Should the law on assisted dying be changed? Yes

Raymond Tallis argues that allowing terminally ill people to choose an assisted death is part of good care, but Kevin Fitzpatrick (doi:10.1136/bmj.d1883) believes it will endanger the lives of disabled people.

Raymond Tallis  
former professor of geriatric medicine

University of Manchester, Manchester, UK

The case for legalising assisted dying for people with terminal illness is easily stated. Unbearable suffering, prolonged by medical care, and inflicted on a dying patient who wishes to die, is unequivocally a bad thing. It is one of the fundamental principles of medicine that you should be allowed to determine what is in your own best interest when you are of sound mind.

Nobody else’s views should be able to over-ride this right. This seems incontrovertible to me now, and yet when I first considered the matter I was opposed to legalising assisted dying. This was because I made numerous incorrect assumptions. These, I believe, form the basis of much opposition to a change in the law, and I want to address them.

We must set aside the claim that more or better palliative care can deal with all instances of unbearable suffering. My experience as a doctor for 35 years, often working with excellent palliative care teams, showed that. The increasing recourse to continuous sedation—reducing a person to a vegetative state—by UK palliative care doctors is an implicit admission of this.

Experience outside the UK also shows the groundlessness of the worry that the availability of the “easy” option of assisted dying would stunt the much needed development of palliative care services. In Belgium, for example, investment in these services increased before the introduction of euthanasia legislation after a law was passed asserting the right of every citizen to palliative care.

Trust and the slippery slope

Others have claimed that legalising assisted dying would erode trust in the medical profession. The evidence is against this. A survey of nine European countries put the level of trust in the Netherlands at the top. It should not come as a surprise that when decision making in end of life care is not wrapped in a mist of ambiguity, or beset by ethical, clinical, and legal fudging, as it is in the UK, doctors are more, not less, trusted. It is also reassuring to know that the medical team will not walk away from you at your hour of greatest need.

What about the argument that legalisation of assisted dying would take us to the top of a slippery slope that would lead, through assisted suicide for people with non-terminal illness, to the involuntary euthanasia of people who have no wish to die? Again, international experience does not support this. In Oregon there have been no calls to extend the legislation beyond safeguarded assisted dying for the terminally ill since it was introduced, and the proportion of deaths by this means has remained at or below 0.2%. In the Netherlands and Belgium the rates of non-voluntary euthanasia have roughly halved since legalisation of assisted dying. Given that a recent study has shown that 0.3% of deaths in the UK were the result of non-voluntary euthanasia, we are on a slippery slope already and legislation would prevent rather than promote descent down it. Crucially, there is no public appetite for extending the law beyond assisted dying for the terminally ill, which has enjoyed the steady and unwavering support of over 80% of the UK population.

The possibility that assisted dying would be offered to or imposed on vulnerable people was a particular concern to me as a geriatrician. The Oregon experience, however, points in the opposite direction. There is an under-representation of those who are traditionally thought of as disempowered: those who seek help to die tend to be comparatively well-off, middle class people who are used to being in control.

Humane choice

Only a few people would require assisted dying, but many more are comforted from knowing it is available if necessary. The Oregon experience shows that only 0.5% of those who consider the option actually go on to have assisted death. Legislation that requires an interval between expressing a wish for assistance and cashing the prescription can accommodate the possibility that people may change their mind. The alternatives—death from dehydration or starvation, botched suicides, ghastly journeys to Switzerland—testify to the cruelty of the present
law and (as in the case of continuous sedation or over-liberal interpretation of the double effect) show how dangerous fudges are often employed to circumvent it.

Living well includes dying well, and supporting a dying person who seeks help to die is an expression of this. It is not to devalue human life, or the life of a particular person, or to collude in their devaluation of themselves. It is to accept their valuation of a few remaining days or weeks that they cannot endure for reasons that are self evident and should be respected.

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