

### The case for neutrality on assisted dying — a personal view

Tony Nicklinson's case has yet again thrown into the spotlight the issue of assisted dying and brought, again, arguments for and against, from an array of individuals and organisations. The issue was the basis of the recent Independent Falconer Commission<sup>1</sup> and after thousands of written and oral submissions, this Commission came to an unambiguous view, namely '... current status of assisted dying is inadequate and incoherent' and 'there is a strong case for providing the choice of assisted dying for terminally ill people'. Arguments on either side are well rehearsed and laid out in the Falconer report: Those against often raise 'What if ...?' questions; for example, 'What if a patient is coerced into accepting assisted dying?' 'What if this is the thin edge of the wedge?' and 'What if this represents the re-emergence of the eugenics movement'? Equally strong arguments are cited by those who advocate a change in the law — they talk about the rights of the mentally competent individual to choose their time and place of death, especially given the policy of 'no decision about me without me'. Perhaps the most persuasive approach to arguing this point is to cite personal experience, as did Tess McPherson,<sup>2</sup> Ann McPherson's daughter. Ann herself a protagonist<sup>3</sup> of assisted dying had established the campaigning group Healthcare Professionals for Assisted Dying (HPAD). Ann died of pancreatic cancer in 2012, having not achieved her desired wish to allow her own death to be assisted.

I, like many, have a personal view on this issue, and I, like many giving evidence to the Falconer Commission, am able to voice this view. This paper is not however about the pros and cons of assisted dying or about what my view is. Instead it is about the pros and cons of any Royal College or medical body having a collective view, at all. My view should not be more or less valid merely because of who I am (Chair of the Royal College of General Practitioners). Similarly the RCGP's 'collective' view should not trump the view of the man on the Clapham Omnibus. Moreover, a collective view is a misnomer, given that a recent poll of GPs found that there was no overwhelming

consensus for either stance. We should not assume that our present position fairly represents the divergent views of our 44 000 members, who will vary in their strength of opinion, religious beliefs, and knowledge of, and experience in, care of the dying.<sup>4</sup> It is my view, that all Royal Colleges and Medical, Nursing, and other umbrella medical organisations should join with the Royal College of Nursing<sup>5</sup> and the Royal College of Psychiatrists<sup>6</sup> and take a neutral stance on the issue of assisted dying and should not be publicly opposed to or support any change in legislation that may allow assisted dying for terminally ill, mentally competent adults.

At the heart of the case for neutrality is that the decriminalisation of assisted dying should be a matter for society as a whole to decide, using established parliamentary processes. No particular group within it should have a disproportionate influence on this decision; in particular medical bodies should not impose the beliefs of some of their members on to patients and carers and oppose (or indeed support) a law on assisted dying. Godlee,<sup>7</sup> in her editorial in the *BMJ* draws parallels with the depth of personal, professional, and religious arguments around abortion reform in the 1960s and how the medical profession resisted changes in the law for fear of loss of clinical autonomy. The same could be said for the current assisted dying debate. This time, however, instead of loss of clinical autonomy it is perhaps the fear of being drawn into difficult areas of clinical practice, hitherto unknown in UK medical work, that is driving the debate.

As with the abortion law, individual healthcare professionals, as responsible citizens, are, of course, entitled, perhaps obliged, to express their views about the ethical and clinical case for, and the potential social impact of, a law allowing assisted dying for the terminally ill. But the legitimate role of all our medical, nursing, and professional representative bodies, should be confined to speaking on those areas where we have an expertise that goes beyond that of the public; for example, advising on the necessary safeguards and codes of practice should any law be passed, and on matters such as assessing prognosis and setting guidelines for optimal end-of-life care. They should be concerned with areas of regulation, monitoring, and

#### ADDRESS FOR CORRESPONDENCE

##### Clare Gerada

Riverside Medical Centre, Hobart House, St Georges Wharf, Wandsworth Road, London, SW8 2JB, UK.

E-mail: [clare.gerada@nhs.net](mailto:clare.gerada@nhs.net)

establishing criteria for implementation of the law, not whether the law should happen or not.

Parliament, not the profession, must decide this issue, based on their experience, knowledge, wisdom, and taking into account the views of their constituents. This is the power we, as individuals, bestow on MPs. It is not for doctors to do their bidding for them.

##### Clare Gerada,

GP in London and Chair of Council, Royal College of General Practitioners, London.

#### Competing interests

These views are my own and not those of the position I hold.

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