare percentages and analysis of variance to compare means.

To answer the fifth research question, we compared the refused requests in which consultation did take place with the refused requests in which it did not take place, using chi-square tests.

Results

Frequency of Consultation and Discussion in Cases of Refused Requests

Table 1 shows that consultation took place in 54% of cases in which the family physician refused a patient's request for EAS. This is less often than in cases in which the patient's request was granted (97%). Discussion with a colleague

Table 1. Frequency of Consultation and Discussion with a Colleague in Cases of Granted and Refused Requests for EAS (Rounded Percentages)*

	Granted requests (%)	Refused requests (%)
No. of observations	$n = 171$†	$n = 120$‡
No discussion or consultation	2	23
Only discussion with colleagues	1	23
Only consultation	39	21
Consultation and discussion	58	33

*$\chi^2 = 96.6$, $df = 1$, $p < 0.001$.
†5 missing observations.
‡4 missing observations.

took place in 59% of granted requests and 56% of refused requests. In cases of refused requests there was more often no consultation or discussion with another physician than in cases of granted requests (23% and 2%, respectively).

Reasons for Not Consulting or Discussing with a Colleague

The most important reason for not consulting or discussing with another physician in cases of refused requests was that the situation was already clear for the attending family physician (consultation 84%, discussion 93%), followed at distance by a lack of time (consultation 10%, discussion 11%) (Table 2). Of the six times that consultation did not take place in cases of granted requests, "the situation was clear" and "the patient requested it" each were mentioned three times as reason for not consulting.

Aspects Included in Consultation

Table 3 shows that the following aspects were included in more than half of the cases in which the patient's request was refused: whether the patient's suffering was unbearable and hopeless (70%), whether EAS was justified (63%), whether the request was well considered and persistent (57%), and whether there were alternatives for palliative treatment (53%). In comparison, in cases of granted requests, several topics were addressed less often (unbearable and hopeless suffering, well considered and persistent request, voluntary request, the patient's life expectancy, and the method of life termination), while one topic—whether the decisionmaking process was influenced by transference or countertransference—was addressed more often in cases of refused requests (9% and 35%, respectively).

Table 2. Reasons for Not Consulting or Not Discussing with a Colleague in Cases of Granted and Refused Requests for EAS*

	No consultation		No discussion	
	Granted requests abs.	Refused requests (%)	Granted requests (%)	Refused requests (%)
No. of observations	$n = 6^{\dagger}$	$n = 53^{\ddagger}$	$n = 68^{\#}$	$n = 51^{\$}$
Situation was clear	(3)	84	96	93
Patient's request	(3)	—	4	—
Talking to colleagues would endanger the confidentiality	(2)	—	4	—
No time	(—)	10	—	11
Too early in decisionmaking process for consultation	(—)	4	—	—
Other reason	(1)	8	2	—

*More than one answer could be given.
†Because of the small number of cases only absolute figures are given.
‡Four missing observations.
#Twelve missing observations.
$Ten missing observations.

Table 3. Aspects Included in Consultation and Discussion with a Colleague in Cases of Granted and Refused Requests for EAS* (rounded percentages)

	Consultation			Discussion		
	Granted requests (%)	Refused requests (%)	*p*-value	Granted requests (%)	Refused requests (%)	*p*-value
No. of observations	$n = 161^{\dagger}$	$n = 63$		$n = 97$	$n = 65^{\ddagger}$	
Unbearable and hopeless suffering	97	70	<0.001	72	58	n.s.
Well-considered and persistent request	85	57	<0.001	41	50	n.s.
Voluntary request	72	28	<0.001	38	19	0.018
Patient's life expectancy	69	47	.002	60	42	0.041
Whether EAS was justified in this case	56	63	n.s.	45	56	n.s.
Possible palliative alternatives	49	53	n.s.	53	40	n.s.
Possible curative alternatives	37	42	n.s.	33	35	n.s.
Method of life-termination	30	12	0.006	43	8	<0.001
Presence of transference and counter-transference	9	35	<0.001	29	31	n.s.
Attending family physician's emotions	—	—	—	3	—	n.s.
Referral of the patient	—	2	n.s.	—	8	n.s.
Other topics	1	2	n.s.	2	6	n.s.

*More than one answer could be given.
†Five missing observations.
‡Thirteen missing observations.

While in cases of refused requests an average of 4.3 aspects (standard deviation 2.2, range 1–9) were included in the consultation, this was 5.1 (standard deviation 2.0, range 1–9) in cases of granted requests. This difference was statistically significant ($f = 14.27$, $p < 0.001$).

Aspects Included in Discussion

In cases of refused requests there were no differences between consultation and discussion in the frequencies of the various aspects included. In discussion too the most frequently included aspect was unbearable and hopeless suffering. Three aspects were significantly less often included in discussion in cases of refused requests than in cases of granted requests: whether the request was voluntary (19% and 38%, respectively), the patient's life expectancy (42% and 60%, respectively), and the method of life termination (8% and 43%, respectively) (Table 3).

While in cases of refused requests an average of 3.6 aspects (standard deviation 2.3, range 1–9) were in the discussion, this was 4.2 (standard deviation 2.4, range 1–9) in cases of granted requests. This difference was statistically significant ($f = 5.84$, $p = 0.017$).

The Consultant's Judgment

In 77% of the cases in which the family physician refused the patient's request and consultation took place, the consultant was of the opinion that the request

could not be granted. This applied to 2% of cases in which the family physician granted the request ($\chi^2 = 1.47.37$, $df = 1$, $p < .001$).

Patient Characteristics and Reasons for Refusal

Table 4 shows that in cases of refused requests in which no consultation took place, patients were relatively less often 80 years or older (19% versus 37%) or male (34% versus 50%) and suffered relatively more often from psychiatric disorders other than depression (10% versus 0%) than in cases of refused requests in which consultation did take place. However, these differences were not found to be statistically significant.

In cases in which consultation did take place "there were still alternative treatments available" seems to be a reason for refusal more often than in cases in which consultation did not take place (48% versus 33%). However, there were also no significant differences found in the family physician's reason for refusal of the request between cases in which consultation did or did not take place.

When analyzing differences in patient characteristics and reasons for refusal between family physicians who consulted or discussed with a colleague and family physicians who did not, one difference was found: for family physicians who consulted or discussed with a colleague the availability of alternatives for treatment was more often a reason for refusal than for family physicians who did not consult or discuss the case with a colleague (47% versus 24%; $\chi^2 = 4.09$, $df = 1$, $p = 0.043$ [data not shown]).

Family Physician Characteristics

Table 5 shows that for some family physician characteristics there were differences between cases in which consultation did or did not take place. In the group of family physicians who did not consult a colleague, the family physician was more frequently male (76% versus 57%), working in a solo practice (46% versus 31%), and generally agreed to a lesser degree with the statement "consultation is necessary in every case of EAS" than in the group of family physicians who did consult a colleague.

Discussion

This study shows that some form of discussion with colleagues takes place in approximately three-quarters of all cases of refused EAS requests. It takes the form of consultation in approximately half of the cases. This is less often than in cases of EAS requests that are granted. The most important reason for not consulting or discussing a case is that the situation was already clear. In both consultation and discussion the family physicians included fewer aspects in cases of refused requests than in cases of granted requests. Only the presence of transference or countertransference between physician and patient was an aspect included more often in consultation in cases of refused requests than in cases of granted requests. In cases of refused requests, when consultation took place approximately three-quarters of the consultants were of the opinion that EAS should not be performed, while this hardly ever happened in cases of granted requests. Some differences were found in patient characteristics and reasons for

Table 4. Characteristics of the Patient and Reasons for Refusal in Cases of Refused Requests for EAS in Which Consultation Did and Did Not Take Place (rounded percentages)*

	Consultation (%)	No consultation (%)
No. of observations	$n = 63^{\dagger}$	$n = 53^{\ddagger}$
Patient's age		
0–49 years	12	17
50–64 years	20	19
65–79 years	32	45
80 years and over	37	19
Patient's sex		
male	50	34
female	50	66
Diagnosis		
malignant neoplasm	40	37
depression	12	12
other psychiatric disorders	—	10
deterioration; no specific diagnosis	10	6
disease of the nervous system	10	2
disease of the circulatory system	7	10
disease of the respiratory system	7	6
AIDS	5	8
other diseases	9	10
Attending family physician's reasons for refusal[#]		
suffering was not unbearable and hopeless	51	56
alternative treatments still available	48	33
patient had depression	42	44
personal objections in this case	25	33
negative judgement of the consultant	20	—
request was not well-considered and durable	17	22
patient had no understanding of the illness	15	17
patient was not competent	10	9
fear of judicial consequences	10	6
request was made under pressure of the family	10	2
never perform EAS	8	13
did not know the patient sufficiently	5	2
too early in disease process	3	6
contact with patient was not good	3	2
other reasons	2	4

*No statistically significant differences were found between cases in which consultation did or did not take place.
[†]Diagnosis: five missing observations, reasons for refusal: four missing observations.
[‡]Diagnosis: two missing observations.
[#]More than one answer could be given.

refusing the request between cases in which consultation did or did not take place. However, they were not found to be significant. There were some differences in family physician characteristics, e.g., family physicians who did not consult a colleague were more often male.

One limitation of this study is that the data are based on self-report. In a previous nationwide study using similar methods we found that the frequency

Table 5. Characteristics of the Family Physician in Cases of Refused Requests for EAS in Which Consultation Did and Did Not Take Place (rounded percentages)

	Consultation	No consultation
No. of observations	$n = 63$	$n = 53$
Family physician's age[#]		
<40 years	20	19
40–44 years	15	24
45–49 years	38	30
50–54 years	22	22
≥55 years	5	6
Family physician's sex*		
Male	57	76
Female	43	24
Type of practice[†]		
Solo practice	31	46
Duo practice	31	35
Group practice	10	0
Health center	29	19
Ever performed EAS[#]	78	80
Ever been a consultant[#]	70	70
Attitudes toward consultation		
Consultation is necessary in every case of EAS[‡]		
* Totally agree	87	67
* Agree	7	24
* Agree more than disagree	2	0
* Neither agree or disagree	0	2
* Disagree	5	7
I consult another physician before I have decided whether or not to perform EAS[#]		
* Totally agree	36	25
* Agree	32	21
* Agree more than disagree	5	21
* Neither agree or disagree	10	10
* Disagree	17	23

*$\chi^2 = 4.68$, $df = 1$, $p = 0.030$.
†$\chi^2 = 8.77$, $df = 3$, $p = 0.032$.
‡$\chi^2 = 9.53$, $df = 4$, $p = 0.049$.
#No statistically significant differences were found between cases in which consultation did or did not take place.

of consultation might have been overreported.[9] On the other hand, because consultation was defined in relation to the notification procedure, respondents might have thought that in cases of refused requests discussion with colleagues should not be regarded as consultation. This would result in underreporting.

A possible reason for the finding that consultation occurs less frequently in cases of refused requests is that family physicians tend to consult a colleague late in the decisionmaking process, i.e., when they are almost certain that they are prepared to grant the request. In an earlier study we found that 63% of the family physicians agree with the statement "I consult another physician before I have decided whether or not to perform EAS."[11] Since the most important

reason for not consulting is that the situation was already clear, another reason might be that in many cases of refused requests it was not difficult for the family physician alone to decide whether to refuse or to grant the request. This could, for instance, be the case for patients whose main diagnosis is a psychiatric disorder, because family physicians never or rarely ever perform EAS in such cases.[1]

It is not clear why, in general, fewer aspects were included in consultation in cases of refused requests than in cases of granted requests. Only one aspect, "the presence of transference or countertransference," was included more often in cases of refused requests. An explanation could be that the possible influence of transference or countertransference on the decisionmaking process is a reason to be hesitant about the performance of EAS, while the aspects that were included less often are more relevant when a family physician is more confident about performing EAS, because they are included in the requirements of prudent practice (e.g., unbearable and hopeless suffering, well-considered and persistent request) or because they are relevant for the performance of EAS (the method of life termination).

In discussions with colleagues also, on average, fewer aspects were included in cases of refused requests than in cases of granted requests, but the differences were smaller than for consultation. Moreover, the frequency of discussion is similar in cases of refused and granted requests. Possibly, discussion is more relevant than consultation in all phases of the decisionmaking process.

This study produced no clear findings on what variables are of influence on whether consultation takes place before refusing a request. Although no significant differences were found in patient characteristics and reasons for refusal between cases in which consultation did or did not take place, there were some variables that seemed to occur less frequently in cases in which consultation did not take place: the patient being 80 years or older, the patient having a psychiatric disorder, and the availability of alternative treatments. Since in these situations EAS is performed relatively less frequently, these findings support the assumption that in particular family physicians consult in cases in which they are not quite sure about whether to grant the request or not.[9,12] Some differences in physician characteristics were found. It is not clear why female family physicians tend to consult more often than men. One reason why family physicians working in a solo practice consult less often might be that they are generally more inclined to deal with problems by themselves.

Family physicians not only often consult or discuss with a colleague in cases in which requests for EAS are granted, but also, although less frequently, in cases in which requests are refused. That consultation (and also discussion) contribute to the attending family physician's decisionmaking process is suggested by the fact that the most frequently mentioned aspects included in the consultation are similar to the most frequently mentioned reasons for the attending family physician's refusal. Beyond that, in one out of five cases the negative judgment of the consultant was explicitly mentioned as one of the reasons for refusing a patient's request.

Because of the impact of their decision, and the contribution consultation can make to the decisionmaking process it is important that physicians are stimulated to more often consult another physician also if they are hesitant about granting a request. This is especially important looking from the patient's perspective. In the project "Support and Consultation in Euthanasia in Amster-

dam," this is done by emphasizing to family physicians the importance of consulting a physician early in the decisionmaking process, and by the availability of independent, specially trained consultants who can be reached 24 hours per day.[10]

Notes

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