

Ethical and practical questions in satisfying the human right to unconsciousness at the end of life: a reply

The correspondence offers two different perspectives related to our article [1] on general anaesthesia at the end of life (GAEL). Morfey's thoughtful analysis and conclusion [2], that anaesthetists should engage more with the ethical dimensions of inducing unconsciousness, is consistent with the message of our article. Morfey touches upon the complex philosophical question of the difference between death and unconsciousness at the end of life [3]. A full discussion would require more space than is available here; however, it suffices to note that anaesthesia in dying patients is conceptually distinct from death (since the former is in theory reversible, while the latter is not). It is also legally distinct, since no jurisdictions in the world have adopted a 'higher brain' standard of death. The main concern of Iliff et al. [4] is that general anaesthesia could have the 'double effect' of hastening dying and is therefore akin to physician-assisted suicide or euthanasia. As we explained, it is unhelpful and misleading to conflate the two. French law elegantly makes that distinction, where euthanasia is illegal but unconsciousness at end of life is enshrined as a human right. Apart from the fundamental intent being different, we cited several studies confirming that life was not foreshortened when general anaesthesia at the end of life was employed [5]. Even if, in a particular case, careful induction of anaesthesia nevertheless caused cardiorespiratory depression then this is no different from the double effect of using high dose opioid for pain relief in the dying.

We are perhaps most concerned with Iliff et al.'s false logic that because general anaesthesia is currently used so rarely at end of life, it is therefore not needed. The depressing circularity of this argument should be self-evident (akin to saying that because people in a famine are not eating, they do not need food). To correct their phrasing by inverting the clauses: it is because general anaesthesia is used so rarely that there is a false perception it is not needed. We already know from surveys that a significant proportion of patients would welcome the option of unconsciousness at end of life [6]. Iliff et al. then resort to workforce constraints as a reason to deny patients what is, at least in other countries, a fundamental human right to unconsciousness. We agree that shortfalls in the anaesthetic workforce are serious and have commented on this problem before [7]. While this creates a need to plan a service, workforce pressures alone do not make all new services intrinsically inappropriate. The closing paragraph of the letter by Iliff et al. seeks to place the sole responsibility for all aspects of end-of-life care on palliative care physicians. Implicit in their argument is the suggestion that there is no room for improvement or innovation in current treatments. If this were correct, there would no longer be any need for palliative care research. There is no doubt that current approaches to palliative care are extremely effective and help the vast majority of dying patients. However, what is to be done when a patient specifically asks to be unconscious at the end of their life? Satisfying this request in a reliable and humane way is outside the remit of most specialties, except anaesthesia.

We think the view one takes of our article depends almost wholly on whether one regards the desire for unconsciousness at the end of life as a human right or not [8]. Only if so does the next question arise of how to satisfy this right in an effective and humane manner within the bounds of the law, although the Moyle protocol we re-discovered in large part already provides the answer [1].

A. Takla
J. Savulescu
D. J. C. Wilkinson
J. J. Pandit
University of Oxford

Oxford, UK
Email: jaideep.pandit@sjc.ox.ac.uk

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