

Assisted dying is not the solution

A modern fallacy is that we can either have our own way without cost to society or someone else, or that our desires always trump another's need or freedom. This is none clearer than in the area of wanting to be killed.

For doctors to help patients to die would be contrary to every tenet of what is precious in the doctor–patient relationship. For a doctor to actively and deliberately cause the patient's death, or prescribe a lethal concoction but leave the patient to swallow it, breaches the essential contract whereby a patient trusts the doctor to do all that is possible to relieve distress.

The authors write on behalf of the Association for Palliative Medicine which is an organization of over 1000 palliative medicine doctors working in hospices, hospitals and the community. The Association for Palliative Medicine remains opposed to any change in the law concerning assisted dying, and welcomes the opportunity to respond to Lord Joffe's editorial in the May edition of *BJHM* (Joffe, 2009).

Palliative care will be undermined

Accepting assisted dying may weaken the commitment to improve the lives and suffering of the terminally ill. It may become a convenient 'solution' when patients experience suffering that is difficult to alleviate. Physicians who have received better training in end-of-life care are less likely to have performed assisted dying, but if palliative care is not an available option then assisted dying may be seen as the only solution to end suffering (Matthews, 1998; Emanuel et al, 2000).

Joffe (2009) is wrong to say that palliative care has flourished in the Netherlands and Belgium since the introduction of assisted dying. These societies have palliative care, but without specialist accreditation (European Association for Palliative Care, 2006). Joffe argued that in Belgium, the quality of palliative care was third only to Iceland and the UK, but it was ranked second to the UK in per capita number of beds for palliative care and third in palliative care resources (Bernheim et al, 2008;

Joffe, 2009). Lord Joffe has confused quantity of palliative care resources with quality of palliative care, which is quite different.

Patients would lose confidence in doctors

If assisted dying were permitted, patients may no longer trust that the aim of treatment was to heal and care. They may withhold information from doctors, such as pain or depression, in the worry that this might be interpreted as a request for assistance to die. Patients may fear that they would be asked to consent for assisted dying for reasons of resource allocation. Patients may no longer trust doctors if they believe they are being abandoned during suffering.

The slippery slope argument

Lord Joffe quotes the Netherlands to demonstrate that legalizing euthanasia does not lead to a slippery slope of deaths (van der Heide et al, 2007; Joffe, 2009). His argument is weak, first because the paper to which he refers questioned Dutch doctors retrospectively about their end of life decision making before and after the introduction of the Euthanasia Act.

This research, reliant on self-reporting of physician-assisted deaths, carries an inherent bias: physicians are less likely to report deaths that do not meet the stipulations of the act. Physicians were asked the reasons why they did not report their assisted dying: 76% did not perceive the act as ending life, 9.7% had doubts about whether the criteria for careful practice had been met and 6.6% regarded the ending of life as a private agreement between physician and patient (van der Heide et al, 2007). When doctors openly give such reasons for not reporting physician-assisted dying, it cannot be said that numbers of assisted deaths have truly fallen but that doctors are confident that failing to report means they will not be held accountable.

Second, euthanasia was decriminalized in the Netherlands in the 1960s. Today's doctors will have picked up the profession's acclimatization to euthanasia as part of normal practice (in other words, the slippery slope).

Vulnerable members of society will be put at risk

To reassure us that this will not occur, Joffe claims that future assisted dying bills would contain safeguards. Some of these are sensible and pragmatic. However, there are others that will not safeguard vulnerable members of society, most notably: consultations with two independent doctors to confirm the patient is 'suffering from a terminal illness, is mentally competent ...and has made an informed decision' (Joffe, 2009).

Suffering

Joffe's proposed assisted dying bill was for patients with terminal or serious and progressive physical illnesses who were felt to be suffering unbearably (Joffe, 2003). If assisted dying was permissible it would initially be confined to those patients who had unbearable suffering, yet this is a subjective test (George, 2009; Kellehear, 2009). As it became more accepted, attitudes may change towards what is considered to be suffering and possibly even towards the value of human life. Suffering may be extended to include perceived burdens on family and finances.

Capacity

As with all medical procedures, patients would need to give informed consent before receiving assistance to die. To give consent requires a patient to have capacity and be acting without coercion or manipulation. If symptoms are not adequately controlled a patient may become depressed. Depression prevents patients from looking forward to the future and so they would lack capacity to make a decision about ending their life. One in five patients receiving lethal prescriptions in Oregon were judged to have had undiagnosed and treatable depression (Ganzini et al, 2008).

Sanctity and value of life

Society considers life to have intrinsic worth and, as such, killing is wrong. Permitting assisted dying would imply that society thinks it better to be dead than terminally ill. Lives of terminally ill people would carry less value than those of an

apparently healthy person. Patients may view themselves as being a burden to others and feel obliged to request assisted dying. It is impossible to legislate against such coercions or undue influences.

Impact on the medical profession

Assisted dying requires either prescription or administration of a lethal medication. The outcome of this will not just affect the patient, but also his/her family and doctor. There is significant literature on the impact this has upon clinicians and this is one reason why the Royal College of Psychiatrists oppose change (Hicks, 2006).

What is the solution?

Palliative care strives to enhance patient dignity and choice towards the end of life. Access and provision of good palliative care needs to be improved, rather than changing the law to permit assisted dying. Most requests to hasten death are expressions of distress and fear. Permitting assisted dying would threaten the trust and communication between doctors and patients which are essential for successful relief of these issues.

A survey of Association for Palliative Medicine member showed that the majority oppose a change in the law on assisted dying. Thus the major body of doctors

who actually work with the dying, day-in, day-out, see assisted dying as unnecessary. It is dangerous for the silent majority of terminally ill patients who do not request it. It is also potentially disastrous for how patients will come to view doctors in the future. *BJHM*

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KEY POINTS

- Access and provision of good palliative care needs to be improved for patients towards the end of life.
- The majority of physicians working with dying patients oppose assisted dying.
- There is evidence to support concerns about legalizing assisted dying.
- A change in the law is not the solution.