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Opinion

# End of Life: Opinion

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## Opinion

To end of life a patient or expedite demise by using any medical interventions on voluntary patient's demand, known as Assisted Dying (AD), it includes: Physician Assisted Suicide (PAS) and euthanasia [1]. PAS in which doctor offers a patient medications to be administered by the patient purposely to commit suicide on voluntary patient's request [1].

Netherlands, Belgium (where AD is allowed) and The European Association for Palliative Care (which is against AD) define euthanasia as a physician knowingly kills a patient by administering medication upon voluntary patient's wish [2-4]. In contrast to euthanasia, in withdrawing and withholding Life-Sustaining Treatment (LST) patient will die from disease progression not from these interventions and there is no intention to accelerate demise. LST is treatments that lengthen life without improving the prognosis. In Muslim countries where suppression or removing LST is allowed, euthanasia and PAS are illegal. Muslims believe that only God decides the time and the way of death. Exception only for certain crimes.

If palliative care considered ineffective this gives patients the right to ask for AD within the palliative care unit [5]. But since terminal sedation for intractable symptoms can be offered in palliative care units as another choice, palliative is certainly not futile [6], and an impression of palliative futility is clinically inappropriate [7]. In Islam palliative sedation is allowed as long as there is no intension to end one's life, so where religious prohibits AD, intermittent or continuous palliative sedation can be a solution for intractable symptoms and suffering along with high quality palliative care.

Health care providers may oppose an integral palliative care because once it is available to patients; they may lose motivation to survive. Others support the integral palliative care model [8]. Although palliative care and euthanasia activities in Belgium have boosted each other [5,9], this has been doubtful and unclear [10].

Patient's autonomy is considered when patient requests LST. Sometimes LST may be harmful, patient has no right to ask for injurious or ineffective treatments but has the right to reject medical treatment even it results in earlier death [11,12].

Justice is considered when deciding not to initiate or to stop LST, example doctors decide who is entitled for an Intensive Care Unit (ICU) bed, when there are limited ICU beds, and this judgement considers together benefits and burdens to a patient and competing requirements for the bed by other patient [13].

Doctors also can use futility to stop or not to start LST unilaterally, if it deemed to be ineffective symptomatic treatment and will not upgrade patient's lifestyle [14]. This also enables clinicians to avoid difficult discussions needed to convince relatives with high expectations.

The doctrine of double effect has been used to defend giving high-doses of sedating and narcotic drugs to relief symptoms during the removal of mechanical ventilation and accidentally shorten life [13].

A shared decision-making is important. Rarely patients may not wish to receive information or discussion for making decision for care, may be for cultural, personalities, religious or believes reasons [15-17]. It is a cultural norm in place where I am working that females leave decisions of their plan of care to male family members.

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