

What are the legal and ethical issues surrounding the ending of life?

In this article, Joy Wingfield, professor of pharmacy law and ethics at the school of pharmacy, University of Nottingham, and Richard O'Neill, associate head of the school of pharmacy, University of Hertfordshire, outline some of distinctions made by the law on ways of dying and the ethical debates and issues that surround the taking of decisions to end a life



Pharmacists have been urged to consider their personal stance on “assisted dying” particularly in the light of the Assisted Dying for the Terminally Ill Bill now under consideration in Parliament.¹ Before embarking on such reflection pharmacists may welcome some information on the legal and ethical perspectives that are at issue.

Homicide

English law uses the term “homicide” to characterise the unlawful killing of a human being. Murder is an ancient offence recognised in common law and successful prosecution requires proof of an intention to kill or cause grievous bodily harm — often referred to as a “guilty mind”. It must be further proved that the relevant act by the accused did cause the death in question. However, some deaths that result from a definite intention to kill are nevertheless regarded as the lesser crime — and therefore attracting a lesser penalty at law — of manslaughter. Manslaughter is then described as voluntary or involuntary depending on the circumstances. Voluntary manslaughter may be the verdict when a defence such as diminished responsibility or provocation is claimed even

though there was an intention to kill. Pharmacists are unlikely to have to worry too much about either of these possibilities.

Involuntary manslaughter, however, is a much more likely charge in the event of a mishap in health care. Two forms of involuntary manslaughter are recognised in law: constructive manslaughter, where there was no intention to kill but the defendant committed an unlawful act that led to death, and manslaughter by gross negligence. This last offence is typically at issue where a breach of a health professional’s duty of care leads to death and the failure is judged to be criminally negligent. This offence is often used where a health professional is considered so negligent as to be unsafe and the civil process of suing for compensation is deemed inappropriate. So a pharmacist who is actively involved in causing the death of a patient may be at risk of prosecution for manslaughter.

Suicide

Alongside these considerations, pharmacists should be acquainted with the law on suicide. The Suicide Act 1961 abolished the offence of actually committing (and, therefore, also attempting) suicide but retained an offence

for any person who “aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide”. Moreover, the Offences against the Person Act 1861 makes it an offence to “unlawfully and maliciously administer to or cause to be administered to or taken by any other person any poison or other destructive or noxious thing, so as thereby to endanger the life of such a person”. Charges of criminal assault and battery may also arise under this Act if a patient is given treatment without his or her consent, or in spite of his or her refusal. Thus any pharmacist who is actively involved in helping someone to commit suicide, even though it may only be through the provision of prescribed medicine, might be at risk of prosecution under both of these Acts.

Most pharmacists will, nevertheless, recall cases where doctors have been acquitted of assisting suicide or murder even though they took deliberate action aimed at ending a patient’s life, usually by administering a lethal dose of a drug.^{2,3} In both of these cases (and others), the principal defence was based upon their intentions: the doctors claimed that they intended to ease intractable pain with medication that also hastened death. These cases are

often referred to as “active euthanasia” and the defence as using the “principle of double effect” (see below). More complications arise from trying to establish in law the exact nature of death. It has been possible for several decades to maintain an individual in a “persistent vegetative state” (PVS) where consciousness is absent, the brain is virtually dead but the brain stem continues to be alive and control reflexes. “Life” then can continue indefinitely on a life support machine. So death is not always an active process; it may simply involve deliberately discontinuing treatment, “turning off the machine” or allowing “nature to take its course”. Often the courts are also asked to rule in these cases, particularly where the patient is a premature neonate with severe and intractable disabilities,⁵ someone in a PVS⁵ or a competent but terminally ill patient who expresses a wish to die.⁶ In such cases, the courts are almost always asked to give judicial authority to cease to take active steps (often referred to as passive euthanasia), which can also include artificial nutrition and hydration, to keep such patients alive.

Capacity and consent

Even where the patient is competent to make decisions about his or her own future, the courts do not yet sanction assisted suicide. In the Dianne Pretty case,⁷ paralysis meant she was unable physically to take her own life. Nevertheless, her request for her husband to be granted immunity from prosecution under the Suicide Act was refused; she died in precisely the way that she wished to avoid. Where the progression of a terminal disease is likely to lead to loss of capacity, the Mental Capacity Act⁸ offers legal status to the making of an advance directive, or “living will”. This can direct doctors in particular as to the wishes of the dying individual regarding resuscitation or extreme measures to preserve life. However, an advance directive would not have assisted Dianne Pretty, who wished to die before she lost capacity. There have been a series of Bills put before Parliament seeking to resolve these difficulties. An earlier Bill from Lord Joffe proposed to legalise voluntary euthanasia where the doctor actually assisted the patient to die. The current Bill has been modified to legalise only the situation where a doctor would be able to prescribe a lethal dose of a medicine but the patient must still self-administer. So, this might still not address predicaments like that of Diane Pretty.

Ethical concerns

For some, these legal semantics are irrelevant. Many people hold deep religious or cultural convictions on the sanctity of life: that life is sacred and no circumstances would ever justify the hastening of death, whether by the hand of the dying person or anyone else. Others hold, equally strongly, that life is a fact and such objections do not prevent interferences with that life through the treatment of disease or surgery, even plastic surgery to change one’s “God-given” appearance, during life. Why, then, is an exception made when a

Arguments and ethical analyses used in debates on voluntary euthanasia

Arguments in favour of voluntary euthanasia

- Autonomy and respect for rights — one should have “a right to die”; individual liberty is paramount
- Mercy/compassion — facilitating death demonstrates “doing good” or at least “not doing harm”; one should aim for death with dignity; suffering may outweigh the benefits of living
- Economics — preservation of life (particularly in persistent vegetative state) “wastes” health care resources and costs a lot of money

Arguments against voluntary euthanasia

- Manipulation/exploitation — vulnerability of the seriously ill, the elderly, the mentally damaged
- Slippery slope — any changes will lead to involuntary euthanasia and eugenics
- Unnecessary — hospice and palliative care will suffice
- Contrary to the essence of medicine — the medical role is to preserve life; undermines professional integrity and trust between patient and doctor
- Morally wrong — offends against the sanctity of life, intrinsic value of life regardless of quality, offends ethical codes

Ethical analyses — rights and duties theories

- Would support autonomy, rights and respect
- Crucial role of consent
- Importance of patient’s right to self determination
- Advance directives protect autonomy
- Involuntary euthanasia violates right to life

Ethical analyses — consequentialist or utilitarian theories

- Concerned with maximising welfare
- Emphasises consequences — greatest overall good or least overall bad
- Means are not important
- Can weigh consequences for all involved
- Medical futility is an accepted concept and judgements on the value or quality of life are already made regularly

decision is made to end one’s own life? Still others may reflect on the human rights concepts in which most accept that every human being has a right to life or, more accurately, not to be unlawfully killed. There is, however, no corresponding right to die. Moreover, some take the right to dignity and a private life and the right not to be subject to cruel and unusual treatment as supporting a right to die at a time and in a manner of your own choosing.

Ethicists attempt to analyse the circumstances of dying according to normative moral theories of intentions, consequences

and virtues demonstrated. The principle of “double effect” provides that an act with both a good and bad effect may be ethically permissible if only the good effect is intended and the good result outweighs the bad result. We can then argue as to whether death is preferable to intractable pain, what constitutes an intolerable life, which disabilities are insupportable and which are not. Such questions are, of course, individual and intensely personal. Arguments about the difference, if any, between acts and omissions also exercise moral philosophers. Is “letting die” morally different from killing? Most of us instinctively feel it is but are more hard-pressed to explain why or to set the borders between unacceptable killing and allowing a merciful death. Debates about a “slippery slope” also abound: if we allow this step, then another will surely follow until we are allowing the unthinkable — legalised murder of our weakest citizens.

We cannot hope to do justice to the complexity of this topic in a short article but we have set out a simplistic summary of the issues (see Panel). We do not venture an opinion as to the role of pharmacists in the deaths of the terminally ill. However, practising pharmacists must already be involved, knowingly or not.

Consider the following scenarios:

- Patients in nursing homes who refuse medication despite knowing that it may keep them alive
- Seriously high doses of narcotics in excess of those needed to control pain
- Provision of artificial nutrition and hydration at the insistence of relatives rather than the patient
- Routine use of “do not resuscitate” criteria when elderly persons are repeatedly admitted to hospital
- Inadequate palliative care services for those with heart failure and strokes

As pharmacists increasingly take responsibility for medication and clinical care of patients, it would be helpful to expose and explore these situations with each other and with other health professional colleagues. We hope that this article assists with some of the concepts and issues that are involved; others must interpret them in practice.

References

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