The UK debate around Assisted dying, Dignity in Dying

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Abstract

Assisted dying is a conflict-ridden and debatable subject, and a broad range of interests should inform any proposed policy changes to promote autonomy and end and mitigate intense suffering by providing a 'safe and comfortable' death to patients who believe they would otherwise have to endure unbearable suffering at the end of life. Some could argue that palliative care can't do it all, especially with its inconstant availability.

The British Medical Association (BMA) and some Royal Colleges have recently changed their attitude on physician-assisted suicide from 'combated' to forms of 'impartial'.

For the last few years, the toll took the UK system to vote for assisted dying and wanted to legalize it. Some countries have legalized it for some time, and some British nationals fly overseas to have it conducted. The drugs that are being prescribed and administered, are both for physician-assisted suicide (patient ingestion) and for euthanasia (physician-administered).

Keywords: assisted dying; assisted suicide; physician-assisted suicide; euthanasia; medical ethics; non-maleficence; law.

Introduction

'Assisted dying' is a legal practice in some countries. Physician-assisted suicide, which licenses clinicians to prescribe lethal drugs for patients to self-ingest, is currently legal in all such legislatures. In addition, euthanasia, in which clinicians inject lethal drugs intravenously to end a patient's life, is practiced in Belgium, Luxembourg, Canada, New Zealand, Spain, the Netherlands, some Australian states, and Colombia (4).

'Total pain' depicts the complex assemblage of psychological, social, and spiritual distress that comprises some individuals' suffering. Also, it recognizes the loss of independence as an intolerable indignity.

Assisted dying is defined by The Parliamentary Office of Science and Technology in the United Kingdom as:
'The involvement of healthcare professionals in the provision of lethal drugs intended to end a patient's life at their voluntary request, subject to eligibility criteria and safeguards. It includes healthcare professionals prescribing lethal drugs for the patient to self-administer ('physician-assisted suicide') and healthcare professionals administering lethal drugs ('euthanasia') (3).

In all three models, a doctor prescribes the lethal prescription after confirming the person has mental capacity, is aware of alternatives such as palliative-hospice care (PHC), the request is enduring, was not made under duress, and that the medical eligibility criteria are met(3).

The three most frequently reported end-of-life concerns behind the request for PAS have been a decreasing ability to participate in enjoyable activities (90%), loss of autonomy (90%), and loss of dignity (72%) (3).
Autonomy is where 'no decision about me, without me' is the norm.

Usually, those who are seeking assisted dying will be terminally ill, suffering incurable, inoperable, unbearable pain, and seeking a dignified end. Also, they wish to stop being a burden to their families, loved ones, and medical care professionals (10).

However, in certain situations, the doctor made an erroneous diagnosis of a terminal condition, and the patients have made an unexpected or even "miraculous" recovery. Therefore, the fault of assisting death is not revocable; but the error of keeping alive is revocable (8-9). Also, the peril of agonising, deadly suffering has become exaggerated and is infrequent due to advancements in medicine, pain alleviation, medications, improved palliative care, and hospice. Thus, palliative care should constantly be tried first before any other deadly measures (8).

Some countries such as Switzerland were the first to start it in 1942. However, in the US, ten states have conducted it as a way of physician-assisted dying with Oregon being the first state to commence in 1997. In 2002, in the Netherlands, a doctor was immune from punishment for the magnitude of suffering of some patients from incurable unbearable sufferings including minors under 12 who needed parental approval. In Belgium, it was legalized for terminally ill patients in 2002 and psychiatric conditions. In Canada, it was introduced in 2016 for those whose death is anticipated. In Australia, voluntarily assisted dying for terminally ill or those with intolerable suffering was introduced in 2019 in Victoria. In Spain, a law started in 2021 to allow euthanasia to be legal in debilitating conditions. Austria, Luxembourg, Portugal, and Colombia also joined the cause.

It has been transpiring that annually, over 120,000 patients have no access to specialist palliative care, yet only 10 travels to Switzerland annually to access assisted suicide, which requires traveling and a payment of nearly £15,000 (2).

The term assisted dying can be confusing and misleading for some, as 43% only understand the implied term. A recent poll showed that three-quarters of Britons are in favour of doctor-assisted suicide for terminally ill conditions.

Suicide is higher among anaesthetists as they are experts in handling drugs with lethal potential. Additionally, there is no evidence to legalize physician-assisted suicide where the suicide rate increases, undermining prevention efforts, plus the 'assisted dying' applicants are at risk of distressing deaths (2).

Also, if doctors are expected to administer death, actively ending life would incur profound adverse effects like shock, sense of powerlessness and isolation. Other moral injuries consequently would be conflict and disagreement with families, fear of coercion accusation, feeling guilt, and thus leaving their professions as doctors are meant to save a life, not to end it.

Given the widespread disquiet felt by doctors, a law with minimal medical involvement would be the most reasonable (3).

Medications used for physician-assisted suicide, enteral route

The following are employed

Sedatives: Chloral hydrate, 20 gm Amitriptyline not reported Barbiturates Pentobarbitone 9-15 gm Phenobarbitone 20 gm Secobarbital 9-15 gm Brallobarbital not reported Sodium thiopental not reported **Cardiotoxic:** Digoxin 50 mg Propranolol 2gm **Entiemetics**	**Benzodiazepines:** Diazepam 1gm Lorazepam 0.25-2 gm IV Midazolam 10 mg IV **Analgesics:** Morphine 15 mg-3gm Detroproproxyphene not reported Metoclopramide 10-20 mg Ondansetron 8 mg Haloperidol 5 mg **Neuromuscular block:** Backup as required IV. Not reported

Medications used for physician-assisted suicide, central route

The following are employed:

Sedatives/ hypnotics: Propofol, 1-2 gm Vesparax not reported Chloral hydrate 35-40 mg Thiopentone 1-2 gm, 20 mg/kg Pentobarbitone 1-15 gm Phenobarbitone 3gm Secobarbital 9 gm **Benzodiazepines:** Diazepam 10-120 mg Lorazepam 1.5-5 mg Midazolam 2-120 mg Morphine 16-480 mg Fentanyl 25-1500 microgram	**Cardiotoxic:** Potassium chloride not reported Bupivacaine 400 mg **Neuromuscular block:** Rocuronium 50-300 mg Pancuronium 18-20 mg Cisatrancurium 30-40 mg Vecuronium 10-60 mg

The most common lethal drugs used by clinicians to assist suicide were high doses of barbiturates, frequently either pentobarbital or secobarbital. Very high-dose barbiturates have long been a popular method for assisted suicide.

Drug combinations have been used called ‘DDMA’ (diazepam, digoxin, morphine sulfate, and amitriptyline) and ‘DDMP’ (diazepam, digoxin, morphine sulfate, and propranolol).

In countries where euthanasia is practiced, drug combinations also vary widely and include benzodiazepines, sedatives, neuromuscular blocking agents, opioids, and cardiotoxic agents (1,4).

In the process of euthanasia, practitioners usually administer a general anaesthetic first, often a barbiturate or another sedative like propofol, to prompt coma. Some similarly administer an anxiolytic (benzodiazepine) before the coma-inducing sedative and, where used, to alleviate propofol-induced pain.

After the anaesthetic, a neuromuscular blocking agent tracks in to paralyze all striated muscles, and to eliminate any movements, equally to impede respiratory effort and to abolish muscular spasms (4).

The Hippocratic oath of medicine implies and emphasizes that doctors should commit to not cause harm, to preserve life, and thus, killing in itself is something doctors don't want to do and have the blame and the guilt. Ending life is a harm in itself and has no place in healthcare per se. It's fundamental for patients' safety and the foundation to trust doctors. Thus, the concept is a fallacy, and treatment is lawful if it will help, work, and benefit. Therefore, nature is allowed to work its way if pathology is incurable. However, in palliative care, a deep sedative can be continued to mitigate the pain felt on the patient's request to stay unconscious in their final days, which can be defended, not to speed up death. However, physician-assisted suicide is a kind of independent act and is different (6). Thus, medical ethics forbid and prohibit physicians from committing killing as the arguments have consequences for the profession, patients' well-being, and patient-doctor relationships and undermine the public trust as a whole, to safeguard all and meet the four pillars of medical ethics (6).

Additionally, suppose this conduct is legalised and allowed. In that case, it will raise risks of abuse by the unscrupulous to persuade or coerce individuals to opt for assisted dying, jeopardise the vulnerable, complicate patient care, and increase clinician workload, potentially causing stress on patient care (8).

Beneficence and non-maleficence

Doctors seek to act in the best interests of their patients and not cause harm whatsoever. In case of doubt, doctors should weigh the benefits with risks, as they don't want to be known as "Doctor Death".

The two parties argue between proponents who see relieving suffering by ending a life that allows patients to define their needs in terms of benefits and harm to avoid loss of control and dependence, while opponents see it from a compassion prospect through a combination of pharmacological, physical, social, psychological, and spiritual interventions, to change patients' perceptions and understand what is happening to them to help mitigate pain and distress. It's not an easy thing, though.

However, it seems it might be legalized in the future as activists are campaigning for a law change in England, Scotland, and Wales (3).

There are three existing models of physician-assisted suicide: Switzerland, Oregon (USA), and Victoria (Australia) (3).

Up-to-date debates about the issue cover a series of medical, legal, moral, ethical, and religious aspects. Hitherto, public views stay underexplored and thus won't count for the formation of public policy (7).

The UK and the bill

Politicians are contending to allow terminally ill patients to end their own lives if they wish to do so by some criteria: being 18 years old and over, registered with a medical practice, and declaring their wishes clearly and explicitly without coercion for 12 months. However, if only diagnosed with a mental disorder or a disability, it won't apply, as defined by the bill. Additionally, medical practitioners are not obliged to raise the matter with a patient. The law proposes that a medical professional can discuss the concept and exercise their professional judgment if needed. Also, if a medical professional doesn't want to discuss it, they can refer to another who is willing to engage with the matter (11). This preliminary discussion will involve the patient's diagnosis, prognosis, treatment available, palliative care, hospice, and any other care options. If there is any doubt about the patient's terminal illness, an assessment by a specialist can be conducted in regard to the capacity to decide by a registered psychiatrist. Should the patient confirm their wishes to go ahead, a coordinating doctor must witness the first declaration signed by the patient, followed by the first assessment to ensure the proposed bill of terminal illness is a clear statement of intention without being pressured. Then, a second assessment is to be carried out by an independent doctor who checks the eligibility and the assessment about coercion. This would take a seven day period of reflection, and if there is any disagreement after the second assessment, to refer to a different medical professional. Both doctors should have the necessary training concerning the qualifications needed and the experience and are not materially gaining after their death. The bill explains how this will take place, the nature of the substance used, how it will bring death, if complications arise, further steps, and if to withdraw at any time (11).

The high court will decide if the bill's requirements are fulfilled, and if the judge refuses to certify the declaration, then it goes to the court of appeal. Once all are approved, a second 14-day period of reflection will follow unless death is imminent within a month, to reduce to a 48-hour reflection period. Then, the coordinating doctor and another person should witness a second declaration. Also, if there is a disability and the patient is unable to sign, the patient should know a person for 2 years with good standing in the community to act as a substitution. Once all is done and the period of reflection comes to an end, the proceeding with the assistance to end life can go ahead. If the patient decides to change their mind, they can inform the coordinating doctor or the GP, and they can decide not to self-administer the approved substance to end the process (11).

The coordinating doctor would prepare the lethal substance for the patient to self-administer or a medical device to allow the patient to end their life. The doctor won't administer the deadly substance. However, they must remain with the patient until death happens, but they won't need to be in the same room. If the coordinating doctor isn't able, or is unwilling to continue, an auxiliary can be appointed.

Religion

There are divisions between religious and non-religious as the belief that assisted dying is wrong and unlawful and the belief that life is holy (11).

Conclusion

The subject carries a lot of debate and is divided between morality and public trust in medical professionals, and how it could benefit or harm patients who wish to end their lives. It is not easy though as doctors are meant to treat, alleviate and travel through their patient's illness journey and not to end it.

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