Moral distress and euthanasia:

what, if anything, can doctors learn from veterinarians?

'Do 3 more years with a high quality of life justify this therapy, which will be associated with 6 months of serious discomfort for the patient? ... Is it better to choose chemotherapy or to allow 'natural' death?' (Hypothetical question)

These and related questions are no longer exclusively associated with human medicine. Many animals, accordingly classified as companion animals, nowadays have the status of family members, and palliative veterinary medicine has caught up enormously in recent years. On these matters, it is worthwhile for veterinarians to take a look at human medicine and clinical ethics. But, equally, there are issues where GPs and human medicine can benefit from the experience of veterinarians.

A 'GOOD DEATH'

The standard good death ideal of small animal practice (that is, a veterinary practice) involves an animal's euthanasia at the end of its life.[1] Small animal practitioners are not only familiar with euthanasia and grieving family members but also with their own feelings accompanying the act of ending a patient's life.

In the UK and elsewhere, the legalisation of euthanasia or physician-assisted suicide (PAS) is currently debated. Examining the effects of killing on the involved physicians with a view to small animal practice, with its decades-long experience in this field, seems therefore sensible.[2] We propose elsewhere to approach questions surrounding end-of-life decisions with an eye on both medical and veterinary ethics.[1,3] But it is also essential to first consider which experiences from small animal practitioners may be transferable to GPs to begin with.

Many veterinarians experience moral distress as a result of not being able to do the right thing, for instance when there is a conflict between themselves and the animal's owner.[4] With regard to end-of-life decisions, the majority of these conflicts fall into one of two categories: either the vet perceives euthanasia as the right thing to do for this pet in this situation but the owner refuses to have their animal killed, or the vet perceives euthanasia as wrong (at least right now) but the owner wants to have their pet immediately killed.

Duncan and Jeffrey, in focusing exclusively on the latter kind of conflict, regard this as a *'one-way pressure to euthanasia'* in the veterinary profession and argue that this is relevant for physicians *'who have been reassured that there will be no compulsion to participate in PAS'*.[2]

MORAL DISTRESS IN VETERINARY MEDICINE

Considerable moral distress (even suicidal tendencies) regarding animal euthanasia are well documented but there is no consensus in the literature on the underlying reasons.[5,6] Many veterinarians perceive the option to euthanise as a gift they value very highly and in fact as advantageous in comparison with human medicine.[7]

Findings suggest that whether euthanasia is perceived as a gift, a burden, or even a pressure on the part of animal owners depends not least on whether veterinarians feel they are doing the right thing or whether they feel pressured to perform euthanasia against their better judgement.[8] This ambiguity — euthanasia has famously been described as *'a double-edged sword in veterinary medicine'*[7] — is only marginally addressed by Duncan and Jeffrey.[2] They made it appear as if veterinarians unanimously perceive euthanasia very negatively and as if euthanasia was one major reason for considerable moral distress and higher suicide rates in the veterinary profession. This is an inadequate depiction of current research.

SIGNIFICANT DISSIMILARITIES BETWEEN HUMAN AND ANIMAL EUTHANASIA

Given that there could be cases of medically indicated euthanasia that veterinarians might still perceive as stressful, the controversial hypothesis that the act of killing as such can contribute to moral distress and increased suicide rates in veterinarians might be accepted here, for the sake of the argument. This still does not necessarily correspond to the *'gap between agreeing with the theoretical concept of euthanasia or PAS and being*

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actively involved in the process' in human medicine.[2]

One reason is that, for all their similarities, there also exist considerable dissimilarities between human and companion animal patients.

In veterinary medicine, there is usually no direct access to the patients' preferences or consent regarding end-of-life decisions. Human medicine, on the other hand, cares for patients with different capabilities and capacities to consent. Arguably, how stressful the active termination of a life is perceived depends, among other things, on whether or not the patient is able to make autonomous choices and to consent. It is morally relevant for the physician whether their patient is competent, formerly competent with a living will/presumed will, or never was competent. If this is accepted, a comparison between euthanasia of humans and animals is only or at least especially meaningful with regard to a very specific group of human patients, namely those who were never able to consent (for example, small infants or people who are severely cognitively disabled from birth). Approaching end-of-life ethics with an eye to these human patients and companion animals would be worthwhile for both doctors and veterinarians, but generalisations should be made very cautiously.

In summary, it can be assumed that in both human and veterinary medicine there exists a discrepancy between a doctor's belief that euthanasia would be the right thing to do and an emotional discomfort with the actual act. This being said, the discrepancies may very well have different origins or lend themselves to comparison only in very specific cases and patients. It would be too hasty to equate euthanasia with serious moral distress and higher suicidality as a lesson learned from veterinary medicine.

CONCLUSION

GPs and palliative care providers are well advised to exchange experiences with their colleagues from small animal practices. However, because of the extremely wide range of reasons that can precede animal euthanasia (terminal illness, financial constraints, danger to the public, and even mere convenience), it is likely that the emotions associated with euthanasia can be extremely varied.

Physicians, unlike veterinarians, are usually dealing with patients who have expressed their wish for euthanasia. Killing humans as such could be valued differently from killing pets. Cases that allow a comparison are therefore limited to the euthanasia of patients who can behaviourally express (dis)approval, but who were never capable of consenting, such as small infants and severely cognitively disabled patients. However, at least in human medicine, this moves the debate very much to the margins and significantly narrows the group of patients suitable for fruitful comparison.

This does not preclude that the act of ending a life itself, regardless of the reasons preceding or accompanying it, may cause significant distress to both physicians and veterinarians or may completely be rejected. It is possible to support euthanasia and PAS (in general or in specific cases) on a purely theoretical level and still feel considerable emotional and psychological distress in the face of actually performing the deed. To our knowledge, however, this has not yet been investigated interdisciplinarily.

For future research, it would be interesting to see whether veterinarians and physicians who have performed euthanasia report similar experiences with regard to the decision-making process and the act of killing, or whether differences can be found and if these (dis)similarities can be mainly attributed to different professions or species affiliation, context (for example, dependent on the reasons for or circumstances of the euthanasia), the doctor or veterinarian's character traits, or other aspects.

More in-depth research on these and related matters is doubtlessly needed.

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