Why the Assisted Dying Bill should become

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It’s the right thing to do, and most people want it

Lord Falconer’s Assisted Dying Bill is expected to receive its second reading in the House of Lords this month. *The BMJ* hopes that this bill will eventually become law.

The bill would allow adults who are expected to live six months or less to be provided with assistance to end their lives.[1] Two doctors must be satisfied that the person is terminally ill, has the capacity to make the decision to end his or her life, and has a clear and settled intention to do so. This decision must have been reached voluntarily, on an informed basis, and without coercion or duress. Both doctors must be satisfied that the person has been fully informed of the palliative, hospice, and other available care options.

Once both doctors have countersigned the declaration that the person wants to end his or her life, the attending doctor can prescribe the life ending medication, which would be dispensed only after a “cooling off” period of 14 days (or six days if prognosis is less than a month). The person would administer the medication themselves. This is what differentiates “assisted dying” from “voluntary euthanasia,” where the doctor administers the lethal drug(s).

What are the arguments for such a law? People should be able to exercise choice over their lives, which should include how and when they die, when death is imminent. In recent decades, respect for autonomy has emerged as the cardinal principle in medical ethics and underpins developments in informed consent, patient confidentiality, and advance directives.[2] Recognition of an individual’s right to determine his or her best interests lies at the heart of efforts to advance patient partnership.[3] [4] It would be perverse to suspend our advocacy at the moment a person’s days were numbered.

As shown by harrowing personal accounts, some terminally ill people want the option to call “time.”[5] [6] [7] And the majority of the British public want the option too. The 2010 British Social Attitudes survey shows that 82% of people are in favour of a change in the law on assisted dying.[8]

What are the arguments against such a law? People opposed to the bill cite the difficulties of establishing that someone has less than six months to live. Yet most studies suggest that doctors consistently overestimate rather than underestimate prognosis.[9]

Another argument is that individual choice should be limited when it has a profound effect on others. But we already accept people’s decision to reject life saving treatments, if they have mental capacity, regardless of any effects their subsequent deaths may have on those they leave behind. The Falconer Bill allows for the secretary of state to issue codes of practice on the assessment of mental capacity, “recognising and taking account of the effects of depression or other psychological disorders that may impair a person’s decision making.”

Those who oppose a change in the law often shift their arguments to hypothetical victims, some of them glimpsed at the bottom of a slippery slope. It’s therefore important to say who will and will not be affected by the new law. The Assisted Dying Bill does not cover people with disabilities who are not terminally ill, other people with non-terminal illness, people who are not mentally competent, or children. That much mentioned victim—the elderly lady who believes she has become a burden to others and offers herself up for assisted dying—will not qualify.

Passing the law would not represent a leap in the dark: the US state of Oregon, on which the bill in England and Wales is closely modelled, has allowed assisted dying since 1997. Last year, 122 dying Oregonians were given life ending prescriptions; 71 took the life ending medication and died. Altogether, "assisted deaths" accounted for 2.2 per 1000 total deaths in the state.[10]

Extrapolating Oregon's figures to England and Wales, each year about one patient per general practice of 9300 patients would discuss the issue of assisted dying; each general practice would issue one prescription for life ending medication every five or six years, and every eight to nine years one patient per general practice would take life ending medication.

Oregon's experience confounds claims that assisted dying legislation impedes the development of palliative care. Oregon is now regarded as a national leader in palliative care.[11] Tellingly, the Oregon Hospice Association, initially opposed to assisted dying, found "no evidence that assisted dying has undermined Oregon's end of life care or harmed the interests of vulnerable people."[12] In 2011 the European Association for Palliative Care concluded that palliative care in European countries with legalised assistance to die is as well developed as it is elsewhere.[13]

Some doctors are unhappy about the part they would be asked to play. However, the bill makes robust allowance for conscientious objection—a provision that has worked well for the almost 50 years of the Abortion Act. Discovering what "the average doctor" thinks about assisted dying, however, has been difficult, with professional bodies going through extraordinary contortions to avoid asking individual members for their opinions.

Ultimately, however, this is a matter for parliament, not doctors, to decide. Last month the UK Supreme Court upped the ante. Its president said that unless parliament satisfactorily addresses the Suicide Act 1961, which prevents doctors helping patients to end their lives, the court could force change upon them by declaring the act incompatible with the European convention on human rights.[14] Let us hope that our timid lawmakers will rise to the challenge.

References

1. ↲
   UK Parliament. Bill documents. Assisted Dying Bill [HL] 2014-15. http://services.parliament.uk/bills/2014-15/assisteddying/documents.html.
2. ↲
   Gillon R. Medical ethics: four principles plus attention to scope. BMJ 1994;309:184.
3. ↲
   Richards T, Montori VM, Godlee F, Lapsley P, Paul D. Let the patient revolution begin. BMJ2013;346:f2614.
4. ↲
   Richards T, Godlee F. The BMJ's own patient journey. BMJ2014;348:g3726.
5. ↲
   McPherson T. My mum wanted assisted dying but we watched her die slowly and in pain. BMJ 2012;344:e4007
6. ↲
   Leith P. A brother's suffering. *Spectator*2012 Oct 27. www.spectator.co.uk/features/8707911/a-brothers-suffering/.
7. ↲

Syer C. “I gather there’s somewhere in Switzerland I can go . . .” *Financial Times Magazine* 2014 Mar 14.www.ft.com/cms/s/2/d14c0722-a97f-11e3-9b71-00144feab7de.html#axzz367LUNmX9.

8. ↲ McAndrew S. Religious faith and contemporary attitudes. In: Park A, Curtice J, Thomson K, Phillips A, Clery E, Butt S, eds. British social attitudes: 2009-2010. The 26th report. Sage, 2010:87-113.
9. ↲ Glare P, Virik K, Jones M, Hudson M, Eychmuller S, Simes J, Christakis N. A systematic review of physicians’ survival predictions in terminally ill cancer patients. BMJ2003;327:195.
10. ↲ Oregon Health Authority. Oregon’s Death with Dignity Act: 2013. www.healthoregon.org/dwd.
11. ↲ Morrison RS, Meier DE, Augustin R, Souvanna P. America’s care of serious illness: a state-by-state report card on access to palliative care in our nation’s hospitals joint publication by centre to advance palliative care and national palliative care research centre. J Palliative Med 2011;14:1094-6.
12. ↲ Jackson A, Oregon Hospice Association. The reality of assisted dying in Oregon. All Party Parliamentary Group on Compassion in Dying. House of Lords, 2006.
13. ↲ European Association for Palliative Care. Palliative care development in countries with a euthanasia law. 2011.www.commissiononassisteddying.co.uk/wp-content/uploads/2011/10/EAPC-Briefing-Paper-Palliative-Care-in-Countries-with-a-Euthanasia-Law.pdf.
14. ↲ Dyer C. Supreme Court says law on assisted dying may change in the future. BMJ2014;348:g4290.