The ethics of assisted suicide

SOCIETY is now recognising and accepting that human life has a natural end and that, as such, it should not be preserved simply because a treatment exists. Such thinking has led to intense national and international debate, raising the issue of autonomy and the right of individuals to choose the manner and time of their death. Human rights legislation in the form of the Human Rights Act 1998 has enhanced the debate. Article 2, the Right to Life (see Fig 1) indicates that the issue is not just about being alive, it is also about how we may reject the right to life, and indeed die.

Early in 2002, two cases relating to end-of-life decisions were debated in the UK courts. The first case was that of Miss B, a 43-year-old lady who became paralysed in 2001 following a bleed into her spinal column. She was ventilator-dependent, with no hope of recovery or cure. She went to the court to demand that doctors stop treating her against her will. Following a High Court judgement, she was not granted the request to die, and she died peacefully in her sleep following the disconnection of the ventilator that kept her alive (Kmietowicz, 2002).

Another, but very different, case was that of Dianne Pretty who, suffering from advanced motor neurone disease, petitioned the courts to be allowed to die with dignity. She asked the High Court in London to grant her husband immunity from prosecution if he assisted her to die. Following the court’s refusal of her plea she challenged the decision in the European Court of Human Rights, Strasbourg. Its ruling in April 2002 outlawed the idea, stating that conceding to the request would undermine the protection of future life (Dyer, 2002).

The euthanasia debate was fuelled once again in January this year when 74-year-old Reginald Crew, also with motor neurone disease, felt compelled to take drastic action about his wish to die and travelled to Switzerland in his quest. Swiss law does not state that assisted suicide is legal but the more relaxed laws consider the practice a ‘humane act’.

Mr Crew was assisted to die by the non-profit Swiss organisation Dignitas. Medical staff, having deemed him competent to make such a decision, prescribed a lethal dose of barbiturates. He ended his life in a flat in Zurich with his wife and daughter at his side. Mrs Crew now faces the uncertainty of whether or not she will face prosecution regarding the death. While she did not assist in her husband’s death, the Crown Prosecution Service may be asked by the British police to decide whether the act of taking him to Switzerland constitutes assisting a suicide.

These three cases are not the first, nor will they be the last, to be debated with reference to how we choose to die. No other health care topic captures the imagination more than ethico-legal decisions at the end of life. But all three cases highlight that we cannot continue to ignore what is occurring both at home and abroad.

There are few certainties in life, but one that we will all have to come to terms with, at some time or another, is that of our own death. For many, the thought of death may not be disturbing, but the way in which we die and the events leading up to our death might be. As Winslade (1997) states: ‘We do not choose to be born, nor do we have a choice about whether we will die’.

But some people, like those mentioned above, do wish to be in control of how they die – to them, a ‘good death’ is as important as a ‘good life’. Allowing people to have a ‘good death’ means recognising not only how they choose to live their lives but also the manner in which they choose to die. It is upholding the principle of autonomous choice with reference to where, when, and the manner in which they die.

Why should it be wrong for someone to ask for assistance with the process of dying and be aided to a peaceful and dignified death? It is essential that as a society we acknowledge that health care should be seen not only as an intervention necessary to extend life but also as an important factor in how someone dies.

**FIG 1. RIGHTS AND FREEDOMS ISSUES FROM THE HUMAN RIGHTS ACT 1998**

**RIGHTS AND FREEDOMS**

**ARTICLE 2**

**RIGHT TO LIFE**

1. Everyone’s right to life shall be protected by law.

No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary –

- in defence of any person from unlawful violence;
- in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- in action lawfully taken for the purpose of quelling a riot or insurrection.

**ARTICLE 3**

**PROHIBITION OF TORTURE**

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.


There is continuing national and international debate with reference to autonomy and the right to choose the manner and time of our death. It is now recognised that human life has a natural end and that, as such, it should not be preserved simply because a treatment exists. Three cases are briefly discussed which raise the issue of whether or not we should be permitted by law to choose how and when to die. The ethical principle of autonomy and the influence of religion are considered. Central to the debate about end-of-life choices is the recognition that not all persons can be healed and not all suffering can be relieved.

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The ethical principle of autonomy is advanced by many as being central to the decision-making process, particularly with relation to health care. The argument is that by respecting a person we are respecting his/her autonomy and capacity to make choices and personal decisions about life and death. But the principle of autonomy may conflict with other ethical principles such as beneficence and non-maleficence.

Professionals have a duty to do good and to do no harm. The principle of autonomy, however, ensures that people have the freedom to make judgements and decisions and to act on them. A health care professional, therefore, is obligated to respect autonomous choice, respecting not only how people choose to live their lives but also the manner in which they choose to die.

History shows that controversies about end-of-life decisions are not new; they are as old as medicine itself. In ancient Greece and Rome there was no objection to the practice of assisted suicide; indeed many physicians regarded it as part of their role. If patients could convince the senate that there was good reason for ending their life, the physician would provide a lethal drug thus ending their suffering. However, with the rise of organised religion the practice of assisted suicide was rejected, sanctity of human life being cited as the reason: what God has given, only God can take away. Now, in today’s increasingly secular society there is no universal view on this issue. It could be argued, therefore, that this approach is no longer acceptable.

The origins of modern discussion and political conflict over right-to-die issues began in this country in the late 19th century when a number of intellectuals proposed assisted suicide for the hopelessly ill (Glick, 1992). The debate came to a head in 1931 when a well-respected public health official in England presented a scholarly review of the history of euthanasia and suicide, ending with a forceful recommendation that assisted suicide be legalised in Britain. This did not happen, but the debate continues some 70 years on, with several unsuccessful attempts to change the law regarding assisted suicide.

Following the Dianne Pretty case, the government reiterated its stance on assisted suicide; however, public opinion polls after the case showed that more than 80 per cent of the public support a change in the law. Perhaps now is the time for the government to regulate medically assisted death. The British Medical Association, the Royal College of Nursing and Parliament, however, overwhelmingly oppose this. They have, to date, chosen to steer away from officially condoning it or to taking steps to control it, believing that the public see health care professionals as people who save life, not people who hasten the dying process. However, the General Medical Council is expected to produce new guidelines soon on end-of-life decisions in relation to withholding or withdrawing life-prolonging medical treatment (BMA, 2001).

As discussed above, UK law outlaws the provision of the means to help another person to die. The law is clear inasmuch as it outlaws assistance from a third party to help someone end his/her life — the third party will most likely be charged with a criminal offence. In England and Wales, the nature of the offence is set out in the 1961 Suicide Act, making it no longer a criminal offence to attempt to commit or successfully commit suicide. However s.2 (1) of the Act states that assisting suicide remains an offence, carrying a maximum penalty of 14 years’ imprisonment.

In Scotland the position is somewhat different and perhaps a little less clear than it is in England and Wales. Gavaghan (1997) notes that ‘attempting suicide was a crime at common law, at least until the 18th century. By the 20th century, this crime had become entirely obsolete; neither committing nor attempting to commit suicide are in themselves punishable in Scots law’. However, the anomaly arises where the person who aids or abets a suicide can be liable for prosecution as an accomplice to a non-existent crime. In proven cases of assisted suicide, charges will be brought under the general laws of murder or culpable homicide (manslaughter in England). UK law is therefore clear: assisting a suicide does constitute a criminal offence both north and south of the border (and in most countries).

Conclusion
At the heart of the debate over end-of-life choices is the recognition that not all persons can be healed and not all suffering can be relieved. Health care professionals must recognise that sensitive and compassionate management of death is only one aspect of a longer dialogue about end-of-life choices. This dialogue should occur between those administering and those receiving health care. It is important to acknowledge that the provision of health care extends to all phases of a patient’s life, and that includes his/her death.

There can be no doubt that the desire for assisted suicide has increased with the sophistication of medical technology. As McLean (1999) suggests, ‘Medical advance and technology can result in prolonging life or slowing the dying process’. She cites Angell (1990) who states that ‘Some people now fear living more than dying, because they dread becoming prisoners of technology’. It is not only the issue of technology that has fuelled this debate; intractable pain, dependence on others, loss of dignity are just some of the arguments advanced for assistance with dying.

Assisted suicide is an issue where the interests of the individual cannot be separated from those of society as a whole. There may never be a simple solution to the debate. There are fears that decriminalising assisted suicide could lead to abuse and the possibility of killing someone who did not want to die. However, there is a forceful case for legislation. Legal guidelines would turn a covert process into a transparent one; they would ensure that there is evidence of free and informed choice and, not least, it would allow those suffering from incurable conditions to die how they choose.

KEYWORDS
Assisted suicide ■ Ethics

REFERENCES


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