

Assisted dying: opinion for and against

The legalisation of euthanasia, or assisted dying has long been a subject of heated debate, which intensified with the introduction of the parliamentary Bill, *Assisted Dying for the Terminally Ill*, by Lord Joffe. Although this Bill was blocked by the House of Lords last year, similar bills will be introduced in the future. **Dr Simon Kenwright** argues the case for, and **Dr Helen Watt** states the case against, assisted dying.

The case for assisted dying

The aim of the bill, *Assisted Dying for the Terminally Ill*,¹ is the relief of suffering in a small, carefully selected group of patients when other treatments fail if—and only if—that is clearly what the patient wishes. Philosophers are fairly evenly divided on the ethical issues surrounding this bill; religious, medical, and disability groups provide a range of opinions. Those who are against the bill often focus on anxieties about how it would work in practice.

Although the media often focuses on relatively young terminally ill patients seeking an end to their lives, findings from the first nine years of the US state of Oregon's Death with Dignity Act (1998–2006)—on which the UK assisted dying bill is based—show that older people are more likely to want help in dying. The median age of the 292 patients whose death was assisted under the Act is 70. Overall, these deaths accounted for only one death in 800, and annual numbers remain steady. Cancer was the underlying illness in 81% of patients.² By contrast with these small numbers, nearly 20% of those dying had wanted a serious discussion about assisted dying. In the UK we do not know the size of the problem, but a recent UK report noted a 50% increased relative risk of suicide among patients with cancer.³ This statistic probably reflects a much greater need to discuss this approach, with the majority wishing to keep assisted dying in reserve.

In a review of end-of-life issues in older people, Harris and Noble⁴ listed the principles (centred around the wishes and needs of the patient) that underpin a good death. These issues are almost identical to those of supporters of assisted dying, who add just one further treatment option, necessary for a small group of patients when all else fails. It is treatment that is offered, not suicide, which is important for legal, insurance, and moral reasons.

The ethical distinction between what is now accepted by many doctors and assisted dying of the terminally ill is questionable. The emphasis is on the stated intention of the doctor not on the outcome for the patient. Grey areas include: the withdrawal or withholding of treatment, even though death will inevitably result (some religious groups object, seeing it as euthanasia); and terminal sedation and palliation of symptoms when a patient refuses potentially life-prolonging treatment, which could be seen as abetting suicide.

Legally, doctors can give a potentially lethal dose of medication if the intention is to relieve suffering—known as double effect. Over the years, those who argue against a change in the law have said the option of double effect makes any change unnecessary. However, this approach is no longer tenable after the case of Dr Shipman, and with the realisation that optimum prescribing of drugs should not shorten life.⁵

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Key points – for assisted dying

- Assisted dying is a treatment aimed at relieving unbearable suffering, and allows the dying patient to have greater choice in the place and circumstances of death and to die with dignity
- Assisted dying is for patients who clearly and freely want it
- It is an extension of good palliative care, not an alternative
- Stringent checks would be needed to ensure appropriateness; older medical practices based on the double effect are no longer appropriate
- Public opinion strongly supports some form of assisted dying
- As a society, and as doctors, we need to openly discuss death

The present tolerance of case law as regards mercy killing and those helping patients to go to Dignitas (a Swiss organisation that helps people commit voluntary euthanasia) contrasts with the potential criminal sanctions for a doctor who is at the limit of the grey areas. Some years ago a medical ethics textbook gave practical advice on hastening death if all else failed to relieve symptoms.⁶ Here, the intent was to end life, and we will never know just how widespread this practice is or whether the patients involved agree to it.

The many factors involved in dying can make accurate prognosis difficult⁷ but doctors need to share probabilities with patients in many aspects of medical care—some with greater significance for the patient than assisted dying. It is not a major issue for cancer patients in the last 6 months of life because doctors tend to overestimate survival.⁸

Opponents of assisted dying express concern about depression—ie, the patient wants to die because they are depressed rather than because their illness is causing them unbearable suffering. Assessment of depression can be difficult because it can be masked by physical disease. However, hospice staff and other care teams should recognise that the patient is depressed before the patient requests assisted dying. But if they do not, then the Bill highlights

the need to address this issue. Assessment of the patient requesting assisted dying will be time consuming, and must be documented to protect patients and carers, with review of diagnosis and other treatment options as well as checking competence. It must be clear, on more than one occasion, that the patient is competent and that assisted dying is what the patient really wants. Evidence for this assessment includes advance directives, particularly when these are specific for the disease in question. Directives have their drawbacks and problem areas should be discussed. Some doctors still prefer their own view of best interests. Family input may be unreliable—as in other areas (eg, surgery, gastrostomies), so the possibility of outside pressure has to be considered.

Despite the rather paternalistic views of groups representing vulnerable people (not vulnerable individuals themselves), it would be a retrograde step to exclude specifically the disabled—the very group who might be in greatest need of assistance—always provided that the person can comply with the stringent recommendations involved in assisted dying. There is no evidence that assisted dying increases the risk to vulnerable people.⁹ What makes suffering unbearable is very complex and a whole-patient approach is needed. In the latest Oregon report,² nearly 100% of patients listed loss of both autonomy and participation in enjoyable activities as factors leading them to request assisted dying. Pain was the major problem for less than half of patients.² Autonomy is not absolute but the issue of control is key, and the present palliative-care view is being challenged: ‘the goal of controlling the patient’s psychological, social and spiritual problems...should be abandoned.’¹⁰ That does not mean these should be ignored but putting the patient in control where appropriate is a core aspect of assisted dying.

Some doctors would prefer to prescribe high doses of drugs they know for assisted dying: essentially just extending (misusing) a system of double effect or terminal sedation but with the above checks. Hospice groups and principal campaigners for assisted dying both prefer other drugs to be used. Overall, barbiturates in Oregon seem to have been remarkably satisfactory. As with all medical interventions, there will be occasional complications and side-effects, but the aim is to end suffering the

patient finds unbearable. Rarely, intravenous self-administration will be needed to ensure those with severe physical disability or gut obstruction are not disadvantaged. Just how far doctors will need to be involved beyond the medical assessment and (probably) the prescribing is unclear and suitably trained lay people or other professionals could provide much of the support needed.¹¹ A small group is producing a suggested code of practice. Medical members include a hospice doctor, two hospital physicians (one with a particular interest in care of the elderly) as well as a GP and a psychiatrist.

Good palliative care must be available, but it is unsatisfactory for some patients, not just because of poor control of specific symptoms. More end-of-life research is needed but faces many difficulties.¹² The Bill for assisted dying clearly emphasises to patients that control still rests with them—very important to some people for dignity in dying. Doctors need not be involved if that is their choice, but helping patients to end their suffering (when all else has failed and they are already dying) is an act of compassion that can only enhance the bond between doctor and patient.

The case against assisted dying

Do we value the lives of all our patients, even those we think do not value their own lives? Should we value not only the patient's health—in the limited sense of quality of life—but also his or her presence in the world? This is the central

question in discussing euthanasia: the deliberate ending, by act or omission, of a life seen, by the doctor, or the patient, or both, as lacking in value.

Often presented as an issue of autonomy, euthanasia, even voluntary euthanasia, tends to involve an endorsement by a doctor of the view that someone's life is not worth living. Conditions are proposed for euthanasia: it is not normally thought to be sufficient that the patient wants to die. After all, would a doctor perform euthanasia on a patient whom the doctor thought was merely temporarily depressed? Surely not—any more than he or she would amputate a limb, simply because the patient for some reason thought that the limb should be removed.

All suicidal people want to die: if we give euthanasia to some, but not to others, we are endorsing the view that some people are (in the words of the disability activist Alison Davis) 'right to want to die.'¹³ If physically well suicidal people are supported in living, rather than assisted in dying, why is it not also possible to provide such support to people who are disabled or terminally ill and suicidal? Conversely, if we really believe death is a benefit to anyone with specific disabilities, why not provide this benefit to those who are unable to request it?

Non-voluntary euthanasia is, in fact, a natural sequel to voluntary euthanasia: if death is seen as a benefit urgently needed by some, this benefit is likely to be extended to a wider pool of patients. In the Netherlands, euthanasia has been legal for decades, and a series of

Key points – against assisted dying

- Euthanasia is the deliberate ending, by act or omission, of a life seen by the doctor, or patient, or both as lacking in value
- Voluntary euthanasia leads to non-voluntary euthanasia, since the so-called benefit of death is extended to those who are unable to request it. Official Dutch surveys have noted a high incidence of non-voluntary killing
- Doctors should avoid complicity in suicide and should affirm the value and dignity of all their patients' lives

government-ordered surveys have been undertaken to track the outcome. The results are very much more alarming than the optimistic gloss of the survey authors and the Dutch Government might suggest.¹⁴ In particular, figures for active non-voluntary life termination are sometimes as high as 1,000 a year, not including those killed by terminal sedation or palliative drugs given with the explicit purpose of ending life.¹⁵ By no means are all of those killed without request non-competent at the time of death. The survey authors candidly acknowledged that non-

voluntary life termination seems rather difficult to prevent; they suggest that if patients want to live, they should say so clearly, verbally, and in writing, before they are unable to do so.¹⁶

It is, of course, true that some killing by doctors occurs in countries where it is illegal. However, covert voluntary euthanasia is no more a reason to legalise this practice than is covert non-voluntary euthanasia a reason to legalise non-voluntary killing. In fact, the legalisation of voluntary killing is likely to result in other forms of killing by doctors being taken less seriously. In the Netherlands, very few doctors have been prosecuted for breaking laws on euthanasia and assisted suicide, and those few convicted have been treated with remarkable leniency.

The US state of Oregon, which enacted a law permitting assisted suicide (although not euthanasia) in 1997, is often presented as a model for other legislatures to follow. In fact, Oregon polices assisted suicide even less than does the Netherlands: self-reporting by doctors is not followed by investigation, but merely a passive reporting by the relevant authority.¹⁷ And although no studies like the official Dutch surveys have been done in Oregon, there is anecdotal evidence of patients being pressured to die or being undertreated on the grounds that they have a suicide prescription and need no more care.¹⁸ It is worth noting that reported pain in Oregon has

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worsened since assisted suicide was legalised¹⁹ and that the State, which funds assisted suicide, is less ready to fund essential medical services for those who want and need them.

But do not patients, or some patients, have rights of autonomy that need to be respected? Yes, they do—but not to the point of doctors' complicity in suicide. Assisted suicide harms not only the patient, but also wider society, which receives the message that some people's lives are, quite literally, not worth living. In this context, it is worth remembering that euthanasia and suicide can be done by omission—providing, of course, that the aim in stopping or refusing treatment is to hasten death, not simply to avoid a potentially burdensome procedure.²⁰ In particular, advance directives will sometimes (though not always) have a suicidal motive²¹ and should be scrutinised for signs of this motivation, as well as for any sign that the patient lacked sufficient information about the treatment or care refused. The UK Mental Capacity Act,²² which has been rightly

criticised, nonetheless commendably prohibits the people who assess a patient's best interests from being motivated by the desire to hasten death. Such a motive is sadly not unknown among health professionals, perhaps especially those who find their own mortality and fragility psychologically troubling.

Elderly people are already disadvantaged in terminal care, and will suffer further if euthanasia is seen as a quick fix for their needs. There is ample evidence from the Netherlands that where euthanasia is legalised, patients are killed without their request, even if this act is illegal. Euthanasia and assisted suicide confirm to suicidal people the low estimate of their lives' value, while the non-suicidal are, at least, disheartened by the public view of lives such as theirs. No doctor should agree with a suicidal patient that his or her life has no value. Individuals working in geriatric medicine should lead the way in valuing the lives of all their patients, including those who, in pain or distress, do not see their own lives as worthwhile.