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Guest Editorial

A Rend in the Fabric of Medicine

Michael Trimble

In February the Royal College of Physicians of London (RCP) fulfilled its commitment to resurvey its members regarding the question of assisted dying. In some ways it was a strange time to be raising the issue as, since the last survey in 2014, there have been a number of unsuccessful attempts to challenge the current legal position either through parliament or the courts and the issue seems settled for the time being. However, assisted dying is an emotive issue about which individuals have strongly held views. That some remain keen for change was demonstrated by *Health Care Professionals for Assisted Dying's* campaign which was timed to coincide with the RCP's survey. The result of the survey was split: 43.4% of respondents thought the RCP should be opposed to a change in the law on assisted dying, 31.6% want the RCP to support a change and 25% thought the RCP should be neutral. Following the poll, the Council of the RCP decided almost unanimously to move to a position of neutrality. Whilst the College may be keen to stress that neutral means neutral, proponents of assisted dying are already presenting the results in terms of the College having withdrawn opposition to the legalisation of assisted dying.

There are many, including within the profession, who view assisted dying as a good and compassionate thing. Professor Ray Tallis expresses his incredulity "That anyone could oppose such a humane ambition as decriminalization of assisted dying." My own view is that it would be a grave mistake for the profession to start down this road. What may be framed as a matter for personal choice, in fact, has massive implications for both the profession and society.

If a patient's right to die with a doctor's assistance was to be recognized in the United Kingdom, what might the implications be? It is often forgotten that for every right there is a corresponding duty: If someone has a right to die with medical assistance at a time of their choosing then someone else must have a duty to fulfil that right. Perhaps this accounts for the fact that on the whole the profession has been much less enthusiastic about assisted dying than the public. If assisted dying becomes legal, then it becomes an expected part of the health service. Who would be responsible? Analysis of the 2014 RCP survey shows that Palliative Care physicians have the least enthusiasm for assisted-dying, with 85% of respondents being opposed. Perhaps it will fall, as with so many other tasks, to the general physicians. What about conscientious objection? It can be seen already in the aftermath of the Republic of Ireland's referendum on provision of abortion services that there is debate as to the scope of individual conscience in regard to a state-funded service. What about the trainees? If physicians are expected to provide this service, then they will need appropriate training. Will this become part of the Internal Medicine curriculum? How will competency be assessed? How many deaths will it take? It has been said that to go against the public wish for assisted-dying is an example of medical paternalism. However, at the same time we are urged to tell our patients to stop smoking, lose weight and drink less. How is one paternalism and the other allowing patient choice?

There is also scope for confusion in the terminology used in the RCP survey. Rather than *physician assisted suicide,* the RCP has favoured the term *assisted dying* which they define as

> The supply by a doctor of a lethal dose of drugs to a patient who is terminally ill, who meets certain criteria and who requests those drugs in order that they may be used by the person to end their own life.

In fact, there is no standard or legal definition of assisted dying and this is not the only possible use of the term. In the book *Debating Euthanasia*, Law Professor Emily Jackson states that she will "use the term assisted dying to refer to both euthanasia and assisted suicide." And indeed the distinction is not clear cut. Even using the RCP definition, if the patient cannot physically take the medication it is tacitly implied that it would need to be administered. Physician assisted-dying blurs into euthanasia, but that is not the question which was asked in the survey.

I understand that those who advocate assisted dying are motivated by compassion. It is hard to watch someone suffer, standing by wishing you could do something. But we need to be aware of the broader consequences. Once the line is crossed, it becomes harder to draw the boundaries for acceptable ethical practice. There are wider issues around the question of when a life could legitimately be ended. Physicians act for the good of their patients and if death becomes seen as a 'good' then how can it be withheld from anyone who seeks it? Whilst Dignity in Dying maintain their campaign is for limited provision of assisted dying to adults with a terminal illness and a life expectancy of 6 months, others, for example Humanists UK, would be less restrictive. For Ludwig Minelli, human rights lawyer and founder of Dignitas, the Swiss euthanasia clinic, "It's a right, a human right, without condition except capacity of discernment."

Concern regarding the blurring of the boundaries of acceptable practice is more than idle speculation. A recent

journal article describes worrying trends in the experience of doctors in the Netherlands. This included the increasing number of requests from patients for assisted dying for non-medical reasons and difficulties with the physician's role in the midst of pressure from patients or families to provide the service. Of concern was the move of the clinician from caregiver to 'mere provider' of the service; the moral discomfort of physicians assisting death in patients whose pain is 'mostly existential'; and compromise in the criteria used to assess patients for the suitability for assisted dying. We would do well to heed this experience and watch carefully regarding future trends. The situation in Belgium is more extreme, as euthanasia is extended to children, the mentally ill, and, in some cases, those who have not requested it.

In medicine, when discussing ethical issues, we may refer to the principle of 'sanctity of life'. Legal scholar John Keown prefers the term *inviolable*. Whether one believes that human life has been set apart as special by God or marked out as such by society, we recognise that it is inviolable: Taking a human life is wrong. In my opposition to assisted dying I will doubtless be accused of employing a 'slippery slope' style argument, however I would prefer the analogy of making a rend or tear in the fabric of medical practice. With a slippery slope you at least may have an idea where you will end up but a tear can progress along unanticipated lines – and is always damaging.

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