Medical assistance in dying: a disruption of therapeutic relationships

Medical assistance in dying may disrupt therapeutic relationships and will challenge beliefs

Medical assistance in dying, whether voluntary euthanasia or physician-assisted suicide, has been a recurring topic for societal debate. Voluntary euthanasia is the deliberate and intentional act to end a competent person’s life, at their request, to relieve their suffering.1 Physician-assisted suicide relates to the medical provision of the means or knowledge for someone to commit suicide via the self-administration of a prescribed medication.1 Amid growing societal support2 and stability of worldwide medical opinion, there has been a 66% increase in the legalisation of physician-assisted suicide since 2015,3 which indirectly legitimises such practices through the broad influence it has on societal support. Canada and the American states of California and Colorado legalised physician-assisted suicide in 2016.3 In Australia, the Victorian Parliament passed a Bill in 2017 to legalise physician-assisted suicide, while the debate currently continues in other Australian states and New Zealand. By contrast, in May 2018 Guernsey failed to become the first place in Britain to permit physician-assisted suicide.3

Undeniably, people requesting medical assistance in dying, and their advocates, are distressed by the perceived unbearable suffering associated with terminal illness and the uncertainty that confronts them. A systematic review highlighted that perceived unbearable suffering relates to pain and physical symptoms, as well as psycho-social and existential components that contribute to total suffering, such as becoming burdensome to others; developing feelings of hopelessness; loss of identity, meaning or dignity; feeling socially isolated; and being tired of existence.5

The therapeutic relationship between clinician and patient provides an opportunity to help and support people experiencing suicidal ideation, irrespective of their diagnosis. This is an ongoing relationship that benefits the patient via respect and expert communication that engenders trust.6,7 In addressing expressions of suicidal ideation, clinicians use the therapeutic relationship to sensitively explore total suffering and facilitate the disclosure of important hidden agendas.6,8 However, the relationship is altered by the feelings and attitudes of each party. Patients requesting medical assistance in dying may feel hopeless about their existence; similarly, doctors (or other clinicians) may feel equally hopeless about their ability to help. Both confront death from different perspectives, and the doctor may consider medical assistance in dying appropriate. In this case, the patient has transferred feelings of helplessness onto the doctor, who in turn has exhibited countertransference of their helplessness onto the patient through their management plan.6

What guides our practice during these difficult consultations are the codes of medical ethics, professionalism and law that support the therapeutic relationship. The common ethical principles of health care involve respecting the individual’s rights in decision making (autonomy); doing no intentional harm (non-maleficence); acting to benefit the patient (beneficence); and providing fair and equitable care to all (justice).9 The Hippocratic Oath underpins medical professionalism, which has been defined as signifying “a set of values, behaviours and relationships that underpins the trust the public has in doctors”10 and should maintain patient safety via clinical governance. Further, professional codes of conduct and the law seek to ensure that clinicians do not abuse their powers. Every decision made within the therapeutic relationship should balance all the principles of medical ethics with professional practice, in order to legally and consistently benefit the care of all patients who are part of such a relationship.

Legislating medical assistance in dying disrupts this consistency by legally undermining the balance required. It asks clinicians to change their focus on suicide prevention for all to suicide assistance in specific cases. People requesting medical assistance in dying challenge our beliefs about the meaning and value of who we are and what we do as health care professionals. The request to knowingly assist in a patient’s death confronts our personal beliefs and professional ethics. We may agree with the futility of existence in some circumstances, but would we want to provide medical assistance in dying? Changing the law from preventing to permitting the intentional ending of someone’s life presents a new dilemma. Either we declare a conscientious objection which denies patient autonomy and disrupts the therapeutic relationship; or we comply with their legal request and contravene professional practice and aspects of medical ethics (non-maleficence and justice). The quality of health care depends on the shared decision making that evolves from the therapeutic relationship, where the influence of knowledge, power and trust deserves careful
Exploring the meaning of patients’ symptoms may be an important part of the therapeutic relationship. A study of palliative care physicians found that exploring symptom meaning provided information, alleviated anxiety and facilitated individualised care. It also strengthened the relationship, as the physicians had to be more present to the suffering they encountered. Engaging with patients from a more human perspective reinforces the fact that we share their vulnerabilities. We also share fears of ageing, dying and death that increase the closer we perceive we are to death. In addition, as health care professionals we may have a greater mortality salience (awareness of death and dying) than the general public, which increases our anxieties about death and dying. These factors have implications for health care in an ageing population if we are to deliver better care and cope with our vulnerability as human beings.

People with a terminal diagnosis are not only coping with a more prominent death anxiety but also need to find meaning and value in their changed lives. Are they still valued by society? What has been the purpose of their life? What will happen to them after they die? Recent research suggests that feeling powerful reduces our death anxiety, whereas disempowerment increases death anxiety. Therefore, the therapeutic relationship in end-of-life care should aim to minimise the power differential between clinician and patient, empower the patient and their family in their care, and provide expertise with respectful and compassionate care via effective communication.

The change from living with an illness to dying from it requires time to adjust and accept the new realities of life, and perhaps regain some semblance of control. A timely process of transition to palliative management may help patients and their families avoid feeling powerless, unclear and uneasy about what is happening. Implied in the transition to dying from an illness is some acceptance of death. One theory suggests that we can accept death in one of three ways. First, death is a natural end to life (neutral acceptance). Second, death provides a gateway to eternal happiness; for example, through religious beliefs of an afterlife (approach acceptance). Third, death may be viewed as an escape from the total suffering of life (escape acceptance). Some people find meaning and purpose in waiting for death as part of the escape acceptance, but for others, medical assistance in dying and suicide provide them with an opportunity to control the timing and modality of their death. Of course, a proportion of people will never accept death and request potentially fatal treatments with minimal benefit as part of an autonomous right and ongoing hope. Should we provide futile treatments to respect their wishes? In such cases, there will always be a poor transition to palliative or terminal care.

Overall, better planning of end-of-life care is required. Have we considered how our own anxieties about death affect the care we provide to people who are dying? The importance of recognising how death anxiety affects us has led to recommendations for undergraduate training in death anxiety. A recent study found that increased death anxiety in medical students was associated with low psychological health and negative attitudes towards palliative care. Optimal end-of-life care consultations require an attempt at understanding how it must feel to be dying, which in turn challenges us to think about our responses to our own mortality. Perhaps through recognising our own fears, we may listen to understand and learn from people who are dying.

Societal change may mean that laws determine whose suffering warrants medical assistance in dying, but health care professionals will still need to manage the enduring suffering of those who are ineligible. For example, many dementia patients may not have the required decision-making capacity to request medical assistance in dying. A literature review to guide and support future dementia care found that death anxiety in professional caregivers could lead to a disconnect in care, increased stress and burnout, reduced psychological wellbeing, and potentially ageism. Health care professionals encounter people at their most vulnerable, experiencing life at critical and emotional times. We require collegial and organisational support for each other in order to continue effective care while aiming to avoid compassion fatigue and burnout. Medical assistance in dying will not help develop the necessary teamwork and inter-professional relationships to deliver and sustain optimal end-of-life care. Clinicians will be caught between legal, professional and personal positions that are likely to divide opinions about optimal end-of-life care.

Modern societies may continue to adopt medical assistance in dying amid increasing mortality salience from an ageing population, which would pose major health care challenges. Medical assistance in dying represents a need within society and medicine to control death and relieve all suffering. These are the personal and societal fears of human existence that no pill can universally cure. Neither palliative care nor medicine can eradicate total suffering; similarly, politicians and lawyers do not have such power. There may be an illusion of a medical solution to alleviate suffering, but the real answers lie in how we connect and support each other as a society, as health care providers, and as professionals entrusted to care for people who are dying and their families.

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References are available online at www.mja.com.au.


