Legalising assisted dying puts vulnerable patients at risk and doctors must speak up

If proposed legislation on assisted dying involves doctors, then we must make our reservations known, says **Bill Noble**

Assisted dying can be defined as legal, physician assisted suicide for mentally competent adults who are terminally ill. Now that another piece of legislation has had its first reading in the UK House of Lords,[1] the debate is on again. I have no religious objections, but I recoil from the vision of a society where death is a therapeutic option; the idea that there are two categories of suicidal people, those deserving and those undeserving of death; and the idea that doctors should do the sorting and the killing.

In June 2012, the *BMJ* carried editorials supporting the call from the Healthcare Professionals for Assisted Dying (HPAD) for medical organisations—such as the BMA and the royal colleges—to adopt "studied neutrality" on the question of legalising assisted suicide.[2 3] The *BMJ*'s editor, Fiona Godlee, is right to argue that society and not the medical profession should determine the law. But if organisations representing doctors step back, while legislation insists on doctors' involvement, we abrogate responsibility for our patients and the next generation of doctors.

Doctors worry about the idea that ending your life before you lose dignity will become a new cultural norm. The US state of Oregon is the new model; but why should we take a moral lead on personal rights from a country without gun control, unwilling to ensure adequate healthcare for all its citizens?

Stories such as that of HPAD founder Ann McPherson, whose distress went unrelieved, cannot be denied.[4 5] Palliative care cannot remove every kind of distress. Some patients suffer to the extent that they wish to be dead, but few attempt suicide or ask that we end their lives. Much more common is the relative who wants to see an end to the suffering. Wishing for death is not a purely individual decision, uninfluenced by family and society. Nor should the retention of dignity become a social prerequisite to continued existence.

I see vulnerable patients under pressure. Older people, who are already ejected from our NHS funded and governed care, acquiesce to be nursed in commercial institutions of variable and uncertain quality. Their wish not to be a burden on family is powerful, and I have seen patients reject treatments to shorten survival to make it easier for their family. If assisted dying is legalised, I fear that our society's neglect of older people, poverty, and the lack of home care services will drive up demand for assisted suicide.

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The US state of Oregon is the new model; but why should we take a moral lead on personal rights from a country without gun control, unwilling to ensure adequate healthcare for all its citizens?

Politicians should examine who is asking for assisted dying; and why now. It is widely assumed that baby boomers are pushing for a change. Apart from a few widely publicised exceptions, it's not baby boomers who are dying, it's their parents. I wonder whether the increasing call for institutionalised suicide is born of the experience of witnessing distressing deaths rather than the prospect of our own. This might explain the fact that the legislation would do nothing to meet the demands of patients too disabled to take their own dose or those with a disabling, but not terminal, condition that renders life intolerable. Even though intolerable mental illness would be a powerful motive for suicide, psychiatric patients will never be recognised among the deserving by the proposed legislation.

Most members of the BMA, Royal College of Physicians, Royal College of General Practitioners, and Association for Palliative Medicine oppose the legalisation. Their memberships are not neutral, and the public should know why. If professional organisations fail to join the argument, the debate will be poorer for it. The public has a legitimate interest in understanding what the profession has to say on the subject. Many doctors share Iona Heath's reservations about the effectiveness of legal safeguards to prevent coercion.[6]

The argument that doctors should not influence legislation on this subject seems rather thin if we end up with a system in which doctors have to decide whose distress is bad enough and whose capacity is good enough to receive assistance to commit suicide. This concept of the deserving versus the undeserving suicidal patient is deeply problematic. There really are no technicalities that must be assigned to the physician other than certification of death. Armed with a set of instructions and the medical records, a lawyer or social worker could make the kind of assessments that are envisaged, before assisting suicide. A patient proposed that the ideal team would be two judges and an executioner.

Yet the wish to have the blessing of a trusted doctor seems powerful within the movement to promote assisted dying. They want and need our approval. But any society that chooses legalised assisted suicide should at least own up to the process being a social and legal intervention rather than a medical one. If society is seeking the blessing of the medical profession for a system of assisted dying, we should be clear and open about our views both individually and collectively, no matter how diverse or inconvenient for the legislators.

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- Head to head: Should the law on assisted dying be changed? Yes (*BMJ* 2011;342:d2355)
- Head to head: Should the law on assisted dying be changed? No (*BMJ* 2011;342:d1883)

FROM THE FRONTLINE **Des Spence**

The power of doing nothing

I recently booked a ticket on a sleeper train from Glasgow to London, and it was surprisingly cheap. At the station, I soon realised why; I had booked a seat and not a bed on the overnight train.

Sleeping in an upright chair—velour seats, stained headrest, other people's sweat—gave a flashback to my childhood in the 1970s and the overnight train journeys to London I took many times with my brothers.

I was always scared, but I learnt much about life (although I never received a Duke of Edinburgh award). Whenever I was fearful, my brothers reassured and comforted me. These experiences toughened me up and made me cope and face my fears.

Medicine is about comfort and reassurance, not about diagnostics, big machines, and glass fronted hospitals. In medicine, most patients present with anxiety—for the fear of illness is far, far greater than the risk of illness.

"You'll be OK" is the only phrase anyone ever wants to hear. Even in terminal situations, our role is to reassure, tell everyone that they are doing well, and that it's all OK

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These unfounded fears are whipped up by a thoughtless public awareness campaign, a celebrity "illness" splash to aid a fading career, insensitive comments of a relative, or Googled minor symptoms that always suggest "consult your doctor, you may have cancer." Anxious patients know that they have blown things out of proportion, but they just can't shake off these worries.

So every patient has an agenda, often hidden for fear of seeming foolish. But with experience, respect, and humour, these unfounded anxieties of cancer, heart disease, or the weird and wonderful world of internet misdiagnoses spill forth.

This is the opportunity to reassure and take away the fear; "you'll be OK" is the only phrase anyone ever wants to hear. Even in terminal situations, our role is to reassure, tell everyone that they are doing well, and that it's all OK, soak up the angst and anxiety, and take away the fear. Reassure not refer.

Regrettably, at undergraduate and postgraduate level, every medical text spectacularly fails to understand this. We do not select doctors on their ability to effectively reassure and communicate. Concerns and patients' agendas are missed and the opportunity to reassure is lost.

An uncertain doctor suggests investigation under the pretext of reassuring the patient, but in fact this is only to reassure themselves. So a patient who previously felt foolish now feels that there "must" be something wrong.

Of course, investigations lead to spurious results, referrals, and endless health anxiety. A system clogged with now fearful patients and dissatisfied doctors. Doctors must face their fear of uncertainty and learn to reassure—the power of doing nothing with style.

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THE BEST MEDICINE **Liam Farrell**

Private medicine's real manifesto

Historians may one day look back and say that there was a time, in the 20th century, when people actually cared about each other. That once the world was more than just a jungle—full of monsters rising on all sides to smite us, where the strong prosper and the weak are devoured.

But that time is passing, as our health minister perfects the trick of throwing up his hands in horror while simultaneously washing them, like a little Tory Pontius Pilate.

And as the NHS is slowly eroded, private medicine is blossoming. It even has a conference now: Private Practice 2013 is "for clinicians looking to launch or expand their private practice" and who "want to start a private practice and offer a higher quality service."

So it's timely to present the real manifesto for private medicine.

1) Always remember that you are a client, not a patient. Your main purpose is for us to generate income. Our doctors will be professional, I'm sure, but if you do happen to get better, that's just a bonus.
2) Health is a commodity, disease the product line, and doctors the sales force. We'll obfuscate with weasel words like "providing a better service," but remember point 1.
3) We do things to you; that's what we do. There is money in procedures. Sitting you in a bed and watching you for a few days is not a big earner. Masterly inactivity will not launch us into the million dollar club.
4) Old, chronically ill, or mentally ill people are unsuitable for our services.
5) Private health screens are the whores of medicine. They make even us a bit ashamed.

Always remember that you are a client, not a patient. Your main purpose is for us to generate income

6) "Robes and furred gowns hide all/Plate sin with gold/And the strong lance of justice hurtless breaks." We disguise our mendacity with a veneer of luxury. The waiting room has carpet and ferns; the whorehouse parlour look is quite deliberate, and you won't have to share it with the riff raff. In contrast, the NHS has always been the Ryanair health service—austere, without frills, it doesn't aim to give you what you want but what you need.
7) Of course, if the worst happens and you get really sick (or unprofitable), you will be turfed back to the NHS. Looking after sick people: that's what it's for, isn't it?

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