'With the UK contemplating Assisted Dying legislation, and an increasing tendency to treat what may once have been felt to be irreversible, is there still a role for 'allowing natural death'?'

1992 words

Introduction

Given the current extraordinary rate of medical and technological advancements, the UK's deliberation over Assisted Dying legislation may appear, in some ways, paradoxically timed. Medical conditions that may once have amounted to a death sentence have become a clinician's bread and butter. Antibiotics cure pneumonias that once killed within days, monoclonal antibodies have transformed the trajectory of many cancers, people living with HIV can now expect a normal lifespan. Our capacity to hold death at arm's length - to shrink the tumour, give fluids, PEG-feed, transfuse, and then do a little more - has never been greater.

Yet as our ability to delay death expands, so too does our ability to hasten it. In this widening spectrum of intervention, is there still room to simply *Allow Natural Death*? Can we reliably recognise the moment when further treatment offers only suffering, not benefit?

This essay seeks to determine whether Allowing Natural Death still has a meaningful role in modern medicine and, if it does, how we protect the fragile space it occupies.

Defining '*Allowing Natural Death*'

It is important that Allowing Natural Death (AND) is properly defined to ensure both consistency in its application and of its implications.[1] AND can be defined as a medical order in End Of Life (EOL) Care – care in the last year of life - that emphasises comfort, dignity and symptom relief, and instructs life-prolonging or invasive interventions are withheld to allow the natural dying process to occur.[1,2] The term AND has been suggested as a replacement for Do Not Resuscitate (DNR), a signed form documenting the decision that if your heart or breathing stops your healthcare team

will not try to restart it.[3] Many argue the scope of AND extends beyond that of DNR.[1,3] Instead of what will not be done, such as withholding CPR, the focus of AND shifts to what *will* be done to support patients in EOL care.[1]

Allowing Natural Death supports a more patient centered and compassionate EOL experience by helping patients avoid lower quality of life (QoL) and increased regret often associated with aggressive, non-beneficial interventions.[4] Aggressive EOL care in cancer patients has been linked to poorer family perception of the care their loved ones receive, in this way choosing AND can also benefit families by supporting a more gentle and aligned approach.[4] By focusing on comfort, rather than escalation, AND preserves patient dignity and focuses on symptom management, which can create a more peaceful end of life environment for all involved.

The Changing Landscape around Dying

In November 2024 the Terminally Ill Adults (End of Life) Bill passed its second reading in Parliament.[5] This provoked strong and contrasting emotions across the UK. Supporters of the Assisted Dying Bill in England define *Assisted Dying (AD)* as 'prescribing life ending drugs for terminally ill, mentally competent adults to administer themselves after meeting strict legal safeguards'.[5,6] If the Bill passes, one of its provisions will be the individual would have to be judged to be terminally ill and be reasonably expected to die in the next six months.[5]

Currently, Assisted Dying is illegal in England and Wales under Section 2 of the Suicide Act (1961).[7] There is, however, evidence that the position may be starting to shift. The second reading of the Bill has reopened the conversation about whether the UK should follow the ten US states that already allow AD.[6] Several European countries

also permit some form of AD, including Switzerland (*assisted suicide*) and Belgium (*voluntary euthanasia*).[6]

Currently, individuals in the UK who want the option of AD are making the decision to travel abroad, at a cost of over £15,000 to complete.[8] Since 1998, UK citizens have made up almost 15% of all AD (or assisted suicide) at Dignitas in Switzerland, an organization providing physician assisted suicide, with at least 33 individuals from the UK doing so in 2022.[9]

A report by Dignity in Dying revealed that 27% of individuals who witnessed a loved one experience significant suffering at the end of life indicated that they might have explored assisted dying had it been legally available.[10] Whatever one's view on AD, this data certainly indicates that if the Terminally Ill Adults Bill progresses to becoming law, numerous terminally ill adults in the UK will exercise this option to end their lives, in turn reducing the space for Allowing Natural Death.

At the other end of the spectrum of medical intervention is the growing ability to treat conditions that were once considered irreversible. One striking example is the development of Chimeric Antigen Receptor (CAR) T-cell therapy. This involves engineering a patient's own T-cells to express artificial receptors that recognise specific tumour antigens, in turn enabling the immune system to target cancerous cells.[11] CAR T-cell therapy has been successful in achieving remission for a select group of patients with hematological cancers, altering prognoses that were previously poor.[12] This example represents only a fraction of the expanding capacity of modern medicine to sustain life.

Perhaps a more widely recognised example is the use of dialysis in managing renal failure. Over 3 million people in the UK live with moderate to severe Chronic Kidney Disease (CKD), a condition that can progress to end stage renal failure and ultimately result in renal function too low to sustain life.[13] These patients may be offered renal replacement therapy, in the form of dialysis or renal transplant.[14] As of 2022, approximately 30,000 people in the UK were receiving dialysis – an unquestionably life-saving treatment and another illustration of how modern medicine now sustains conditions that were once life shortening.[14] However, dialysis is an intensive and burdensome therapy that massively impacts daily life.[15] Consequently, some patients choose conservative management instead, deciding to prioritise comfort and QoL over life-prolonging treatment.[15]

The UK's aging population is further reshaping the landscape of dying. In 2022, 12.7 million people were aged 65 or over (19% population), compared to 7.5 million (13%) in 1972.[16] This figure is predicted to reach 22.1 million (27%) by 2072.[16] As people live longer there will be an increase in individuals living with chronic and ultimately terminal illnesses, increasing the demand for palliative care.[17] In fact, the need for palliative care is projected to increase by 42% by 2040.[17] This highlights an increasing need for clear options within palliative care itself, such as Allowing Natural Death.

The Potential to Overtreat at EOL

A decision to prioritise patient comfort and QoL is particularly relevant in End of Life Care, and Palliative care more broadly. The use of a range of interventions such as enteral feeding and palliative chemotherapy can improve QoL and, in some cases, prolong it.[18,19] However, with so many different treatment options readily available, it has become difficult to identify when such treatment options no longer change the

trajectory of an illness and instead prolong suffering, and come at the expense of comfort and dignity.[20,21]

In patients with advanced, irreversible disease - such as a patient with stage 4 cancer experiencing repeated infections - each new deterioration often triggers a reflex to escalate care: chest drains, further chemotherapy, mechanical ventilation. These measures can consume the final weeks of a person's life in hospital, separated from those they love, and may not have the effect of restoring meaningful QoL.[22] In fact, an integrative review in 2020 found studies showed palliative chemotherapy in advanced cancer was generally associated with lower QoL and was linked to shortened survival, poorer quality of death and death in intensive care.[23] Additionally, research shows that many people nearing the end of life continue to undergo repeated imaging.[24] Scans can be uncomfortable, carry potential side effects, and add unnecessary cost and resource use, while offering little to no benefit in end of life care.[24] Researchers suggest that ordering more tests may unintentionally divert clinicians and families from important and open conversations about dying.[24]

The tendency to treat because we are able to makes the case for Allowing Natural Death stronger. As the capacity to intervene grows, so too does the need for deliberate, ethically grounded alternatives. Without a well-defined role for AND, there is a risk dying patients become recipients of default escalation, simply because the options exist.

Where Allowing Natural Death Sits

Allowing Natural Death does not represent abandonment, nor does it pre-empt broader debates on assisted dying. AND offers another option for EOL patients,

acknowledging that there comes a point where certain treatments can inflict more harm than good, which arguably goes against a core principle of medical ethics non-maleficence.[25] AND represents an option to withdraw life-prolonging or invasive interventions and allows a natural disease to take its course, in turn shifting focus to what will be done to support EOL patients.[1]

In recognition of the need for clearer, patient-centred planning around dying, the UK introduced the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process in 2016.[26] A ReSPECT form creates a concise, transferable summary of personalised recommendations for situations in which a patient cannot express their treatment wishes.[26] The process empowers individuals, through joint decision making, to articulate their values, set boundaries and clarify the level of treatment they consider acceptable.[26] Importantly, ReSPECT provides a formal mechanism through which a patient's decision to Allow Natural Death can be communicated and upheld, providing patients and their loved ones with peace of mind.[26,27]

For many individuals, death is not merely a physiological process but an accepted and often spiritually significant transition. Several major religions believe dying to be a passage to another existence or completion of earthly life.[28] AND helps preserve this dimension by reducing over-medicalisation of death and enabling the final stage of life to unfold in a manner more aligned with personal beliefs, cultural values and relationship priorities.[29]

Crucially, AND can also function as a protective framework for clinicians who may feel personally pressured to "do more" now that treatment options are so broad.[30,31] Establishing a clear, ethically grounded rationale for non-intervention affirms that

sometimes the most compassionate care is not achieved through treatment escalation but rather in accompanying patients through the natural course of their illness.

68% of all people who died in 2023 (369,790 people) spent time in hospital during the six months preceding death.[32] Such admissions may not always be consistent with patient preference and may represent reflexive interventions rather than deliberate, value aligned planning. Earlier conversations about AND can help prevent unwanted hospitalisation in favour of home-based or other preferred settings.[33]

Looking ahead, as the role of AND becomes even more meaningful it must evolve itself. It is not enough for AND to be understood merely as withdrawal of effort or a lack of treatment. Instead, AND should be reframed and clearly defined as a mode of active, intentional, and supported dying - a deliberate clinical choice to withhold life-prolonging or invasive interventions that can be decided during the ReSPECT process.[1,26] In this way, AND can mirror the hallmarks of palliative care, including advance care planning, anticipatory prescribing, informed decision making, emotional and spiritual support and an explicit acknowledgement of the limits of medicine.[1,2]

Conclusion

As the UK contemplates Assisted Dying legalisation and medicine becomes increasingly capable of sustaining life, the role of Allowing Natural Death not only persists but grows in importance. Assisted Dying may offer relief for a small number of patients whose suffering cannot be alleviated by other means and who desire control over the timing of death, whilst an expanding medical capability offers life-prolonging potential that is valuable when aligned with patient goals. AND offers a

grounded middle path: it neither prolongs nor hastens death, but supports a dignified, compassionate, and meaningful dying process aligned with patient values.

For “Allowing Natural Death” to remain an accepted option for patients receiving Palliative Care in the UK, the term must become better understood and more confidently adopted. Its meaning and practice also need to evolve, to frame AND as an intentional approach to End of Life Care. In an era increasingly focused on control, perhaps Allowing Natural Death stands as a significant example of humility in medicine.

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