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End-of-Life care: advanced care planning, euthanasia and suicide

Abstract. *End-of-life planning for elderly people provides a necessary condition for a respectable and decent aging and death, which meets the wishes and expectations of the elderly person. Nevertheless, decision-making in this respect is based on the values and experience of formal and informal caregivers that are often ignorant of the wishes of the elderly. Respectively, the elderly person's wish to end life should be viewed as a call for help and distress, as the phenomenon becomes more frequent. Elderly people do not really wish to die. Rather, they fear end-of-life treatments that are performed against their wish and beyond their control in a humiliating and painful manner, and without truly offering benefit to their lives. Consequently, elderly people see death as a relief from pain and a promise for peace. Moreover, choosing death over life, provides the elderly person with a renewed sense of control. Thus, the Western society pushes the elderly person to prefer euthanasia or suicide over a life of dependence, humiliation and pain.*

Keywords: *end-of-life care, euthanasia in elderly, suicide in elderly*

Building life-sustaining programs, upholding patient autonomy, and respect for the patient's desires are the main instruments of the physicians who care for the elderly. Furthermore, treatment should entail emotional therapy with a focus on the spiritual needs of the elderly such as discussion about death. It is crucial that caregivers stress the message that they will not undertake life-prolonging interventions without the will of the patient, nor will they make decisions instead of the elderly to give up treatment.[1]

[1] A.P. Frances Wand, C. Peisah, B. Draper, C. Jones, H. Brodaty, *Case Report. Rational Suicide, Euthanasia, and the Very Old: Two case Reports*, "Hindawi Publishing Corporation Case reports in Psychiatry" 2016, pp. 1–5.

Research indicates that in the lack of advanced planning of rest-of-life treatment, relatives often make decisions and act on the basis of subjective desires rather than according to the priorities of the elderly. Therefore, discussion and planning ahead may enable to voice the preferences of the elderly regarding the future. Moreover, timely planning helps the elderly to express real wishes concerning medical treatments. In the process of planning the therapy the elderly can determine their future treatment in case of diminished physical, cognitive and mental abilities. Collaboration between family members and caregivers allows the proper preparation of the senior to death and reduces the level of tension among family members involved. Hence, determining a treatment plan for the remainder of life while expressing the needs and desires of the elderly contributes to the morality of the treatment.[2]

Death is a natural extension of life. However, end-of-life planning and the inclusion of the elderly person in treatment decisions is not routine in the work of a physician. The absence a structured plan for future therapeutic preferences becomes critical when an elderly is suffering from dementia. Morally, no caregiver, whether a relative or a physician, can take responsibility for decisions for another person. No caregiver knows for sure the patients' explicit wishes if the patient has never uttered them. Consequently, the caregiver decides for the patient on the basis of personal experience or various interests that may prove to be entirely unrelated to the patient. Advanced planning, as a routine part of the treatment and physician visits, will provide an appropriate and dignified response to the wishes of the patient with and without cognitive decline.[3]

End-of-life plans, making decisions about desired treatments, leaving a will and other important issues are common in old age. The problems often arise surroundingthe subject that people try to avoid – the matter of death. The wish to die is common among elderly and is perceived by society as natural. Empathic caregivers may be able to understand how this wish should be translated. Does the desire stem from the negative feelings of the elderly, and is it a silent cry for help[4]? Bollig et al.[5] believe that the desire of the elderly to die is mainly due to the perception that death brings pain relief and happiness. But it is not a whole answer. An observation into the reality of the elderly person will help the caregiver to find a suitable solution to the problem that lies behind the desire to die.

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[2] G. Bollig, E. Gjengedal, J.H. Rosland, *They Know!-Do they? A qualitative study of residents and relatives views on advance care planning, end-of-life care, and decision-making in nursing homes*, "Palliative Medicine" 2016, No. 30(5), pp. 456–470.

[3] K.H. Dening, L. Jones, E. Sampson, *Preferences for end-of-life care: A nominal group study of people with dementia and their family carers*, "Palliative Medicine" 2012, No. 27(5), pp. 409–417.

[4] A.P. Frances Wand, C. Peisah, B. Draper, C. Jones, H. Brodaty, *Case Report. Rational Suicide, Euthanasia, and the Very Old*…, pp. 1–5.

[5] G. Bollig, E. Gjengedal, J.H. Rosland, *They Know!-Do they? A qualitative study of residents and relatives views*…, pp. 456–470.

The notion of seeking assistance to take steps toward death is not new and occurs among people with chronic, mental and age-related illnesses. The desire to die lies in the hope for achieving a peaceful death. In ancient Greek "euthanasia" means "good death." Natural death is characterized by peace and mental readiness. Euthanasia is expressed in an increase in the dosage of the drug by a patient himself, by disconnecting the patient from a machine that provides life-saving cardiac support, or a measure of actions that help another person commit suicide, such as providing medicines, means, knowledge, and physical assistance.[6]

The aging of the population in the Western society, led to a proportional increase in the number of elderly, resulting in lack of adequate health services for seniors, dementia, economic burden on family members, and many other factors that require formal and informal caregivers to formulate a clear and uniform policy for regulating and supervising matters related to euthanasia. It is imperative to understand that the tremendous emotional burden of the family caregiver in the case of dementia. Thus, they experiences a sense of guilt when unable to afford high-quality treatment. On the other hand, the process of euthanasia is accompanied by similar emotions that grow when there is no absolute certainty about the wishes of the patient.[7]

Despite the high prevalence of desire to die among the elderly, think about suicide is typically a social taboo. In Western societies, under exceptional circumstances such as terminal illness that involves great physical and mental suffering, suicide may be perceived as understandable and even positive.[8]

The aging of the population in modern Western society exposes the elderly to a particularly long and painful death, without effective intervention, regardless of disease. The almost universal perception of Western culture that old age involves many mental and physical suffering encourages the elderly population to view death not only as a positive solution but as the only solution for the challenges of aging.[9]

Rezende and his colleagues (2014) concluded that one of the main reasons for the desire to die among the elderly population is the social indifference towards the elderly population, which draws its strength from the perception that life of old people entails suffering, illness and death. The phenomenon of suicides among the elderly is characterized by taking a rational stance and an informed choice of all options available to the elderly. It is a profound decision that stems from a social inability to take responsibility for the significant rate of suicides.[10]

[6] D.S. Botseas, A.L. Drosou, *Euthanasia: Act of Charity, or Murder*, "Hellenic Journal of Surgery" 2014, 86(1), pp. 1–4; D.F. Rezende, G.N. Oliveira, L.G. Vianna, I.B. dos Santos, *Euthanasia: would elderly people from socio-economic classes D/E perform it or allow it on their relatives*? "Journal Kairos Gerontologia" 2014, No. 17(17), pp. 125–135.

[7] K.H. Dening, L. Jones, E. Sampson, *Preferences for end-of-life care*…, pp. 409–417.

[8] D.F. Rezende, G.N. Oliveira, L.G. Vianna, I.B. dos Santos, *Euthanasia*…, pp. 125–135.

[9] A.P. Frances Wand, C. Peisah, B. Draper, C. Jones, H. Brodaty, *Case Report. Rational Suicide, Euthanasia*…, pp. 1–5.

[10] Ibidem.

Elderly may want to die because they are well aware that their rest of life in contemporary society is neither optimal nor human, with the prospect of increased suffering to patients and their families[11].Creating a better reality can help the elderly to experience a sense of usefulness and to transform the wish to die into the desire to experience new things. Aging can be a new beginning of new experiences with activities that bring feelings of belonging and usefulness to the surrounding.[12]

So, medical and social observation of the elderly desire to die, is too narrow a view of a widespread phenomenon. The aging of the world population in general, and the population of Western society, in particular, have in the present era created a common socio-cultural and historical reality for the elderly. Western society has given rise to the phenomenon that the elderly are more afraid of the life that is expected in old age than death, despite being mentally healthy. Society is unable to provide a sense of security, and caring for those reaching old age. Worse still, society does not take responsibility.[13] Accordingly, the social discussion surrounding the risk factors for suicides, illness and mental disorders does not provide an adequate explanation for the phenomenon of suicides and euthanasia of elderly. Physical and psychological morbidity alone does not provide a basis for understanding the phenomenon. The reality is much more complicated and encompasses the entire population of the elderly in Western society and constitutes a basis for social conditions characterized by social and family neglect, emotional suffering, social loneliness, and personal narratives of loss among the elderly.

In other words, good health at an older age does not guarantee the absence of a desire to die at an older age. It is true that maintaining good health and moral autonomy are the foundations of a life of happiness in old age.[14]

Other scholars call to delve deeper into the interpretations given to physical and mental suffering. Those who view suffering as a bad thing will necessarily support medical assistance for suicide and will consider assisting the stopping of suffering as positive. In other words, a patient suffering from a terminal illness has a fundamental right to cease suffering permanently.[15] The individual is responsible for his/her body, will, and life. Furthermore, many physicians treating patients with incurable diseases claim that every patient has the right to make decisions related

[11] K.H. Dening, L. Jones, E. Sampson, *Preferences for end-of-life care*…, pp. 409–417.

[12] E. van Wijngaarden, C. Leget, A. Goossensen, *Ready to give up on life: The lived experience of elderly people who feel life is completed and no longer worth living*, "Social Science & Medicine" 2015, No. 138, pp. 257–264.

[13] L.E. Weinberger, S. Sreenivasan, T. Garrick, *End-of-Life Mental Health Assessments for Older Aged, Medically Ill Persons With Expressed Desire to Die*, "The Journal of the American of Psychiatry and the Law" 2014, No. 42(350), pp. 350–361.

[14] D. Machado Duran Gutierrez, A. Braga Lima Sousa, S. Grubits, *Suicidal ideation and attempted suicide in elderly people – subjective experiences*, "Ciencia & Saude Coletiva" 2015, No. 20(6), pp. 1731–1740.

[15] C. Mitchell, *Why Doctors Must Not Be Complicit in Killing Their Patients*. "Ethics & Medicine" 2015, 31(2), pp. 69–70.

to the future treatmentof the illness, based on actual medical condition and possible prognosis of the disease in the future based on an honest opinion of the physician. Even when the patient chooses death as a preferred alternative, the physician must respect the choice. Indeed, when a society agrees to euthanasia and provides a moral basis, legal validation must be provided to prevent abuse of this possibility and to delegate responsibility for this decision.[16]

Those who oppose suicide or euthanasia emphasize the guiding value of Western society and Western medicine – the sanctity of life. As it is written in the Ten Commandments: "*Thou shalt not kill*!" Further, the central values of medicine require the doctor to be a guardian of life. Therefore, when authorities allow ending the life of the sick, they should turn to the executioner rather than the caregiver. According to British doctors, euthanasia is a form of murder, and therefore incompatible with life-saving people.[17]

Nonetheless, the value of the patient's right to make decisions over his/her body and life obscures the limits of the value of the sanctity of life and causes physicians to forget that autonomy as a gateway to emotional well-being of a patient is not the absolute human good. According to etymology, the root of the word "patient" in the Latin language is "suffer." It is therefore natural that suffering harms human autonomy. Contemporary medicine can limit the period of suffering through various medical interventions.[18] In the view of van Wijngaarden et al.[19] contemporary Western society has not been led by the value of the sanctity of life as a significant social valuefor a long time.With the aging of the baby boomers, the ethos of neoliberal values, such as the need for self-determination, personal autonomy, and individualism, has become more dominant than the value of the sanctity of life. Awareness of death in a Western society combined with a desire for self-control over these processes in the individual's life will lead to an increase in the rate of euthanasia. Modern Western society will change and euthanasia will become a therapeutic alternative in the self-management of the end-of-life program. When a person makes decisions about all the processes, including how to die, the person's fundamental right to express the desire to die, and even to receive assistance in fulfilling his/her will, also if he/she does not suffer from chronic or malignant diseases that cause additional suffering. Although, euthanasia should be based on four primary rules: the suffering of the patient, despite appropriate treatment (!), the frequency of expressing the patient's desire to die, the age of the patient, and the severity of the illness as compared to the treatment options. Active euthanasia (taking activities to shorten life) is seen in Christian faith as a violation of God's

[16] D.S. Botseas, A.L. Drosou, *Euthanasia*…, pp. 1–4.

[17] Ibidem.

[18] C. Mitchell, *Why Doctors Must Not Be Complicit*…, pp. 69–70.

[19] E. van Wijngaarden, C. Leget, A. Goossensen, *Ready to give up on life*…, pp. 138, 257–264.

law, a violation of human dignity and a crime against life. However, in Brazil, there is a possibility of stopping medical interventions that may prolong life without interrupting regular treatments.[20]

Willingness to die out of physical or mental pain is influenced by many psychological and spiritual factors. Patients do not want to die, they beg for proper treatment of suffering.[21] One of the worst examples is elderly who have dementia. Research findings show that treatment for dementia patients is at a very low therapeutic level and does not meet the patient's requirements. The health system in modern Western society does not provide adequate treatment for dementia patients and does not guarantee the quality of life in the rest-of-life treatment of the rest of life. Moreover, treatment of dementia patients is often inhumane. When a single alternative to death is a life of suffering, humiliation, and pain, the sharp rise in the proportion of seniors who express a desire to die or commit suicide is not at all surprising.[22]

Rezende et al.[23] warn that euthanasia not only suspects relatives of foreign interests, but may primarily cause doctors to have fewer palliative plans, give up searching for a solution other than death, and impair the professionalism and integrity of the medics. It is essential to understand that the role of physicians traditionally is to alleviate the suffering of patients, and when impossible – to be with them until their last breath with dignity. Taking an active role in the deaths of patients may harm the public's trust in doctors. The doctor is not a murderer, his/her job is to save lives.[24]

Despite professional values, such as *primum non nocere* (don't damage), physicianswill have to cope with conflicting social messages and binding professional ethics. According to current approaches, society has a moral responsibility for protecting individual life. However, an increasing amount of countries view euthanasia and suicide as a plausible situation in certain situations. Respectively, it seems that in the future, prior moral values in modern Western society will change.[25]

In modern times, ethical, moral, and medical observation of euthanasia and suicide assistance no longer provide a complete picture and other considerations should be addressed. A modern Western society that exists in a reality of limited resources leads the discourse regarding euthanasia and rest of life treatments to

[20] D.F. Rezende, G.N. Oliveira, L.G. Vianna, I.B. dos Santos, *Euthanasia*…, pp. 125–135.

[21] D.S. Botseas, A.L. Drosou, *Euthanasia*…, pp. 1–4.

[22] P. Kouwenhoven, N. Raijmakers, J. van Delden, J. Rietjens, D. van Tol, S. van de Vathorst, G. van Thiel, *Opinions about euthanasia and advanced dementia: a qualitative study among Dutch physicians and members of the general public*, "BioMedicalCenter Medical Ethics" 2015, No. 16(7), pp. 1–6.

[23] D.F. Rezende, G.N. Oliveira, L.G. Vianna, I.B. dos Santos, *Euthanasia*…, pp. 125–135.

[24] C. Mitchell, *Why Doctors Must Not Be Complicit*…, pp. 69–70.

[25] L.E. Weinberger, S. Sreenivasan, T. Garrick, *End-of-Life Mental Health Assessments*…, pp. 350–361.

an economic discussion. The aging of a population in contemporary Western societies alongside the increase in the percentage of elderly in the population place additional burden on the family due to the costs of extending life, and highlight the high public costs that rest on the public health system. Currently, the data are under-evaluated in most countries or are missing altogether.[26]

In conclusion, public interest in the subject euthanasia, health care and treatment costs, expose physicians to moral dilemma. According to which, the physician is caught between two values that may present contradictory objective. On the one hand, the value of the sanctity of life requires the physician does everything to save lives, regardless of the age of the patient. On the other hand, a modern Western society places the value of autonomy at any price, according to which the physician must fulfill the wishes of the elderly under any conditions, even when it involves suicide. Pain, a worsening of the quality of life, dependence on the other – is routine. This is not enough to stop life according to the value of the sanctity of life. On the other hand, autonomy in therapy is a value that obligates the physician. Therefore, even when a senior is no longer able to make decisions, the caregiver must continue to fulfill the wishes of the elderly person.[27]

Today, there is not enough information about the views of seniors regarding medical assisted suicide/euthanasia. Collecting and organizing data will contribute to decision-making and legislation that regulate these issues while preserving the dignity and desire of the elderly and ensuring the neutralization of foreign interests of formal and informal caregivers. Regulation of the issue will prevent the damage to trust between doctor and the elderly, will balance between the value of self-autonomy in therapy and the sanctity of life, and enable an end-of-life planning according to the wishes of the elderly person and the ethics of medicine.[28]

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