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Special Article - Suicide, Parasuicide and Deliberate Self-Harm

Progress with Legalising Physician Assisted Dying in England

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Editorial

I became interested in helping with this in 2001. This occurred as a result of my friendship with Lord Joffe, who had introduced 2 Bills in the House of Lords, neither of which succeeded.

I was particularly attracted by the concept of having the option of control over when and how I would die if I were suffering uncontrollably at the end of a terminal illness.

At that time the majority of the medical profession was against this, so I joined Dignity in Dying and was given the task of trying to help doctors reach a more positive view about the benefits associated with physician assisted dying. To this end we formed a subcommittee, "Healthcare Professionals for Assisted Dying". We organized lectures and debates around the regions and brought our message, when given the chance, to the Annual Representatives Meeting of the British Medical Association.

Progress has been slow but rewarding and at the last ARM a vote for neutrality rather than opposition was passed. This has also been adopted by several of the main Royal Colleges of medicine.

The problem now is to change the view of parliamentarians. Repeated surveys of the public reveal 80% in favour of a change in the law. Nevertheless, when the last Bill introduced to the House of Lords in 2015 was passed and then went successfully through the committee stages, it was rejected when it came to Parliament by a significant majority. However, another Bill is to be brought to the House of Lords later this month. It is similar to the previous one and we hope will pass through all the committee stages without difficulty. In the meantime, we have been active in contacting individual members of Parliament with the purpose of helping them to see the key points in what is being proposed and compare this with the vociferous objections of those opposed.

It is important in any discussion on this subject to be careful to use correct terminology. It is here that the differences between physician assisted dying, assisted suicide and euthanasia need to be understood and correctly defined.

One of the problems has been that our opponents consistently use the term Assisted Suicide instead of Physician Assisted Dying. The former implies a doctor helping someone to die who is suffering from a disability but may have many years to live, whereas the latter is confined to patients who have a terminal diagnosis and are not expected to live longer than six months. If patients who are given such a prognosis wish to have the option of control over their death, they would be assessed by two independent senior doctors who, having confirmed the diagnosis, would establish mental competence and ensure there has been no pressure by others to seek this option. One of the criticisms used frequently by opponents is that prognosis is imprecise and that the patient may live longer than the six months expected. However, this should not be a problem as the patient would be unlikely to take the lethal medicine unless their suffering or indignity became intolerable during the last few weeks or days of life. In this regard, it is interesting to note the experience of Oregon where a similar law has been in place for over 20 years. Only one third of those who signed up for a physician-assisted death use this because their care has made it unnecessary. It is therefore important that in England, palliative care physicians come to see physician assisted dying as part of rather than opposed to good end-of-life care.

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