

CATHOLIC MEDICAL QUARTERLY

AUGUST 2011

THE LIVERPOOL DEBATE ON ASSISTED DYING

---

A SPEECH BY LORD ALTON OF LIVERPOOL GIVEN IN NOVEMBER 2010.

An unhappy feature of the current ‘assisted dying’ debate is the way it has become polarised. It is often presented to us as being either about compassion or about morality. But this is to miss the point. Compassion and morality are common currency among both supporters and opponents of ‘assisted dying’, though they may approach them from different standpoints. The real debate is about public safety – about whether it is possible to license ‘assisted dying’ for a determined few without putting larger numbers of others at risk.

It would be disingenuous and insulting for me to suggest that Dr. Tallis has no regard for questions of ethics and equally disingenuous and insulting to imply that those of us who uphold the law have no regard for suffering or pain.

Campaigners for changing the law recognise that questions of public safety are the reasons why on three occasions, after hours of debate and a Select Committee Report occupying 246 Hansard columns and two volumes of 850 pages of evidence and witness statements, Parliament has on three occasions weighed the evidence and rejected the proposition before you tonight.

Campaigners for change tell us not to worry because any ‘assisted dying’ law would come with ‘safeguards’ to protect the vulnerable. However, the safeguards that are being proposed were criticised five years ago by a parliamentary Select Committee as being inadequate, yet nothing has been done since then to strengthen them. The campaigners also point to the very few jurisdictions in the world where ‘assisted dying’ in one form or another has been legalised and they tell us that it is working well in those places. But it isn’t! There are some serious problems with the way ‘assisted dying’ is working in these places.

Let’s begin by looking at the so-called safeguards. These are supposed to ensure that ‘assisted dying’ would be available only to certain, strictly-defined categories of people – broadly speaking, the terminally ill and the mentally competent. Five years ago a select committee of the House of Lords conducted an exhaustive inquiry Lord Joffe’s *“Assisted Dying for the Terminally Ill” Bill*, which contained the sort of safeguards we are hearing advocated today. The committee did a very thorough job. It took evidence from over 140 expert witnesses, including (I should say) Professor Tallis, in four countries – the UK, the US State of Oregon, Holland and Switzerland. It did not reach a consensus on whether Lord Joffe’s Bill could be commended to Parliament, but its report makes very interesting reading. I would commend it to anyone as a good place to start in any study of the subject of ‘assisted dying’.

---

SIX MONTHS TO LIVE?

Lord Joffe proposed – and the campaigners are still proposing – that ‘assisted dying’ should be offered to people who are terminally ill and that terminal illness should be defined as an incurable illness with a predicted life expectancy of six months or less. This places a premium on accurate prognosis. Someone who is asking for ‘assisted dying’ on the strength of a six-month-or-less prognosis may well think again if there is a prospect of living longer. So this

raises the question: just how accurate is prognosis of terminal illness? 'Not very' was the answer the select committee received. Professor Tallis himself told the committee that "*Medicine is a probabilistic art.*" Another senior doctor put it this way:

*"Prognosticating may be better when somebody is within the last two or three weeks of their life. I have to say that, when they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor."*

Yet another physician, a specialist in palliative medicine, told the committee about his own experience of signing benefit claim forms for terminally ill patients believed to have six months or less to live.

*"I would not like to count", he said, "how many of those forms I have signed for patients still living after a year, eighteen months or even longer."*

And he added: "*The reality in clinical practice is that we can be wrong.*"

The Royal College of General Practitioners wrote to the committee that (and, again, I quote):

*"It is possible to make reasonably accurate prognoses of death within minutes, hours or a few days. When this stretches to months, the scope for error can extend into years."*

These statements are corroborated by the official reports of what is happening in Oregon, where the six-month criterion is used as a basis for prescribing lethal drugs to terminally ill patients under that State's "*Death with Dignity Act*". The annual reports from the Oregon Public Health Department show that some of those who are given these drugs on the basis that they have six months or less to live are keeping them for up to three years before using them to end their lives. How long they might have lived if they had not taken the drugs is anyone's guess.

The trouble is that the general public tends to regard medicine, not as the "*probabilistic art*" that Professor Tallis has rightly called it, but as an exact science, which it isn't. They are used to hearing colloquial phrases like "*three months to live*", which are all too often taken at their face value. The select committee recognised this problem, and it recommended that (and I quote from its report):

*"If a future bill should include terminal illness as a qualifying condition, this should be defined in such a way as to reflect the realities of clinical practice as regards accurate prognosis."*

So what have the campaigners done in response? Absolutely nothing! We see the same old definition of terminal illness trundled out over and over again. Five years on from the select committee's recommendation Margo MacDonald's euphemistically-named "*End of Life Assistance Bill*", which is now in the Scottish Parliament, is still seeking to legalise physician-assisted suicide and physician-assisted euthanasia for people who have received a prognosis of six months or less. Yet the weight of medical opinion given to the Select Committee was that, if we had to have legislation of this nature, it should be framed in terms of weeks, not months.

---

#### MENTAL COMPETENCE

Now let's take a look at the other principal 'safeguard' – that a person receiving 'assisted dying' must be mentally competent. Here again, we have a popular notion that mental competence – or mental capacity – is something that can be determined, if not by a doctor, then by a consultation with a psychiatrist. But in real life it's rather more complex than that.

It is perfectly possible to be mentally competent (in the sense of being *compos mentis* and having one's normal thinking processes working) and yet to be clinically depressed. The

campaigners recognise this. They propose that, if a doctor who is assessing a patient for 'assisted dying' should have any doubts about that patient's mental capacity, then the patient must be referred for psychiatric examination. In saying this they are following exactly the model of the Oregon law.

So the question arises: does this filter work in practice in Oregon?

Research published in the British Medical Journal two years ago suggests not.

The researchers examined a sample of 18 patients who had received lethal drugs from their doctors after being cleared for physician-assisted suicide. They found clear indications that three of these patients – in other words, 1 in 6 of them – had been suffering from clinical depression at the time they were assessed but had not been referred by the doctors concerned for psychiatric examination. Their report concluded that (and I quote) *"in some cases depression is missed or overlooked"* and that *"the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients"* Yet this is the model that is being commended to us for legislation here in Britain.

Of course, the researchers looked only at a sample of cases, and it is possible that that sample may have been untypical. But, while another sample might show fewer or no cases of missed depression, it might equally show more. What is clear is that clinical depression is being missed in Oregon under just such a law as the campaigners are urging us to enact here.

Take the case of Michael Freeland as an example.

He had a long history of depression and suicide attempts and his life was ultimately ended under the Oregon laws.

Dr Gregory Hamilton, an Oregon psychiatrist, said that this man was not in pain because his pain was not treatable; he was in pain because nobody bothered.

Dr. Hamilton added that this was *"just one case among many"*:

*Dignity in Dying*, the re-branded *Voluntary Euthanasia Society*, accepts that there is evidence of some people with depression being given lethal drugs to end their lives, but it states on its website that "all had mental capacity and were able to make rational decisions". That may be so, but is it seriously being suggested that it doesn't matter if people who are clinically depressed are helped to commit suicide so long as they have mental capacity?

Listen carefully to Professor Timothy Maugham, Consultant Clinical Oncologist at Cardiff, who says that in the last four years 3 patients had *"asked me for a way to end it all quickly."*

*"All three of these have been in the throes of depression at the time and with good communication, treatment of depression and ongoing support, have changed their opinion and gone on to face their future in greater peace."*

Professor Maugham says a change to the law is *"a dreadful prospect."*

There is yet another aspect of mental capacity to be considered.

In Oregon the official statistics show that around 1 in 8 of those who received lethal drugs for physician-assisted suicide were suffering from Motor Neurone Disease (MND). Establishing mental capacity among patients with neurological disorders is fraught with particular difficulty. The Select Committee was told by experts in this field that (and I quote the words of Professor Christopher Kennard of the Association of British Neurologists):



*“On the face of it, most of our patients with motor neurone disease are intellectually intact, very much on the ball and able to make decisions. However, we know from research that about 30% of those patients actually have significant cognitive impairment.”*

In other words, it is not just a question of establishing that someone who asks for ‘assisted dying’ has mental capacity and is not clinically depressed. There is also, among some of those who might pursue this course, the additional problem of cognitive impairment, which can be very difficult indeed to spot.

---

#### CAN COERCION BE SPOTTED?

But, even if we could predict the course of terminal illness with accuracy, and even if we could establish mental capacity or competence with certainty, there remains a further danger – how could we be sure that someone who appears to be in earnest about wanting to have his or her life ended is not acting either under coercion from others or out of a sense of obligation to others? The only so-called safeguard that has been proposed in this vital area is that the assessing doctor should have no reason to believe that this is the case and that a witness should confirm that (and I quote from Lord Joffe’s last ‘assisted dying’ bill) “it appears to him that the patient is of sound mind and has made the declaration voluntarily”.

These are no more than paper safeguards. It is simply unrealistic to expect a doctor to detect internal or external coercion in a patient seeking ‘assisted dying’, especially if he or she is not the patient’s regular practitioner. And this brings us to a regular feature of the physician-assisted suicides that are occurring in Oregon.

The official reports of the Oregon Public Health Division tell us that (and I quote) “*a substantial proportion of Oregon physicians are not willing to participate in legalized physician-assisted suicide*” and that many applicants go from doctor to doctor to find one who will assess them and supply lethal drugs. In other words, there is ‘*doctor shopping*’.

What this means in practice is that some applicants for assisted suicide are being assessed by a minority of doctors who know little of them beyond their case notes and who are themselves inclined to look favourably on the notion of ‘assisted dying’. Added to this is the phenomenon of pro-‘assisted dying’ pressure groups seeing themselves, in the words of Oregon’s Compassion and Choices organisation, as “*stewards of the law*” and offering to find compliant physicians for people whose own doctors have refused to participate in physician-assisted suicide.

Oregon’s ‘doctor shopping’ is almost certainly at the root of another phenomenon. For the first year or two after that State’s physician-assisted suicide law came into force, about one in three of those who applied for lethal drugs were referred for psychiatric evaluation. 12 years later, though the number of deaths from this source has risen fourfold, the number of referrals for psychiatric examination has fallen to zero. Why is this? Two explanations have been offered. According to *Dignity in Dying’s* website, it is because of (and I quote) “*improved techniques for screening out ineligible patients prior to any psychological evaluation*”. However, no corroboration is offered for this statement other than what is referred to as “*personal correspondence*” between *Dignity in Dying* and its sister organization in Oregon, *Compassion and Choices*. In other words, the ‘evidence’ consists of a personal – and therefore undisclosed – letter from one pro-assisted dying pressure group to another!

This is what Professor Baroness Ilora Finlay, Professor of Palliative Care and Past President, Royal Society for Medicine, a member of the House of Lords Select Committee, who went to Oregon to see the situation first hand, concluded:

*"In Oregon, there is a culture of doctor-shopping. The pro-assisted-suicide organisations link patients to a compliant doctor. The Oregon health department's report showed that a tiny number of doctors provide all the lethal prescriptions. Such doctors from pro-assisted-suicide organisations are hardly going to be unbiased in their "in good faith" assessments.*

*"Let us not be fooled into thinking that a second, independent doctor is a rigorous check. Dr. Shipman's cremation forms were all signed by doctors independent of him. That safeguard failed in several hundred cases. More than 90 per cent of doctors in palliative medicine in this country want nothing to do with this, as we work day in and day out with those with end-of-life diseases, on their management and care."*

I was also struck by the findings of a research paper published last month by the think-tank *Living and Dying Well*. Could it be, the researchers ask, that the sharp fall in referrals for psychiatric evaluation in Oregon is just another consequence of 'doctor shopping'. Could it be, they ask, (and here I quote) *"that a physician who is prepared to process an application for physician-assisted suicide might perhaps be less inclined than others to regard such a request as a pointer to possible psychological disorder or depression?"* That sounds to me the more plausible explanation.

Professor Tallis centres his argument for changing our law on the experience from Oregon. The same evidence has led others to opposite conclusions and is far from uncontested.

A distinguished American jurist, His Honour Judge Neil Gorsuch, in *A reply to Raymond Tallis*, published in *The Journal of Legal Medicine*, trenchantly repudiates the assertion that Oregon's law is good law – and it begs the question that if it is such good law, why aren't other American States queuing up to enact similar provisions. Judge Gorsuch says:

*"While Dr. Tallis repeatedly touts Oregon's assisted suicide law as a model worthy of emulation elsewhere, that very law makes no mention of suffering: terminally ill individuals can kill themselves freely whether they suffer great pain, little pain, or none at all..."*

*"Although Dr. Tallis calls on us to believe that the slippery slope can be avoided, he offers us no reason to ignore the empirical evidence, logical extensions, and stated intentions of others within the euthanasia movement."*

---

#### CAN WE SAFELY EMBED ASSISTED DYING WITHIN HEALTHCARE?

I have talked so far about the 'safeguards' that we have seen in recent 'assisted dying' bills and I have set out for you the reasons why I believe these fall well short of the mark. Now I want to deal with a safeguard that doesn't appear in any of these bills.

I feel sure it is common ground between Professor Tallis and me that, if 'assisted dying' were ever to be legalised in this country, it should be restricted to a very small minority of highly resolute and strong-minded individuals and that it should be structured in such a way as to avoid giving encouragement to others to pursue it. Yet it is here that we have one of the most serious weaknesses in the 'assisted dying' bills we have seen to date – namely, that they are proposing not assisted suicide or euthanasia, so much as physician-assisted suicide and physician-administered euthanasia.

In other words, they are placing 'assisted dying' within the comfort zone of the health care system. This embedding of the practice within health care, in the face (it has to be said) of opposition from the majority of British doctors, is probably intended to make the practice easier to commend to Parliament and the public, but it carries with it a serious hazard.

We rightly trust our doctors to give us the advice and the treatment that they believe to be in our best interests. From the point of view of most patients, what a doctor recommends or is prepared to do is liable to be seen as the right course of action for that patient. This is not paternalism, it is simply a recognition of the asymmetry that exists in the relationship between doctor and patient.

Very few of us have the knowledge and experience to challenge our doctor's view of what is the best clinical course of action to follow in our own circumstances.

For this reason physician-assisted suicide and physician-administered euthanasia carry with them a suggestion of clinical endorsement of the act, a sharing of responsibility with a trusted professional. Here we have, in the proposals of the campaigners, not simply an inadequate safeguard but a condition – the involvement of the medical profession – which makes 'assisted dying' particularly unsafe.

This fatally corrupts the precious doctor-patient relationship. This is why the British Medical Association, the Royal College of Physicians, the Royal College of Anaesthetists, the Royal College of Surgeons of Edinburgh, and the British Geriatric Association all oppose any change to the law. 95% of the membership of the Association for Palliative Medicine of Great Britain & Ireland, which represents over 800 UK specialists in palliative care, is opposed to any change in the law.

And the General Medical Council unambiguously and robustly asserts that:

*"A change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationships with patients. Acting with the primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence."*

---

#### THE VULNERABLE PATIENT

It is sometimes argued that a patient who is suffering and wants help to end his or her life should not be abandoned by the doctor on the final journey. But, while arguments like this may sound compassionate, they do not really stand up to rigorous thinking. If we are talking, as I hope we are, about limiting 'assisted dying' to a very small number of highly-determined people, such people are unlikely to be deflected from their project by the fact that the procedures they are required to follow are outside the health care system. On the other hand, embedding 'assisted dying' within health care risks sending the message to the less resolute that it is just another avenue of medical treatment and that, if a doctor is prepared to provide it, it must be the right course for them in their clinical condition. If 'assisted dying' were ever to be legalised here, it must be as a highly exceptional event, not a routine procedure. Placing it inside health care is most certainly not the way to achieve that.

Many who give this issue the serious reflection and consideration which it deserves are also wary of an argument which can become driven by resources rather than clinical decisions or ethics:

On October 10th, 2008, Baroness (Mary) Warnock chillingly pointed us towards a future requirement not to be a burden on our loved ones or society; that the right to die will become a duty to die:

*"If you're demented, you're wasting people's lives - your family's lives - and you're wasting the resources of the NHS."*

What does this say about the mental competence of those who will apparently make free decisions? More strikingly, what does it tell us about the values of a society where becoming an economic burden will determine your right to treatment, compassion or care?

There have been signs of a belated recognition on the part of the 'assisted dying' lobby of the economic pressure which can be brought to bear on administrators and doctors in an NHS starved of resources, and the subtle pressure which can be placed on patients.

To address some of these concerns Sir Terry Pratchett has talked about "tribunals" for assessing applications for 'assisted dying', and Lord Joffe has spoken of the possibility that the job might be done by "the courts".

Neither of these ideas has been fleshed out, and it is not clear to what extent they would result in removing doctors from the process. For example, how would any "tribunal" secure medical advice? And who would write prescriptions for lethal drugs? Nonetheless, they are a step in the right direction. What is clear enough is that, if any system of 'assisted dying' is to be at all safe, it must operate under the aegis of the Ministry of Justice, not the Department of Health. After all, what we are talking about here is not a form of health care but an exception to the criminal laws which prohibit assisting suicide and euthanasia.

---

#### ASSISTED DYING IN AN IMPERFECT WORLD

A fundamental problem with the campaign for 'assisted dying' is that it assumes the existence of a perfect world – a world in which all terminally ill patients know what they want without any trace of doubt or despair, in which all doctors have the skills and time to conduct thorough assessments and in which all relatives are what the media like to call 'loved ones'.

The real world just isn't like that. It is one thing for people like us to talk about 'assisted dying'. We know our rights and we know the law, and we are accustomed to dealing with doctors and lawyers and to standing up for ourselves. We can look after our own interests without much difficulty and we are not likely to be coerced, either by others or by our own emotions, into seeking to end our own lives against our better judgement. But it is a mistake to read our ways of thinking across to the great majority of people out there who are not familiar with the complexities of medicine and law and whose experience of living has been all too often one of being done unto by persons in authority rather than of doing.

Doctors are busy people. They have neither the time nor, for most of them, the inclination to be landed with the additional task of assessing patients for help with suicide, much less for putting them down via euthanasia. And, while the majority of families are loving towards those of their members who are sick, some are not – let us not forget that most elder abuse takes place within families. We have criminal laws, not because most people behave decently, but because a small number do not.

Yes, there are determined people who are serious about wanting assistance to end their lives prematurely and who may feel frustrated that the law will not allow them to have it. But there are many more seriously ill people who are ambivalent, who move from hope to despair and back again, who are afraid of what their future may bring or who are worried about the burden that their illness is imposing on the families. It is to protect people like this, as much from themselves as from others, that we have laws against euthanasia and assisted suicide.



It is sometimes wrongly asserted that the law as it stands is not clear. That is simply not true. One of the country's leading lawyers, Lord Carlile – Alex Carlile QC – puts it like this:

*"I want to challenge the assertion that the present law lacks clarity. I suggest that the present law could not be clearer than it is..."*

*"You may be prosecuted if, first, there is enough evidence to sustain a prosecution and, secondly, that it is in the public interest for a prosecution to occur. What could be clearer law than that?"*

And not only lawyers and physicians oppose a weakening of the protection which the current law provides.

One of the most vociferous opponents of any change to the law has been the Disability Rights Commission and the organisations which campaign for disabled people.

Jane Campbell, who has spinal muscular atrophy, and is a Commissioner of the Equality and Human Rights Commission, and now Baroness Campbell of Surbiton, says this:

*"Disabled peoples' lives are invariably seen as less worthwhile than those of non-disabled people. Descriptions such as tragic, burdensome and even desperate are routinely used without objection. Unless one is extraordinarily strong, this negativity impacts on the individual disabled person. If suicide were a legally and socially acceptable option, too many would succumb to this fate believing being 'put out of misery' to be expected of them... This Bill is dangerous and threatening. I and many other severely disabled people will not perceive your support for it as an act of compassion but one founded in fear and prejudice."*

It is all very well for opinion pollsters to tell us that the majority of their respondents say they think the law should be changed to allow 'assisted dying'. But imagining what we would want if we were seriously ill is not the same thing as actually being in that position. Physicians in palliative medicine, who work with dying people day in and day out, report that requests for help to 'end it all' are rare and that, when they do occur, they are almost always a cry for help and reassurance rather than determined demands for 'assisted dying'. As with many emotive issues, such as capital punishment, immigration and membership of the European Union, Parliament has to take the wider and evidence-based view rather than simply to allow itself to be stamped by opinion polls.

Here on Merseyside we are blessed by some wonderful hospices. I am a patron of Jospice and Zoë's Place and a supporter of others. Good hospice provision and palliative care are the way to a good death, not a law which would put public safety at risk.

Shirley Williams – Baroness Williams of Crosby – puts the argument succinctly:

*"I have visited a number of hospices and one of the most prominent was in Crosby in Merseyside where I was a Member of Parliament. It is amazing what has been achieved—a mood of happiness and contentment reigns in many of them."*

*"One of my correspondents who has been a palliative care medical practitioner in the north of Scotland for 23 years used the phrase, "It is easy for the right to die to turn into a duty to die". That is what lies at the heart of many of the objections that some of us want to raise."*

All of us are acutely aware of hard cases; but we also know that hard cases make bad law. And, as the 1994 Select Committee concluded, there would be repercussions for the whole of society were this law which protects to be changed:





*“Individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.”*

Let me say in conclusion that this is not a black-or-white issue. I can see what the campaigners for ‘assisted dying’ are driving at, and they have some good arguments on their side. With advances in medical science, we are living longer but not always healthier lives. But an ‘assisted dying’ law is not the answer.

The law that we have is *robust* enough to deter malicious or manipulative action but also *flexible* enough to deal sensitively with genuinely compassionate instances of ‘assisted dying’. It is a law with a stern face but a not unkind heart. We tinker with it at our peril.

---

#### ARGUMENTS FOR DEFENSIVE USE

---

##### RESEARCH SHOWS THAT VULNERABLE PEOPLE ARE NOT BEING PUT AT RISK IN OREGON

The research in question is methodologically flawed. To take one example, the researchers attempted to establish whether elderly people in Oregon were more prone to resort to physician-assisted suicide (PAS) than others. How did they do this? They set the lower age limit for ‘elderly’ at 85 years – yes, 85! – and they compared death rates from PAS among the over-85s with PAS rates among – wait for it! – those aged 18 to 64 – i.e. the young and middle aged. They ignored completely those aged between 65 and 84, whom most people would regard as elderly and who (as the official Oregon figures show) make up nearly two thirds of all PAS cases.

Or, to take another example, they established that “college graduates” were over seven times more likely to resort to PAS than non-college graduates. From this they concluded that legalising physician-assisted suicide did not put people of lower educational attainment at risk. But it does not seem to have occurred to them that perhaps it might put better-educated people at risk!

---

##### OPINION POLLS SHOW THAT MOST PEOPLE FAVOUR A CHANGE IN THE LAW

The polls don’t distinguish between those who feel strongly about changing the law and others who know little about the subject but feel it is not unreasonable to say ‘yes’ when asked questions such as whether people who are “suffering pain and distress” should have “a choice” to have “help to die” subject to “strict safeguards”. The House of Lords select committee five years ago received a postbag of over 12,000 letters and emails on this subject. People who take the trouble to write to parliamentary committees on a subject may be considered to have considered and strongly held views. The balance of opinion here was almost exactly 50/50.

Most of us lead busy lives and draw most of our information on this, and on most other, subjects from what we read and see in the media. But the media report the exceptional – the handful of journeys to Switzerland for assisted suicide, the rare trials of people accused of assisted suicide or euthanasia. They don’t focus on what normally happens – that most deaths are peaceful, that most relatives are loving and caring, that most people want good care rather than to kill themselves – because normality doesn’t sell papers or boost listening and viewing figures. Acquiring our knowledge in this way is necessary for most of us, but we need to be aware that it carries a risk of distortion. And these distortions are apt to show up in what people tell opinion pollsters.

RESEARCH SHOWS THAT DOCTORS ARE ALREADY ACTING ILLEGALLY BY ENDING THE LIVES OF SERIOUSLY ILL PATIENTS, SO WE SHOULD LEGISLATE AND REGULATE THE PRACTICE

The research, by Professor Clive Seale, also shows that the incidence of illegal action by doctors in Britain is “extremely low” (Professor Seale’s words) and comparative studies by him show clearly that, where ‘assisted dying has been legalised (e.g. in Holland), the rate of illegal action by doctors is significantly higher than in the UK. Indeed, in one of his surveys Professor Seale comments that the argument that legalisation results in regulation cannot be substantiated.

THE DIRECTOR OF PUBLIC PROSECUTIONS HAS MADE CLEAR THAT HE WILL NOT PROSECUTE IN CASES OF ASSISTED SUICIDE

Not so. The DPP made clear in his prosecution policy published earlier this year that nothing in it can be interpreted as offering immunity from prosecution to anyone. He also made clear that the victim’s state of health will not be regarded as a mitigating factor in deciding whether or not to prosecute and that a doctor’s or nurse’s involvement in assisting suicide will be regarded as an aggravating factor. Proposals to legalise physician-assisted suicide for the terminally ill are therefore swimming 180 degrees against existing prosecution policies.

A SIGNIFICANT MINORITY OF DOCTORS SUPPORTS A CHANGE IN THE LAW, AS THE FORMATION OF HEALTH PROFESSIONALS FOR CHANGE INDICATES. AND THE ROYAL COLLEGE OF NURSING HAS ALSO CHANGED ITS STANCE TO NEUTRALITY

Surveys of medical opinion regularly show that around 7 out of 10 doctors are opposed to a change in the law and that, of the minority who favour legal change, some would be unwilling to participate personally in ‘assisted dying’. If we had such a law here, therefore, we would see the ‘doctor shopping’ that is such an unhappy feature of the Oregon scene.

As for the RCN, its change of stance was based on responses to a consultation by just 1200 out of a membership of 390,000 – i.e. by 0.3% of the College’s members. Nor has the RCN published any guidance for nurses in the wake of the DPP’s prosecution guidelines; the BMA alerted doctors within a week to the risks involved in assisting a patient’s suicide.

THE FRANCES INGLIS CASE SHOWS THAT (IN THE WORDS OF DIGNITY IN DYING) “THE MURDER LAW IS NOT EQUIPPED FOR COMPASSION”

Mrs Inglis was convicted of murder earlier this year after two attempts (the second successful) to end the life of her brain-damaged son. She claimed she was acting out of compassion but there had been no request from her son to have his life ended. Mrs Inglis was convicted of murder but given the lowest minimum sentence possible – 9 years imprisonment. The Court of Appeal confirmed the verdict but reduced the sentence to five years. If this is not compassion, it is hard to imagine what would be. Mrs Inglis had ended her son’s life without any request from him to that effect simply on the basis that she considered him to be suffering. Is Dignity in Dying seriously suggesting that such acts should be overlooked or met with a suspended sentence?