Is medical assistance in dying just medically-administered death?

As medical assistance in dying seemingly gains traction, this editorial discusses the arguments for and against it, looking at the balance of patient autonomy and alleviation of suffering vs the potentially far-reaching and unintended consequences. The authors hope that this provides a platform for further debate and education around assisted dying.

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Introduction

The debate around physician-assisted suicide is not a new one to the British public nor the medical profession. Debated in parliament since the 1990s, topical in literature in the 2000s, and with a small but growing number of countries legalising it alongside euthanasia (together known as MAID – medical assistance in dying or 'assisted dying'), it remains illegal in the UK. Resistance from MPs to pass a bill legalising assisted dying, most recently in 2021, has been considered responsible by some and overly restrictive by others. Given the spectrum of different positions held by Royal colleges, this editorial outlines key arguments in the debate around medical assistance in dying while emphasising that education and honest discussion are key to understanding and enabling mutual respect between opposing sides.

The case for medical assistance in dying

The starting point for supporting medical assistance in dying is that of autonomy. In an era of patient empowerment and shared decision making, it seems peculiar that patients should be denied autonomy – choice and control – when it matters most. An intertwined argument is the alleviation of pain and suffering at the end of life. The recognition of palliative care as a medical specialty in the late 1980s, with its focus on holistic care and high-quality symptom control at the end of life, was a notable step towards achieving this, but seems to have halted at what some consider the ultimate relief of pain and suffering – the facilitation of death.

Should there be a majority of the public in support of assisted dying in a democratic society, one would expect it to be sufficient weight to end the debate, especially given the proposed safeguards of a terminal diagnosis (prognosis of <6 months to live) in a patient that has capacity and is free from coercion, with two clinicians certifying these criteria are met. Legalisation would end the inequality of the rich accessing medical assistance in dying abroad while still allowing for conscientious objectors among the profession when it comes to metaphorically, or literally, 'pressing the button'. However, these objectors would likely still be required to make an 'effective referral' to a non-objecting physician: complicity in an ethical minefield (McDougall et al, 2022).

Legalising medical assistance in dying might have additional secondary benefits. The organ pool generated, as well as the significant cost savings (Shaw and Morton, 2020) to the NHS, cannot be ignored in the current economic climate. The cost of inpatient care in the last year of life is astronomical, greater than ten times the annual cost for patients over 50 years old and not in their last 5 years of life (Stoye, 2019). In Canada, expansion of the qualifying criteria for medical assistance in dying was initially projected to save the government $150 million in 2021 (Office of the Parliamentary Budget Officer, 2020). There can be no denying the financial savings to any government implementing assisted dying in its healthcare provision. Difficult decisions are already being taken to rationalise NHS resources to a more sustainable model. Could medical assistance in dying be another tool to realise this strategy?

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The case against medical assistance in dying

If medical assistance in dying was introduced, what would be the cost to the moral integrity of the profession and the social fabric of society? The undermining of suicide prevention efforts, palliative care provision and, more critically, the value of life itself is a hefty price to pay. The marginalisation of those in society who meet the eligibility criteria is a real concern: the sick, elderly, vulnerable and disabled. Readily available, fully funded medical assistance in dying could become the path of least resistance when faced with bureaucratic, inaccessible, and costly health and social care provision, demonstrating a form of structural coercion. In Canada, this has resulted in vulnerable individuals seeking medical assistance in dying ahead of reasonable alternatives to alleviate their suffering through a biopsychosocial approach (Coelho et al, 2022). Initially suicidal after catastrophic health events, patients often report a good quality of life and no desire to die, through medical assistance in dying or otherwise, after receiving effective treatment and care, and having undergone rehabilitation (Tchajkova et al, 2021).

For those with longer-term conditions, other challenges remain. Acknowledging the difficulties in identifying truly voluntary requests, with the risk of family or physician coercion and potentially conflicts of interest, is not straightforward. The shift in medical culture from healing, comforting and caring to that of doctors directly causing death does not sit well with many. Patients knowing that their physicians have the power to take life may have repercussions for decision making and relationships built on trust at every level of healthcare. Furthermore, the impact on physicians themselves could be long-lasting and detrimental, both personally and professionally (Kelly et al, 2020).

The terminology used is crucial to provide an accurate understanding of the stakes involved. Although emotionally neutral terms such as assisted dying and medical assistance in dying gain popularity in the support camp, they fail to accurately articulate what the process entails: physicians assisting suicide and delivering euthanasia – in other words, medically-administered death. This is reflected by the confusion regarding the term assisted dying among the public (All-Party Parliamentary Group for Dying Well, 2021). The proposed safeguards are not nearly as 'safe' as they seem. Assisted dying or medical assistance in dying become misnomers when patients who are not actively dying become eligible, as demonstrated in many countries where legalislation has been swiftly followed by ever-expanding inclusion criteria. Examples include, but are not limited to:

- No requirement for a terminal diagnosis in many of the jurisdictions where medical assistance in dying has been legalised bar some American states, Australia and New Zealand – medical assistance in dying has only been legal in these latter two for the past 3 years
- Expansion to include a sole diagnosis of a mental health condition in Luxembourg and other European countries
- Use of advanced directives for medical assistance in dying in Austria, Belgium and the Netherlands
- The proposed 'Completed Life' Bill in the Netherlands looking to legalise medical assistance in dying for any over 75-year-olds seeking to end their lives even in the absence of any medical conditions.

Doctors cannot afford to sit on the fence on an issue with such significant ramifications for patients, the profession and the public as a whole. Being 'neutral' on the matter of whether or not doctors administer death to their patients is far from neutral – as demonstrated by the Royal College of Physicians (2020) needing to clarify its own stance. It is concerning that other Royal colleges are shifting to 'neutral' on the basis of polls with low turnouts (Miller, 2023). Within a year of the Canadian Medical Association taking a neutral stance on the issue, medical assistance in dying was legalised in Canada.

Conclusions

Medically-administered death is a controversial subject, that is likely to be debated for the foreseeable future. The authors stand against the legalisation of any form of assisted suicide or euthanasia – it is not health care; death is not a medical treatment. The answer

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Key points

- Medical assistance in dying remains controversial among the medical profession, politicians and the public at large.
- Arguments for assisted dying centre around autonomy – choice and control – at the end of life, compassion and cost savings.
- Arguments against assisted dying centre around suicide prevention, concern regarding coercion, protection of the vulnerable, maintaining trust in the doctor–patient relationship, unintended consequences of moral injury to clinicians, and incremental extension of eligibility criteria.
- Efforts to improve end-of-life care should focus on palliative care – the administration of death is not healthcare.

to suffering at the end of life is high quality palliative care. The authors acknowledge that this view is not universal, and highlight the need for professional and public education to progress the debate on a matter that will inevitably affect all clinicians. This article highlights the key arguments, to stimulate readers to engage with the literature and come to their own conclusions.

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Conflicts of interest

J Shenouda is a member of the Royal College of Anaesthetists' Ethics Committee; J Haslam is an unpaid member of the steering group for Our Duty of Care, a group of UK healthcare professionals who oppose assisted suicide and euthanasia.

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