Assisted dying: no change in the law is necessary

UK law has long-recognized the rights of patients to refuse any medical intervention, even if by so doing they put their lives at risk. Furthermore, changes in UK legislation, in the form of the Mental Capacity Act 2005, have made it possible for patients to make advance decisions to refuse life-sustaining treatment. Provisions in the Mental Capacity Act 2005 also allow patients to appoint lasting powers of attorney to a trusted relative or friend to permit them to make life or death decisions on the patient's behalf should the patient become incapacitated.

Patients in the UK need not fear that doctors will deprive them of adequate analgaesia at the end of life. Most studies show that appropriate use of opioids and sedatives in palliative care patients does not result in hastening of death (Sykes and Thorns, 2003).

The so-called 'doctrine of double effect' very rarely needs to be invoked since when opioid doses are titrated against symptom severity they are very safe. However, in exceptional circumstances, and in cases when the therapeutic index for opioids may be reduced, doctors and patients can be reassured that case law supports them in putting relief of distress above concerns about coincidental shortening of life. Specialist palliative care services can provide patients with the opportunity to maximize the quality of remaining life and can provide a dignified death.

The limits of personal autonomy

The principal driver for a change in the law is a belief in the supreme importance of unfettered patient autonomy. Patient choice is clearly an important factor in clinical decision making. As a society we generally accept that individuals have a right to do as they please as long as they are not harming others. Suicide is not illegal in the UK. However, that does not mean that it is something that should be encouraged or that patients should be given help to undertake.

Last year the Department of Health published an update of the *National Suicide Prevention Strategy for England* (Department of Health, 2002, 2007). In the strategy it was explained why, as a society, we have an obligation to try to reduce the number of suicides:

> **'Each suicide represents both an individual tragedy and a loss to society. Suicide can be devastating for families and other survivors – economically, psychologically and spiritually'.**

Every year many hundreds or thousands of people try to commit suicide for what they may consider to be entirely rational reasons – perhaps because of marital breakdown, bereavement or because they are 'tired of life'. Not all such patients are psychiatrically ill, and many would be deemed 'competent' to make such decisions on their own behalf. However, while acknowledging the distress that such individuals are suffering and while not criminalizing them for attempting suicide, society rightly feels a responsibility to discourage and reduce the frequency with which such attempted suicides occur. Why should suicidal terminally ill patients be valued any less by our society?

Individual rights *vs* the good of society

It is important that the law respects both the rights of the individual and the common good of society. There is currently a clear distinction between what is permitted and what is criminal. The intentional killing of patients (even with their consent) is against the law, as is assisting a patient to commit suicide. These laws are there to provide protection to the vulnerable.

Changing the law to allow physician-assisted suicide or euthanasia would put the safety of a large majority of patients at risk. Vulnerable patients might be placed under pressure (either deliberately or inadvertently) to accept an assisted death. If physician-assisted death was recognized as just another medical procedure it would soon become routine to offer assisted suicide or euthanasia to patients as one among many therapeutic options. How many patients might then agree to physician-assisted death because they knew that it was available and they felt that it was 'expected' of them? Ultimately any legitimate medical procedure can become the focus of a performance target. Do we trust our (and all future) governments and institutions not to abuse the awesome power that would be placed in their hands by a change in the law?

The most recent attempt to legalize physician-assisted death in the UK (Lord Joffe's Assisted Dying for the Terminally Ill Bill; House of Lords, 2005a) focussed on assisted suicide in the terminally ill. However, logically if the reason for changing the law is to respect patient autonomy then there should be no reason to restrict access to assisted dying to the terminally ill or to patients who are able to take the lethal medication themselves.

Indeed Lord Joffe himself admitted that he wished to see a much more liberal law on the statute book. In his evidence to the select committee he said:

> **'We are starting off, this is a first stage… I believe that this Bill should initially be limited, although I would prefer it to be of much wider application' (House of Lords, 2005b).**

Proponents of assisted dying will not stop at the legalization of assisted suicide for the terminally ill. Any new legislation will be tested to its limits, amended and extended incrementally until assisted dying is available to all patients as a matter of course. Moreover, once legislation is on the statute book it may not even be necessary to go back to parliament to extend its application. Any law is open to (mis)interpretation and one can easily foresee the meaning of terms like 'terminal illness' or 'suffering' becoming increasingly loosely applied.

Experience from the Netherlands

Experience from the Netherlands is not encouraging. The most recent survey of end-of-life practices in the Netherlands estimated that 2.2% (approximately 3000 patients/year) had their lives ended by euthanasia, physician-assisted suicide or by the administration of drugs without explicit request (van der Heide et al, 2007). Proponents of physician-assisted dying see these figures as reassuring because they represent a small decrease in the number of cases of euthanasia since the previous survey was conducted in 2001. However, over the same period the use of 'continuous and deep sedation' had increased from 7.1% to 8.2%. The authors of the report speculated that continuous deep sedation and euthanasia were not mutually exclusive in all cases.

In a separate study (Rietjens et al, 2004) it was reported that hastening death was partly or explicitly the intention of the physician in 64% of cases when continuous deep sedation was prescribed. This suggests that physicians may be using continuous deep sedation as a way to circumvent the procedural requirements for the administration of euthanasia.

Assisted dying is bad medicine

Palliative care professionals are dedicated to improving the care of dying patients. Why then do the overwhelming majority of palliative care physicians oppose a change in the law? We contend that it is because they perceive that physician-assisted suicide or euthanasia would actually represent 'bad medicine' as well as 'bad law'.

In our day-to-day clinical practice we are frequently referred patients with supposedly 'refractory' symptoms whose distress is quite rapidly ameliorated by specialist intervention. We also meet patients who are terrified by what the future might hold because they have been told to expect a painful or distressing death. Indeed research in Oregon (where physician-assisted suicide is legal) has suggested that many patients opt for assisted death because of fears about future suffering rather than any current distress (Ganzini et al, 2003). Legalizing physician-assisted death would reinforce a belief among the general public and among some health professionals that the only way to kill the pain is to kill the patient.

Conclusions

We believe that current legislation provides patients with adequate choices about end-of-life care while at the same time providing protection for vulnerable groups. We believe that a change in the law to permit assisted dying is neither necessary nor desirable and may actually make it more difficult for patients to 'die with dignity'. BJHM

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KEY POINTS

- The law needs to balance the autonomy of individual patients against the common good of society.
- Patients already have complete autonomy to refuse life-sustaining treatment, even if they subsequently become incompetent.
- The current law protects vulnerable patients.
- Legalization of assisted suicide or euthanasia for a few determined patients would be detrimental to the good clinical care of the majority.