Physician assisted suicide — a good death?

The conference, 'Physician assisted death – a good death?' at the Royal College of Physicians in Edinburgh in early October, invited healthcare professionals, lawyers, students in related disciplines, and concerned members of the public, to consider the very important subject, 'What is a good death today?' In some countries it is legal for doctors to assist a person to commit suicide, but Lord Joffe's proposals to the House of Lords and MSP Jeremy Purvis' proposals to the Scottish Parliament in favour of patient-assisted death (PAS) have both been rejected. Yet, a recent study in the *Journal of Medical Ethics* examined statistics relating to assisted dying schemes in Oregon (where 50–60 people per year opt for the scheme) and the Netherlands, and reported that there was no evidence for current concerns around legalised PAS or voluntary euthanasia. They found no justification for fears that the vulnerable in society might be subjected to pressure and be disproportionately likely to take the decision to end their lives.

Reverend Professor Kenneth Boyd, Professor of Medical Ethics at Edinburgh, summarised the pros and cons; the autonomy argument along with the need to relieve suffering, versus the intrinsic wrongness of killing, the possible threat to the integrity of the profession, and concern about the slippery slope. He provided a historical context. The extent to which relief of pain can be justified has always been an issue; 'When anaesthesia was first introduced, it was opposed by the church'.

Professor Kenyon Mason, author of a major textbook, 'Law and medical ethics', stated that his personal preference for mode of death was, 'Swiftly, on the 18th green', and then went on to discuss the current contradiction in consent to death. For lethal treatment, consent is impossible; for lethal refusal of treatment, consent must be accepted. Roger McGough's choice of death, 'Let me die a young man's death', was quoted by Reverend Ewan Kelly, previous doctor, hospice chaplain, and lecturer in pastoral care and theology. He emphasised that, 'Consideration of the spiritual dimension of humanity is fundamental to any discussion of physician assisted suicide'. Disability rights and legislation were part of the consideration; 'Able-bodied people can commit suicide; disabled may be denied the right'.

In typically rigorous style, Professor Sheila McLean, Director of the Institute of Law and Ethics at Glasgow University, said that the argument was about competence and autonomy, which was linked to extent of capacity. In Scotland, we are aided by the Adults with Incapacity Act but, 'There is some question whether or not a choice to die can ever be properly called autonomous'. Her view, however, was that, if competence and autonomy can be satisfied, a person's chosen death can, and should, be available and that doctors need not necessarily be involved. She strongly believed that more honesty was needed about double effect, when increasing palliative medication results in death, and the legislation needed to be reviewed.

So, how do we, as doctors, manage to respect the wishes of dying patients who do not want to continue living, while striving to optimise their quality of life? Amidst all the fascinating legal and ethical arguments, the contribution which captured the reality of the issue came from a GP in the audience describing an elderly patient who seemed depressed and was not eating. All manner of pathologies had been imagined by the family. The GP sat down with her, addressed plans for her death, whenever it occurred, and reassured her that she could have some control over where and how she died. Her mood lifted, she became more active and went on to enjoy the rest of her life.

Woody Allen's view is a common one, 'It's not that I'm afraid of dying, it's just that I don't want to be there when it happens', and even people trained in matters of life and death can be reluctant to really deal with death and plan for it. One of the organisers of this conference was Professor Scott Murray, Professor of Primary Palliative Care at Edinburgh, whose work on illness trajectories and palliative care drew attention to the need to try to understand how patients with limited life expectancy may die and plan accordingly. 'Where we cannot alter the course of events we must at least, (when the patient so wishes), predict sensitively and together plan care, for better, or for worse'. His subsequent paper, 'Advance care planning in primary care',[2] published in the *BMJ* last October, described the effective use of the practice palliative care register and further elaborated the value of joint planning between the patient and their primary carers, and the use of 'advance decisions'.

Professor Murray is chairing at another RCPE conference at the end of October, 'Improving end-of-life care in the 21st century'. It promises to be equally stimulating and valuable.

Lesley Morrison

REFERENCES

1. Battin MP, van der Heide A, Ganzini L, *et al*. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups. *J Med Ethics* 2007 **33(10)**: 591–597.
2. Murray SA, Sheikh A, Thomas K. Advance care planning in primary care. *BMJ* 2006 **333**: 868–869.