Risks of legalising assisted suicide

This is one in a series of articles on the topic of euthanasia, assisted suicide and end of life care available on the website johnwyatt.com

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This article summarises the risks of legalising assisted suicide, sometimes referred to as 'assisted dying'

a) Wrong diagnosis

Sadly, serious mistakes in diagnosis are not uncommon, even in specialist centres. The last few years have seen a number of public scares as major errors have been revealed in pathology laboratories responsible for the diagnosis of cancer. How likely is it that assisted suicide might be carried out in the mistaken belief that the patient was terminally ill, when in fact the disease was self-limiting. Assisted suicide legislation would open up more possibilities for serious medical mishaps.

b) Wrong prognosis (prediction of life expectancy)

Even when doctors make the right diagnosis, they are frequently wrong as they attempt to predict how long a patient will survive. Most medical prognostication in terminal illness is more akin to educated guesswork than scientific calculation. Yet the proposed legislation assumes that a doctor can confidently predict both that the patient is terminally ill and that death will occur naturally within an arbitrary period of 6 months. One high profile example of inaccurate prognosis was the Lockerbie bomber Abdelbaset al-Megrahi who was freed from a Scottish prison in August 2009 on grounds that he was about to die. Detailed medical reports by eminent UK specialists indicated that he had an estimated three months to live with prostate cancer. In reality he survived until May 2012, 2 years and 9 months later.

c) Pressures on vulnerable people at the end of life

As Cicely Saunders argued, the availability of assisted suicide and euthanasia would put implicit pressure on the sick and the elderly, all too conscious of the demands they put on their relatives. Many people at the end of life are concerned that they might become a burden to others. Although the proposed legislation states that the request for suicide should come from the patient, in the highly regulated nature of medical care in the UK, once assisted suicide legislation was enacted it is likely that doctors would be instructed to make sure that all of their terminally ill patients were aware that assisted suicide was an option. To fail to inform patients about the option of suicide, even if the doctor thought it was totally inappropriate, would open the doctor to the possibility of being sued. Assisted suicide would be added to the list of "treatment options". How many vulnerable people would perceive the option of medical suicide as a duty? If there is no possibility of life termination, then I do not need to justify my desire to continue living. But once life termination becomes a 'treatment option', then I need to provide some justification for my desire to continue to live.

d) Abuse by relatives

Proponents of assisted suicide dismiss the possibility that relatives might pressurise elderly and infirm people for their own gain. But in the real world inhabited by clinicians, social workers and law enforcement agencies this is sadly not unusual. There is the possibility of serious abuse by relatives, who might see assisted suicide as a legally approved opportunity to relieve themselves of a burden of caring, and preventing the dissipation of life savings on expensive nursing care. This is not to imply that most relatives harbour malevolent thoughts to the terminally ill. But their own emotional distress can be a major source of pressure for health carers. "I can't bear to watch her in this state. Why can't you give her something to end it all?" How long will it be before the 'right to die' becomes a 'duty to die'?

A palliative care consultant told of the relatives of a dying person in her care, who repeatedly expressed concerns that their mother's pain was not controlled. They continued to ask that pain relief and sedation should be increased, although the lady in question appeared settled and peaceful. Subsequently it became apparent that there was an insurance policy in place and that a substantial amount of money would be paid to the relatives if their mother died before a certain anniversary. Once the anniversary came and went but the person was still alive, the relatives seemed to lose interest in the degree of pain control…

e) Accidental failure of suicide procedures
(This section is rather grisly and those of a sensitive disposition are advised to skip to the next section.)

All doctors with experience of assisted suicide recognise that "failures" will occur from time to time. In a study published in the New England Journal of Medicine, complications occurred in 7% of cases of assisted suicide, and problems with completion (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16% of cases. The physician decided to administer a lethal medication (intravenously) in 18% of the cases of assisted suicide because of problems with the procedure. The Royal Dutch Medical Association recommends that a doctor be present when assisted suicide is performed, precisely so that euthanasia can be performed if necessary.

Following oral administration of large doses of barbiturates there are reports of extreme gasping and muscle spasms. While losing consciousness, vomiting and aspiration may occur. Panic, feelings of terror and assaultive behaviour may take place from the drug-induced confusion. In one reported case in Oregon, after a man took the drugs intended to induce death his physical symptoms were so disturbing that his wife called the emergency services. He was taken from his home to a hospital where he was revived.

A Dutch doctor with practical experience of both voluntary euthanasia and assisted suicide said, "Thinking that physician-assisted suicide is the entire answer to the question of ending of life of a suffering patient…is a fantasy. There will always be patients who cannot drink, or are semiconscious, or prefer that a physician perform this act. Experience has taught us that there are many cases of assisted suicide in which the suicide fails. Physicians need to be aware of the necessity to intervene before patients awaken".

Yet the proposed UK legislation takes no account of the possibility of complications in the suicide procedure. Doctors would not be allowed to intervene by administering further lethal medication even if severe aspiration and brain damage resulted from a botched suicide attempt. How long before direct medical killing is seen as an acceptable response when suicide goes wrong?

f) Risks from the prescription and supply of lethal medications

The assisted suicide procedure would require that doctors prescribe and supply to the patient highly lethal medication for their own use. The possibilities of errors, accidents and abuse are obvious. The Falconer commission stated, "We are very concerned to avoid the potentially dangerous ramifications of allowing lethal medication to be kept in an unregulated manner in the community, in a private home, residential care home, hospice or hospital. We have suggested a number of safeguards that could ensure the lethal medication that would be required to bring about an assisted death was stored and transported safely. Most importantly, the doctor responsible for prescribing the lethal

medication, or another suitably qualified healthcare professional, would be expected to deliver the medication to the patient personally and wait until the patient had either taken the medication or declined to take the medication. If the medication was unused we recommend that it should be legally required that it is returned to the pharmacy." Although this proposal seems well-meaning, the presence of the doctor or healthcare professional could provide subtle pressure for the patient to take the lethal medication so as not to waste the professional's valuable time.

g) Gradual and incremental extension of the grounds for assisted suicide.

As discussed in chapter 5, the proposed grounds for assisted suicide are highly arbitrary and cannot be justified on rational grounds. Legislation in other countries has different time limits and criteria. Following enactment of the legislation there would still be a steady stream of suffering and tragic individuals demanding the right to have an assisted suicide in the UK. Many of the high profile media cases that have caused such public sympathy (including Daniel James, Tony Nicklinson and Sir Edward Downes referred to in chapter 1) would not be eligible for assisted suicide under the proposed legislation. It is inevitable that media campaigns and legal challenges would continue, and it seems highly unlikely that the grounds for assisted suicide would remain unchanged.

h) Effects of assisted suicide on health professionals and on society as a whole

Although it is proposed that no doctor will be forced to participate in assisted suicide, as discussed above it is likely that it would eventually become mandatory for all doctors to make their terminally ill patients aware that assisted suicide was an option. Would health professionals put as much emphasis on suicide prevention for the rest of their patients if assisted suicide is available for some of them? Would a minority of doctors who were strongly in favour of assisted suicide make their services widely available?

Finally, there is the effect on society of legalised medical killing, and the existence of a specialised group of people who are authorised to plan and assist killing under certain circumstances. Would suicide gradually become rehabilitated and promoted as a rational and reasonable way to die? Would the prevention of suicide become seen as paternalistic and out-moded? Respect for human life and resistance to suicide has been part of the glue that has bound our communities together for hundreds of years. Would legalised medical killing cheapen respect for human life in society as a whole?

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