

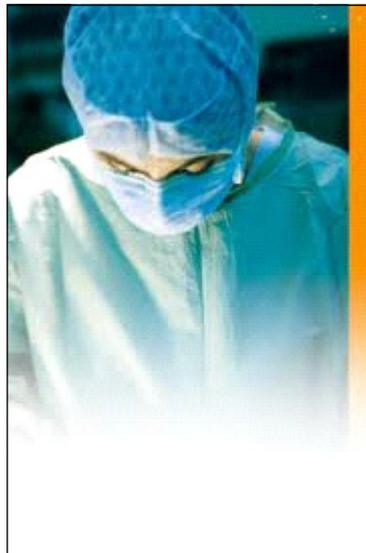
What's wrong with assisted dying

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Campaigns in support of assisted dying seem to be predicated on an excessively rosy view of society and the individuals within it, says **Iona Heath**, writing in a personal capacity

Within a relatively recent historical context, which includes the involvement of doctors in state sponsored killings, personified by Josef Mengele, and the devastating private enterprise of Harold Shipman, the apparently burgeoning enthusiasm for assisted dying seems perhaps a little surprising. The common assertion is that allowing doctors to help people to die, within a carefully regulated framework of strict safeguards, will relieve more suffering than it causes. I am not so sure, and I can identify two main reasons for my discomfort.



The first is a deep concern that it will be impossible to draft a law robust enough to protect the vulnerable. As the philosopher Onora O'Neill made clear, speaking at the Royal Society of Medicine in June 2010, support for assisted dying is based on respect for individual autonomy, yet the influence that one person can have on another makes legislation to permit assisted dying intrinsically risky. Most of the discussion of and support for assisted dying revolves around exceptional individuals who are intelligent, articulate, and facing the prospect

of intolerable suffering and who clearly understand their situation and predicament. Yet legislation has to protect everyone, including those who struggle to express or even fully understand what is happening to them. It seems to me to be impossible to ensure that an apparently voluntary request for assisted dying is not in some small way coerced. It is all too easy for sick and disabled people to believe that they are becoming an intolerable burden to those closest to them, and indeed they often are a burden. In such circum-

stances a request for assisted dying can become a sort of sacrifice on the part of the dying person, with complicit, self interested support from relatives, professionals, or carers.

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Campaigns in support of assisted dying seem to be predicated on an excessively rosy view of society and the individuals within it. Most European governments can now be considered benign, but this has not always been so, and the current situation is no guarantee that it will be maintained. A malign government coming into power with legislation supporting assisted dying already in place is a deeply disturbing prospect. As individuals, very few of us act always in the interests of others; and, because of this very basic truth, the legalisation of assisted dying, despite the very best of intentions, may render the most vulnerable even more so.

The second reason for my discomfort is that medicine seems once again to be preparing to offer a technical solution to an existential problem. One of the huge challenges of human life is to find ways of living a meaningful life within the limits of a finite lifespan that will always involve loss of love and the inevitability of grief. Doctors have a regrettable tendency to ignore this reality and to persist in active and invasive treatment beyond the point at which it has become futile and even cruel. As an example, in devastating neurological diseases nature provides the body with a way out.

In severe dementia or after a catastrophic stroke, the affected body could be said to be meant to die from a rapid aspiration pneumonia resulting from the loss of an effective swallowing reflex. It has become routine to close off this cor-

poreal exit strategy by the introduction of a percutaneous endoscopic gastrostomy (PEG) tube. This risks prolonging life in distressing conditions and thereby making suffering worse. It has become increasingly clear that medicine does not know when to stop. In his book about the last illness and death of his mother, Susan Sontag, David Rieff described her ruthless desperation to remain alive and her willingness to undergo any treatment to this end, however small the chances of success. He



asked why none of her doctors had the courage or humanity to stop her causing herself such dreadful futile suffering.

The world's population is living longer, and this is partly because of the successes of medical science. However, **ageing is a fundamental cause of disease and death, which means that, when one cause of death is closed off by medical intervention, it is inevitable that another opens. Preventive interventions are necessarily less effective in old age because prognosis is already limited.**

It can never be appropriate to treat someone in their 80s in the same way as someone in their 30s, not least because the physiology of the ageing body is different, more vulnerable, and more susceptible to the adverse effects of drugs. This is not ageism; it is person centred care. When doctors fail to recognise and acknowledge existential suffering in the dying and take refuge in excessive technological interventions, patients become frightened and, no longer able to trust their doctors, may request assisted dying. But two technological wrongs do not make an existential right. I don't want assisted dying, but I also don't want a PEG tube.

Human society has not yet realised that Aristotle's golden mean applies to healthcare as much as to any other human endeavour or attribute. People easily understand that too little healthcare is harmful but seem to have great difficulty in grasping that too much also causes harm.

I am no less fearful of pain and suffering than anyone else, but I'm still inclined to agree with the character in Emmanuel Carrère's book *Other Lives but Mine*: "As a rule, he thinks one must live lucidly, experiencing everything that happens, even suffering."

1 Rieff D. *Swimming in a sea of grief: a son's memoir*. Simon and Schuster, 2008.

2 Carrère E. *Other lives but mine*. Serpent's Tail, 2012.