

ARTICLE

Assisted dying – the debate: *Videtur... sed contra*^a

Philip Graham & Julian C. Hughes

Philip Graham is Vice Chair of Dignity in Dying. He is Emeritus Professor of Child Psychiatry, Institute of Child Health, London. He has published on a wide range of topics, including ethical issues in psychiatry. **Julian C. Hughes** is a consultant in old age psychiatry in Northumbria Healthcare NHS Foundation Trust and Honorary Professor of Philosophy of Ageing in the Institute for Ageing and Health, Newcastle University. His research focuses on ethics and philosophy in connection with ageing and dementia. He is a member of the Nuffield Council on Bioethics.
Correspondence Professor Julian C. Hughes, Ash Court, North Tyneside General Hospital, Rake Lane, North Shields, Tyne and Wear NE29 8NH, UK. Email: julian.hughes@ncl.ac.uk

a. *Videtur... sed contra* translates roughly as, 'It seems ... but alternatively', and was a formula used for the presentation of arguments in philosophy in the Middle Ages.

[†]Legislative and judicial aspects of this subject will be considered in Welsh SF (2014) Crossing the Rubicon? Legal developments in assisted suicide. *Advances in Psychiatric Treatment*, 20, in press. Ed.

SUMMARY

Should the law be changed to allow health professionals to assist mentally competent, terminally ill people to end their own lives? In this article Philip Graham (P.G.) puts the arguments in favour of such a change in the law and Julian Hughes (J.H.) opposes these arguments. J.H. then sets out why he believes such a law should not be passed and P.G., in turn, sets out counter-arguments. Before concluding comments, both P.G. and J.H. independently make brief closing statements supporting their own positions.

LEARNING OBJECTIVES

- Understand the differences between various types of 'assisted dying'.
- Appreciate some of the ethical arguments in favour of and against changes in the law on assisted dying in the UK.
- Understand some of the empirical data involved in arguments about assisted dying.

DECLARATION OF INTEREST

P.G. has no interest to declare, apart from the fact that he is 81 years old and, unless legislation along the lines he advocates here is passed fairly soon, he will not live to benefit from its provisions. J.H. gives financial support to the organisation Care Not Killing.

At the present time, the Royal College of Psychiatrists has taken a neutral position on assisted dying:

'Assisting a person to die is illegal in the United Kingdom. A change in the law is a matter for Parliament. Should Parliament consider changing the law, the College would be pleased to advise on matters relating to persons suffering from mental disorders or those who may lack mental capacity.' (Royal College of Psychiatrists 2014).

There are various ways in which a person may be assisted to die. In Box 1 we provide definitions of these.

There is growing pressure in the UK for changes in legislation to permit assisted dying. Indeed, on 15 May 2013, Lord Falconer of Thoroton published his Assisted Dying Bill, which would change the law in England and Wales and 'enable competent

adults who are terminally ill to be provided at their request with specified assistance to end their own life' (House of Lords 2013).[†] Arguments in favour (P.G.) and against (J.H.) a change in the law are set out below. Before concluding, we make brief closing statements supporting our positions.

Respect for individual choice

Philip Graham:

Around 500 000 people die each year in England and Wales (Office for National Statistics 2012a). Of these, around 15% or 75 000 die within a month of being taken terminally ill (Office for National Statistics 2012b). Nearly all of the remainder die from an illness that lasts months or years, with symptoms that can be largely if not entirely controlled by good palliative care. It is, however, a myth that end-of-life care can relieve all symptoms.

Some dying people, a few weeks or months before they die, say very clearly and persistently

BOX 1 Glossary

Assisted dying

Mentally competent people (i.e. those with capacity to make this particular decision) who are terminally ill (variably defined as having an expectation of life of not more than 6 months or 1 year) and want to end their own lives would be legally permitted to have the assistance of health professionals to enable them to do so. This may also be called assisted suicide (see below) in dying people.

Assisted suicide

Mentally competent people who are not terminally ill but want to end their own lives, whether or not they experience intolerable suffering or whatever other criteria are used to justify voluntary euthanasia, would be legally permitted to have the assistance of health professionals to enable them to do so.

Voluntary euthanasia

Physicians would be permitted, under certain conditions, to end the lives of people who, usually because of intolerable suffering, express a wish to have their lives ended whether or not they are terminally ill (as defined by the notion of assisted dying).

that their unremitting symptoms, combined with a level of dependence they find humiliating, lead them to want to die earlier than would otherwise be the case. Extrapolating from the evidence from the US State of Oregon (Oregon Health Authority 2013) (where legislation of a type very similar to that which my colleagues and I would wish to see enacted in England and Wales has been in place for around 17 years), it is estimated that in England and Wales about 3.5 per 1000 or about 1750 people each year would wish to end their own lives with healthcare professional assistance, if it were legal to do so. About two-thirds of these, around 2.3 per 1000, or about 1150 people, would so end their lives, while the remaining one-third would not avail themselves of the opportunity. Why should this choice not be available to them?

Respect for the autonomy of the patient is a major principle of modern healthcare. In all other aspects of healthcare we respect the right of the mentally competent patient to make an informed choice. Why at this literally most vital phase of a person's life should we ignore this principle? Of course, if you are suffering intolerably, your general practitioner (GP) may help you to die. The best evidence, from a UK survey, suggests that about 0.5% of deaths (around 2500 in England and Wales) occur as a result of illegal direct assistance, i.e. euthanasia (Seale 2009a). Because this is illegal and unrecorded we have no idea whether these people wished to have their lives ended in this way.

The Director of Public Prosecutions (2010) has made it clear that a relative who assists a terminally ill person to die will, in all probability, not be prosecuted, provided that the dying person has clearly expressed a wish to die and the relative did not stand to gain from the death. Why should terminally ill people be allowed unskilled assistance but not the help of a doctor?

Julian Hughes:

I think Philip is right to lead with the argument about autonomy, because it does seem to be the best argument for any form of assisted dying. I shall shortly put a counter-argument; but I do not think the counter-argument is the best argument against all forms of assisted dying (I think that comes later). Thus, in many debates on this issue the arguments pass each other by.

The Seale (2009a) survey deserves careful scrutiny. It establishes that very few doctors are assisting their patients to die as opposed to alleviating their symptoms, whereas it is sometimes said that killing patients is common practice. There is also a question about those for whom palliative

medicine does not seem to be sufficient. Perhaps these are people who would benefit from palliative sedation. This is, however, a complicated subject (Broeckeaert 2011). Some palliative sedation might amount to assisted dying, some might not. But this argues for more research and resources to go to palliative care rather than for a change in the law relating to dying.

The main response to Philip's question about this 'major principle of modern healthcare' is twofold. First, if it is 'major' it is certainly not the only principle: doing good and avoiding harm are alternatives. How we then construe 'doing good' is obviously vital, but there is at least an argument that the intentional killing of innocent human life (which certainly sounds harmful) should not be regarded simpliciter as a good to be aimed at. Nor should beneficence collapse into respect for autonomy. We might then have to decide between principles, which means looking elsewhere, which in turn undermines the predominant status of autonomy. Second, we should recognise that none of us is fully autonomous. 'Relational autonomy' is more apt. And then I have to see that my actions and the laws that might support them could have consequences for others and, hence, the justifiable concerns about the safety of a permissive law.

Philip's final point only really argues for a slight change in the Director of Public Prosecution's guidance about who should be prosecuted for breaking the law. But there are reasons for thinking that the public interest is not well served by the prosecution of, say, a loving wife who assists in the death of her terminally ill husband, but is well served by the prosecution of a professional who assists or encourages the suicide of a patient.

Public opinion

Philip Graham:

In the latest British Social Attitudes (BSA) Survey (Park 2008) 82% of the general public agreed that a doctor should probably or definitely be allowed to end the life of a patient with a painful, incurable disease at the patient's request. Seventy-one per cent of religious people in the 2010 BSA survey (McAndrew 2010) and, in an earlier 2007 survey, 75% of people with a disability (still a considerable majority) agreed that a doctor should be able to end the life of a patient in these circumstances (Clery 2007). Doctors themselves are divided on this issue, with a relatively small majority opposed to such legislation. The division of medical opinion means that all medical Royal Colleges should follow the lead of the Royal College of Psychiatrists, whose statement is quoted at the beginning of this article, and take a neutral position.

Public opinion should not necessarily be allowed to dictate government policy. There is a small majority of the public who believe in the reintroduction of capital punishment for certain types of murder, but legislators are right to think that the significant possibility of an irreversible miscarriage of justice should trump public opinion in this matter. In the case of assisted dying there is no reason to think that public opinion is misguided.

Julian Hughes:

A ‘relatively small majority’ of doctors opposed to the legislation turns out to be 62–64% (Seale 2009b). A systematic review suggested that only 23% of doctors would be willing to perform euthanasia and only 25% physician-assisted suicide (McCormack 2012). Would public opinion tolerate someone else to do the killing? Moreover, the closer doctors work to dying (e.g. palliative physicians, geriatricians), the more likely they are to be against a change in the law. Perhaps their experience of death is reassuring, while their concern for the vulnerability of their patients is paramount.

But what about the death penalty? The figures in favour of this have gone down, except for particular types of murder (e.g. of children). So, just as those who advocate assisted dying legislation do so only for particular patients, should we say that – based on public opinion – the death penalty could be reintroduced only for certain types of murder? The equivalent to a miscarriage of justice would be where the person expressed a wish to die at one stage, but was then pleased to have survived later. This is not uncommon; but strange that it does not seem to worry the advocates of change.

The slippery slope

Julian Hughes:

The worry about slippery slopes is that assisted dying will slowly spread to include non-voluntary or involuntary dying. Here it could be argued that the figures from The Netherlands are reassuring, at least to the extent that the percentage of deaths where life was ended without the explicit request of the patient has fallen from 0.8% in 1990 to 0.2% in 2010. But it must be kept in mind that 23% of cases of euthanasia or physician-assisted suicides in The Netherlands in 2010 were not reported to a euthanasia review committee (Onwuteaka-Philipsen 2012). It may be that this group of patients are different in some way, perhaps closer to death and not requiring extraordinary means to bring about their deaths, but they remain outside legal safeguards.

The real issue is that we are now seeing what we once did not see, namely the use of euthanasia in The Netherlands for groups of people, such as those with dementia, who lack capacity (Effting 2011). Some years ago an ethicist from The Netherlands told me that euthanasia would not occur in someone with dementia. But it is a real concern (van Delden 2004). In fact, more recently an ethicist from that country has said to me that the issue now being debated is that of existential suffering, just on account of being old. Might this be a good enough reason for euthanasia? And this takes us closer to the nub of the issue.

Empirical and conceptual arguments

The main argument against a permissive law, in my view, involves the distinction between an empirical slippery slope – whether it has in fact been seen in this or that country, which leads to debates about the figures – and a conceptual or logical slippery slope (Jones 2011).

The conceptual point is this: once we allow any form of assisted dying, there will be no principle to stop us sliding down the slippery slope to non-voluntary and involuntary active euthanasia. This poses a question that is not adequately answered by those who wish to change the law: what will the new principle be? The question and concern persist even if no one has slipped down the slope; for at any point someone might. I would suggest that the experience in The Netherlands, with the gradual emergence of euthanasia in connection with dementia, let alone simply old age, shows how (in the absence of the principle) slippage becomes more likely.

The point was best put by Professor John Finnis when he gave evidence to the House of Lords Select Committee considering the Assisted Dying for the Terminally Ill Bill in 2005:

‘At present, there is a clear principle: never intend to kill the patient; never try to help patients to intentionally kill themselves. That is the law, it is the long-established common morality, it is the ethic of the health care profession and it is Article 2 of the European Convention on Human Rights, and so forth. There is a “bright” line [...]. The principles on which any attempted line would be based undermine each other and subvert the attempt to hold a line. If autonomy is the principal or main concern, why is the lawful killing restricted to terminal illness and unbearable suffering? If suffering is the principle or concern, why is the lawful killing restricted to terminal illness? Why must the suffering be unbearable if there is real and persistent discomfort?’ (Finnis 2005: Q1973, p. 553).

In other words, the onus is on those who wish to change the law to define their new principle and

defend it against the charge that it will sanction killings which were not intended under the new law.

Philip Graham:

Julian focuses on The Netherlands for support for the idea that, if legislation to allow assisted dying for the mentally competent, terminally ill were passed in England, there would soon be a move to extend the grounds to people who were not terminally ill or were suffering from dementia. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 in that country provided for people who made a voluntary well-considered request for assistance to die, who faced lasting and unbearable suffering and who understood their situation. The legislation also allowed advance requests for voluntary euthanasia in the event of loss of capacity to be made. There has been no extension of the law since that time: it remains in force as originally conceived. Further, as Julian admits, following this legislation there was a marked reduction in the number of patients whose lives were ended without their explicit request. It is also worth mentioning that, although the evidence is not strong, what there is suggests that the trust of patients in their doctors is higher in The Netherlands than it is in the UK (Kmietovicz 2002). Further, the current law is supported by 92% of the Dutch population (Commission on Assisted Dying 2011).

In any case, a far better comparison is with the State of Oregon. Legislation passed there in 1997 is very similar (but with a variation I shall describe later) to current proposals for a new law in England and Wales. In the intervening 17 years there has been not a glimmer of a suggestion that the law should be extended there.

Conceptual slopes

Julian talks about a conceptual slippery slope. This is a slippery argument indeed. Is he suggesting that people who are suffering terribly and who wish for skilled help to end their own lives should be prevented from having such help because of some philosophical reservation? I find it unacceptable that any sort of ideology, philosophical or religious, should obstruct the right of people who do not share such ideology to end their own suffering. Julian suggests that a new principle is operating here that would allow assisted dying in anyone who wanted it – ill but not terminally ill, mentally incompetent, just old or whatever. No one pressing for legislation wishes the grounds to be extended in this way. Qualified surgeons are allowed by law to carry out

knife attacks on the body. No one suggests that this should not be allowed because it is a breach of the cardinal principle that assaulting another person's body is a crime and if you let surgeons do it, violent criminals will expect to be allowed to commit their offences unpunished.

Sanctity of life

Julian Hughes:

Various religions argue both that life is a gift from God and that human beings are born in the image of God. Therefore, the intentional killing by one human being of another innocent human being is wrong (the word 'innocent' leaves room for the possibility of non-wrongful killing in self-defence). The difficulty with this view is that it only makes sense if the background religious beliefs are accepted. So while religious believers are free to put forward such arguments, they will only be compelling insofar as the background religious beliefs are accepted.

Nevertheless, there is also a secular argument that life itself should be regarded as a good. This would have to be accepted as a given – something foundational – that as living things we seek to flourish, to live as best we can. Furthermore, as human beings the life that we live should seek perfection in certain sorts of ways and deliberately to aim at the destruction of (innocent) human life is counter to one understanding of human flourishing. In this sense it can be argued that the 'inviolability' of human life precludes assisted dying (Keown 2002). This argument, which has Aristotelian roots, obviously needs considerable fleshing out (for which, see Finnis 1983).

Philip Graham:

Julian first implicitly acknowledges that the belief held by some religious people that intentional death is always sinful is an inadequate argument against a law that allows terminally ill people who are mentally competent to end their own lives if they are experiencing intolerable suffering. He is right because no one would expect a person holding such religious beliefs to end their life in this way, nor would one expect a doctor holding such a belief to participate professionally. (This has worked well in abortion.)

He then goes on to suggest that because non-religious people regard life a 'good', which they surely do, human life should be inviolable. He fails to distinguish between different evaluations of an individual's life – the value accorded to human life in general, the value of my life as I judge it and the value of a small, final portion of my life in which I

am suffering unbearably. A life that is, in the eyes of the person living it, worse than death, is not 'good' any more.

Assessing competence

Julian Hughes:

Those who seek change in the law for assisted dying usually stress that valid consent would be a requirement. Thus, patients must be fully informed, they must not be coerced and they must have capacity to make the decision. We shall come to the issue of coercion; and let us presume it is possible to ascertain that a person is fully informed, which would include information about alternatives, such as the provision of good-quality palliative care. But the issue of capacity remains tricky and it underpins the argument about autonomy, because in the absence of the requisite capacity the person's autonomy is called into question.

Different jurisdictions have different laws governing capacity. The worry about assisted dying is that judgements about capacity will be determinative. But such judgements contain a significant evaluative element. It has been accepted in law that the level of capacity required depends on the seriousness of the decision to be made (*Re T (adult: refusal of medical treatment)* 1992). Well then, a decision to end one's life must require a high degree of capacity. Arguably, therefore, any degree of pain or depression would affect a person's ability to make decisions in the most rational way. Others might argue to the contrary. This subjective element suggests difficulties for any change in the law, which should not be underestimated.

First, capacity assessments regarding assisted dying might be driven by the assessor's judgement about what is best for the person, which might be influenced by a host of prejudices of one sort or another. Second, the person's capacity might be influenced by quite subtle elements of their mental and physical state, some of which might be amenable to treatment. Advocates of change will say that a law could be drafted to take account of these concerns, but the point is that assessments of capacity *just are* much more subjective and evaluative than the law suggests. A number of these and related concerns have been voiced by Hotopf *et al* (2011a). In a response to Philip's criticism of their paper (Graham 2011), they replied that they suspected that mental capacity assessments in the context of assisted dying 'are unlikely to be value neutral' (Hotopf 2011b). On the basis of research in connection with a different type of capacity, I would suggest that this is likely to be an understatement (Greener 2012; Emmett 2013).

Philip Graham:

Julian suggests that because capacity assessments are not 'value neutral' they are likely to be swayed by the beliefs of the physicians making them. In other words, though he does not put it so crudely, a doctor who thinks a patient should be given the right to end their own life is likely to agree that the patient is mentally competent regardless of the evidence or, at least, in the face of significant evidence to the contrary.

Yes, the judgement of capacity will inevitably have a subjective component. This is why it is important that safeguards are built in to ensure that those who are not mentally competent are barred from proceeding with assisted dying. The proposed legislation as it stands (House of Lords 2013) requires two independent doctors to agree that the patient meets the criteria laid down for meeting the requirements, including that of mental competence. The Secretary of State would issue a Code of Practice that would include the assessment of the person's capacity to make such a decision. Further, the Code of Practice would ensure that the independent doctors will recognise and take account of the effects of depression or other psychological disorders that might impair a person's decision-making. Patients found to be in need of psychiatric treatment would be offered it. This is an area in which British legislation would provide stronger safeguards than is currently the case in Oregon and, for reasons that Julian sets out in the next section, I think that is right.

It is widely believed that people who wish their lives to end are not necessarily suffering from a mental disorder. Doctors and, where there is doubt, psychiatrists should be able to decide when a terminally ill patient does or does not have a mental disorder. At my advanced age I have inevitably seen a number of my friends die. Recently, a close friend of my own age who had heroically endured chemotherapy for 18 months came towards the end. He had an undiagnosed cancer with multiple, painful fractures, and was humiliated by his need for help with toileting and feeding. A few weeks before he died he said to me 'Philip, I have had enough. If there were a law allowing me to end my life, that is what I would want for myself'. Yes, he was sad, exhausted, off his food, sleeping poorly and he saw no future for himself. But no psychiatrist would, I believe, have made a diagnosis of depressive disorder.

Safety

Julian Hughes:

People might be killed by mistake. Just as plenty of people who attempt suicide, although

not terminally ill, are then pleased to survive, similarly, people with a terminal illness who express suicidal thoughts or inclinations change their minds with the right help (see the personal stories posted on the Care Not Killing website at www.carenokilling.org.uk/personal-stories). Hotopf *et al* (2011a) state that, on the basis of their clinical experience working in a hospice, the remaining weeks and months of the lives of those who have changed their minds ‘have rarely lacked meaning for them or their families’.

A report in Oregon concluded: ‘the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug’ (Ganzini 2008). Worries about safety have emerged in other countries where assisted dying is already legal (e.g. de Diesbach 2012).

Another worry takes us back to coercion, albeit a covert form. Insidiously, with a change in the law, the option of death becomes normal. Older people, people with dementia, those with intellectual or physical disabilities start to feel or seem like a burden. The family, or society, would be better off without them. So be it.

Philip Graham:

Julian seems to think that as soon as a terminally ill patient expresses a wish to die current proposals will ensure that the whole process will be carried through as expeditiously as possible. This is not the case. Those who have been involved in framing the legislation are well aware that most expressions of a wish to die are transient. For this reason, when a terminally ill patient expresses a wish for an assisted death, he or she will be assessed by two independent doctors and, if they agree that the patient is indeed eligible for an assisted death there will be a cooling off period of a fortnight before the patient’s wish to end life is confirmed. This will ensure that the wish to die is indeed not transient but has been persistent over time. Further, those who are given the go-ahead for an assisted death will have ample opportunity not to use the lethal medication prescribed for them. This is the option taken by about one-third of the people in Oregon.

Julian quotes anecdotes provided by the organisation Care Not Killing and Matthew Hotopf and colleagues in support of his view that people who change their minds often have fulfilling lives subsequently. This information is irrelevant as the people they describe did not go through the rigorous procedure proposed in the legislation now being put forward and most would not be eligible for assisted dying as they are not terminally ill. The procedure we propose is, in fact, far safer than

the present law allows. At the moment, if someone dies as a result of what might seem to be an assisted death, an inquiry has to be carried out *post hoc* to determine, for example, the motivation of the dead person and those who helped him or her to die. We are proposing that this should happen before the irrevocable decision is taken.

The worry about coercion by relatives is understandable. The proposed legislation will lay a duty on those involved in the procedure to ensure this does not happen. The systematic evidence from Oregon is that those who carry through with a wish to end their own lives, far from being vulnerable individuals, are vivid and engaging, strong and forceful personalities, the very last sort of people one would expect to be coerced against their will (Ganzini 2003).

Closing statements

Philip Graham:

I have tried to make clear, I hope successfully, why the arguments in favour of a change in the law to allow mentally competent, terminally ill people to have the assistance of health professionals to end their own lives are so powerful. The current situation is that a small, but not insignificant, minority of dying patients suffer needlessly because even the best palliative care cannot help them. A change in the law would produce a less dangerous situation than exists at present. Currently, when patients are helped to die by other people, motivation has to be assessed after the event rather than before it. The arguments from patient autonomy, compassion for the dying and the overwhelming support of public opinion all favour change. The opposing arguments (the ‘slippery slope’, sanctity of life, concerns about safety, risk of coercion, etc.), while doubtless sincerely held, are unconvincing when the evidence is carefully examined. A blend of compassion and good sense requires new legislation. I hope to see it in my lifetime.

Julian Hughes:

Our arguments pass each other by: autonomy versus the principled prohibition of intentional killing. I asked: ‘What will the new principle be?’ Philip did not answer. Instead, he talked of a philosophical ideology. He says that no one wishes the grounds to be extended (ignoring Lord Joffe’s talk of ‘subsequent stages’ to his earlier Bill: Joffe 2004: p. 57, Q122), but disregards the evidence from The Netherlands that the practice of euthanasia (not the law) is being extended to include people with dementia and now the frail elderly with ‘existential’ suffering. Philip’s talk of

surgeons is simply misplaced: the same principle which allows the surgeon to open my abdomen also prohibits a stranger from stabbing me. There is no change in principle. But allowing me to help my patients to kill themselves is a change and I'd like to know what the new principle would be and how it would hold the line against non-voluntary and involuntary killing. The prohibition on intentional killing is ideological: Lord Walton (1994) called it 'the cornerstone of law and of social relationships'.

Conclusions

In this debate we have presented arguments for and against a change in the law on assisted dying. We do not pretend that we have exhausted the arguments. They will be further pursued in public and political arenas, and psychiatrists should understand the arguments since they may be asked to comment on them. If a change in the law were to come about, psychiatrists would, as individuals, have to decide under what circumstances they would wish to be involved with assisted dying. They certainly would be required to help in assessing the mental state and decision-making capacity of those who wished to die.

The issues involved in this debate are complex, emotive and potentially deeply divisive. Views are held passionately, with conviction, on both sides. Two things should unite doctors and other healthcare professionals involved in the debate. First, we should recognise that neither side has a monopoly on compassion. The care of patients motivates both sides. Second, we have to recognise that end-of-life care is not optimal for many people, whether or not they would seek assisted dying. Our arguments require, therefore, appropriate humility and consideration of the views of those with whom we are nevertheless prone to disagree.

References

- Broeckaert B, Claessens P, Schotsmans P, et al (2011) What's in a name? Palliative sedation in Belgium. Reply to Chambaere et al. *Journal of Pain and Symptom Management*, **41** (6): e2–e5.
- Clery E, McLean S, Phillips M (2007) Quickening death: the euthanasia debate. In *British Social Attitudes: The 23rd Report – Perspectives on a Changing Society* (eds A Park, J Curtice, K Thomson, et al): 35–54. Sage.
- Commission on Assisted Dying (2011) *Report of the Commission on Assisted Dying*. Demos.
- de Driesbach E, de Loze M, Brochier C, et al (2012) *Euthanasia in Belgium: 10 Years On (Dossier of the European Institute of Bioethics)*. European Institute of Bioethics.
- Director of Public Prosecutions (2010) *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*. Crown Prosecution Service.
- Eftting M (2011) Voor het eerst in Nederland euthanasie op zwaar dementerende patiënte [For the first time in the Netherlands euthanasia of severely demented patient]. *Volkscrant*, 9 Nov.
- Emmett C, Poole M, Bond J, et al (2013) Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: comparing practice with legal standards. *International Journal of Law and Psychiatry*, **36**: 73–82.

- Finnis J (1983) *Fundamentals of Ethics*. Clarendon Press.
- Finnis J (2005) *Assisted Dying for the Terminally Ill Bill [HL]: Vol II: Evidence*. TSO (The Stationery Office).
- Ganzini L, Dobscha S, Heintz R, et al (2003) Oregon physicians' perceptions of patients who request assisted suicide and their families. *Journal of Palliative Medicine*, **6**: 381–90.
- Ganzini L, Goy ER, Dobscha SK (2008) Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. *BMJ*, **337**: a1682.
- Graham P (2011) Assisted suicide: two sides to the debate. *British Journal of Psychiatry*, **198**: 492–3.
- Greener H, Poole M, Emmett C, et al (2012) Value judgements and conceptual tensions: decision-making in relation to hospital discharge for people with dementia. *Clinical Ethics*, **7**: 166–74.
- Hotopf M, Lee W, Price A (2011a) Assisted suicide: why psychiatrists should engage in the debate. *British Journal of Psychiatry*, **198**: 83–4.
- Hotopf M, Price A, Lee W (2011b) Assisted suicide: two sides to the debate. Authors' reply. *British Journal of Psychiatry*, **198**: 493.
- House of Lords (2013) *Assisted Dying Bill [HL Bill 24, 55/3]*. TSO (The Stationery Office).
- Joffe J (2004) *Assisted Dying for the Terminally Ill Bill [HL]: Vol II: Evidence*. TSO (The Stationery Office).
- Jones DA (2011) Is there a logical slippery slope from voluntary to nonvoluntary euthanasia? *Kennedy Institute of Ethics Journal*, **21**: 379–404.
- Keown J (2002) *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*. Cambridge University Press.
- Kmietovitz Z (2002) R.E.S.P.E.C.T. – why doctors are still getting enough of it. *BMJ*, **324**: 11–4.
- McAndrew S (2010) Religious faith and contemporary attitudes. In *British Social Attitudes: 2009–2010. The 26th Report* (eds A Park, J Curtice, K Thomson, et al): 87–113. Sage.
- McCormack R, Clifford M, Conroy M (2012) Attitudes of UK doctors towards euthanasia and physician-assisted suicide: a systematic literature review. *Palliative Medicine*, **26**: 23–33.
- Office for National Statistics (2012a) *Mortality Statistics: Deaths Registered in England and Wales*. ONS.
- Office for National Statistics (2012b) *National Bereavement Survey (VOICES), 2011*. ONS.
- Onwuteaka-Philipsen BD, Brinkman-Stoppelenburg A, Penning C, et al (2012) Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet*, **380**: 908–15.
- Oregon Health Authority (2013) *Oregon's Death with Dignity Act – 2013*. Oregon Health Authority (<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>). Accessed 24 Apr 2014.
- Park A, Clery E (2008) *Assisted Dying and Decision Making at the End of Life*. National Centre for Social Research (<http://www.natcen.ac.uk/media/3046/assisted-dying-and-decision-making.pdf>). Accessed 24 Apr 2014.
- Re T (adult: refusal of medical treatment)*[1992] 4 All ER 649.
- Royal College of Psychiatrists (2014) Miscellaneous College Policies: Assisted dying. Royal College of Psychiatrists (<http://www.rcpsych.ac.uk/policyandparliamentary/miscellaneouscollegepolicies/assisteddying.aspx>). Accessed 24 Apr 2014.
- Seale C (2009a) End-of-life decisions in the UK involving medical practitioners. *Palliative Medicine*, **23**: 198–204.
- Seale C (2009b) Legalisation of euthanasia or physician-assisted suicide: survey of doctors' attitudes. *Palliative Medicine*, **23**: 205–12.
- van Delden JJM (2004) The unfeasibility of requests for euthanasia in advance directives. *Journal of Medical Ethics*, **30**: 447–52.
- Walton J (1994) Medical Ethics: Select Committee Report. *Hansard House of Lords Debate*: 9 May 1994; Vol. 554, cc1344–412.

MCQ answers

1 d 2 e 3 b 4 a 5 c

MCQs

Select the single best option for each question stem

1 Assisted dying, as the term is used in Lord Falconer's Bill, refers to the procedure whereby:

- a a doctor can end the life of a terminally ill patient provided that the patient has made a competent request for this to occur
- b a doctor can end the life of a patient with unbearable suffering provided that the patient has made a competent request for this to occur
- c a doctor can help a patient to end his or her own life if the patient experiences unbearable suffering and has made a competent request for such help
- d a doctor can help a patient to end his or her own life if the patient is terminally ill and has made a competent request for such help
- e a doctor can give a dying patient opioids and benzodiazepines to ease his or her suffering.

2 Which of the following is not a standard argument used in ethical debates about assisted dying?

- a there is no reason why respect for autonomy should not be extended to the request for assisted dying in those close to death who make such a request with full capacity, having considered and tried options such as palliative care, as long as sufficient legal safeguards are in place
- b there should be an absolute prohibition on the intentional killing of innocent human life or there will be a slide down the slippery

slope towards non-voluntary and involuntary euthanasia or physician-assisted dying

- c there is something about the nature of human life itself which suggests that it should be inviolable
- d most people in the UK, as elsewhere, want a change in the law and their democratic rights as citizens are thwarted by the failure of the legislature to effect such a change
- e given belief in life after death, the exact means and timing of death is not of enough consequence to warrant opposition to a change in the law.

3 Which of the following statements is true?

- a if the experience of the state of Oregon were to be repeated in England and Wales and the same or a very similar law were to be enacted, we could predict that there would be about 1750 assisted deaths annually
- b if the experience of the state of Oregon were to be repeated in England and Wales and the same or a very similar law were to be enacted, we could predict that there would be about 1150 assisted deaths annually
- c between 62 and 64% of the British public are in favour of assisted dying according to the latest British Social Attitudes survey
- d between 62 and 64% of British doctors are in favour of assisted dying according to the latest British Social Attitudes survey
- e between 23 and 25% of doctors admit in confidential surveys that they have assisted their patients to die as opposed to having alleviated their symptoms.

4 Which of the following statements about the law in England and Wales in relation to assisted dying is currently not true?

- a anyone who kills a relative suffering from a terminal illness will always be prosecuted
- b a doctor who deliberately kills a patient suffering from a terminal illness will be prosecuted even if valid consent has been obtained
- c the level of mental capacity required to make a decision depends on the seriousness of the decision to be made
- d depression and other psychological disorders need to be excluded as factors which might affect a person's decision-making capacity
- e the law must take into account the possibility of coercion in connection with consent.

5 The main role of the psychiatrist in assisted dying is likely to be:

- a providing a countersignature for the prescription of a controlled drug
- b agreeing with a second doctor that the condition is terminal
- c advising on the treatment of possible mental disorders
- d determining the patient's best interests
- e assessing whether or not deprivation of liberty safeguards are required.