Legalised euthanasia will violate the rights of vulnerable patients

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The chameleon of euthanasia continues to change, and the current shade is physician assisted suicide. The politically correct position for clinicians is "studied neutrality" since doctors will not really be involved in assisted suicide. Thus the issue has slipped past the BMA,¹ and the recent House of Lords' report on assisted dying suggests that euthanasia and assisted suicide are different.² This cannot be. What doctor prescribing for assisted suicide would refuse to complete it with euthanasia? In the Netherlands just under one in five physician assisted suicides ends in lethal injection.³ Were physician assisted suicide legalised, doctors would have the new duty of therapeutic killing,⁴ even if they planned only to prescribe lethal medication. Both are killings justified as treatment, hence we use the term therapeutic killing simply because it describes precisely what is done. Medicine cannot escape; quite aside from patient safety, legalising physician assisted suicide will have a profound and ubiquitous effect on clinical codes, duties, and practice.^{w1-w15}

Change is unjustified

Autonomy and suffering are the usual justifications for change. The autonomy argument is thin. In all legislatures, the final decision for physician assisted suicide or therapeutic killing rests with the doctor. Patients' perception of total control over this type of death is illusory. Evidence from Oregon shows that patients have to shop around for compliant doctors, and in the Netherlands about a fifth of requests are denied because patients are not suffering enough.⁵⁻⁷

Protecting the vulnerable

The cardinal argument against legalised euthanasia, however, is the insoluble ethical conflict between meeting individuals' demands for therapeutic death and ensuring that incapable, vulnerable, or voiceless

patients will not have lethal treatment prescribed as their best interest. Coercion is a real, immeasurable risk. As with cardiopulmonary resuscitation, clinicians will have to discuss the potential for assisted suicide with all dying patients. Arguably this promotes freedom, trust, and openness, yet, as disabled people find with discussions about resuscitation, it could also infer a duty to die.^{8,9} Requests for physician assisted suicide because of "being a burden" have risen in Oregon from 1:5 to 1:3 since its Death with Dignity Act was implemented.¹⁰

Treatments are medical goods. Since justice dictates that rights to appropriate treatment are universal, if assisted suicide is legal it becomes an optional treatment, not just for patients who want it but also for those who need it. A moral obligation exists for death to be a legitimate interest for all our patients. Therefore, assisted suicide or therapeutic killing becomes our proper duty towards anyone claiming or appearing to suffer unbearably, regardless of prognosis or capacity to consent. The inevitable accommodation of this shift in the status of assisted suicide and therapeutic killing is seen clearly in the Netherlands. Therapeutic killing is now extended to children,^{11,12} people with psychiatric illness,^{13,14} and those who are mentally incapable.¹⁵ Therapeutic killing without consent has become laudable and morally necessary.^{16,17} The Netherlands now plans a committee to decide on such cases nationally.¹⁸ Even UK protagonists recognise that safeguards are limited and expect legislation to be incremental.² Yet therapeutic killing without explicit request, or of those lacking capacity, is the ultimate violation of autonomy. Although the principle of autonomy is extended for requesting individuals, this is at the expense of others' freedoms.

Such collateral damage from the entitlement to therapeutic killing is inescapable. Dutch legislation has failed to improve reporting beyond 54% of all cases or to limit therapeutic killing without consent,^{16,19} which consistently accounts for about 1 in 7 of reported cases.¹⁶ Experience is similar in Belgium.²⁰ Oregon does not police its deaths. The size of this problem is unknowable, and the argument that this promotes autonomy in the sick population as a whole is misleading and unsustainable. Extrapolating the current Dutch figures to the United Kingdom suggests that at steady state, 13 000 deaths may result each year, with around 2000 occurring without request or consent.²

Moral consequences

In short, any safeguards have no ethical basis once any form of assisted suicide or therapeutic killing is sanctioned. The real question, therefore, is whether we are happy with the moral cost to society and loss of life

SERGE LITENBERG/REUTERS

Dutch protests in 2001 as parliament debated legislation and euthanasia

References w1-w15 are on bmj.com

among vulnerable patients as a result of reclassifying the freedom to die to the right to be killed.

Naturally, once promoted to a medical good, therapeutic killing becomes a legitimate consideration in resource management. In the first Dutch report in 1990, only one case was cited of a dying patient who was killed to free the bed,²¹ whereas in the latest survey, 15% of doctors were concerned about economic pressures.¹⁶ The nursing literature records similar experience.²²

Achieving a good death

Finally, suffering is extremely complex, part of our humanity, and not exclusive to people who are dying. Paradoxically, as disease overwhelms the dying person, the challenge is not how to be killed, but how either to hang on, or to let go, of life. Suffering can be mitigated but it requires the highly specialised skills and perseverance of a multidisciplinary team and goes well beyond controlling symptoms with drugs.²³

Although the presence of specialist palliative care is no argument against therapeutic killing, its absence certainly is, and lack of even basic, consistent provision across the UK is clear.²⁴ An average general practitioner cares for fewer than five dying patients a year; educational programmes consistently find general practitioners and hospital consultants are poor at controlling symptoms and relieving suffering, and many still believe that opioids and sedatives hasten death.²⁵⁻²⁶ It is unsurprising, then, that many clinicians have seen suffering patients who they have been unable to help. Many doctors assume that they already kill frequently with analgesia or sedation when they do nothing of the sort.

On a balance of harms, legalising physician assisted suicide or therapeutic killing is a far greater risk than compassion for the small minority pleading to be killed might imply. In detailed evidence to the Select Committee the implications for individual doctors in the UK was glossed.² Every doctor caring for patients will be asked at some stage to assist suicide or kill therapeutically. Before another bill is laid before parliament every doctor must think through all the moral and practical implications for their own practice, for all the others in their clinical team, and, of course, for other patients in their care. Promoting autonomy for all is to help people understand that they can let go and to learn the skills to assist them to do that.²³

Competing interests: RJDG and DJ gave oral evidence to the Select Committee on the Assisted Dying for the Terminally Ill Bill on behalf of the Association for Palliative Medicine. IGF was a member of that committee.

Contributors and sources: The authors are among the national leaders in specialist palliative care, practising clinicians, and have researched, taught, and published widely in the discipline. IGF is also professor of palliative medicine, School of Medicine, Cardiff University. This article arose from discussions to distil the issues that emerged from a systematic literature review by RJDG of euthanasia and assisted suicide. RJDG is the guarantor.

- 1 British Medical Association. *Assisted dying*. www.bma.org.uk/ap.nsf/Content/Endoflifeissues?OpenDocument&Highlight=2,Annual,Representatives,Meeting,2005 (accessed 31 Aug 2005).
- 2 House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. *Report [HL Paper 86-II]*. London: Stationery Office, 2005.
- 3 Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der Wal G. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med* 2000;342:551-6.

Summary points

Any legislation will leave vulnerable groups open to therapeutic killing without consent

Since this is the ultimate violation of autonomy assisted suicide cannot be separated from euthanasia

Arguments that legalised euthanasia promotes autonomy do not stand

Doctors need to consider carefully the full implications of legalisation

- 4 British Medical Association, General Medical Council. *Oral evidence to the select committee on the assisted dying for the terminally ill bill [HL] Vol II Evidence*. London: Stationery Office, 2005:125-6.
- 5 Ganzini L, Nelson HD, Lee MA, Kraemer DF, Schmidt TA, Delorit MA. Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon death with dignity act. *JAMA* 2001;285:2363-9.
- 6 Ganzini L, Nelson HD, Schmidt TA, Kraemer DF, Delorit MA, Lee MA. Physicians' experiences with the Oregon death with dignity act. *N Engl J Med* 2000;342:557-63.
- 7 Haverkate I, Onwuteaka-Philipsen BD, van der Heide A, Kostense PJ, van der Wal G, van der Maas PJ. Refused and granted requests for euthanasia and assisted suicide in the Netherlands: interview study with structured questionnaire. *BMJ* 2000;321:865-6.
- 8 Campbell J. A right to die? I'm more concerned that everyone has the right to live. *Times* 2004 Dec 2.
- 9 Templeton S-K. Better for old to kill themselves than be a burden, says Warnock. *Times* 2004 Dec 12.
- 10 Oregon Department of Human Services. *Fifth annual report on Oregon's death with dignity act*. <http://egov.oregon.gov/DHS/ph/pas/docs/year5.pdf>.
- 11 Leenen JJ, Ciesielski-Carlucci C. Force majeure (legal necessity). Justification for active termination of life in the case of severely handicapped newborns after forgoing treatment. *Camb Q Healthc Ethics* 1993;2:271-4.
- 12 Van Thiel GJ, van Delden JJ, de Haan K, Huibers AK. Retrospective study of doctors' "end of life decisions" in caring for mentally handicapped people in institutions in the Netherlands. *BMJ* 1997;315:88-91.
- 13 Jochemsen H. Dutch court decisions on nonvoluntary euthanasia critically reviewed. *Issues Law Med* 1998;13:447-58.
- 14 Sheldon T. Dutch GP cleared after helping to end man's "hopeless existence". *BMJ* 2000;321:1174.
- 15 Sheldon T. Euthanasia endorsed in Dutch patient with dementia. *BMJ* 1999;319:75.
- 16 Onwuteaka-Philipsen BD, van der Heide A, Koper D, Keij-Deerenberg I, Rietjens JA, Rurup ML, et al. Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet* 2003;362:395-9.
- 17 Sheldon T. Dutch GP found guilty of murder faces no penalty. *BMJ* 2001;322:509.
- 18 Sterling T. *Netherlands hospital euthanizes babies*. http://aplancasteronline.com/4/netherlands_child_euthanasia (accessed 15 Sep 2005).
- 19 Jochemsen H, Keown J. Voluntary euthanasia under control? Further empirical evidence from the Netherlands. *J Med Ethics* 1999;25:16-21.
- 20 Deliens L, Mortier F, Bilsen J, Cosyns M, Vander SR, Vanoverloop J, et al. End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. *Lancet* 2000;356:1806-11.
- 21 Dutch Department of Health. *The Remelink report*. The Hague: DoH, 1990.
- 22 Hendin H. The Dutch experience. *Issues Law Med* 2002;17:223-46.
- 23 George RJD, Martin J. Non-physical pain: suffering in action. In: Hoy A, Finlay I, Miles A, eds. *The effective prevention and control of symptoms in cancer*. London: Aesculapius Medical Press, 2004:107-26.
- 24 House of Commons Health Select Committee. *Palliative care fourth report session 2003-4, HC 454-I*. London: Stationery Office, 2004.
- 25 Sykes N, Thorns A. Sedative use in the last week of life and the implications for end-of-life decision making. *Arch Intern Med* 2003;163:341-4.
- 26 Thorns A, Sykes N. Opioid use in last week of life and implications for end-of-life decision making. *Lancet* 2000;356:398-9.

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Endpiece

Advantage of excess

Excess, upon occasion can be exhilarating, because it prevents moderation from acquiring the deadening effect of a habit.

W Somerset Maugham (1874-1965)

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