

'Assisted suicide': is this what we really want?

The BMA's Annual Conference has recently voted, by the slenderest of majorities from a depleted quorum of delegates, to adopt a position of neutrality on any future bill seeking to legalise medical assistance with suicide. But does that represent the settled view of practicing clinicians, especially GPs on whom any change in the law would probably ultimately fall? The debate on the practical implications for general practice and for the provision of care for the terminally ill is now urgent.

In 2003 Lord Joffe introduced a Patient (Assisted Dying) Bill, which did not progress and then in 2004 he introduced his Assisted Dying for the Terminally Ill Bill which was referred to a Select Committee on which Lord Joffe himself sat; the Committee's report will be debated in October and Lord Joffe has said he plans to introduce another Bill shortly.

It has been said that the decision over euthanasia and physician-assisted suicide is for society to decide, through its elected representatives in parliament. Indeed any change in the law on intentional killing must be made by parliament, but medicine, nursing, allied professions and ancillary staff will be directly involved in a way that others in society will not. Last year the Royal College of Physicians and the GMC adopted a neutral stance on the principle underlying Lord Joffe's Assisted Dying for the Terminally Ill Bill,¹ although the GMC added pointedly that:

'... acting with the primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence'.¹

The RCGP Council has now decided it cannot continue a neutral stance because its Members and Fellows professional practice will be radically altered if Lord Joffe's next Bill proceeds. The Royal

College of Nursing remains resolute in opposing such legislation.

Several hundred practising doctors, many of them GPs, wrote to The Select Committee; three-quarters expressed their opposition to the suggestion that the medical profession should be involved in any new law that legalised either assistance with suicide or euthanasia. The opinion polls among doctors that the Select Committee saw told a similar story: this is something that the majority of doctors don't want to have foisted onto them as a 'therapeutic option' or, as it was put euphemistically by Professor Raymond Tallis, as 'part of the whole package of care'. But, interestingly, the opinion polls also showed that the strongest opposition came from those doctors with most experience of end-of-life care. Among the 726 doctors in palliative medicine, a survey with an 84% response rate revealed that over 90% of responders opposed legislation permitting euthanasia or physician-assisted suicide.

So what are we to make of all this? Why are we getting resolutions of neutrality from medical academies, regulatory bodies and some representative organisations when, apparently, there is little appetite for euthanasia among doctors working in the field?

There has been a well orchestrated campaign towards euthanasia and physician-assisted suicide for some years. Evidence from Oregon suggested that the campaign to physician-assisted suicide was largely successful as doctors took a neutral stance in 1994 when it was debated there. However, healthcare systems are very different in the US; in Oregon there is no specialisation in palliative medicine, and patients have to sign out of active treatment before they can access any hospice care. Although some conditions are not eligible for treatment on their Medicare/Medicaid programme, the State of Oregon will still

pay for physician-assisted suicide for those untreated. So, now about one in every 700 deaths in Oregon is by physician-assisted suicide, not for the relief of intractable symptoms but more for those who feel a great need to be in control, with fear of being a burden becoming a more prominent reason over recent years. Holland has a much lower incidence of physician-assisted suicide, as euthanasia is the preferred mode of ending patients' lives; there one in 38 of all deaths are from voluntary euthanasia, rising to one in 32 when all non-voluntary euthanasias are included. These are mainly conducted by Dutch GPs, not in hospital. In Holland, however, the Select Committee heard from Lord Joffe himself:

'... that in the Netherlands doctors really worry about assisting patients to die — it is not something they move into enthusiastically and it causes considerable concern.'

Indeed some GPs find it so upsetting that they need to take the day off after the death.

The Select Committee also heard of the proposed safeguards around the proposed legislation. The key problems with safeguards that witnesses identified were that prognosis prediction is notoriously inaccurate even when predicting the last 6 months of life; that diagnostic errors abound (the Royal College of Pathologists told us that 30% of death certificates are inaccurate); that there is no way of knowing when a requesting patient is under pressure, not so much from greedy relatives as from his own desire not to be a personal or financial burden on his children, although coercion is extremely difficult to detect; and that diagnosing reversible depression (very common among people diagnosed as terminally ill) is extremely difficult. This is not screened for in Oregon or Holland,

yet it greatly affects a patient's competence to make the ultimate decision — to commit suicide or to be killed. We heard that unbearable suffering is so subjective and fluctuating that any assessment of what is 'unbearable' is not possible. And no so-called conscience clause will truly protect GPs from some degree of involvement.

Snap opinion polls in the UK suggest that four-fifths of the general public want the law changed — a statistic that may be explained by people's own bad experience of watching a loved one dying. Many of these experiences were in the relatively recent past: the Channel Four's Dispatches programme *On Pain of Death* (18 July 2005) recorded complaint after complaint from people who said that their dying relatives had received no pain relief to speak of from their GPs or the doctors in their local hospitals. For sadly, while (as the Select Committee was told) Britain has the best palliative care in the world in qualitative terms, its quantity and distribution around the country leave much to be desired. The result is that terminally ill people are dying in pain unnecessarily. Anecdotal, inadequate training in the use of analgesics and hesitancy in prescribing higher doses of opioids when needed is being compounded by fears of false accusations in this post-Shipman era.

There have been many changes to general practice recently. Care of the terminally ill patient at home is an area of clinical practice that GPs consistently state they value; some choose to remain available out of hours for a particular patient even though they are personally off duty. Many in primary care are pursuing education in palliative care — indeed several hundred GPs have graduated from the Cardiff University Diploma in Palliative Medicine. Fifty years ago, when greater life expectancy left people to die of painful and drawn-out malignant or degenerative diseases and morphine was only given as 10 mg maximum 4-hourly p.r.n., there was a case to be made in extremis for euthanasia. Such a case cannot be made honestly today — provided we are willing to care and we do not opt for the quicker and cheaper alternative of ending lives to end distress.

Let us be clear, when talking of euthanasia or physician-assisted suicide, this is fundamentally different to titrating up doses or to withdrawing and withholding and intervention. Admittedly, the final end point in all these situations is death, but such a reductionist philosophy does not reflect clinical reality. Symptom control sometimes means titrating up doses of opioids and other drugs with sedative side effects, occasionally to the point that the person who is dying is sedated. When sedated and dying, it is difficult to know whether the patient's death is being brought forward by the sedation (as the doctrine of double effect would explain), or indeed if it was delayed as the patient was no longer exhausted by intractable distress. But the primary intention here is not to kill the patient. When treatment is futile, it should not be given, so withdrawal of futile interventions becomes good practice. When a treatment is refused or would not provide benefit, then similarly it should not be administered. But the symptoms that a patient experiences must still be managed and the patient supported until natural death occurs. The term 'passive euthanasia' is a misnomer.

With physician-assisted suicide or euthanasia the primary intention is to kill the patient over the next minutes or hours. A lethal overdose is administered. For physician-assisted suicide, the patient ingests a prescribed 9–10 g of barbiturate after preloading with metoclopramide to prevent vomiting; this volume is about a tumbler full of barbiturate solution or the tablets can be crushed and mixed with apple sauce to make them more palatable. In euthanasia the usual practice is to induce coma with a large intravenous dose (several grams) of thiopental or similar anaesthetic induction agent, often followed by curare so the totally paralysed patient dies in respiratory failure.

So, make no mistake — if we do have euthanasia or medical assistance with suicide foisted onto us, we will see our profession altered. Once the concept of an individual's wishes becomes paramount rather than (as it is now) the concept of principled autonomy, there will be pressure to override other medical ethical decisions — in such fields as

prescription, surgery and discontinuance of life support. The GMC won their appeal against the original Justice Mumby J's decision on Leslie Burke's case — it had to be thus, otherwise patients could demand irrespective of need or resources. So, currently a patient's autonomous wish alone is not paramount. Mr Burke feared being left to die of hunger and thirst, sentient yet unable to speak; he was right to be fearful, but such terrible care should not happen and when the Mental Capacity Act comes into force in April 2007. It will enshrine a decision-making process of best interest decisions for those who lack capacity, as well as ensuring the criteria of valid advance decisions to refuse treatment, even when death is the immediate result. But this is not euthanasia by the back door.

What if a change in the law had to be accepted? I believe that in that event the damage, not only to the profession but to society as a whole, could be much reduced if the implementation of euthanasia were to be placed outside mainstream health care. Such a separation should ensure that there is no inadvertent blurring of the line between care and killing. It would provide reassurance to seriously ill patients who are fearful of going into hospital lest their lives be ended without their explicit consent; and it would protect both the integrity of medical ethics and the careers of those of who are opposed to 'therapeutic killing'.

In a word, therefore, this is a Rubicon we should not cross. If the law on intentional killing is altered to allow physician-assisted suicide/euthanasia, every clinician looking after sick patients will inevitably be involved at some time. Would you be willing to administer the lethal injection? If not, don't expect others to.

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REFERENCE

1. Select Committee on the Assisted Dying for the Terminally Ill Bill. Assisted Dying for the Terminally Ill Bill [HL]. London: The Stationary Office, 2005. <http://www.publications.parliament.uk/pa/ld/lasdy.htm> (accessed 4 Aug 2005).