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Clear thinking on the end-of-life debate

## FACING FACTS

### Why Assisted Suicide is not a Job for Doctors



Living and Dying Well is a public policy research organisation established in 2010 to promote clear thinking on the end-of life debate and to explore the complexities surrounding 'assisted dying' and other end-of-life issues.

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## FOREWORD

Dignity in Dying has written a new report *'The Inescapable Truth'* calling for an "assisted dying" law. The report contains stories of suffering recounted by bereaved family members and references a commissioned study, by the *Office of Health Economics, "Unrelieved Pain in Palliative Care in England"*. It estimates that 17 patients every day die experiencing unrelieved distress, even in hospices, where analgesic regimes are most effective.

As a doctor practicing palliative care in all settings for 40 years, I have known few patients with this degree of distress. However, according to Dignity in Dying's figures, each of us has a one in eighty chance of a bad death. This estimate differs greatly from my experience and that of other specialist colleagues, who regularly tackle previously unrelieved distress to the great relief of patient and family alike. These peaceful deaths will not make for headline news or garner huge publicity precisely because they are so common in the UK.

The individual research projects that were used to make the calculation of unrelieved distress amongst the dying are usually interpreted to mean that our scientific understanding, practice or organisation of palliative care remain inadequate to the task. Hardly surprising, considering the pitiful amount spent on palliative care research - only £3.25 million annually - close to twice the annual budget of Dignity in Dying. Due to lack of resources for our services, we cannot reach 20% of the population that could benefit; and our NHS leaves most of the provision to be paid for by hospices and other charities. Our changing demographic means that palliative care need will increase by 42% by the year 2040.

Dignity in Dying thinks that the answer to this intolerable problem is access to assisted suicide for 17 people a day and that its regulation by doctors will be unproblematic. However, even if these terminally ill patients were assisted to die, they would still die in pain. Assisted suicide is not a medical treatment. Campaigners imply it is devoid of distress. The reality in countries with legalised assisted suicide or euthanasia is that those who ask for assisted death are not like the 17 patients, whose stories Dignity in Dying recounts, but are overcome by other fears often relating to loss of control or their perceived loss of their dignity.

Others fear being a burden to their families or dread pain that in reality may never come or could be relieved. The independent report from the US National Council on Disability published on 11 October 2019, concludes that the basic dangers of legalising assisted suicide are inherent and cannot be eradicated by any type of so-called safeguard.

UK palliative care may be a world leader but compared to many NHS services it remains inadequately researched and resourced because of a lack of political will to mainstream its funding commensurate with the rest of the NHS. More should and could be done, in order to address this ongoing challenge. Lack of resources should not be the reason for anyone to choose to die before their time.

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## EXECUTIVE SUMMARY

The campaign group Dignity in Dying- formerly the Voluntary Euthanasia Society- recently released a report entitled *'The Inescapable Truth: How 17 people a day will suffer as they die.'*

Their headline statistic was based on a report by the Office for Health Economics, (OHE) sponsored by Dignity in Dying, which claimed that this proportion of dying people will still suffer on a daily basis, despite the availability of good palliative care.

The OHE report draws heavily on third party perceptions and is based on seven assumptions. It is therefore perplexing that Dignity in Dying reiterate throughout their report that this statistic of 17 people per day is a reality when it is an estimate and not a certainty.

The report includes a number of distressing end-of-life scenarios but without any additional information it is impossible to analyse their wider significance. The authors also vividly describe several distressing symptoms but without acknowledging that successful management is possible or the progress that continues to be made in this area of end-of-life care.

*'The Inescapable Truth'* implies that pain relief and sedation can result in death despite the fact that this runs directly counter to current evidence and fails to separate dangerous practice from good palliative care.

Dignity in Dying has long championed the Oregon model of assisted suicide and yet, their report fails to acknowledge that the evidence from the US state shows that fear of being a burden ranks higher among applicants than fear of lack of pain control. The latest data from Oregon shows that more than half of the applicants for assisted suicide in 2018 said that they were concerned about burdening family, friends or caregivers, while only 25.6% listed 'inadequate pain control/fear of' as an end of life concern.

It is also worth noting a recent report by The National Council on Disability, which examined how assisted suicide laws are working in the USA, including in the US state of Oregon. The report clearly states that the council *"considered recommending ways to 'improve' assisted suicide proposals and laws by making their provisions more stringent, but has decided against doing so, because the Council does not believe that added safeguards, modified safeguards, or indeed safeguards of any kind, will remove the inherent dangers in assisted suicide laws"*.

The fundamental flaw at the heart of *'The Inescapable Truth'* is the assumption that assisting patients with suicide is a role for doctors despite the fact that the majority of UK doctors do not want any involvement in deliberately ending the lives of their patients. This reality is the hard truth which Dignity in Dying cannot continue to ignore, if they wish to be regarded as credible contributors to the end-of-life debate.

## INTRODUCTION

In September 2019 the campaigning group Dignity in Dying (DiD) published a document entitled *'The Inescapable Truth,'*<sup>1</sup> which claimed that 17 people a day in the UK will suffer when they die, despite the availability of good palliative care.

The report recommends a major change in the criminal law which would allow doctors to provide lethal drugs to their patients in order to address the problem of pain at the end of life.

The report was based on both qualitative and quantitative research which included 25 semi-structured interviews with people "affected by the limits of palliative care." It does not state how many patients, relatives and healthcare professionals in total were interviewed.

The quantitative research is extrapolated from another report by the Office for Health Economics,<sup>2</sup> commissioned by DiD and two opinion polls, conducted by YouGov and Populus,<sup>3</sup> which DiD also sponsored.

In this report, we examine and assess the report's three major "key findings" which include, suffering at the end of life, end of life practices and licensing physician assisted suicide.

## SUFFERING AT THE END OF LIFE

The first key finding listed in DiD's report states, *"at the end of life some people experience severe pain and other symptoms that result in suffering."* It then goes on to say that even if every dying person who needed access to palliative care received it, 6,394 people a year would still have no pain relief at the end of their life which equates to 17 people every day. As stated above, this figure is extrapolated from a report on pain relief at the end of life, published by the Office for Health Economics.

The OHE report explains that surveys suggest that the lowest rate of patients dying without experiencing pain relief is in hospices, where they make up 1.4% of patients. The OHE estimates that if this figure of 1.4% is applied to all patients who are dying across the UK, the number of deaths without effective pain relief would be just over 6,000 or about 17 per day.

A closer look at the Office of Health Economics report illuminates that each step which brings them to their final estimation has a degree of uncertainty. Their data is based on seven separate assumptions and draws heavily on third party perceptions of another person's pain at the end of their life,<sup>4</sup> which the OHE concedes is a limitation of its study.

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- 1 Dignity in Dying, *The Inescapable Truth: How Seventeen People A Day Will Suffer As They Die*, 2019
  - 2 Zamora, B., Cookson, G. and Garau, M. *Unrelieved Pain in Palliative Care England: a consulting report*. London: Office for Health Economics, 2019
  - 3 Dignity in Dying, *The Inescapable Truth: How Seventeen People A Day Will Suffer As They Die*, p8, 2019
  - 4 National Survey of Bereaved People (VOICES): England, 2015. London: Office for National Statistics (commissioned by NHS England) (2016)

**While the final estimate reached by the OHE report is not unreasonable, the statistic of 17 per day should still be treated as uncertain due to the methodology which is clearly laid out.** Nevertheless, Dignity in Dying portray this statistic throughout their report as *'The Inescapable Truth'* when it is clearly an estimate and not a certainty.

DiD's report based on the OHE's research concluded that *"suffering occurs even when high quality specialist palliative care is present, meaning that the provision of care will not address this problem."*

In order to illuminate the types of suffering a small minority of individuals might endure at the end of their life, the report contains a number of quotes from semi-structured interviews about the experience of different individuals facing or witnessing terminal illness. The report also includes four testimonies from different people on their own experience of serious illness, a patient's, or a relative's.

While the quotes which dominate the majority of the report describe highly regrettable scenarios and make for difficult reading, it is hard to fully comprehend and analyse their wider significance, without additional detail regarding the individual concerned, such as their full medical profile and history.

For maximum impact, the report also begins with a foreword by Nick Boles MP who lists a number of rare but distressing symptoms and declares:

*"17 people died in this manner yesterday. 17 more will die that way today, and tomorrow. This will continue to happen despite the best efforts of our wonderful hospices."*

The latter assertion is misleading, firstly because it presents a mere estimate as an inevitability and second, it gives the impression that palliative care in the UK cannot be improved, which is unlikely to be the case for any area of specialist medicine.

Thanks to the advancement of medical science, continued academic research into pain relief and symptom control and greater education and awareness about analgesics among healthcare professionals, there are many ways in which the quality of palliative care in the UK can further improve.

For example, in their report DiD dedicate an entire section to nausea and vomiting at the end of life, among a list of other symptoms which terminally-ill people might experience. While this common symptom is manageable, it is recognised that more research is necessary in order to enhance understanding of this common problem.<sup>5</sup>

When, for instance, the British Medical Bulletin published a paper in 2010<sup>6</sup> on management of

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5 Behm B., Fernandez C., Davis M.P, Gastrointestinal Symptoms: Nausea and Vomiting. In: MacLeod R., Van den Block L. (eds) Textbook of Palliative Care. Springer, Cham (2018)

6 Dylan G. Harris, Nausea and Vomiting in Advanced Cancer, British Medical Bulletin, Volume 96, Issue 1, December 2010, Pages 175–185

nausea and vomiting in advanced cancer, the researchers concluded: *“On-going basic science research to enhance our understanding of the neurophysiology of the emetogenic pathway is (also) fundamental to identify new potential mechanisms of anti-emetic drug action.”*

Despite the reality that this area of medicine can be improved, the take away message from DiD’s report is that palliative care has advanced as much as possible, when this is evidently not the case.

The distressing examples of poor pain and symptom control which DiD lays out in its report require a remedy, but it is essential to balance these rare cases with the real picture of what dying looks like for the vast majority of people in the UK and the high standard of care which is delivered, despite the limitations outlined in the foreword to this report.

The UK is widely recognised as a pioneer in palliative care, as the country which founded the hospice movement and where palliative care has been recognised as a clinical speciality for the last three decades. **In 2015 the Economist’s Quality of Death Index<sup>7</sup> ranked the UK as the best place in the world to die.** These facts prompt the question, how much more could palliative care achieve with better funds, universal access and improved training for those in both specialist and general fields of medicine?

It is incorrect to conclude that the only solution to distressing symptoms is to offer lethal drugs to seriously ill individuals at the end of their lives.

## END OF LIFE PRACTICES

The report discusses a number of end-of-life practices including the doctrine of double effect, palliative sedation and the withdrawal of treatment and concludes that *“many healthcare professionals do not consider there to be a clear difference between end of life practices like these and assisted dying.”*

The authors also argue that the current law on assisted suicide did not sufficiently protect victims of the Gosport War Memorial Hospital Scandal and suggest that euthanasia is already happening covertly across the UK.

Dealing first with the disturbing events at the Gosport War Memorial Hospital, the report, commissioned by an independent panel into events at Gosport, was unequivocal when it clearly stated:

***“It may be tempting to view what happened at the hospital in the context of public debate over end of life care, what a ‘good death’ is, and assisted dying. That would be a mistake. What happened at the hospital cannot be seen, still less justified, in that context. The patients involved were not admitted for end of life care but often for rehabilitation or***

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<sup>7</sup> The 2015 Quality of Death Index: Ranking palliative care across the world. London: The Economist Intelligence Unit (2015).

*respite care. The pattern of prescribing and administering drugs was excessive and inappropriate in the ways explained in this Report.*<sup>8</sup>

Furthermore, events at Gosport might have been even harder to detect if the clinicians had been able to hide behind fabricated or coerced requests for life-ending lethal drugs.

Moving on to the other conclusions in DiD's report, the authors state at the beginning of their report, *"current end of life practices lack the safeguards, regulations and guidelines that would be present under an assisted dying law."* They make the very serious accusation that *"there are cases in the UK where healthcare professionals intentionally end the lives of dying people with compassionate motives, blurring not only the principles of medical ethics but also the boundaries established in criminal law."*

What evidence is there to support this claim? DiD point to an opinion poll which they sponsored which found that *"62% of healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to a patient's request to end their suffering."*

The accusation that euthanasia is happening under the radar in England and Wales is a regular refrain from the assisted suicide lobby and a claim which needs careful examination.

In 2005 a House of Lords Select Committee published an extensive report on 'assisted dying' which examined the issue of covert euthanasia among many other things. The report concluded that based on the evidence it had read and heard, it was unlikely that covert euthanasia was taking place on the scale which some surveys suggested at the time, given, *"the trend towards death taking place in hospital rather than at home, the increasing prevalence of team-working in clinical care, the greater tendency for people to litigate where they suspect malpractice, and the potential for confusion with the legal administration of drugs to prevent restlessness and anxiety in the last hours of life."*<sup>9</sup>

The most recent and in-depth research on the topic of covert euthanasia was conducted by Professor Clive Seale in 2009 who gave evidence to Lord Falconer's Commission on Assisted Dying in 2011. Reflecting on two of his recent surveys, Professor Seale said:

*"Both surveys of UK doctors showed there were no cases at all reported of doctor assisted suicide but that euthanasia occurred in a half a per cent of all deaths reported in both the surveys, which is actually lower than in other countries where the same survey has been done."*

Commenting on his findings, Professor Seale said that they revealed: *"In the UK doctors are particularly collegiate; they like to share their decisions, not just with patients and relatives, but also with each other and with nursing staff as well. There is a kind of joint quality to decision*

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8 Gosport War Memorial Hospital: The report of the Gosport Independent Panel. London: Her Majesty's Stationary Office (House of Commons) Chapter 12: 12:34 (June 2018).

9 House of Lords Report, Paragraphs 237-239, 2005

*making in the UK medical practice that is very marked compared to other countries. And with that situation decisions don't go unscrutinised.”<sup>10</sup>*

While no one is suggesting that doctors never flout the law on assisted suicide- we know from every day news that professionals in different walks of life occasionally break the law or abuse their power - **the evidence suggests that covert euthanasia is rare in the UK** and as a result the argument that the practice is so common that seriously ill patients would be safer under an assisted suicide law, lacks credibility.

The authors of the report also state, as we have highlighted above, that some healthcare professionals do not think there is a “clear difference” between doctors assisting their patients to kill themselves-‘assisted dying’- and current end of life practices such as the use of opioids, the withdrawal of treatment and palliative sedation. They do not qualify what evidence they have that “many” doctors and nurses cannot recognise the difference.

This section of the report raises a broader question about common misconceptions among the public and healthcare professionals about certain aspects of end-of-life care. **The reality is that it is a common myth that ‘double effect’ (DE) is part of effective palliative care.**<sup>11 12</sup>

The Association for Palliative Medicine (APM) touched on this issue in 2009 when they released a statement on the doctrine of double effect. The statement, which was reviewed in 2012, reads:

*“There is a misconception that morphine related drugs and sedative drugs bring about death more quickly and that doctors both know this and in some way condone their use with the double effect. The APM refutes this claim: it knows of no credible research evidence to suggest that a patient’s life is shortened either by opioids or sedatives when used in line with accepted palliative care practice. The APM believes that DE is unnecessary to justify the use or dosing regimes necessary to manage pain or distress in all but the most exceptional circumstances.”<sup>13</sup>*

A paper released by the British Medical Association in 2017 on improving access to analgesics at the end of life corroborates the APM’s assessment: *“There is little evidence to suggest that the appropriate use of analgesics to control pain at the end of life hastens death. If analgesics are properly adjusted against a patient’s pain, the risk of respiratory depression is small, and it is unlikely to have an effect on a patient’s lifespan.”<sup>14</sup>*

The BMA’s report also highlighted that fear still exists about the use of opioids at the end of life amongst doctors and patients and therefore, it called for improved education and training in the use of analgesics and better communication between doctors and their patients, in order to increase understanding and reduce fears in this particular area.

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10 Demos: Commission on Assisted Dying, 2009

11 Regnard C et al. So, farewell then, the doctrine of double effect. *BMJ*, 2011; 343: 4512.

12 Regnard C, George R, Proffitt A. Dangerous opioids or dangerous prescribers? *Palliative Medicine*, 2018; 32(10): 1537-8.

13 Association of Palliative Medicine Position of Palliative Medicine: APM Position on the Doctrine of Double Effect: 2009

14 British Medical Association: Improving analgesic use to support pain management at the end of life. (March 2017)

Despite the tone of DiD's report, **the doctrine of double effect, is an outdated lens through which to view how pain is managed at the end of life, given the effectiveness of modern analgesia and the common understanding that it is possible to administer opioids without hastening the death of a patient.**

The same can be said for palliative sedation. In guidance published in 2009, which was reviewed again in 2012, the Association of Palliative Medicine clearly stated: *"Rarely, patients may experience distress when symptoms cannot be controlled even after exhaustive attempts with specific interventions. In these circumstances some patients may require sedating medication to diminish awareness of their suffering. If medication is sedating in its effect, the dose should be monitored in order to ensure that it is the minimum required to relieve the patient's distress. Medication used in this way does not shorten life."*<sup>15</sup>

The statement also contained a crucial qualification: *"Sedation in palliative care is thus sedation while the patient dies and is not sedating the patient to death."*

In short, the use of titrated, safe sedation in the UK is reserved for patients with persisting distress at the end of life.

Looking beyond UK guidelines and practice, DiD's report selectively quotes the 'European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care' where it says that *"some physicians administer doses of medication, ostensibly to relieve symptoms, but with a covert intention to hasten death."* This section of the framework sits under the heading 'Abuse of Palliative Sedation' and the text later continues: *"These duplicitous practices represent an unacceptable, and often illegal, deviation from normative ethical clinical practice."*

A fuller examination of this EAPC's framework then, reveals that those doctors who use sedation to hasten death are considered the exception and not the norm.

The evidence and guidelines available on end-of-life practices strongly refutes the conclusion that common end of life practices are *"no less ethically complex than assisted dying"* as claimed by DiD.

On the subject of withdrawing treatment at the end-of-life, DiD's report quotes a palliative care nurse on the matter:

*"There's a very thin dividing line between removing treatment and assisted dying. The intention is the same. You're responding to a request of somebody who's asked for it. The fact it's possible to do that says to me, 'Why don't we just have assisted dying?'"*

In our report, 'True Cost or True Facts' we looked at the issue of withdrawing treatment and why it is not comparable with 'assisted dying.'<sup>16</sup>

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15 Association for Palliative Medicine Position Statement: APM position on using sedation at the end of life, 2009

16 Living and Dying Well, True Cost of True Facts? 2018

A patient in the UK, has a right to refuse life-sustaining treatment or to request its discontinuation – namely, when a patient no longer consents to ongoing treatment. Unless a doctor has reason to believe that the request stems from a lack of capacity for the decision or is not being freely made, that request must be respected. Where treatment is withdrawn, a doctor has an ongoing duty of care to ensure that the dying process is carefully managed in order to avoid any distress to the patient. The practice of withdrawing treatment does not constitute assisting with a suicide. It amounts to a patient accepting, rather than seeking death. The doctor who complies with this request is not acting with the intent of deliberately ending the patient’s life prematurely but is caring for a patient as they die of their underlying disease.

In conclusion, it is not difficult to recognise the clear ethical and clinical distinction between a doctor providing lethal drugs to their patient to shorten life sometimes by months or years, and a doctor attempting to relieve suffering through modern analgesia or carefully managed palliative sedation. The difference is obvious, no matter how hard campaigners try to insist otherwise.

## LICENSING PHYSICIAN ASSISTED SUICIDE

It is not a surprise that among the report’s key findings the final conclusion is that introducing a so-called assisted dying law would be beneficial to terminally-ill patients and *“increase their quality of life.”* What this means in practice, is setting up a licensing system whereby doctors can prescribe lethal drugs to seriously ill patients who wish to end their lives and have been told that they have six months or less, to live.

The authors state that the *“comfort and reassurance of knowing they would have the means to relieve their suffering and die at home at a time of their choosing would be considered just as valuable as having access to the best palliative care.”*

This might well be the case for a minority of determined people who wish to end their lives prematurely but if the law on assisted suicide was changed in order to accommodate for this, it would not only affect the determined few but the rest of society, including its most vulnerable members.

A witness who specialised in end-of-life care, told a 2005 House of Lords Select Committee that if ‘assisted dying was legalised, then patients ***“for the rest of their lives would be faced with this enduring choice as to whether they should ‘go for’ assisted suicide and euthanasia on the grounds that they have become a burden to their families because they perceive that they are useless.”***<sup>17</sup>

If we look at what is happening in jurisdictions where assisted suicide has been legalised, it is evident that the scenario quoted above, is a common occurrence.

Dignity in Dying has long proposed a model of assisted suicide for the UK, similar to the one in

<sup>17</sup> House of Lords Report 86-II (Session 2004-05), Page 554.

place in the US state of Oregon. If we examine the latest statistics from that region<sup>18</sup> it reveals that among those who applied for assisted suicide, fear of being a burden ranked higher than fear of inadequate pain control. More than half of the applicants said that they were concerned about burdening family, friends or caregivers, while only 25.6% listed 'inadequate pain control/fear of' as an end of life concern.

The data from Washington State which has an almost identical model of physician assisted suicide showed the same phenomenon. According to the latest official report<sup>19</sup>, the top four concerns were loss of autonomy, less able to engage in enjoyable activities, loss of dignity and a fear of being a burden of family or care givers. While 51% of participants cited the latter concern, 38% listed fears about pain and pain control as a key concern.

The authors of DiD's report paint a picture of the "comfort" and reassurance which an assisted suicide law might bring to a select few, but they neglect to mention that for other members of society its availability could prove an added pressure at an already difficult time, of whether to apply for it, and if so, when to finally ingest the lethal drugs. If we consider the data from abroad, people choose assisted suicide for multiple reasons and for some it is not primarily about ending or avoiding their own pain but alleviating their loved ones of a possible burden of caring for them.

DiD also argues that some terminally ill people are so scared of death that they attempt to take their own life and without "professional assistance" attempts can fail. Yet they provide no sound data to back up such a statement. While this may be a sad reality for a very small minority of people facing death, to argue that the solution is to introduce a system whereby doctors are expected to assist fearful and vulnerable individuals with their suicide goes against the fundamental principles of good clinical practice and raises serious ethical questions regarding the doctor-patient relationship.

At the heart of DiD's report is the presumption that the task of assisting suicide is a job for doctors despite the fact that the majority of doctors, particularly those routinely providing care for dying patients, are opposed to the practice. The Royal College of Physicians (RCP) adopted a controversial position of neutrality earlier this year, despite the fact the majority of those consulted, wanted no part in assisting suicide.

The pertinent question to ask, is whether doctors would be prepared to assist patients with their suicides, regardless of their personal beliefs on the topic.

The RCP consultation found that less than a quarter said that they would be prepared to participate and 55.4% of respondents would not be prepared to participate<sup>20</sup>. When this statistic was broken down by speciality, **84.4% of palliative care doctors said that even if physician assisted suicide was legalised, they would not be willing to be involved.**

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18 Oregon Death with Dignity Act, Data Summary, 2018

19 Death With Dignity Act Report, 2018

20 RCP assisted dying survey, Results by specialty and respondent profile, 2019

Why does this matter? If the majority of relevant healthcare professionals want nothing to do with assisted suicide this would render applicants for lethal barbiturates, highly vulnerable. The evidence from Oregon indicates that the practice of doctor shopping is prevalent, essentially where applicants have to 'shop around' for a compliant doctor, who might not know them beyond their case notes and who are less able to spot subtle signs of coercion.<sup>21</sup>

If we place this scenario within an over-stretched NHS, where doctors commonly experience burnout,<sup>22</sup> and sometimes struggle with protecting vulnerable individuals,<sup>23,24</sup> it does not present favourable conditions for a law which would place the burden of assessing patients for assisted suicide on the shoulders of doctors. It would leave the majority of seriously ill patients highly vulnerable to external and internal coercion. Indeed, it may be all too easy for clinicians to give up on patients, seeing a patient's death as a solution in an overburdened service.

## CONCLUSION

Although the UK is one of the best places in the world to die, there are still a minority of instances in which doctors cannot effectively relieve the suffering of their patients. It is widely recognised, however, that both access to palliative care and research into this area of medicine needs improvement.

*'The Inescapable Truth'* evokes a climate of fear about the reality of death in the UK, which is in fact, far from the reality. Furthermore, it presents the statistic of 17 bad deaths a day as an irrefutable certainty when it is really a cautious estimate. Examining the report on which the calculations of unrelieved distress are based, quickly reveals the seven steps into which error could be introduced.

DiD's recommendation of an 'assisted dying law' to address this problem amounts to a major change in the criminal law where rather than striving to ensure a peaceful death for their patients, doctors would be asked involve themselves in deliberately bringing about the deaths of seriously ill individuals by supplying them with lethal drugs. **So-called assisted dying is not simply just another, innocuous, end-of-life treatment option.**

Contrary to DiD's claims, there is no evidence that a change in the law would make patients safer or shield them from abuse. In fact, **the evidence from the US states of Washington and Oregon illuminates that applicants for assisted suicide are often motivated by internal coercion as they regard themselves as a burden on loved ones and carers.** There is no knowledge of how assessments are conducted, and some doctors seem excessively willing to prescribe lethal drugs, with one supplying 35 such prescriptions in one year alone.<sup>25</sup>

21 Living and Dying Well, Oregon: Twenty Years of Physician Assisted Suicide. Looking at the Evidence

22 General Medical Council: National Training Surveys 2019: Initial Findings Report

23 Heslop P et al. CIPOLD: Confidential Inquiry into Premature Deaths of People with learning disabilities. Bristol: University of Bristol, 2013

24 Death by Indifference: 74 deaths and counting. London, Mencap, 2012.

25 Oregon Death with Dignity Act, 2018, Data Summary

It is also worth noting the final conclusion on assisted suicide laws, drawn by the National Council on Disability (NCD) in the United States, which are highlighted in the Executive Summary of this report:

***“The basic dangers of legalising assisted suicide are inherent and cannot be eradicated.”***

Finally, DiD cannot continue to insist that assisted suicide is a job for doctors when the majority of physicians who care for dying patients oppose a change in the law and want no part in it.

It is worth remembering that it is the professionals who witness dying almost every day, who do not believe that introducing an assisted suicide law is necessary. To quote one palliative care doctor in a letter to the Times earlier this year:

*“Doctors who are wary of assisted suicide have not reached this point of view by observing the world from an ivory tower but by standing at the bedsides of their dying patients.”*<sup>26</sup>

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<sup>26</sup> Letter to the Times by Dr Carol Davis: March 26, 2019



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