

Emery and Dr Kevin Connolly have given much pleasure to our readers with their columns on 'Treatment in Art' and 'Conversations with Charles' respectively. I am also grateful to the many physicians across the country who have selflessly contributed to the quality of *Clinical Medicine* by refereeing so many of the submitted manuscripts. And in particular, I wish to pay tribute to Diana Beaven who skilfully guides the ever-vibrant Publications Department; and to Dr Robert Mahler, Emeritus Editor, who has given so much wise advice, always spiced with a cheerful wit.

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## Assisted dying: considerations in the continuing debate

John Saunders

After a long period of gestation, the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill published its report (henceforth the 'Report') on 4 April 2005.<sup>1</sup> It runs to three volumes and a total of 997 pages. Volume I contains the Report itself; Volume II, the evidence; and the slimmer Volume III, a selection of 32 individual written submissions selected from the 14,000 received. The Royal College of Physicians (RCP) has played a prominent role in this debate, representing the Academy of Medical Royal Colleges in its oral evidence to the Select Committee and with four of its Fellows contributing published submissions in Volume III of the Report – one supporting the Bill and three arguing the case against.

### Division in the College and Select Committee

The College's own position has been one of neutrality, a position that has led to widespread comment. This includes a reference in the opening Abstract of the Report itself and in one of the more significant papers in the American literature that followed the Report's publication.<sup>2</sup> It is a position, however, that has led to misunderstanding – neutrality has been construed as disinterest or even passive support for the proposed legislation. Is it 'a matter of little consequence to the Royal College if

the law forbidding doctors to kill, or to assist in killing a patient, were to be changed...?' wrote one distinguished public figure. In fact, the College's position has not been one of either indifference and still less a lack of concern or interest. Rather, it has represented the extent of division that is, rightly or wrongly, perceived among its Fellows on the redrafted Bill – the College opposed the Bill's earlier draft as the Patient (Assisted Dying) Bill, which was not limited to the terminally ill. It is also a reversal of the previous College position approved by Council in 2001, which stated:

*Our main conclusion is that, with the best clinical practice in place, situations where any arguments for euthanasia as we describe them here could possibly be justified are rare indeed. On balance there is, therefore, no current reason for abandoning the profession's established view that acts motivated by a clear intention to end a patient's life cannot be justified on ethical grounds...a doctor ought not to carry out any act that has as its primary intention the death of a patient.* (heavy type in original)<sup>3</sup>

How 'rare' is, of course, yet another point at issue. So too is the number who might request euthanasia or assisted suicide with estimates under the proposed legislation varying between 700 and 13,000 per annum. Obviously this is a significant factor in the ratio of benefits to predicted drawbacks.

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The Select Committee itself was divided. There is no recommendation to support the proposed legislation nor that it should be dropped. But this too is a change from the earlier view of the House of Lords Committee on Medical Ethics in 1994, chaired by Lord Walton, which had opposed the introduction of legislation to legalise active termination of life or professionally assisted homicide ('assisted dying' to its proponents, 'therapeutic killing' to its opponents). The Select Committee Report was debated this October in the House of Lords and the Report itself recommends that any future Bill draws

*a clear distinction . . . between assisted suicide and voluntary euthanasia in order to provide the House with an opportunity to consider carefully these two courses of action . . . and to reach a view on whether, if such a bill is to proceed, it should be limited to the one or the other or both.*

A new Bill proposing patient assisted suicide may therefore be expected later in 2005, an intention announced in the House of Lords during the debate on the Report on 10 October 2005 (note added in proof: introduced 9 November 2005). Once again, the College's view will be important and Fellows should be informed of the issues. Both the Royal College of Anaesthetists and the Royal College of General Practitioners currently oppose the present proposals – the latter having changed its position, following its submission to the Select Committee and after an 'overwhelming' consultation with its members and faculties.

### Ethics and the role of law

The debate is, of course, about making a new law. In doing so, two tests must be passed. The first is ethical: are patient-assisted-suicide (PAS) and/or voluntary euthanasia (VE) morally defensible? The second is juridical: can legislation be drafted that protects the vulnerable, avoids abuse and has no significant major adverse consequences for society to offset the benefits it would offer? As Samuel Johnson said, 'Laws are not made for particular cases but for men in general'. Agreement on the ethics of, shall we say, shooting the driver trapped in his burning cab do not help the juridical questions. For law must necessarily draw a line through the grey areas of human behaviours and situations in order to establish a clear rule. To this degree, law is necessarily arbitrary. Differences of degree do matter and it is false to argue that because a line is arbitrary then it must be equally arbitrary to choose to draw a line at all. Flew calls this fallacy the 'logically-black-is-white slide' and says:

*the very differences about which men care most are differences of degree: those for instance, between age and youth; between riches and poverty; between sanity and insanity; between a free society and one where – in an old phrase – everything which is not forbidden is compulsory.<sup>3</sup>*

Currently, the line between active termination of life and treatment withdrawal is such a line. The difference between, say, the Cox case – in which a rheumatologist injected potassium chloride and was convicted of attempted murder – and the Bland case – in which treatment withdrawal was declared not

unlawful – demonstrate this legal distinction. Doctors draw this line every day.

Juridical considerations raise a series of ethical issues of their own. In considering these, it may be helpful to return to the debates between Devlin and Hart that arose from the Wolfenden Report of 1959.<sup>4-6</sup> The Wolfenden Report recommended that homosexual acts between consenting adults should cease to be illegal. In the ensuing debate, Devlin argued (while accepting the report's practical recommendations) that if we try to create a society with no agreement between morals and the law, society will disintegrate. The philosophical position on liberty was expounded by Thomas Aquinas when he wrote:<sup>7</sup>

*Law . . . does not forbid all the vices from which upright men can keep away but only those grave ones from which the average man can avoid and chiefly those which do harm to others.*

The 'no harm to others' principle received its later, and now more famous, exposition in John Stuart Mill's *Essay on liberty*:<sup>8</sup>

*The only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.*

Yet law in our society does not always follow this principle. Consent is not a defence to assault causing actual bodily harm<sup>9</sup> and many activities that consenting adults may wish to do, with no harm to others, remain illegal. Other examples included duelling, bigamy, abortion, incest between brother and sister, much embryo experimentation and, of course, euthanasia. Our concept of 'harm' then should possibly extend further, to include the satisfactions of living in a society with certain values. On the other hand, the variety of moral and religious views argues the need for mutual respect and, with it, a certain liberalism. Discussions around PAS and VE therefore throw up some of the most fundamental questions of the role of the state in modern society. Incanting the words 'autonomy' or 'choice' is not enough.

### Terminating life under the proposals

There remains much misunderstanding, not only about the wider implications and justification of the proposals in the Bill, but also its practicalities. The active termination of life being proposed has nothing to do with treatment withdrawal and little to do with increasing doses of opiate analgesics. In fact there does seem to be considerable difference of opinion as to whether higher doses of opiates in palliative care shorten or lengthen life.<sup>10</sup> Probably they do not shorten life. Palliative care experts tell us that many doctors assume that they kill patients with analgesia or sedation when they do no such thing. In appropriate circumstances, it is not illegal to withdraw treatment nor to use analgesics in doses that create concerns that death could result. Nor is it ethically contentious for most physicians. Nor indeed do they create any difficulties for those major religious bodies that have been so prominent in 'sanctity of life' debates. This is emphasised by the RCP's position statement on medical treatment at the end of life, approved by Council in 2001:

it is vital that distinctions are drawn between:

- Acts where there is clear intention to end life
- Acts that are predominantly therapeutic, with a foreseen but unintended consequence that life may be shortened: these therapeutic acts are mistakenly perceived by some to be synonymous with the intentional ending of life.

As physicians consider their position on these matters they must realise that the likely practical implication of the Bill is the deliberate and directly intended termination of life by either the prescription of a large dose of barbiturates for the patient to take unaided; or the injection of a short-acting barbiturate followed by intravenous curare. In the former case, while there is no standard recommended dose in Oregon (House of Lords Report, Volume II, 261), the commonest practice is to prescribe 10 grams of liquid pentobarbital or the powder from 9 to 10 grams of secobarbital capsules, dissolved in water or apple sauce. The barbiturate itself is bitter tasting and vomiting is a major concern. Despite routine prescription of an anti-emetic, to be taken half an hour before swallowing the barbiturate, there have been cases of partial regurgitation of the sedative, including a few in which the patients vomited one-third to one-half of the dose. However, Okie reports<sup>2</sup> that in all 208 PAS deaths between 1998 and 2004 – bar one for which information is not available – unconsciousness occurred, usually within a few minutes. Median time from ingestion to death was 25 minutes. Some lived for hours, including at least 17 who lived for more than 4 hours, one surviving 37 and another for 48 hours. In one case, a patient took the full dose, awoke 3 days later ('What the hell happened? Why am I not dead?') and lived for 2 more weeks before dying of lung cancer. The British Bill is likely to lead to this sort of practice, rather than to the active administration of intravenous drugs that occurs in the Netherlands or in Dr Nitschke's suicide machine<sup>11</sup> in Australia's Northern Territory when active termination of life was briefly legal in that jurisdiction. Given the emphasis on PAS as the main thrust of current proposals, physicians must consider the practical implications of demands for these sorts of agents, not delude themselves that this debate is about pain relief and opiates.

### Comparing ethics in PAS and VE: safeguards and moral distance

Is PAS ethically different from VE? The Report highlights the differences in practice in the Netherlands and Oregon. In the former, in 2003, one in 38 deaths resulted from VE or PAS (one in 32 if cases of euthanasia without explicit request are included) whereas in Oregon, where only PAS is legal, one in 714 deaths were recorded. Even ignoring allegations of significant under-reporting in Holland (54% of all euthanasia deaths go unreported to the authorities according to the Report, para 180), these differences are huge. The Report suggests that the difference is real and under-reporting in Oregon much less likely as an explanation. It is also noteworthy that the overwhelming majority of 'assisted deaths' in the Netherlands are due to VE and not to PAS. These differences could be due to several factors:

perhaps one's legal rights are more easily translated into practice in Holland or positively obstructed in practice in Oregon. Perhaps there are genuine cultural differences arising out of the long established practice of VE in the Netherlands even before its legalisation in 2002. Perhaps it is easier to go ahead with ending one's life when someone else will do it, the challenge of swallowing the medicine unaided bringing a change of heart for some – hence the number of prescriptions that are never used. Perhaps some voluntary requests are responses to recommendations or advocacy. Or it may be the quality of palliative care available: 'Your safety net is your end-of-life care and your hospice care. It's not the safeguards that you build into the law.'<sup>2</sup> Or to quote another Oregonian, 'There isn't a huge demand for assisted suicide in good care systems, but there could be a huge demand in much less adequate care systems.'<sup>2</sup> If that is true, it really does make a strong case for improving palliative care before, rather than at the same time, as legislating for active life termination.

But there are two other significant ways in which PAS and VE differ. Firstly, because the agent in PAS is the patient, it can be argued that uncertainty of purpose can be more confidently excluded. Doctors, friends, other healthcare workers and even family members are forbidden to administer the drugs in Oregon: the responsibility for the ultimate act rests with the patient. Even in motor neurone disease – which, along with AIDS, is a far more important pathology than cancers in the profiles of patients requesting PAS/VE – it can be made possible for many patients to self-administer. Secondly, as reported by one witness in the Report, 'the physician's role is just one step further back'. Morally it is hard to see what difference this makes, although *psychologically* the difference is clear enough. Regarding our concern for others, David Hume sceptically commented:

*In general, it may be affirmed, that there is no such passion in human minds as the love of mankind, merely as such, independent of personal qualities, of services or of relation to ourself. It is true there is no human, and indeed no sensible creature, whose happiness or misery does not, in some measure, affect us, when brought near to us, and represented in lively colours: but this proceeds merely from sympathy, and is no proof of such a universal affection to mankind.<sup>12</sup>*

George Orwell expressed the phenomenon of moral distance rather more strikingly when he wrote:

*As I write, highly civilised human beings are flying overhead, trying to kill me. They do not feel any enmity against me as an individual, nor I against them. They are 'only doing their duty', as the saying goes. Most of them, I have no doubt, are kind-hearted law-abiding men who would never dream of committing murder in private life. On the other hand, if one of them succeeds in blowing me to pieces with a well-placed bomb, he will never sleep any the worse for it.<sup>13</sup>*

Killing at a distance in wartime provides the best example of the psychological difference between two acts that are morally identical – those who press the button or order the death are just as morally culpable. The intentions behind PAS and VE are indistinguishable: the deliberate active termination of human life. The doctor would be equally complicit in either and the

outcome the same. There may be juridical, practical and empirical differences, but the direct moral features are identical – just as the moral calculus may be the same in some selected cases of treatment withdrawal and active life termination.

Even in those cases that appear morally equivalent, drawing the line between treatment withdrawal and active life termination has the legal advantage of clarity – it is not merely an arbitrary point to draw the line. But consider the distinction between placing the lethal medication beside the patient's bed, placing it in his/her hand or placing it in his/her mouth. The first of these is PAS; the second perhaps – she could choose not to take the medication; and even in the third – she could spit it out. But in both the second and third cases, the doctor actively participates in the direct event causing death. Surely, it has been argued, these are examples of euthanasia. Reasonable expert commentators are unable to make these distinctions in principle or to advise how they could be maintained in practice.<sup>14</sup> They fail the juridical test. The view of the British Medical Association (BMA) has hitherto always emphasised the moral equivalence of VE and PAS. It is illogical to support the one and oppose the other. Moreover it appears that neither the public nor many experts have a clear distinction in their minds.<sup>15</sup>

### Conscientious objection

Conscientious objection to PAS/VE is an important practical problem. The orthodox Roman Catholic position, for example, was stated by the late Pope John Paul II:

*Abortion and euthanasia are thus crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection . . . In the case of an intrinsically unjust law, such as a law permitting abortion or euthanasia, it is therefore never licit to obey it, or to 'take part in a propaganda campaign in favour of such a law, or vote for it'.*<sup>16</sup>

The initial draft of the Bill addressed the conscientious objector by suggesting a duty to refer the patient to another physician 'without delay'. For many objectors to VE or PAS, this is not likely to be acceptable. Referring a patient to someone who is prepared to deliberately terminate their life is likely to be seen as complicity in killing. For many objectors to VE/PAS, integrity is only maintained by a refusal to be involved in any way. Such liberty is not permitted in the operation of the 1967 Abortion Act, where guidance suggests that referral to another practitioner is required. The General Medical Council (GMC), for example, states:

*If you feel that your beliefs might affect the advice or treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.* (Good medical practice)<sup>17</sup>

The revision of GMC guidance currently in draft goes rather further:

*Where it is not practicable for a patient to make such arrangements for themselves, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.*

Involvement in the deliberate termination of a competent adult life is likely to evoke a stronger feeling of complicity than the destruction of a six-week fetus. In a recent paper, Charo comments:<sup>18</sup>

*Apparently heeding George Washington's call to 'labor to keep alive in your breast that little spark of celestial fire called conscience,' physicians, nurses, and pharmacists are increasingly claiming a right to the autonomy not only to refuse to provide services they find objectionable, but even to refuse to refer patients to another provider and, more recently, to inform them of the existence of legal options for care.*

The situation that he describes has arisen as an artefact of the abortion 'wars' in the USA, but active life termination of adults is surely likely to arouse even stronger appeals to conscience. The GMC draft guidance may not be acceptable to many physicians. The question for many health professionals becomes: what does it mean to be professional? To what extent do they have a collective duty to ensure that their profession provides non-discriminatory access to all professional services?

### Human rights and medical choice

It has been thought that the arrangements in the Bill requiring referral to another physician may contravene the European Convention on Human Rights. It might be argued that under Article 9 (freedom of thought, conscience and expression), the state has a negative duty not to dictate what a person believes or to take coercive steps to make him change his belief. The state also has a positive duty to ensure the peaceful enjoyment of this right and 'to regulate activities where the mere knowledge that they are taking place is sufficient to anger or disturb those who hold religious inclinations to the contrary'. This means that the state could not expect doctors to refer the patient on if the decision not to do so was a matter of conscience. On the other hand, the right could be derogable:

*freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.*<sup>19</sup>

If a right to die were created, then the doctor's freedom of conscience could be overridden. At the time of writing, I am unable to confirm this interpretation. However the bill's sponsor, Lord Joffe, informs me that a draft amendment has been framed in which the patient will have to make the necessary arrangements themselves.<sup>20</sup> It may be argued that this structure is unfair in that a right in law is not easily available to the patient in such circumstances. However, it is difficult to visualise any other arrangement that respects the strongly held views of conscientious objectors. Better an unsatisfactory arrangement, it might be argued, than imperil the success of the Bill in Parliament on these grounds.



## Responsibility of physicians

Debate on PAS/VE is set to continue. Public interest is high and some argue that the proposals themselves do a grave disservice by implying that uncontrolled suffering is a likely end for most of us. A climate of fear is created to increase public support for legal change. Any physician who cares for dying patients has a responsibility to be informed about these issues, to be clear about what is being proposed and what their own personal position is likely to be. There are already ample sources of information available on the internet and contributions in mainstream journals, many of which can be confidently recommended for the quality of their contribution.<sup>21</sup>

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