

A protocol for consultation of another physician in cases of euthanasia and assisted suicide

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Abstract

Objective—*Consultation of another physician is an important method of review of the practice of euthanasia. For the project “support and consultation in euthanasia in Amsterdam” which is aimed at professionalising consultation, a protocol for consultation was developed to support the general practitioners who were going to work as consultants and to ensure uniformity.*

Participants—*Ten experts (including general practitioners who were experienced in euthanasia and consultation, a psychiatrist, a social geriatrician, a professor in health law and a public prosecutor) and the general practitioners who were going to use the protocol.*

Evidence—*There is limited literature on consultation: discursive articles and empirical studies describing the practice of euthanasia.*

Consensus—*An initial draft on the basis of the literature was commented on by the experts and general practitioners in two rounds. Finally, the protocol was amended after it had been used during the training of consultants.*

Conclusions—*The protocol differentiates between steps that are necessary in a consultation and steps that are recommended. Guidelines about four important aspects of consultation were given: independence, expertise, tasks and judgment of the consultant. In 97% of 109 consultations in which the protocol was used the consultant considered the protocol to be useful to a greater or lesser extent. Although this protocol was developed locally, it also employs universal principles. Therefore it can be of use in the development of consultation elsewhere.*

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Introduction

Consultation of another physician is increasingly seen as an important way in which to review the practice of euthanasia or physician-assisted suicide (EAS).^{1–7} In Oregon in the USA, where, under certain conditions, physician-assisted suicide is permitted, consultation is one of the prerequisites. In the Netherlands too, consultation is one of the requirements for prudent practice. These are requirements that have to be met if a physician wishes to avoid prosecution after reporting a case of

EAS through the notification procedure.⁴ Euthanasia is 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 is defined as the prescription or supply of drugs with the explicit intention of enabling a patient to end his or her own life.

Consultation implies that a physician must formally confer with an independent and knowledgeable colleague before performing EAS.⁴ Of course, it is not only important that a physician consults another physician before performing EAS, but also that the consultation is of good quality. Through the notification procedure, the law of precedent and discussions among medical professionals it has become increasingly clear as to what can be considered to be important criteria for good consultation: among other things, the consultant should have an independent position with regard to both the patient and the physician (that is, not knowing the patient and not working in the same practice as the attending physician), should talk to the patient and should also make a written report.⁴

In 1997, the Support and Consultation in Euthanasia in Amsterdam (SCEA) project was initiated to provide all general practitioners working in Amsterdam with a support group of approximately 20 specifically trained general practitioners for consultation or advice on EAS.⁸ The purpose was not only to make it easier for general practitioners to find an independent and knowledgeable consultant, but also to professionalise consultation. The latter is necessary because EAS consultations do not always meet the criteria for good consultation.⁹ To support the consultants in their work and to ensure uniformity, a protocol for consultation was developed, in which an attempt was made to clarify the existing criteria for consultation (where necessary) and to incorporate them into practical guidelines. This article reports on the development of the protocol and its contents, and describes some of the initial experiences of the physicians who worked with the protocol.

Methods

DEVELOPMENT OF THE PROTOCOL

The protocol was developed according to a Delphi-method. The purpose was to get a protocol that would be accepted and used by SCEA physicians. It involved the following steps:

1. An initial draft on the basis of the literature (which is very limited on this subject) and also the authors of this article did their own research.^{4 9-16}
2. In the first round, ten experts were asked to comment on the draft. These experts included six general practitioners who were experienced in EAS and consultation, a psychiatrist, a social geriatrician, a professor in health law and a public prosecutor. Using a written questionnaire, they were asked whether they agreed with the structure of the protocol and the guidelines contained in the protocol. Except for two controversial issues (concerning the independence of the consultant and seeing the patient—discussed below) they all agreed on the structure and the content of the guidelines, but some suggestions were made for making them more precise.
3. In the second round, the draft of the protocol was not only sent to the experts, but also to the general practitioners (ten) who had agreed to function as consultants. In the questionnaire about this draft specific questions were asked about two issues that had appeared to be controversial in the first draft (could the consultant and the attending physician be participants in the same physician group, and should the consultant always see the patient), so that it was possible to follow the opinion of the large majority.
4. The version of the protocol that resulted from the second round was amended again after it had been used during the training of consultants to make it, where necessary, more usable in practice.

EXPERIENCES WITH WORKING WITH THE PROTOCOL.

On April 1 1997 SCEA was initiated with 20 participating general practitioners. Each time they were consulted, they filled in a registration form. On this form, among other things, they were asked how useful the protocol had been for that specific consultation (structured question), and they were also asked to clarify their answers (open-ended question). During the period between April 1 1997 and October 1 1998, 109 consultations took place, and for each consultation a registration form was filled in.

One year after the start of the intervention three focus group meetings were held, each attended by between five and seven consultants, in which the intervention was evaluated. One of the topics was working with the protocol.

Results

STRUCTURE OF THE PROTOCOL

The protocol includes guidelines for consultation and differentiates between steps that are necessary in a consultation and steps that are recommended. The guidelines were structured not only on the basis of distinguishing between procedural and substantive aspects, but also to distinguish between

Box 1. Independence of the consultant

CENTRAL QUESTION:

When requested to take part in a consultation, the consultant must decide whether he or she is sufficiently independent, ie a consultant must not have any business, hierarchic or family connections with the consulting physician or the patient.

NECESSARY

A consultant must not:

- be a practice or group practice colleague of the consulting physician*
- be an assistant or trainee working with the consulting physician*
- have a personal relationship with the consulting physician
- have any (other) hierarchic relationship with the consulting physician
- be involved in any treatment of the patient*
- have a personal relationship with the patient.

RECOMMENDED

- If the consultant and the consulting physician are working in the same physician group or (smaller) institution, because this would imply a greater threat to independence (for example, hierarchic or personal relationship), extra consideration should be given to deciding whether the consultant is independent.
- The consultant should determine whether there are any other (personal) reasons why the consultant is too involved to be able to make an independent assessment.

If the consultant comes to the conclusion that he is not sufficiently independent, he must ensure that the consulting physician contacts another consultant.

* These guidelines are legal requirements

whether the guidelines concerned the consultant or the consultation. In this way, four important aspects of consultation could be distinguished: independence of the consultant (procedural, consultant); expertise of the consultant (substantive, consultant); tasks of the consultant (procedural, consultation), and judgment of the consultant (substantive, consultation). Guidelines for each of these aspects are included in the protocol.

The introduction to the protocol explains both its structure and its goal: to support consultants in systematically acting as consultants. It is also emphasised that not all guidelines will be applicable in each situation, but that it is important at least to explain why following a certain guideline would not be necessary in a specific situation.

INDEPENDENCE OF THE CONSULTANT

Box 1 shows the guidelines given for the independence of the consultant. The general question a consultant should ask him or herself before agreeing to act as consultant in a specific case is whether he or

Box 2. Expertise of the consultant

CENTRAL QUESTION:

When requested to take part in a consultation, the consultant must decide whether he or she has sufficient knowledge and expertise to assess whether the patient's request meets the requirements for prudent practice and whether the attending physician's decision is (has been) medically-professionally correct.

NECESSARY

- The consultant must have sufficient knowledge and expertise to make an adequate assessment of whether the patient's request is voluntary, well considered and persistent, whether the patient considers his suffering to be unbearable and hopeless and whether there are no further alternative treatments available for the patient.
- The consultant must have the necessary communicative skills to be able to communicate adequately with the physician, the patient and the patient's relatives or friends.
- If there is any suspicion that (additional) serious psychological problems could influence the request, a psychiatrist must (also) be consulted.*

RECOMMENDED

- The consultant should have adequate knowledge of palliative care.
- The consultant should have the necessary diagnostic skills to identify any serious problems which could influence the competence of the patient's request.
- The consultant should determine whether there are any specific medical or other problems which could make it necessary to involve additional expertise or consultation (for example palliation, assessment of competence, performance of euthanasia, existential or religious problems). These are aspects which provide additional information which the consultant needs when making his decision.

In principle, a consultant from within SCEA has sufficient expertise. In each phase of the consultation, however, he or she can consider whether he or she should make use of the specific expertise which, for instance, can be provided by a specialist.

* This guideline is a legal requirement

she is independent of both the attending physician and the patient. In the second round a specific question was asked about a controversial aspect of independence: is the independence of a consultant threatened if the consultant and the attending physician participate in the same physician group (physicians who perform on-call services for each other)? Seven persons said the consultant should never be of the same physician group, two said this

was no problem and 11 said this should sometimes be possible (if it was difficult to find another physician or if the consultant really could be independent even if a member of the same physician group). Taking these results together with the notion that legally there is no objection to the consultant being of the same physician group, it was decided it should be recommended that a consultant should consider his or her independence even more carefully if the attending physician participated in the same physician group.

EXPERTISE OF THE CONSULTANT

Box 2 shows the guidelines concerning the knowledge and skills which are necessary for being a consultant. The most important question a consultant should ask him or herself before agreeing to act as a consultant in a specific case is whether he or she has the required knowledge and skills for this case. Moreover, during the consultation a consultant should always be able to determine whether it is necessary to involve someone else, for example a psychiatrist, if there are any doubts about the patient's competence.

TASKS OF THE CONSULTANT

Box 3 lists the activities a consultant should perform during a consultation in order to be able to make the correct decision: discussing with the attending physician; studying the patient's files; seeing the patient, and making a written report of the consultation. In the second round the experts and physicians were explicitly asked about the controversial issue of seeing the patient. All (19) but seven added that in very exceptional cases (for example when they thought that after reading the patient files and talking with the physician, seeing the patient would not add information) it would not be necessary.

JUDGMENT OF THE CONSULTANT

Box 4 shows the guidelines for the judgment of the consultant. The main question concerning the judgment of the consultant was subject to discussion because the law is only concerned with whether the requirements for prudent practice are met in consultation. However, the majority of experts and physicians thought that medical standards were equally important, and were of the opinion that the consultant should also check whether the attending physician also worked with due medical-professional care. Another subject of discussion was the status of the consultant's judgment. The attending physician has the final responsibility for the decision on whether or not to perform EAS and can, if a consultant disagrees, always consult another physician. To prevent attending physicians from continuing to consult physicians until they find a consultant who agrees, the guidelines stipulate that an attending physician should only consult one other physician if the first consultant disagrees with the decision.

Box 3. Tasks of the consultant

CENTRAL QUESTION:

The consultant must consider all the tasks he or she must perform in order to come to the correct decision.

NECESSARY

- The consultation consists of four steps. In the first instance, all four steps must be completed:
 1. Hold a discussion with the attending physician.
 2. Study (a copy of) the medical records (including letters from specialists and any other important documents related to the patient's request).
 3. See the patient.* In this context, the consultant must determine whether:
 - the patient's request is voluntary, well considered and persistent;
 - the patient really considers the suffering to be unbearable and hopeless;
 - there are alternative methods of treatment possible (palliative or curative);
 - there is a written will or a written request from the patient.

Seeing the patient usually implies talking to the patient. If the patient is no longer up to this, it implies examining the patient and possibly talking to a relative or friend. Then, a written will is of extra importance.

4. Make a written report of the consultation.*

RECOMMENDED

- re 1. Hold a discussion with the attending physician –
 - By telephone or face-to-face.
 - In preparation, the consultant will be given insight into the case history (for example a list of important points or copies of letters from specialists).
 - Points of discussion are the case history and the patient's request.
 - Determine whether the attending physician has any specific questions and/or uncertainties (for example with regard to the time of performance, medical-technical aspects or supporting the family). If necessary (because of independence), another doctor can be involved for this purpose.
- re 3. See the patient
 - If there are special reasons why the patient does not need to be seen, this must be well documented (for instance, when, after reading the patient files and talking with the physician, seeing the patient would not add information).
 - Talk to the patient alone (no one else present) in order to obtain an opinion of how voluntary the request is.
 - Take notice of the inter-relationships and communication patterns within the family in order to be certain that the patient is not being influenced.
 - Take notice of any other possible motives for the request, such as fear.
 - Determine whether the written will is adequate or needs to be amended.
 - Determine whether it is necessary to examine the patient (for instance if there is lack of clarity in the medical situation).
- re 4. Make a written report
 - This should include:
 - a. short description of the discussion with the consulting physician;
 - b. activities which formed the basis of the opinion;
 - c. answers to the questions about the request, the suffering and alternatives;
 - d. personal considerations and conclusion (the opinion).
 - The report must be given to the consulting physician, who will hand it to the Medical Examiner as part of the notification procedure.

In the first place, the consultant must complete all four steps. If he does not, he must give good reasons for not doing so.

* These guidelines are legal requirements

EXPERIENCES WITH THE PROTOCOL

In most consultations the SCEA physician found the protocol useful to some extent: 23 (21%) “very useful”; 55 (51%) “useful”, and 16 (15%) “somewhat useful”. In three (3%) of the consultations the SCEA physician did not find the protocol useful (with no further clarification). In 12 (11%) of the consultations the SCEA physicians did not use the protocol because they had already memorised its contents.

In 46 of the 109 consultations the SCEA physicians clarified their answers. It was most frequently mentioned that the protocol was useful as a checklist: 27 (59%), for example said it was “useful in working systematically”, or “useful to check whether all aspects had been addressed”. Other clarifications given by the SCEA physicians were that they had already memorised the protocol (13: 28%); that they did not use the protocol (4);

Box 4. Judgment of the consultant

CENTRAL QUESTION:

The consultant must assess whether the patient's request meets the requirements and whether the consulting physician has acted with due medical-professional care. This refers to the requirements for prudent practice and the prevailing law of precedent.

NECESSARY

- The consultant must assess the extent to which the consulting physician has complied with the substantive requirements for prudent practice:
 1. Is the patient's request voluntary, well considered and persistent?*
 - Determine whether there are circumstances which could influence the competence of the patient (ie use of morphine, brain metastases or psychiatric problems) (well considered).
 - Determine how persistently or often the patient has made the request (persistent).
 - Determine that the patient has not been influenced in making the request (voluntary).
 2. Are there any possible alternatives available, and has the patient been fully informed in this respect?*
 - Determine whether there are any other possibilities to make the patient's life bearable in his own opinion.
 - Determine whether another physician/specialist could provide any further information in this respect.
 3. Is the suffering unbearable and hopeless?* According to the list of important points included in the notification procedure, this should at least include assessment of:
 - the status of the patient*
 - the expected time of death. Although the terminal phase is not a criterion, an estimate should be made of the time remaining before death.*
 - in particular the patient's own opinion. The doctor and consultant must both be convinced that the patient actually experiences the suffering as unbearable and hopeless.*

On the basis of these three points the consultant must come to a final conclusion.

RECOMMENDED

- On the grounds of certain conclusions, it could be recommended to advise the consulting physician to:
 - have further discussions with the patient;
 - ask for additional specialist advice.

The attending physician is, and remains the person who is responsible for deciding whether or not the request will be granted; he or she is not obliged to act according to the opinion of the consultant.

If the consultant is of the opinion that not all of the requirements for prudent practice have (yet) been met, but the physician adheres to his or her decision to terminate life, the physician can still ask the advice of one other consultant via the network. After that, a subsequent consultation can only take place if the patient's situation changes.

* These guidelines are legal requirements

that it did not provide sufficient support in a specific complex case (1), and that the central question that had to be answered in a consultation could have received more attention (1).

In the focus group meetings, all SCEA physicians stated that the protocol had been very useful, and more specifically they mentioned that it was useful as a checklist. There were differences in the way the protocol was used: some SCEA physicians did not refer to it anymore because they had memorised it, some read it at the beginning of the week they would be on call (approximately one week every two months) and a few always took it with them when visiting the attending physician and the patient. It was also mentioned that the protocol had a more general function in representing the consensus on consultation that existed among the SCEA physicians. The SCEA physicians made only one suggestion about guidelines that should be amended, omitted or supplemented: expertise of palliative care should be necessary and not just recommended.

Discussion

In an ideal situation, in the development of a protocol, existing literature will be a major source of information. In developing the protocol for consultation, however, this was not the case. The few empirical studies which have been conducted are only descriptive, and furthermore there is only limited literature available in which physicians and lawyers describe what they consider to be good consultation. Nevertheless, with the help of experts, it was still possible to develop a protocol that was used and also considered to be useful by the SCEA physicians, especially as a checklist. The involvement of the physicians who were supposed to use the protocol, the SCEA physicians, in the development of the protocol was probably also important for the positive results, not only by encouraging commitment, but also by making the protocol practical in use.

In a consultation, the fields of medicine and law are combined. It was noteworthy that the experts often chose the medical, more strict, perspective, in which the main focus is on optimising care, over the judicial perspective, which focuses on the least you have to do in order not to be prosecuted. One example is the exact central question that should be answered in a consultation. In the literature this has never been clearly stated. In formulating the central question, it was decided to consider consultation from a predominantly medical perspective. From the judicial perspective, only the question of whether the requirements for prudent practice were met would be of importance and not the way in which the decision to grant a request was made. For instance, the fact that the physician can be pressured by the patient or members of the family to make a rapid decision, does not necessarily have an effect on whether or not the physician meets the requirements for prudent practice, but it does have an effect on the quality of the physician's decision making. Another example is that from a medical perspective, talking to the patient is considered to be a necessary step in every consultation, whereas according to the law of precedent this is only necessary if the patient's suffering is primarily psychological.⁴

In view of the continuous developments in the field of euthanasia and assisted suicide, and the way in which it is safeguarded (such as the enactment of the notification procedure in 1994, the changes in the notification procedure in 1998 and the developments in the field of palliative care), it is important that the protocol is updated regularly. For instance, it is increasingly important that a consultant has the necessary knowledge of palliative care. Early in 1997, when the protocol was being developed, this was mentioned as a recommendation. However, the general opinion, also in the United States, is that good palliative care is considered to be a *sine qua non* of physician-assisted suicide.¹⁵ Evaluation of the SCEA project showed that the SCEA physicians thought that if more attention was paid to palliative care, for instance during training, they would feel more secure in this area, especially in determining possible alternatives for treatment. Therefore, in a future update of the protocol, adequate knowledge of palliative care will be included as a prerequisite.

Obviously, some aspects of the protocol apply specifically to consultations on euthanasia and assisted suicide in the Netherlands. For instance, the requirements for prudent practice are not the same in the Netherlands as they are in Oregon.¹⁴ In Oregon, for instance, the aim of the consultation is to confirm the patient's diagnosis, prognosis and informed decision and not, as in the Netherlands, whether the other requirements are met. Furthermore, in most countries, euthanasia and assisted suicide are unacceptable. It is debatable whether the protocol is of interest in those countries. If somebody would never consider granting a request for euthanasia or physician-assisted suicide, the protocol is not useful. However, in some of these

countries, for instance in the US and Australia there is debate on the acceptability of euthanasia and the conditions under which it would be acceptable.^{1-3 5 7 17 18} In this debate, similar conditions occur as the ones used in the protocol. For instance, independence and expertise have already been mentioned by Alpers and Lo as important characteristics of a consultant.¹ Moreover, the protocol could also be of use in requests for withdrawal of treatment. In decision making taking place after such a request, the seriousness of the patient's request, the suffering of the patient and the alternatives for treatment will probably (together with the legal situation) be important considerations. Therefore, at least some aspects of this protocol developed in the Netherlands might also contribute to the development of consultation as a method of safeguarding the practice of physician-assisted suicide and/or euthanasia or the withdrawal of treatment elsewhere.

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Nanobots (nanorobotics) are politically-adaptable, intelligent microscopic robots¹

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Walking gingerly through golden oak leaves in a culturally-superior safe environment, with a twenty-four dollar baseball cap hiding a healing temporal scar, it was still my job to confront and reject any residual autistic ideas sneaking past my embedded, temporal-lobe-assistor lozenger. [TLAL]
 As the fourth American recipient to be selected, following a painless gamma-knife corticotomy, my thoughts have been mostly about Hilton Head Island, old navy friends, what my preaugmented brain was ever worth, and what \$32,000 a year might accomplish attacking African Ebolas.

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