Agenda for 2006

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 the 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 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 ef-
fact" (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 "per-
sistent vegetative state" (PVS) where con-
sciousness is absent, the brain is virtually dead
but the brain stem continues to be alive and
control reflexes. "Life" then can continue in-
definitely 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, someone in a PVS
or a competent but terminally ill patient who
expresses a wish to die. 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,1 paralysis meant she
was unable physically to take her own life. N
evertheless, her request for her husband to
be granted immunity from prosecution under
the Suicide Act was refused; she died in pre-
cisely 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 Act2 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 re-
suscitation 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 volun-
tary euthanasia where the doctor actually as-
isted 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 Dianne 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 jus-
tify 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 interfer-
ences 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
decision is made to end one's own life? Still
others may reflect on the human rights con-
cepts in which most accept that every human
being has a right to life or, more accurately,
not to be unlawfully killed. Here 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 circum-
stances 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 in-
tended and the good result outweighs the
good result. We can then argue as to whether
depression is preferable to intractable pain, what
constitutes an intolerable life, which disabili-
ies are uninsurable and which are not. Such
questions are, of course, individual and
intensely personal. Arguments about the dif-
fERENCE, 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
mercyful death. Debates about a "slippery
slope" also abound: if we allow this step, then
another will surely follow until we are allow-
ing the unthinkable — legalised murder of
our weakest citizens.

We cannot hope to do justice to the com-
plexity 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 hydra-
  tion at the insistence of relatives rather
  than the patient.
- Routine use of "do not resuscitate" crite-
  ria when elderly persons are repeatedly
  admitted to hospital.
- Inadequate palliative care services for
  those with heart failure and strokes.

As pharmacists increasingly take responsi-
ability 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.

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 eugeniccs
- 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.

References
5. Wyatt & Anor v Portsmouth Hospital and NHS and Anor [2005] EWCA Civ 1181.
8. Wyatt & Anor v Portsmouth Hospital and NHS and Anor [2005] EWCA Civ 1181.
10. Wyatt & Anor v Portsmouth Hospital and NHS and Anor [2005] EWCA Civ 1181.