Royal College of Physicians

Assisted dying: Briefing from the RCP's Committee on Ethical Issues in Medicine

The Royal College of Physicians will hold a ballot among fellows in early 2019 on the question of physician-assisted dying. This note provides a briefing on the ethical issues involved.

The issue arouses strong feelings on all sides. This is not surprising. The question is one that engages deeply held values. It should also involve reasoning about relevant ethical principles and possible consequences. This note examines that reasoning.

Definitions

Although there are no agreed definitions of the relevant medical practices, it is useful to distinguish:

1. *Withdrawal or Withholding of Treatment.* A physician intentionally withdraws or withholds treatment at the request of a patient with capacity or in the best interests of a patient without capacity.
2. *Physician-Assisted Dying.* A physician intentionally supplies a patient who has capacity with the means to self-administer a lethal dose of a medicine.
3. *Voluntary Euthanasia.* A physician intentionally administers a lethal dose of a medicine to a patient who has capacity and who has expressed a wish to die.
4. *Involuntary Euthanasia.* A physician intentionally administers a lethal dose of a medicine to a patient without capacity, whether or not that patient has expressed a wish to die, but with the intention of acting in the best interests of the patient.

Proposed legislation in the UK has only been concerned with legalizing physician-assisted dying (2) above. No bill so far proposed would have allowed physician-assisted dying in cases where patients lack capacity, but where someone else – a relative or treating physician – judges that it would be in their best interests to die. No bill has propose voluntary euthanasia. It is agreed on all sides that the withdrawal or withholding of treatment at the patient's request is properly and rightly *required* by law.

The ethical debate

The ethical debate involves both issues of principle and assessments of consequences. The issue has been much discussed in bioethics over the last sixty years. The consideration advanced on both sides have remained relatively stable over that time. All agree that those physicians conscientiously opposed to the practice should not be required to undertake it.

Those in favour of changing the law urge the following points:

1. Patients have a right to self-determination (self-determination is also known as autonomy). The principle of self-determination gives patients with capacity the right to refuse medical treatment. Physician-assisted dying enables doctors to respond to a patient's decision that the continuation of life is no longer of value.
2. There is no morally significant distinction between withdrawing or withholding treatment so that a patient dies and assisting a patient who wishes to die.
3. Doctors are under a professional duty to relieve suffering. In some cases, the only way of fulfilling this duty is to help the patient to die.
4. Argument (3) is sometimes accompanied by the empirical claim that the limits to the relief of suffering that palliative care can achieve warrants permitting physician-assisted dying.
5. Patients also fear loss of quality of life, for example in loss of control of basic bodily functions. Or they wish their family members to remember them in a certain way. This is sometimes expressed in the claim that patients fear loss of their dignity. When a patient with a terminal condition decides on the basis of these beliefs that they wish to die, it is right to allow physicians to respond to that wish.
6. Patients can feel they have become an unacceptable burden to their family and wish to be remembered with pleasure and not as a duty or an encumbrance.
7. Permitting physician-assisted dying does not entail a lower social status for those with disabilities, given that it is patients themselves who initiate any decision.
8. In jurisdictions where physician-assisted dying is permitted, there has been no increase in physician-assisted deaths where patients have not validly expressed a wish to die.

9. Procedural safeguards can be put in place to protect the interests of the vulnerable or those who feel untoward pressure from doctors, family members or society at large.
10. It is possible to draw a clear line between physician-assisted dying for those with capacity on the one side and voluntary and involuntary euthanasia on the other.

The arguments of those opposed to legislative change are in most cases mirror-images of the arguments in favour.

A. The deliberate killing of another person is normally wrong in itself, a principle long recognized in civilised society outside the circumstances of legitimate warfare. It is no defence to say that the person killed desired his or her own death.
B. There is a moral difference between the withdrawal of treatment and assisting someone to die, since withdrawing or withholding treatment allows nature to take its course while physician-assisted dying is an active promotion of death.
C. Doctors are under a professional duty to relieve suffering but it is incompatible with the practice of medicine to aid death. Doctors are not competent to determine whether someone has made a valid judgement about the meaning of their life.
D. Argument (C) is often accompanied by the claim that palliative care is capable of the effective relief of virtually all suffering, or it would be so if its provision was extended.
E. Although patients may fear loss of the quality of life, doctors are not competent to judge what makes for a good quality life.
F. Where patients feel that they will become a burden, they should be reassured that they are entitled to good quality medical care.
G. The legal recognition of physician-assisted dying promotes the view that the disabled are of lower social status.
H. In jurisdictions where physician-assisted dying is allowed, some patients are helped to die who were not in the categories originally intended in the legislation.
I. It is impossible to design procedural safeguards that will ensure that vulnerable patients will not liable to wrongful killing.

J. To allow physician-assisted dying is to risk a slippery slope towards voluntary or even involuntary euthanasia.

Some complications

The above list of arguments sketches the main claims of those on the sides of the debate. The following points should be taken into account when coming to a considered judgement.

- Arguments on both sides both involve judgements of principle and empirical judgements of consequences. Judgements of principle are, in essence, beliefs or values, such as respecting patient self-determination or rejecting the deliberate aiding of suicide. Judgements of consequences relate to matters of fact, such as whether changes in legislation in other jurisdictions have led to unwished for deaths or other unintended consequences.
- It is not necessary to hold to all the propositions on any one side to come to a decision. For example, someone might hold that, even if there are no adverse consequences from changing the legislation, it would still be wrong given the proper role of the doctor. Similarly, someone who favoured physician-assisted dying might think that the risks of adverse consequences were worth taking in order to protect patient autonomy.
- Assessing the effects of legislation in other jurisdictions can be undertaken, independently of the moral position one takes. However, when beliefs are strongly-felt, it can be difficult for people to accept results that run contrary to their deeply held convictions.
- Although palliative care may still leave people suffering, in some peoples' eyes it is still the best that can be done.
- There is an extensive discussion in bioethics about the distinction between 'letting die' through the withdrawal or withholding of treatment as against 'being party to the death of another' by assisting death. Those who favour a distinction see a difference between merely foreseeing someone's death as a result of withdrawing treatment and intending someone's death by assisting suicide.
- It is common to both sides that patients have a right to self-determination. But there is dispute about the implications of that right. Taken on its own, if self-determination implies a right to physician-assisted dying that right need not be

limited to the terminally ill. For example, it could include those who are 'tired of life'. This is one of the slippery slopes that opponents of change fear.

- Slippery-slope arguments may over-emphasize what *may* happen rather than what *will*, in all likelihood, happen.
- Some proponents of physician-assisted dying say it is better to be open about a practice that may occur despite the current law. Opponents are more likely to protest that the law should not be changed simply in order to legitimise wrong acts.
- Arguments based on the traditional understanding of the duties of the physician to do no harm would prohibit physician-assisted dying. However, proponents of change point out that the understanding the role of the physician is changing given modern invasive treatments and patients are demanding more control.
- Although many people's views are shaped by religious beliefs, they do not determine one's position. Some agnostics and atheists oppose physician-assisted dying; some devout physicians support it.

Questions to consider before coming to a judgement

1. How far is it the role of the physician to help patients realize a wish to bring on death?
2. How far is it for physicians to deny a patient's wish to bring on death?
3. Is there a moral difference between allowing a patient to die through withdrawal or withholding treatment and aiding a patient to be an instrument of their own death?
4. How serious is the risk that physician-assisted will lead on to assisted dying for those who are not terminally ill or to euthanasia for those who are vulnerable?
5. Would a policy that allowed physician-assisted dying change the role of the physician? If so would those changes be good or bad?
6. What evidence is there about the limits of palliative care provision and its effectiveness in preventing suffering and loss of dignity?
7. What evidence is there about the effect of legislation legalizing physician-assisted dying in other jurisdictions?
8. If you have an established view on the mater, is there any argument or piece of evidence that would lead you to change your mind?

Reading suggestions

Two classic papers that state the arguments for and against physician-assisted dying:

- Brock, Dan W. (1992) 'Voluntary Active Euthanasia', *The Hastings Center Report*, 22: 2, pp. 10-22.
- Callahan, Daniel (1992) 'When Self-Determination Runs Amok', *The Hastings Center Report*, 22: 2, pp. 52-55

For a summary paper that suggests caution is needed given possible consequences, but which also gives a good sense of the arguments for and against:

- Steinbock, B. (2005) 'The Case for Physician Assisted Suicide: Not (Yet) Proven', *Journal of Medical Ethics*, 31, pp. 235-4.

For an argument that physician-assisted dying is consistent with the professional integrity of the physician:

Miller, Franklin G. and Howard Brody (1995) 'Professional Integrity and Physician-Assisted Death', *The Hastings Center Report*, 25: 3, pp. 8-17