Truths & Half Truths About Assisted Dying

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Living and Dying Well

Introduction

Should the law be changed to license doctors to supply lethal drugs to terminally ill patients who seem to them to meet certain conditions? Once again campaigning is being ramped up in the hope of persuading Parliament to do that. This is a complex and emotive issue. It's also a very serious one. The consequences of error are, quite literally, deadly. It's important therefore that legislators should know the facts.

Yet that isn't what they are getting. Look, for example, at the website of the campaigning group Dignity in Dying (DiD) and you will see a list of questions and answers that reduces a complex and serious issue to a series of bland and reassuring statements and assertions that rest of little or no evidence. This over-simplistic Janet-and- John style approach just will not do.

In the pages that follow therefore we have set out, against each of the questions and answers posited by DiD on its website, an evidence-based statement of the reality. Legislators must make up their own minds where they stand on this issue. But the gravity of what is being proposed requires that whatever decisions are made should rest on careful analysis of hard evidence rather than on spin and sensationalism. It is in that spirit that this booklet has been written.

CONTENTS

1. How will assisted dying impact the relationship between doctors and patients?

What is Dignity in Dying saying?

Polling shows that 87% of people say an assisted dying law would increase or have no effect on their trust in doctors.

Changing the law would allow a dying person to have open and honest conversations with their doctors about assisted dying. This is currently impossible within the law.

The Reality

We trust our doctors because we need medical care and they have been judged qualified to provide it. In the same way we trust the pilots of the airliners we board – not because the law says this or that but because we need to travel by air and they have been cleared to fly us.

Doctors can - and do - have open and honest conversations about dying with terminally ill patients, as was made clear in guidance issued in 2013 by the General Medical Council. There is nothing in law or in medical ethics to prevent such conversations. What doctors may not do is to supply their patients with lethal drugs for purposes of suicide. Doctors have a duty of care to patients who show signs of wanting to take their own lives.

However, it is precisely the trust that patients, rightly and necessarily, place in their doctors that represents a real danger if 'assisted dying' (as it's being euphemistically called) is introduced into clinical practice. The doctor-patient relationship is by its nature an asymmetric one, as doctors have greater medical knowledge and experience than most of their patients. As a result patients often look to their doctors not just for medications or treatments but also for guidance. A doctor who agrees to pursue a request

for ‘assisted dying’ risks sending to the patient, however unintentionally, the misleading message that in the doctor’s professional opinion the patient’s outlook is bleak and he/she would be better off dead. The doctor-patient relationship is not just another customer-supplier relationship.

2. Can we be sure assisted dying is not the start of a 'slippery slope'?

What is Dignity in Dying saying?

Fears of a slippery slope are not backed up by evidence. Where assisted dying is legal there have been no cases of abuse and no widening of the law. Assisted deaths in Oregon account for just 0.4% of deaths.

Belgium and the Netherlands are sometimes cited as examples of the 'slippery slope'. But these jurisdictions have always had much broader laws than the one we campaign for.

The current law contains no safeguards to protect dying people who want to control their death. An assisted dying law would protect against a 'slippery slope', not encourage one.

The Reality

There is no evidence to support the claim that 'there have been no cases of abuse in Oregon's law'. Doctors in Oregon who supply lethal drugs to patients are required to declare that to the Oregon Health Authority (OHA) by ticking a series of boxes. But there is no case review system to examine how requests for lethal drugs have been handled. As the OHA makes clear on its website, it does not investigate whether people who have been supplied with lethal drugs met the conditions laid down in the law. With such a closed system it is impossible to say that there has been no abuse of the law.

It is true that there has been no formal widening of access to Oregon's law since its enactment. However, the Oregon Health Authority has admitted that the terms are not as strict as may appear at first sight. For example, a person with insulin-dependent diabetes could render him/herself eligible to receive lethal drugs simply by stopping taking the medication that is successfully managing the condition. There have also been repeated and continuing attempts to widen the formal scope of Oregon's law. And there

has been a recent reduction in the mandatory period for reflection following receipt of lethal drugs.

The annual death rate quoted by DiD refers to 2017. By 2020 the number of reported deaths had increased by 70% over the number in 2017. Oregon is a sparsely populated American State: its total population is less than half that of London. Based on Oregon's 2020 death rate from legalised assisted suicide, a law like Oregon's would result in some 3,500 assisted suicide deaths annually in England and Wales alone.

It is true that the 'assisted dying' law currently being advocated by campaigning groups in Britain is less broad than similar laws in The Netherlands and Belgium. However, those laws have something in common with the aspirations of 'assisted dying' campaigners here. In both cases a law with a natural and rational boundary – that we do not involve ourselves in deliberately bringing about the deaths of other people – has been replaced by a law with an artificial and arbitrary boundary – that it is acceptable to do that to some people but not to others.

Such laws lack rational justification. If the relief of suffering is seen as the aim of an 'assisted dying' law, the question has to be asked: where is the logic in offering lethal drugs to people who are expected to die shortly of natural causes but denying them to others who may have years of chronic illness ahead of them? Because of their arbitrary nature 'assisted dying' laws contain within themselves the seeds of their own expansion.

Nor should we forget that Dignity in Dying, under its former name of the Voluntary Euthanasia Society, has previously advocated laws along the lines of those in The Netherlands and Belgium. Only recently did it decide to narrow its ambitions to assisted suicide and Oregon.

3. Can palliative care work alongside assisted dying?

What is Dignity in Dying saying?

Yes and it has been the case in Oregon where the Oregon Hospice Association acknowledges that assisted dying and palliative care can work together. It now has a neutral stance on the issue. Conversations around death and dying have increased since the law changed there.

When somebody requests assisted dying doctors have to inform them of all their palliative care options. We support efforts to improve access to high quality palliative care.

The Reality

Palliative care has only recently been recognised in Oregon as a specialist branch of medicine. The Mackay Committee was told when it visited Oregon in 2004 that legalisation of assisted suicide had been "in some ways a vote of no confidence about some aspects of end of life care"[1]. By contrast, in Britain palliative care has been a recognised medical specialism for over 30 years and is widely recognised as a world leader in this branch of medicine.

Most hospice care in Oregon is hospice-at-home, in which doctors or nurses with a knowledge of palliative care pay visits to incurably ill patients. Hospice at home exists in Britain too, but here it is just part of a wider spectrum of care, including also day and in-patient hospice care. The Mackay Committee was told that access to State-funded hospice care in Oregon was conditional on waiving the right to any further curative treatment.

Palliative care specialists in Britain are overwhelmingly opposed to 'assisted dying' and most of them say they would not participate in such

[1] House of Lords Report 86-I (Session 2004-05), Page 281

practices if they were to be legalised. Who therefore would inform persons seeking lethal drugs of 'all their palliative care options'? Such briefings could well end up being given by generalist doctors who may or may not be up to date with the latest forms of treatment for incurable illness.

In any case the question arises: can a life-or-death decision be taken solely on the basis of a briefing? Palliative care specialists in Britain encounter patients from time to time who have been referred to them with apparently intractable symptoms and who say they want to end their lives but who, after experiencing specialist palliative care, change their minds.

4. Can we know if a person has capacity to end their own life?

What is Dignity in Dying saying?

Capacity already plays a key role in end-of-life decision-making. People with capacity can refuse treatment, even if that is likely to result in their death.

The Mental Capacity Act (2005) means there is a legal framework that exists to support doctors to assess capacity.

If a doctor doubted a person's capacity they would have to refer them to another professional, such as a psychiatrist.

The Royal College of Psychiatrists have a neutral stance on assisted dying.

The Reality

Refusing treatment that will extend life is not the same thing as seeking lethal drugs to end life. A patient who refuses treatment is not in doing so expressing a wish to die but a willingness to let the disease take its course. In neither law nor medical ethics does treatment refusal constitute suicide. That is not the case with a request for lethal drugs with the intention of ending life. In law that amounts to suicide and the provision of such drugs would be assisting suicide.

The 2005 Mental Capacity Act states that "a person must be assumed to have capacity unless it is established that he lacks capacity". As the Act makes clear, it does not apply to situations where persons may be seeking the means to end their own lives. A doctor who suspects that a patient is contemplating suicide has a duty of care to protect the patient from self-harm.

Capacity is, moreover, decision-specific – the more serious and/or irreversible the decision, the higher the level of capacity required. A

decision to seek lethal drugs lies at top end of any spectrum of gravity. It is perverse therefore to suggest that a doctor assessing such a request must assume the presence of decision-making capacity unless there is evidence to the contrary. The burden of proof in such circumstances needs to be the other way round.

Research in Oregon[2] has indicated that some patients who have ended their lives with legally-supplied lethal drugs had been suffering from clinical depression which had not been diagnosed by the doctors assessing them and had not been referred for evaluation by a specialist in capacity, as Oregon's law requires.

[2] Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey, Ganzini et al, British Medical Journal 2008; 337: a1682

5. Can you support assisted dying if you are religious?

What is Dignity in Dying saying?

Polling shows that 79% of religious people support a change in the law on assisted dying.

Archbishop Desmond Tutu and former Archbishop of Canterbury, Lord Carey, both support assisted dying. Interfaith Leaders for Dignity in Dying (IFDiD) is a group of faith-leaders campaigning for a change in the law.

The Reality

For some people there may be a religious dimension to the question of whether 'assisted dying' should be legalised. But it is not predominantly a religious question and it may be the case that people who would describe themselves as belonging to a religion would support legalisation.

It is not made clear in the answer offered who are those described as 'inter-faith leaders'. From the few details available they appear to be members of various religious groups rather than the leaders of the main faith groups in Britain. Archbishop Tutu and Lord Carey have expressed support for a change in the law and their views are to be respected. But they do not speak for their respective communions. That does not make them wrong: there is room for dissent in all contexts. But neither does their eminence make them right.

6. Does the evidence from Oregon justify support for assisted dying in the UK?

What is Dignity in Dying saying?

The current law in the UK does not work. Evidence from Oregon shows that an assisted dying law is safe and practical.

Assisted dying has been legal in Oregon since 1997. There have been no cases of abuse, no extension of the law and no 'slippery slope'.

None of the fears expressed by those who opposing change in Oregon have come true. Yet opponents of a change in the law in this country still use the same, discredited arguments.

The Reality

No evidence is provided to support the sweeping assertion in the answer offered that 'the current law in the UK does not work'. That's because there isn't any such evidence: the existing law does work. It has the teeth to deter malicious assistance with suicide (something that 'assisted dying' laws don't have) and the discretion not to prosecute where there is clear evidence of genuine compassion.

Nor is there any evidence that Oregon's law is 'safe and practical'. It is (almost) true to say that there has been no formal extension of Oregon's law – there has, in fact, been a recent shortening of the mandatory period of reflection before lethal drugs may be swallowed. But formal extension isn't needed as the existing terms of the law appear to be open to flexible interpretation. For example, the law states that to qualify for receiving lethal drugs, a person must have been diagnosed as terminally ill and given a prognosis of less than six months. But, as indicated in Section 2, it has recently come to light that a person with a non-terminal illness which is

being successfully managed (for example, insulin-dependent diabetes) can qualify to receive lethal drugs simply by ceasing to take the medication that is successfully managing the condition.

The confident assertion that 'there have been no cases of abuse' rests on no evidence at all. A doctor who supplies lethal drugs is required to report the fact to the Oregon Health Authority (OHA) and to tick a series of boxes. But there is no review system to examine with what care a request has been considered. As the OHA itself states[3], it is up to doctors who consider requests to decide whether they meet the requirements of the law. Some of those who seek lethal drugs find that their regular doctors will not consider their requests. They seek out or are introduced to a minority of doctors who have never met them before and have no first-hand knowledge of them as patients. In 2020 one such doctor in Oregon wrote no fewer than 31 prescriptions for lethal drugs.

The published reports tell us little about the quality of the assessments that are taking place. But, as indicated in Section 4, Oregon-based research has indicated that one in six of a sample of deaths from legalised assisted suicide involved people who had been suffering from clinical depression that had not been picked up by the assessing doctors and who had not been referred, as Oregon's law requires in cases of doubt, for specialist psychological assessment.

Meanwhile the number of deaths from legalised assisted suicide is rising year by year. In 2020 there were 15 times as many such deaths as in the first year following the law's enactment. Based on Oregon's current death rate from legalised assisted suicide a similar law in England and Wales would result in around 3,500 such deaths annually - nearly 4,000 in the UK as a whole.

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[3] Oregon Health Authority, 2017 Data Summary, Page 4

7. Does the UK public support a change to the law on assisted dying?

What is Dignity in Dying saying?

The vast majority of people in the UK support an assisted dying law for terminally ill, mentally competent adults. In 2015 the largest poll ever conducted on the issue found that 82% support assisted dying. Support is consistently high regardless of age, gender or political persuasion. There is small but vocal minority of people who oppose assisted dying.

The Reality

The polls are often commissioned by campaigning groups for legalisation and worded in such a way as to lead respondents to the desired answer – ie that the law should be changed. Respondents are told, for example, that there would be strict 'upfront safeguards' (in fact, they are no more than vaguely-worded conditions with no mandatory requirements for meeting them) and that such laws work well overseas (on which see Section 6 above).

The Mackay Committee invited members of the public to write in with their views of whether the law should be changed. Over 12,000 letters or emails were received in response. 50.6 per cent favoured legal change and 49.4 per cent opposed it. The reality is that there is a committed core of support for and opposition to a change in the law, while a majority of the public have little familiarity with the subject but are willing to sign up to propositions which sound compassionate.

This is a subject on which it is easy to whip up support by carefully worded and sequenced questions and by parading emotive cases in the media. But Parliament has to make decisions on the basis of the evidence rather than just slogans or soundbites. The burden of proof is on those who wish to see the law changed to present a convincing and well-researched case for doing so. That burden of proof has not been shouldered.

8. Is it possible to identify terminal illness and predict life expectancy?

What is Dignity in Dying saying?

Many doctors have experience in diagnosing a terminal illness and estimating life expectancy.

For example, doctors have to do this when they process benefit forms for terminally ill people.

Prognosis is not an exact science. Research shows doctors are more likely to overestimate rather than underestimate life expectancy.

The Reality

The Mackay Committee was told by the Royal College of General Practitioners that "it is possible to make reasonably accurate prognoses of death within minutes, hours or a few days" but that "when this stretches to months, then the scope for error can extend into years"[4]. Similarly, the Royal College of Physicians told the committee that "prognosticating may be better when somebody is within the last two or three weeks of their life" but that "when they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor"[5].

While diagnosis of terminal illness is generally reliable, there are nonetheless errors. The committee was told by the Royal College of Pathologists that "significant errors (ie misdiagnosis of terminal illness resulting in inappropriate treatment) occurs in c.five per cent of cases"[6].

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[4] House of Lords Report 86-I (Session 2004-05), Paragraph 118

[5] Ibid

[6] House of Lords Report 86-II (Session 2004-05), Page 730

Oregon's experience shows that some people who receive legally-supplied lethal drugs from doctors postpone taking them and live for longer (in some cases much longer) than predicted after being diagnosed as terminally ill before swallowing them. How long they would have lived if they had not received such drugs is anyone's guess.

Why does this matter? It matters because many people, when diagnosed as terminally ill, understandably ask their doctors 'how long have I got'? The fallibility of prognosis does not matter under the existing law. But it does matter under an 'assisted dying' regime, where handing out lethal drugs is involved, as some patients could take their own lives under the impression that they are close to death, when in fact they could have much longer to live.

There is a difference between assessing someone for a benefit claim and assessing them for the supply of lethal drugs. The danger of a mis-prognosis in one case is that taxpayers pay a small amount of money more than they should; in the other, the danger is that someone's life is terminated. The comparison is inappropriate.

9. Is there a distinction between ‘assisted dying’ and ‘assisted suicide’?

What is Dignity in Dying saying?

Dying people who want to control the manner and timing of their deaths are not suicidal.

Laws which permit assistance for people who are not dying to take their lives are usually referred to as ‘assisted suicide laws’. This is beyond the scope of what Dignity in Dying campaigns for.

In 2015 the House of Lords voted against changing the Assisted Dying Bill to refer to ‘assisted suicide'.

The Reality

The term ‘assisted dying’ is a euphemism employed by campaigning groups in Britain to refer to the supply of lethal drugs to people who have been diagnosed as terminally ill so that those drugs might be used by the recipients to end their lives. The term has no meaning in law. Supplying a person with lethal drugs with the intention that those drugs will be used to end the person’s life constitutes the offence of assisting suicide, which is prohibited under Section 2 of the 1961 Suicide Act. Such behaviour is a criminal offence whatever the state of health of the recipient.

The purpose of the criminal law is to protect us from harm, including self-harm. It applies equally to all of us, irrespective of our age, gender, race - and state of health. An ‘assisted dying’ law implies that the law should treat people who are terminally ill differently from people who are not - that we should do everything we can to protect non-terminally-ill persons from taking their own lives while facilitating the process for others who have been diagnosed as terminally ill.

As a society we rightly treat people who attempt to take their own lives with understanding and compassion. But as a society we are clear that suicide is not something to be encouraged or assisted. That is why we have 'suicide watches' in situations where persons are considered to be at risk of self-harm and why successive governments have supported suicide prevention strategies. The word 'suicide' may sound harsh to some, but it is a reminder of the gravity of the act in question, whatever the individual circumstances of the person concerned. To use other terminology for certain types of suicide in an attempt to make it sound more acceptable is a dangerous misuse of language.

10. Isn't assisted dying happening already?

What is Dignity in Dying saying?

People are being assisted to die in this country outside the law. Research suggests 1,000 people each year receive help to die, illegally, from a doctor at their request.

The Reality

There have been various studies into the possible incidence of illegal actions by doctors in this area, some of which have suggested that there might be individual instances where a doctor has supplied or administered lethal drugs to a dying patient. Giving evidence in 2010 to Lord Falconer's self-styled 'commission on assisted dying', Professor Clive Seale, who has studied the subject in depth, stated:

"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-making in the UK medical practice that is very marked compared to other countries. And with that situation decisions don't go unscrutinised".

As in every other field of human activity, it is impossible to rule out malpractice completely. But, in Professor Seale's words, in the UK "euthanasia, physician-assisted suicide and the ending of life without an explicit patient request are rare or non-existent"[7]. This is radically different from what is being proposed by advocates of legalised 'assisted dying' – namely, that a process should be created for doctors deliberately to end the lives of patients in certain circumstances.

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[7] Seale, C End of Life Decisions in the UK involving Medical Practitioners, Palliative Medicine 2009; 00:1-7

11. Should dying people be free to choose when and how they die?

What is Dignity in Dying saying?

Seeking control is a natural instinct throughout life. It is wrong to say that we should abandon this urge in our final weeks and months.

The current law tells dying people that if they want to control their death, they must travel abroad or do so behind closed doors.

A safeguarded, transparent system would be safer and fairer.

The Reality

The present law says nothing of the sort. It says that assisting the suicide of others is a criminal offence, a prohibition which accurately reflects social attitudes to suicide. If individuals choose to travel abroad to end their lives in one of the small number of jurisdictions where assisting suicide is legal, that is a matter for them. But it is not a reason to change the law here.

Seriously ill people can, if they so wish, refuse or discontinue treatment that may extend their lives. If they do so, their doctors have a continuing duty of care to assist them to live with maximum comfort until they die and, when death comes, to die peacefully.

The 'assisted dying' laws that have been proposed by campaigners offer neither transparency nor safety. The bills that Parliament has seen to date contain no safeguards, but simply vaguely-worded eligibility criteria. These do not require any minimum steps to be taken by those assessing requests for lethal drugs to ensure that the criteria have been met. As such, they are nothing more than statements of what ought to happen in a perfect world. Nor do they include any arrangements for independent review of decisions to supply lethal drugs.

By contrast, the existing law contains real safeguards. Anyone minded to aid and abet another's suicide for malicious or manipulative reasons has to reckon with a spotlight being shone on his or her actions and on any criminal behaviour coming to light. Under an 'assisted dying' law this deterrent would be effectively removed. The only risk that a malicious assister would run is that the request might be rejected.

12. What are the problems with the current law on assisted dying?

What is Dignity in Dying saying?

The current law does not work.

Every ten days somebody from Britain travels to Dignitas to die. Every year over 300 dying people end their own lives at home. Around 1,000 people each year receive help to die, illegally, from a doctor at their request.

These is no regulation of these practices and no safeguards to protect people.

The Reality

No explanation is offered of what the law says or how it is applied. There is just the bland statement that 'the current law does not work'. The legal position has been covered in part in previous sections.

In summary, the law prohibits encouraging or assisting the suicide of another person and it holds in reserve penalties that are sufficient to make anyone minded to engage in such acts think very carefully before doing so. It is unsurprising therefore that assisting suicide is a rare offence in Britain and that the few cases that do occur are usually where there has been reluctance, deep soul-searching and genuine compassion. These are cases that do not call for prosecution in the public interest and, thanks to the discretion which the law gives to the Director of Public Prosecutions, they are not prosecuted.

There is, however, an important difference between not prosecuting a breach of the law which has occurred in highly exceptional and understandable circumstances and licensing such acts in advance for specific groups of people – which is what an 'assisted dying' law amounts to. In the latter case the deterrent against abuse is weakened – a person encouraging an act of 'assisted dying' with malicious intent would have nothing to fear

other than that the request might be refused. The existing law is also in accord with social attitudes to suicide.

While journeys to Dignitas attract media attention, in reality they are very rare. In 2017 0.008 per cent of deaths of Britons took this form. Terminally ill people sometimes do take their own lives in Britain but there is no evidence that they were assisted or that they would have met the criteria for 'assisted dying' that form part of Dignity in Dying's declared political agenda. In any case, is it seriously being suggested that the answer to terminally ill people taking their own lives is to supply them with lethal drugs in order to help them on their way?

The suggestion that doctors are ending the lives of patients on the quiet has been addressed in Section 10. As observed in Section 11, the 'assisted dying' bills that have been presented to Parliament and rejected have contained no safeguards, only vaguely-worded eligibility criteria.

13. What effect would an assisted dying law have on disabled people?

What is Dignity in Dying saying?

Disabled people would only be eligible to have an assisted death if they also had a terminal illness, such as cancer.

It would be illegal to encourage a disabled person to request assisted dying. The safeguards in an assisted dying law would protect and support the public.

Polling shows that 86% of disabled people support assisted dying for terminally ill adults.

Lord Rix was the President of Mencap and campaigned for disability rights for over four decades. Before he died he changed his mind on assisted dying and called on Parliament to change the law.

The Reality

In 2010 Lord Falconer of Thoroton, a prominent advocate of legalising 'assisted dying', chaired a self-styled 'commission on assisted dying', the majority of whose members were known supporters of such legislation. In its report the 'commission' stated:

"We have taken on board the strong concerns expressed by many disabled people and do not consider that it would be acceptable to society at this point in time to recommend that a non-terminally person with significant physical impairments should be made eligible under any future legislation to request assistance in ending his or her life"[8].

[8] Commission on Assisted Dying, Report 2012, Page 306

Those five words ‘at this point in time’ are chilling, suggesting as they do that there may come a time when it might be acceptable to include disability in the qualifying criteria for ‘assisted dying’. As paralympic athlete Tanni Grey-Thompson wrote at the time, ‘what this is telling me is that I’m not a candidate for assisted dying right now but I’m in the waiting room’. It is little wonder therefore that many people with disabilities are concerned about such legislation.

It is all too easy to see persons with incurable illness and with disability as distinct categories of people. In reality, the two conditions can often overlap. Many people with disabilities have unhappy experiences of health care and of living generally, in which the notion that ‘I wouldn’t want to live like that’, while unspoken, is nonetheless there in the background.

The deficiencies of opinion polls, particularly those sponsored by campaigning groups, have been addressed in Section 7.

14. Would an assisted death be free from pain?

What is Dignity in Dying saying?

People who have seen a loved one's assisted death describe it as quick and painless.

In Oregon it takes an average of five minutes for people to fall unconscious and 25 minutes for them to die.

The Reality

The above picture of a "quick and painless" death is not entirely corroborated by the official annual reports of the Oregon Health Authority (OHA). According to the OHA report on Calendar Year 2019 the median length of time between ingestion of lethal drugs and death was 51 minutes within a range of 1 minute to 47 hours (nearly two days). Over the whole period since physician-assisted suicide was legalised, the range of time between ingestion and death was 1 minute to 104 hours (more than four days).

As for difficulties experienced by those swallowing the drugs, the OHA is able to record data only where a physician or other health care provider has been present. This comprises only a minority of occasions. In 2019 information was available for only 61 out of 188 deaths. In 6 out of these 61 cases (10 per cent) complications were recorded, including difficulty in ingesting and regurgitation. In some earlier years there have been recorded instances of people regaining consciousness after swallowing lethal drugs. None subsequently re-attempted the process.

There is a wider point. As here, legalisation is presented as necessary to avoid dying in pain. Oregon's experience contradicts this. The report on 2020 lists the reasons which those who took their lives in that year gave for wanting to do so. Top of the list, cited by over 90 per cent of respondents,

was “less able to engage in activities making life enjoyable”. Pain or the fear of pain comes next to the bottom of the list, cited by just 33 per cent. This is hardly surprising as the science of pain relief has advanced considerably in recent years to the point where it is possible to eliminate or alleviate most forms of physiological pain.

15. Would an assisted dying law protect vulnerable people?

What is Dignity in Dying saying?

The current law does not prevent or protect people having an assisted death. An assisted dying law would protect vulnerable people and be a much safer alternative.

People are travelling abroad for assistance to die, ending their own lives or receiving illegal help from doctors. Authorities turn a blind eye to these practices.

An assisted dying law would bring transparency, regulation and oversight. Two doctors and a judge would explore a person's motivations for requesting assisted dying. They would make sure the person met all the eligibility criteria and also explain treatment options.

Research from oversees shows assisted dying laws has no negative impact on vulnerable people.

The Reality

The existing law does protect vulnerable people. It has a powerful deterrent in the form of the penalties it holds in reserve to deal with malicious or manipulative behaviour while requiring that the few cases that do occur are subjected to fact-based investigation in order to ascertain whether the assistance given has involved criminality. An 'assisted dying' law would effectively remove this deterrent and it would replace fact-based investigation with subjective opinion.

The claims concerning deaths abroad and illegal behaviour by doctors have been addressed above: they have little or no substance. Any contravention of the law is investigated and action taken where necessary. Perversely, it is one of the complaints of the 'assisted dying' lobby that such

investigations may cause distress. Thanks to the deterrent effect of the law, these investigations do not often result in prosecution. But it is nonsense to suggest that the authorities are turning a 'blind eye'.

The assessment process described above is superficial. Doctors, while qualified to diagnose terminal illness and to offer an opinion of life expectancy, are in no position to judge whether other (personal or social) criteria are met. The bills that have been presented to date have contained no requirement for a judge to "explore a person's motivations for requesting assisted dying" but simply that a judge should confirm the decisions of doctors. The criteria themselves are loosely-worded and mandate no minimum steps for a doctor to take to ensure that their terms are met.

There is no evidence whatever to suggest that 'assisted dying' laws "have no negative impact on vulnerable people".

Published April 2021

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