Intentionally terminating life (ITL) and doctors' direct involvement

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Abstract

Intentionally terminating life (ITL) is usually assumed to require a doctor to perform it. However, it does not. Two questions have been conflated. First, is it a moral good for society to facilitate people ending their lives, and if so, in what circumstances? And second, how and by whom is it to be done? If ITL becomes a medical responsibility, the profession changes to incorporate a new duty to end some people's lives. This is the most significant moral question in medicine. Because the political movement to legalize assisted suicide and euthanasia is vocal, organized and well-funded, the first question may become redundant soon. The second will then be upon us without due consideration. This article clarifies several ethical confusions that could derail your analysis. You may favour the legalization of ITL without compunction, oppose it in any form, or you may favour ITL but see it as safe only if implemented separate from medicine. Our intention is that you engage with the moral reasoning and not the emotional polemic of this postmodern debate.

Keywords Assisted dying; dying with dignity; medical aid in dying; physician-administered euthanasia; physician-assisted suicide; suicide

Key points

- Intentionally terminating life (ITL) by assisting a suicide or by administering euthanasia are ethically indistinguishable
- ITL is factually distinct from stopping treatments intended to sustain life or the 'double effect'
- Legalizing ITL makes it an entitlement for anyone who can justify being better off dead
- ITL does not require medical training or skills to deliver it effectively or safely
- Safeguards fail in all medical models. Arguably, they can only work in a judicial-type system with implementation by licensed practitioners sealed off hermetically from medicine and healthcare

Introduction

Society's morality/ethic usually changes over time by *degree* (cf. smoking). However, when legal change follows, a shift happens in *category or type*. Legalizing intentional termination of life (ITL) is an example of this. Hold this degree-type distinction in mind as you read.

Debate about ITL is often combative. Here, we stay above the argument to clarify the language and the key moral concepts to suggest questions, not judgements.

Clarifying the landscape

Language

George Orwell's *1984* was clear that language controls arguments. As ITL has become politicized, so has language. Killing is not tolerated, and assisting suicide and euthanasia are following suit. The latter can be described as follows:

- **(Physician) assisting suicide** (AS, PAS) means directly providing the means for suicide.
- **(Physician) administering euthanasia** (AE, PAE) means an authorized person giving a lethal cocktail by mouth, injection, aerosol or gas.
- Setting up a device for direct delivery that is then activated by the subject is a hybrid of these two.

Unambiguous legislative terms include:

- **medical aid in dying** (Canada), which covers both PAS and PAE
- **termination of life on request and (doctor) assisted suicide** (Netherlands), which is precise and is doctor or nurse-delivered.

Ambiguous terms include:

- **dying with dignity** (Oregon), which has so far been confined to PAS
- **assisted dying** (failed UK Bills), which refers to doctors prescribing drugs and sometimes assisting delivery.

Concepts, common assumptions and fallacies

Are AS and AE morally distinct?: no; modes of delivery are practical, not ethical decisions. Some argue that the causal distance between writing a prescription for lethal drugs makes it distinct from administering them oneself. We disagree. Take antibiotics — the moral decision is that a person ought to have one. If the patient cannot swallow, the antibiotic is given by injection. The same applies to ITL: once the best interest is agreed upon, how it is done is secondary and spans from writing a prescription to injecting a lethal cocktail. This matters because it affects who is eligible and who may be denied ITL. It is unjustifiable discrimination if someone cannot swallow a lethal cocktail (AS) yet cannot have an injection instead (AE).

Are stopping potentially life-sustaining treatment and ITL the same thing?: this is all about causation — stopping something allows an established series of events (causal chain) to continue and conclude, whereas starting something new introduces a new

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causal chain. These are different types of action. Figure 1 shows this diagrammatically:

- Stages 1–4 deal with reversibility.
- Point 5 relates to our discussion. A treatment must stop if it is not working, unwanted or too burdensome. The person dies from the primary illness.
- This may be slow or quick. Dying minutes after a discontinuation (point 6) may mean it feels like a new cause when it is not.
- Point 7 shows a new and distinct cause, such as a lethal stroke or ITL.
- Doctors stop treatments to avoid continued harm, not to precipitate death. Points 5 and 6 are differences of degree within the same category. Common law is unambiguous: 'The fundamental question is whether it is in the patient's best interests, and therefore lawful, to give the treatment — not whether it is lawful to withhold it.'[1]

Factually, stopping treatments, suicide and ITL are not on a continuum: they are distinct.

Causal–temporal fallacies and the double effect: confusing a chance sequence of events with a causal link is easy. The classic situation occurs when someone dies soon after an innocuous injection: it is hard not to feel as though the injection caused that death. The coincidence of dying with the drugs that may be necessary to control symptoms leads many people, including doctors, to believe that therapeutic analgesics and sedatives shorten life and that they must justify this using the double effect, when they do not.[2,3]

'An important safeguard for vulnerable individuals is that ITL is available only for eligible people who meet strict criteria.' Is this sustainable?: in the UK, only suicide has been decriminalized; ITL remains an offence. Legalization of assisted suicide would change its category so that it would cross this legal boundary from suicide being a permissible personal freedom to AS being an entitlement to have someone else do it. By extension, if AS, or any ITL for that matter, sits in the 'statutory space' of medicine, doctors become duty-bound to provide these lethal options to eligible patients who want it. In short, ITL becomes a new duty of care and conscience cannot be an escape from it.

Best interests are independent of physical, mental, psychological or social health, capacity or status. However, most legislatures have attempted to limit eligibility to capacitous terminally ill adults who are free of coercion and have a settled view. This is said to safeguard vulnerable individuals. However, this is unjust, as it denies people fair and equal access. Such distinctions are morally unsustainable, rapidly overruled or simply ignored (see the Key references and Further reading for more on both sides of this argument).

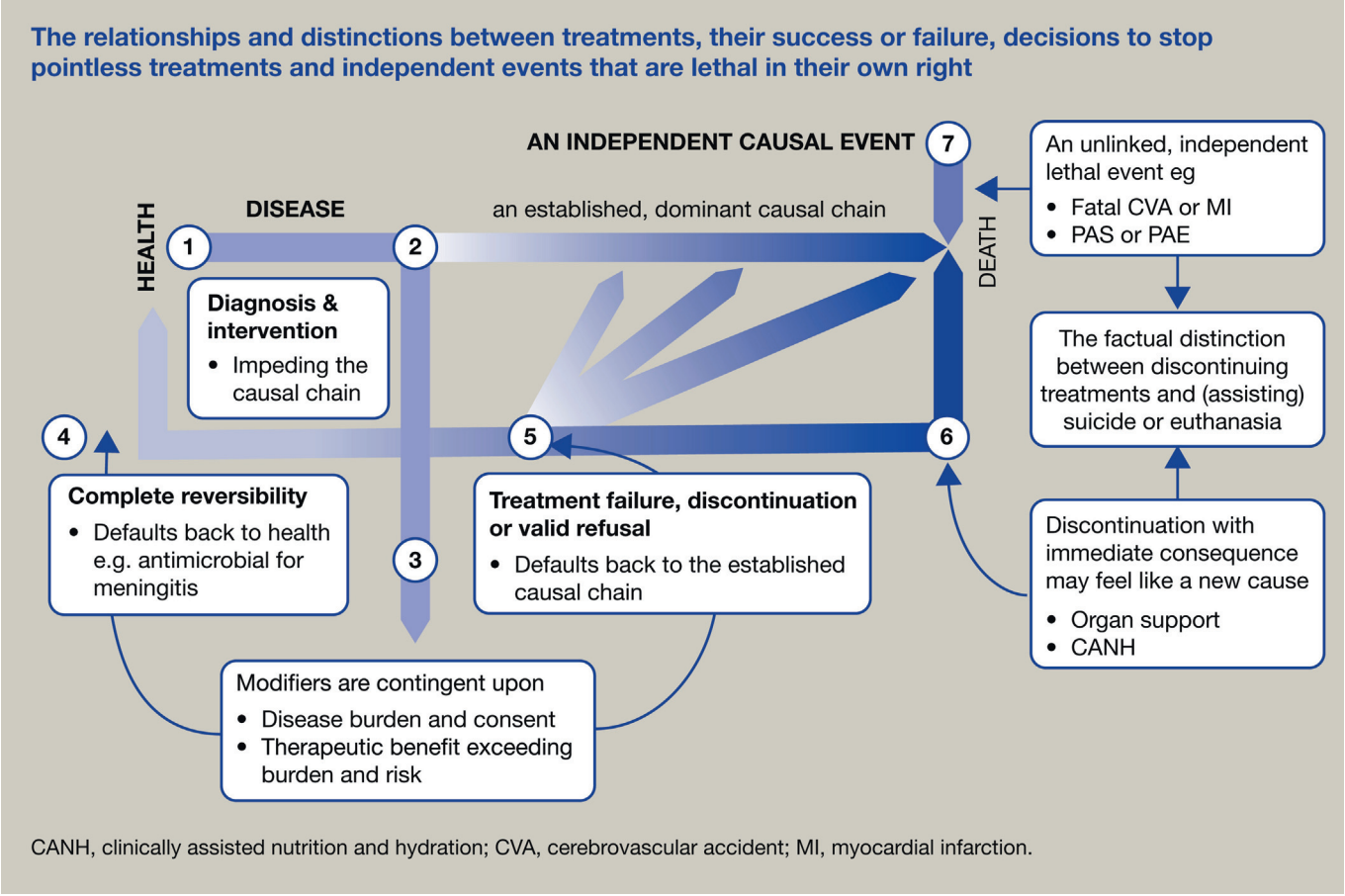

Figure 1

Hazards and risks: perspectives from either side of the argument

The hazard of ITL is absolute — ending a life by mistake. The risk one is willing to tolerate is not, but will vary according to where one sits in the debate.

Those opposing ITL: the challenge from a disabled person familiar with discrimination, fearful of being denied care or feeling burdensome, would be: *'What is worse: to kill someone who might want to live or not to kill someone who wants to die?'*

This statement presents any error as intolerable and is about being alive as a good in itself. Opponents argue as follows:

- Society's foundation is that life is worthwhile — this is why suicidality triggers mental health assessments, etc.
- ITL changes that. Seeing some lives as harmful or intolerable generally becomes legitimate, the language of being 'better off dead' becomes acceptable, and there is a new best interest for such lives to be ended.
- Society then necessarily begins to make assumptions about unacceptable life and discriminates between people. People who live those lives will become burdensome or illegitimate through others' eyes and, ultimately, their own. The protection of universal equality must accede to a new duty to die. Opponents claim that the literature supports this.
- Ultimately, legalized ITL cannot be denied to anyone for whom it is considered a best interest.
- Safeguards are, therefore, a fallacy.

Those proposing ITL: someone dying foreseeably with cancer, advancing neurodegeneration, etc. who finds life increasingly difficult, fears suffering and feels out of control would ask: *'What is worse: to leave a capacitous, dying adult to suffer unbearably or, with ITL, to risk their life ending a bit sooner than they would like?'*

This version seems more open and attractive. It prioritizes the individual and infers contemporary, evaluative terms such as suffering, unbearability, capacity and autonomy to be measureable and consisitent. It also weakens the unacceptability of a mistaken killing by confining access to ITL to people who appear to be dying anyway. The justifications to allow ITL over a blanket default to life are as follows:

- Death may be better than intolerable suffering. Only the person suffering can know that.
- One's life is one's own. The owner is entitled to control it.
- The absence of an ITL option locks some into intolerable suffering for what life remains.
- Proponents accept that they could never say that there would be no risk, but it would be limited to those dying anyway.
- Sufficient safeguards should minimize any risk of mistaken killing.

Safeguards: these set boundaries. They work where they mark differences of type. 'One-way' signs or traffic lights are not suggestions: they mark what is safe, and one thinks very carefully before contravening them. However, speed is a difference of degree and setting limits is arbitrary.

The problem for us is that safeguards around ITL are differences of degree. In this view, were it to be legal, and therefore a change in type, ITL should be available potentially for everyone because any limit to its degree would be discriminatory. Look at the literature on permissive legislatures to see if you agree; see particularly the resources from Dignity in Dying, which supports legal change, Living and Dying Well, which opposes it, and Keep Assisted Dying Out of Healthcare (KADOH) speaks from the medical perspective.

There are different interpretations of the same data: on the one hand, denying evidence of relaxed or abolished safeguards, and on the other, claims that the data are clear evidence of extended eligibility. For example, the Canadian experience makes it difficult to deny progressive and troubling relaxations of criteria and process. Look at the recommended websites to see different perspectives on safety. Come to your own conclusions.

The role of medicine

The main reasons people give for wanting ITL are social: loss of control, feeling burdensome or facing or fearing an intolerable reduction in the quality of life rather than uncontrolled pain and symptoms. So, what is medicine's role? None of the UK's medical bodies currently supports legislation involving doctors. For example, in 2020, the Royal College of General Practitioners 'continue to oppose a change in the law' and the Royal College of Physicians London said 'so that there can be no doubt, the RCP clarifies that it does not support a change in the law to permit assisted dying at the present time'.[4]

To remind you, two questions need separation: *'Should ITL be available?'* — we have dealt with that — and if so, *'Who should do it?'* With the widespread concerns over safeguards being ignored and eligibility criteria extended, weakening further the doctor—patient relationship in an already overstretched health service and the unsustainability of conscientious objection, one wise way forward, should society genuinely want the option of death on request, would be to consider an alternative.

An alternative?

Death is a social event: people die from lives, not just diseases. It is about biography, not biology; and doctors holding the overarching responsibility and authority in decisions over ITL is questionable. While suggesting greater legitimacy, the evidence exposes the weaknesses of doctors being the gatekeepers, judges, executors and monitors of their own decisions to end life.

Second, no legislature evaluates decisions to end life before it has taken place and it is the responsibility of the involved doctors to report either the issuing of lethal prescriptions or medically administered euthanasia. Clinicians' vulnerabilities to unconscious bias and discrimination are unexamined. In the current climate of pressure and strain on healthcare and doctors, this is a real and present danger. The reasons for people seeking ITL are far more complex than simply to control physical symptoms and relieve pain. Unravelling them is outside the competence and training of doctors.

Various academics are looking seriously now at alternative models, for example:

- A socio-legal rather than medical structure in which an independent and multidisciplinary expert panel examines an applicant's justification for ITL ahead of the event to issue a license to proceed or not.

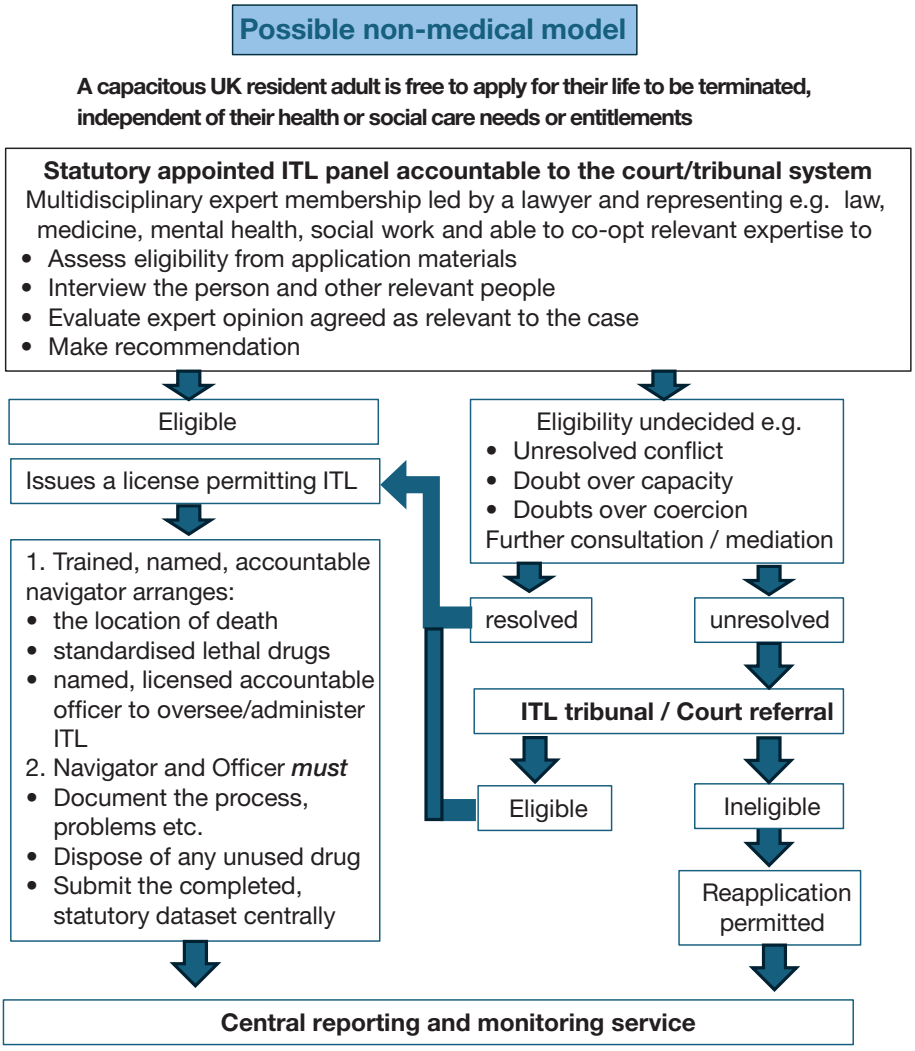

Figure 2

The principal arguments in support of doctors intentionally ending life[5]

1. **Even with universal access to specialist palliative care, some may still experience unbearable physical or emotional distress** — forcing dying people to suffer against their wishes is incompatible with the values of 21st-century medicine
2. **Physician-assisted dying is a legal option for over 150 million people around the world** — where it is lawful, eligibility criteria, safeguards and regulation exist to protect patients
3. **Guidance in the UK for withdrawing life-sustaining treatment, etc. already contains safeguards** — there is no reason why these safeguards could not apply in AS/AE legislation
4. **Current law is not working**
   a. UK citizens can travel to Switzerland to have AS, provided they have the funds
   b. Often lives end sooner because candidates need to be well enough to travel
   c. Under current UK law, technically anyone who provides assistance, specifically doctors, risks criminal investigation
5. **There is widespread public support for, and tacit acceptance of, physician-assisted death within society.** It would be fairer and safer to have a regulated system within the UK
6. **Some dying people want to determine when and how they die but need (medical) advice and support to achieve this**
   a. Doctors/society should not impose personal beliefs on competent, informed adults wishing to exercise voluntary choice
   b. Legislation would contain a conscientious objection clause to protect healthcare professionals not wishing to participate
7. **The existence of legislation brings reassurance and peace of mind for many,** even though only a small percentage will use it

Source: Adapted from British Medical Association (2020).[5]

Table 1

The principal arguments against PAS/PAE[5]

1. **Laws send social messages** — legal change, however well intended, subliminally implies that elderly, seriously ill and disabled individuals 'ought' to consider AS/AE as an option
2. **'Safeguards' are simply statements of the ideal**
   a. They do not reflect the real-world stresses of clinical practice, terminal illness and family dynamics
   b. It is impossible to ensure that decisions are truly voluntary, free of coercion or family pressure
3. **High-quality palliative care can alleviate effectively the distress of the dying process in most cases** — society needs universal expert palliative care, not PAS/PAE
4. **Licensing doctors to provide lethal drugs crosses a Rubicon in medicine**
   a. It differs fundamentally from withdrawing ineffective life-sustaining treatment
   b. A doctor's duty is to support patients to live as well, and as comfortably, as possible until they die, not to end their lives
5. **Currently, seriously ill patients can raise fears, secure that their doctor will not end their life**
   a. Empowering doctors to provide lethal drugs to end life undermines the doctor—patient relationship
   b. Some patients already feel 'a burden' and undervalued and would fear that clinicians would simply 'give up' on symptom control or relieving distress, because they see administering death as a quick and easy solution
6. **Once legal, the processes of lethal intervention normalize**
   a. Eligibility criteria have to widen on the moral grounds of justice and anti-discrimination
   b. Limiting AS/AE to adults, capacitate dying is arbitrary and unsustainable on logical grounds
7. **Nowadays doctors know little of their patients' lives, yet most requests for AS/AE are personal or social not clinical**
   a. AS/AE (ITL) is not a role for hard-pressed doctors
   b. If legal, it should be authorized by the courts and administered by trained operatives hermetically sealed from healthcare

Source: Adapted from British Medical Association (2020).[5]

Table 2

- licensed, named operatives are responsible for the ITL and its reporting to a central reporting and monitoring service
- the process is ultimately accountability to the court
- any medical involvement is then confined to giving relevant factual advice and reports to aid the panel's decision-making.

Figure 2 shows the type of process that a non-medical model might follow, and Tables 1 and 2 summarize the arguments for and against doctors' direct involvement in ITL. ◆

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Willis D, George R. Conscientious objection and physician-assisted suicide: a viable option in the UK? *BMJ Support Palliat Care* 2019; **9:** 464—7.

USEFUL WEBSITES

Dignity in dying: https://www.dignityindying.org.uk — the principal organization promoting assisted death.

Living and dying well: https://livinganddyingwell.org.uk