‘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?’

Introduction

Modern medicine presents a paradox: clinicians can do more than ever to prolong life, yet the UK is moving toward granting terminally ill adults the right to end their lives with medical assistance. This raises an important question about the continuing role of Allowing Natural Death (AND).

AND describes an approach to end-of-life care focused on comfort and dignity, where neither aggressive life prolonging interventions nor active life-ending measures are pursued. Instead, disease is allowed to take its natural course (1). With assisted dying legislation progressing through Parliament and survival rates for conditions such as cancer steadily improving (2)(3), AND appears caught between interventions that extend life and laws that enable patients to end it.

This essay argues AND remains a vital component of ethical end-of-life care. It offers a middle path between maximal intervention and active life-ending, safeguarding autonomy, proportionality of treatment, and the core commitments of palliative care. Rather than diminishing AND’s relevance, medical advances sharpen the distinction between what medicine can do and what it ought to do. This essay will show that AND continues to serve patients who fall outside assisted dying criteria, supports diverse moral and cultural values, and provides an essential framework for navigating the ethical uncertainties created by modern medical capabilities.

The changing landscape of dying

Over recent decades, end-of-life care in the United Kingdom has undergone significant change, shaped by legal precedent and rapid medical innovation. Although all forms of assisted dying remain illegal, actions intended to hasten death may fall under offences such as murder or manslaughter, and assisting suicide is prohibited under the Suicide Act 1961 (4). In October 2024, the Assisted Dying Bill was introduced by Kim Leadbeater MP, and in November 2024 the House of Commons passed the Terminally Ill Adults (End of Life) Bill by 330 votes to 275. This legislation would allow adults over 18 with a life expectancy of less than six months to request medical assistance in dying, subject to approval by two doctors and a High Court judge (2).

The legal foundations of end-of-life practice were set earlier by Airedale NHS Trust v Bland (1993), where the House of Lords held withdrawing life-sustaining treatment from a patient in a persistent vegetative state was a lawful omission rather than an act of killing (5). Meanwhile, medical advances have altered what counts as “terminal” or “irreversible.” UK survival rates for all cancers combined have doubled since the early 1970s (3), and conditions once regarded as fatal, such as HIV/AIDS and advanced heart failure, are now managed as chronic illnesses.

These parallel developments, the expanding ability to prolong life and the emerging prospect of legally ending it complicate the purpose of allowing natural death and heighten the tension between what can be done and what should be done. To navigate this evolving landscape, the four principles of biomedical ethics: autonomy, beneficence, non-maleficence, and justice provide a consistent framework for evaluating assisted dying, medical progress, and the continuing role of AND.

Assisted dying

Current UK proposals restrict assisted dying to mentally competent adults with a terminal illness and a life expectancy under six months, with safeguards requiring voluntary decision making, assessment by two independent doctors, and self-administration of medication (2). Supporters argue this centres autonomy in end-of-life care by allowing competent adults to determine the timing and manner of their death. Within Beauchamp and Childress's framework, autonomy refers to the right to make informed and voluntary medical decisions (6), and many claim this should include the choice to hasten death when continued life is intolerable.

However, autonomy is neither absolute nor uncomplicated. Onora O'Neill highlights choices are shaped by relationships, dependencies, and social pressures, challenging individualistic models of self-determination (7). Even so, some argue respecting autonomy can mean supporting a patient's wish to end their life when this relieves suffering and preserves dignity (8). Evidence from Oregon, where assisted dying has been legal for more than two decades, shows those pursuing it tend to come from higher socioeconomic backgrounds and are primarily motivated by loss of autonomy rather than financial pressure (9). Only a small minority of terminally ill patients initiate conversations about assisted dying, and even fewer complete the process, suggesting legal access does not lead to widespread use (9).

Compassion is also presented as a justification, particularly for patients with severe or refractory distress that does not respond to palliative measures. Yet limitations remain. Strict eligibility criteria exclude children, individuals with dementia, and those in persistent vegetative states. Critics raise concerns about potential coercion, especially among elderly or disadvantaged individuals who may feel a perceived duty to die rather than burden others (10). Assisted dying may also conflict with non-maleficence and the medical duty to preserve life, and clinicians can experience moral distress when personal or professional values clash with a patient's request, complicating efforts to uphold autonomy while maintaining ethical practice (11).

Medical advances

Medical progress has transformed the meaning of a terminal diagnosis, shifting many once fatal illnesses into long term manageable conditions. In England, the one-year cancer survival rose from 65.6% in 2005 to 74.6% in 2020 due to earlier detection and more effective treatments (12). This is highly relevant to debates on assisted dying, as cancer remains the most common diagnosis among those who seek an assisted death, accounting for 67.5% of cases in Canada and 66% in Oregon (13).

These improvements reflect beneficence and justice, since extended survival can offer hope and better quality of life. However, non-maleficence becomes more complex when treatment prolongs the dying process rather than meaningful living. Metastatic breast cancer illustrates this tension. Although median survival for hormone-receptor-positive disease has increased to around five years, patients often undergo multiple lines of systemic therapy, each offering diminishing benefit and increasing harm (14). A similar pattern is seen in metastatic nonsmall cell lung cancer, where targeted and immune-based treatments have improved outcomes, but the disease remains incurable for many, and overall prognosis is still poor (15). These examples show how difficult it is for clinicians to judge when treatment remains beneficial and when it becomes burdensome. In such circumstances, allowing natural death provides an ethically grounded alternative when further intervention cannot offer significant benefit.

Issues of justice also emerge. Many life extending treatments, including targeted therapies and immunotherapies, are costly and not equitably accessible. Socioeconomic status and geography influence who receives these therapies, meaning the benefits of medical progress are unevenly distributed. These inequalities shape the timing and nature of end-of-life decisions. In some cases, choices between further treatment, assisted death, or allowing natural death are influenced as much by unequal access as by clinical need (11).

The role of allowing natural death (AND)

Allowing natural death retains an essential role in contemporary end-of-life care because it offers a pathway for patients whose needs are not met by either maximal life-prolonging treatment or emerging assisted dying legislation. It prioritises comfort, symptom relief, and acceptance of disease progression, providing an approach distinct from both aggressive intervention and the active ending of life (1). Despite major advances in treatment, the ethical legitimacy of AND continues to rest on the longstanding acceptance of withholding or withdrawing interventions that offer no meaningful benefit (16). This principle was affirmed in the Airedale NHS Trust v Bland decision in 1993, which established that clinicians may lawfully allow death when treatment is ineffective (5). The Mental Capacity Act 2005 further embeds this framework by enabling advance decisions to refuse treatment and ensuring that best-interest assessments guide care for those who lack capacity (17).

Importantly, AND supports patient groups excluded from assisted dying proposals, particularly people who lack decision-making capacity, such as those with advanced dementia. Many individuals with dementia reach the end of life without advance plans, leaving families and clinicians to make difficult decisions in uncertainty (18). Studies show that relatives often feel unprepared and may unintentionally project their own preferences onto the patient (19). Without a framework such as AND, these individuals risk receiving burdensome, non-beneficial interventions that prolong dying. AND is equally important for patients living with prognostic uncertainty. Conditions including heart failure, dementia, and chronic lung disease follow variable trajectories that make survival predictions beyond assisted dying criteria difficult, even when decline is progressive (20)(21). AND accommodates this uncertainty by allowing clinicians to shift goals of care toward comfort without reliance on narrow prognostic thresholds. It also respects patients whose religious or moral commitments preclude both assisted dying and invasive technological interventions, offering an option grounded in non-interference and acceptance of natural death.

AND also advances justice. Decisions are guided by clinical and legal frameworks, such as the Mental Capacity Act and national guidelines, rather than judicial authorisation, making the approach broadly accessible (17)(22). Evidence shows that patients and families respond more positively to the term “allowing natural death” than “do not resuscitate,” as it emphasises comfort and quality of life. This clarity supports earlier, more honest conversations about goals of care when curative treatment is no longer beneficial (23).

Ethical & Practical Tensions

Despite increasing interest in assisted dying and the expanding capacity of medicine to prolong life, there remains a strong ethical need to preserve the role of Allowing Natural Death (AND) within UK end-of-life care. Nearly two thirds of adult hospices reported a financial deficit in 2023–2024 due to declining government and fundraising income, with some already reducing services (24). Rising demand as the population ages will intensify this pressure, raising concerns that assisted dying may be perceived as a more cost-effective alternative to comprehensive palliative care. The principle of justice requires equitable access to high quality end-of-life support, yet ongoing underfunding risks undermining fair and ethically grounded decision making.

Trust is central to this landscape, particularly for minority ethnic communities. Although these groups represent 14% of the UK population, they report significantly poorer end-of-life experiences; Black, Asian, and minority ethnic (BAME) respondents are 26% less likely than White respondents to rate care as ‘outstanding’ or ‘excellent’, and those receiving hospice care are half as likely to rate it positively (25). These disparities stem from systemic barriers including limited awareness, cultural stigma, language challenges, and longstanding mistrust of healthcare institutions (26).

Cultural and religious beliefs also influence preferences at the end of life. Many Muslim communities view life as sacred and accept suffering as spiritually meaningful, often favouring continued life-sustaining treatment (27). South Asian families commonly emphasise collective rather than individual decision making, reflecting relational understandings of autonomy (28). Introducing assisted dying into a system already marked by inequities risks deepening mistrust or creating perceptions of pressure on vulnerable individuals. Relational autonomy recognises that choices are shaped by family and community contexts (29), and in under-resourced settings patients may feel obligated to choose death to avoid burdening others.

Conceptions of a good death vary across cultural groups, and AND's focus on comfort, proportionality, and non-interference can accommodate this diversity (30). In this context, AND offers a more inclusive and trustworthy model of end-of-life care.

Conclusion

Allowing Natural Death should not be viewed as in competition with assisted dying but as a complementary, ethically grounded option, particularly for patients for whom assisted dying is inaccessible. AND preserves dignity and proportionality while supporting those who lack decision-making capacity or face prognostic uncertainty, and it aligns more closely with relational and culturally diverse understandings of autonomy. As medicine's capabilities expand and societal attitudes toward death evolve, AND, assisted dying, and life-prolonging treatments must coexist as parallel pathways shaped by different values, needs, and circumstances. The question of AND's continued relevance can only be answered in the affirmative. Safeguarding its role depends on sufficient palliative care funding, culturally competent services, and an acknowledgement that prolonging biological life does not always equate to meaningful living. Policymakers must therefore ensure equitable access to all end-of-life options, guided by ethical frameworks that honour diverse definitions of dignity and a good death.

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