

The NHS and society

What if 'assisted dying' were legalised?



The legalisation of assisted dying is an issue that divides opinion. Those in favour argue that the current law means that terminally ill people suffer against their wishes. Here Baroness Finlay argues against changing the law.

Reading time: 7 mins



Prof Ilora Baroness Finlay of Llandaff

Ilora Finlay is professor of palliative medicine at Cardiff University and has taught end-of-life care internationally. She is a crossbench Peer in the House of Lords; her private member's Access to Palliative Care Bill is before parliament. She co-chairs the independent think-tank Living and Dying Well.

The result of the referendum over Britain's membership of the European Union has been declared. In the run-up to the referendum, all sorts of 'what if' questions were asked and predictions made. But much of it was speculation.

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If we ask 'what if "assisted dying" were legalised', the position is different. We have the published experience of four jurisdictions to go on – Oregon and Washington State in the United States and The Netherlands and Belgium in Europe. Parliament has comprehensively rejected legislation proposals on a number of occasions, but what if things were different? The published experience from elsewhere provides a guide as to what we could expect.

What if Oregon's physician-assisted suicide legislation were adopted here? In 1997 Oregon legislated for doctors to supply lethal drugs for assisted suicide to terminally ill people who asked for them and met certain conditions – they should be deemed terminally ill, 'reasonably considered' to have less than six months to live, have mental capacity and not be under any pressure.

Let's look first at the data. Each year the Oregon authorities publish a factual report on how the law is working. Over the first 15 years, these reports showed a steady year-on-year increase in deaths from legalised physician-assisted suicide; by 2013 there were four and half times as many deaths as in 1998, the first year of the law's operation. Since 2013, however, there has been a marked change. In both 2014 and 2015 the number of deaths rose by 80 per cent, and last year there were more than eight times as many physician-assisted suicide deaths as in 1998.

What can the data tell us about the future rate of deaths? Well, a guide to this is the prescribing rate for lethal drugs. This rose sharply (by 40 per cent) between 2014 and 2015. Why is this important? It is important because recipients of prescribed lethal drugs don't always take them in the same year they are prescribed, and the evidence shows that a high prescribing rate in one year results in more deaths in the next or subsequent years.

Those calling for legalised 'assisted dying' here downplay the data. They say that the actual numbers of physician-assisted suicide deaths in Oregon are relatively small. And so they are: deaths have risen from 16 in 1998 to 132 in 2015. But Oregon is a tiny state in terms of population – its 3.8 million inhabitants comprise less than half the population of London. So, if we take Oregon's current death rate from physician-assisted suicide and apply it to England and Wales, we can predict just under 2,000

assisted suicide deaths annually if we had a similar law here. And that's not the end of the story – Oregon's numbers are rising year by year.

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But it's not just the numbers that we need to think about. The official reports also tell us that a small number of doctors are writing most of the prescriptions – one physician wrote 27 prescriptions for lethal drugs for assisted suicide last year. In other words, some patients are 'doctor shopping' for a lethal prescription. This means people are being assessed by doctors who have never met them before and know next to nothing about them as patients.

The Oregon reports also tell us how long those supplied with lethal drugs live before taking them. Over the 18 years since Oregon's law came into force, the time between the first request for lethal drugs and death through ingestion ranged from 15 to 1,009 days. There's no indication of how many people were at the lower and the upper end of the scale, but the reports are clear that some people have lived for up to nearly three years beyond their first request for physician-assisted suicide before taking their own lives. How long they might otherwise have lived is anybody's guess.

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The point here is that lethal drugs were prescribed for these patients on the basis that they had less than six months to live. Every doctor has been faced with the question: 'how long have I got?' The answer is only a best guess. But prognosis is an important factor in any decision to 'end it all'. Yet it is a fallible tool. It was described in 2013 by Professor Sir Mike Richards, National Clinical Director for Cancer and End-of-Life Care, as 'fraught with difficulty'. I myself had referred to me 25 years ago a man whom three doctors had given three months to live. He is alive and well today. Yet the 'assisted dying' bills that have been put before parliament in the past few years treat prognosis as if it is a scientific tool. It isn't, and we need to recognise that.

What if we had The Netherlands' 2001 legislation, which also permits physician-administered euthanasia – where the doctor injects lethal drugs (coma-inducing drugs plus a paralysing agent to cause death by asphyxia)? The death rate there has followed a similar profile to Oregon's – level or modestly rising at first, then turning sharply upwards later. Last year 1 in 26 of all deaths in The Netherlands was through either physician-assisted suicide or physician-assisted euthanasia – that equates to just under 20,000 deaths annually in England and Wales alone.

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And then there is the legislative drift that the Dutch official reports reveal. Increasing numbers of people are having euthanasia because of psychiatric illness (56 cases last year) or dementia (109 cases last year). In 2015 doctors agreed to administer euthanasia to a woman in her 20s suffering from post-traumatic stress disorder and 'therapy resistant' anorexia nervosa. Some Dutch campaigners want suicide drugs to be available to people who are not ill but just 'tired of life'; recent press reports suggest that such a bill is to be put before the Dutch parliament. It is doubtful that Dutch legislators foresaw this when they enacted Holland's Termination of Life on Request and Assisted Suicide Act in 2001 – an honest title that avoids euphemisms like 'assisted dying', which are used to cloak the realities here.

And what if we had Belgium's euthanasia law? Official reports there also show steep increases in deaths from euthanasia and ever more reasons – including depression, impending sight loss, botched transgender surgery and a variety of chronic disorders – reported as the rationale for euthanasia.

We are assured that the calls for an 'assisted dying' law here are limited to Oregon-style physician-assisted suicide for the terminally ill. But is it realistic to expect such limitations to hold? If the aim of 'assisted dying' is to relieve suffering, could it not be argued that it is illogical to offer it to terminally ill people, who expect to die in the near future of natural causes, but withhold it from others who may have to endure years of unhappiness from chronic illness or psychological distress? What happens to those who are physically or psychologically unable to ingest lethal drugs unaided? Logically, legalised physician-assisted suicide leads inexorably to legalised physician-administered euthanasia.

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Because they are based on purely arbitrary criteria, 'assisted dying' laws contain within them the seeds of their own expansion. Already in Oregon there has been an attempt to re-define terminal illness as encompassing people with twelve rather than six months to live.

We would do well to heed the words of Baroness Butler-Sloss, former President of the Family Division of the High Court:

'Laws, like nation states, are more secure when their boundaries rest on natural frontiers. The law that we have rests on just such a frontier. It rests on the principle that we do not involve ourselves in deliberately bringing about the deaths of others. Once we start making exceptions based on arbitrary criteria such as terminal illness, the frontier becomes just a line in the sand, easily crossed and hard to defend.'

We tinker with the law at our peril.

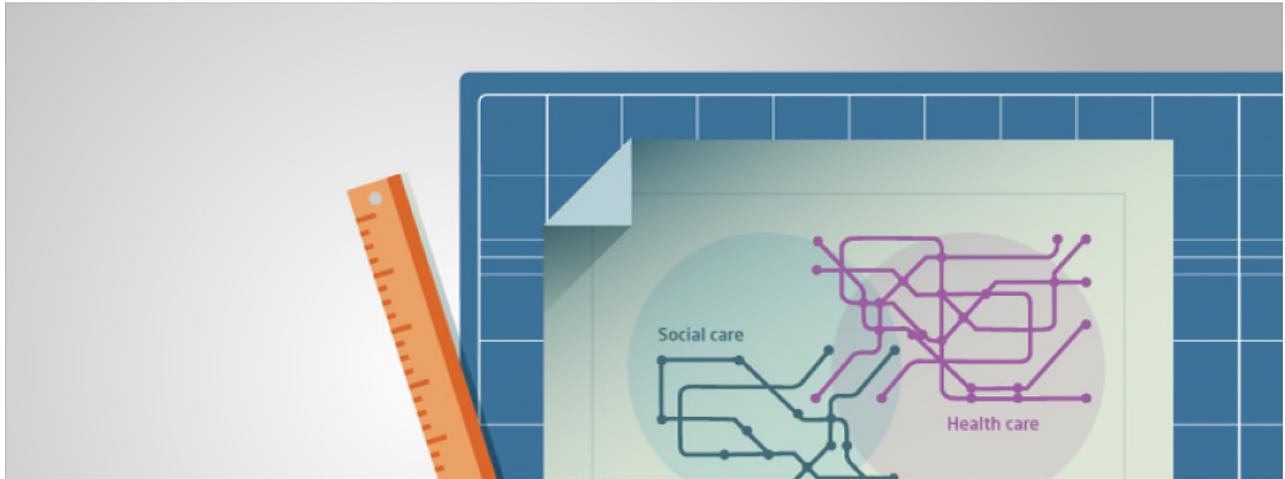
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