Text for UN Draft General Comment on Article 36 / call for comments

Submitted by Christian Medical Fellowship (CMF).

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 4,500 British doctor members in all branches of medicine, and around 800 medical student members. We are the UK's largest faith-based group of health professionals. A registered charity, we are linked to about 80 similar national bodies in other countries throughout the world.

In this submission we comment on paragraphs nine and ten of the UN Draft General Comments

Para 9

Exceeding its authority

We question the right of the Committee to interpret the UN treaty as including the right to abortion. The 2011 San Jose Articles[1] make clear that: '*No United Nations treaty can accurately be cited as establishing or recognizing a right to abortion. Accordingly, any such body that interprets a treaty to include a right to abortion acts beyond its authority and contrary to its mandate.*' The same Articles make clear that each unborn child is by nature human and, as such, is entitled to recognition of their inherent dignity and to protection of their inalienable human rights.

A presumption in favour of the unborn child

This is recognized in the Universal Declaration of Human Rights,[2] the International Covenant on Civil and Political Rights,[3] and other international instruments. The Convention on the Rights of the Child[4] explicitly protects children 'before birth' and international law in general creates a presumption in favour of the unborn child in that it prohibits the application of the death penalty to pregnant women.

As guardian of the implementation of the International Covenant on Civil and Political Rights, **the Human Rights Committee should surely be upholding the right to life of unborn children,** rather than drafting policy that would, in effect, exclude the unborn child from a right to life. Whilst we recognise the Committee's recommendations do not carry legally binding force, they are likely to influence the interpretation of the treaty by UN agencies, and will undoubtedly be cited by judges in court and by lobby groups wishing to persuade governments to liberalise abortion policy.

Conflicts with existing legislation

[1] http://sanjosearticles.com/
[2] http://www.un.org/en/universal-declaration-human-rights/
[3] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx
[4] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

Whilst we recognise your intention is to protect women who might otherwise resort to unsafe abortions, the wording of the draft, we suggest, is in conflict with this country's existing legislation as well as that of others. As drafted, in will have a destabilising effect and will serve only to encourage those who wish to liberalise further the practice of abortion.

Unsafe practices

Your draft comment that States should not 'introduce humiliating or unreasonably burdensome requirements on women seeking to undergo abortion' will be interpreted as supportive of those who wish the procurement and provision of abortion to be liberated from any legal restraint. Without that restraint, it is inevitable that cheap, unsafe practices will once again blight the horizon. Abortion will be accepted as retroactive contraception, undermining your stated desire to improve access 'to information and education about reproductive options, and to a wide range of contraceptive methods'.

Lacking evidence and definition

The recommendations of the Committee effectively require States to make provision for legal access to abortion in any case in which the pregnant mother's life or health is in danger, as well as in cases of rape, incest, fatal fetal impairment, and other scenarios in which continuing the pregnancy would cause the woman 'substantial pain or suffering'. Contrary to expectations, most women who become pregnant as a result of rape choose to keep their babies.[5] Of those who elect to have an abortion, 80 percent subsequently regret their choice.[6] It is difficult to see how a law that allows abortion after rape or from sex with a family (or 'extended' family) member, could be framed. It takes months to establish guilt through the courts in the case of rape by which time any baby conceived by violation would already have been born.

Fatal fetal impairment is not a medical term. Even with prenatal scans and where the diagnosis is clearly known, there are unpredictable variations in survival times. There is no agreed list of lethal or fatal conditions in medical literature because, for almost all conditions, there are mixed outcomes and babies often survive beyond birth, sometimes for longer than anyone expects. Any attempt to create a list of so-called fatal conditions would be both arbitrary and subjective.

We should not rank the value of a person according to either the circumstances of their conception or the degree to which their health is unimpaired. A child with severe disability is no less a person and is protected in law from discrimination.[7] The same rights should be extended to the unborn child.

'Substantial pain or suffering' is a phrase without definition and open to a wide range of different and subjective interpretations. It leads to confusion between clinicians and arbitrariness in application.

In summary, we believe your recommendations overreach your authority, fail to respect the terms of the Covenant you are mandated to guard, undermine the existing legislation in some nation

[5] http://www.rcni.ie/rape-pregnancy-and-abortion-in-ireland-rcni-release-new-figures-today/
[6] From survey quoted in Victims and Victors: Speaking Out about Their Pregnancies, Abortions, and Children Resulting from Sexual Assault by David C Reardon. Acorn Publishing. January 2000.
[7] https://www.gov.uk/guidance/equality-act-2010-guidance

states, fail to reflect evidence, lack necessary definition, will in effect remove from unborn children the right to life and will foster a yet more aggressive stance by the abortion industry.

Para 10

Current wording invites incremental extension in practice

We welcome the Committee's remark that 'individuals planning or attempting to commit suicide may be doing so because they are undergoing a momentary crisis which may affect their ability to make irreversible decisions, such as to terminate their life'. However, the draft appears to advocate assisted suicide for those who 'experience severe physical or mental pain and suffering and wish to die with dignity'.

The Committee does not suggest that assisted suicide be reserved for those with terminal illness, expected to die within a fixed period, for example six months. It simply refers to ongoing physical or mental anguish, a very wide catchment. The Comment goes on to insist upon 'robust legal and institutional safeguards' but fails to take into account the trajectory of experience in countries that have already legalised assisted suicide or euthanasia, where such 'safeguards' have clearly been ignored and/or incrementally extended in practice.

Experience in Oregon and Washington

In Oregon, for example, existential reasons are by far the most common ones given for seeking assisted suicide – 93% citing 'loss of autonomy' and 73% 'loss of dignity'.[1] These patients would meet the Committee's criteria of severe mental pain and wishing to die with dignity. Similarly, in Washington in 2013, 61% of people opting for assisted suicide gave the fear of being a burden to family, relatives and caregivers as a key reason. Many such patients change their minds following formal psychiatric assessments and treatment of underlying depression.[2] In one Oregon study, 26% of those seeking assisted suicide met the criteria for depression but less than 3% of such patients were referred for psychiatric assessments.[3] In the same study, researchers found that 2–17% of those in Oregon and the Netherlands, who died by assisted suicide, had been suffering from clinical depression at the time. Over time, there has been a downward trend in the number of individuals receiving physician assisted suicide in Oregon who are first referred to a mental health professional on the grounds that a suspected mental disorder may be impairing judgement. In 1999, the figure was 37%; the number in 2010 was 1.5%.[4]

Experience in the Netherlands

In countries where euthanasia was introduced for those with terminal illness, where survival was not expected beyond six months, it was not long before equality legislation was being used to extend euthanasia to include those who felt their lives were no longer worth living, including children in some cases.[5] Now, it seems, in the Netherlands euthanasia is being applied to end the lives of some whose lives others believe to be 'not worth living'.[6] [7] [8] Incremental extension takes place as activists bring new cases to the courts using the arguments of autonomy and compassion, ultimately making a mockery of so-called robust safeguards.

‘Duty to die’

Legalising assisted suicide will have the inevitable effect of placing pressure on vulnerable people to end their lives – to ease the burden of care on their family or the state, or to release much-needed funds or property to the next generation. A ‘right to die’ would rapidly become a ‘duty to die’.

Other pressures to extend

Financial cost is another driver of incremental extension – it's much cheaper to kill than to treat. At a time of national financial restraint, and with the high cost of in-patient care, the temptation for authorities to 'stretch' the scope of application would be ever-present. It costs on average £3,000 to £4,000 a week to provide in-patient hospice care in UK, but just a one-off cost of around £5 to pay for the drugs which would help a person commit suicide. Cancer treatments like chemotherapy, radiotherapy or surgery cost much more. Do we really wish to place that temptation before families, healthcare providers and health ministers?

Undermines doctor-patient relationship

It is significant that doctors and palliative care workers are amongst the most vigorous opponents of moves to legalise assisted suicide. They study and work to preserve lives, not to end them; to be purveyors of health, not death. A law making them responsible for assisting suicide would be against the Hippocratic tradition that has guided doctors for over 2,000 years. It would also undermine the trust that is crucial to the doctor-patient relationship. The patient's confidence that the doctor will always act in such a way as to do no harm is foundational to that relationship. Giving doctors the power deliberately to end the lives of their patients will inevitably redefine the nature of the relationship and risks undermining that essential trust and confidence. Doctors could eventually become hardened to causing death, and begin to see their most vulnerable patients as 'disposable'.[9] Such patients could decide not to ask for medical help, for fear that they be encouraged to consider assisted suicide by doctors who they feel they can no longer fully trust.

Conscience coerced

Assisted suicide puts doctors in the unenviable position of having to make a value judgment about whether a patient's quality of life was such as to preserve or terminate it. The patient's autonomous decision therefore impinges on the autonomy of the physician – the patient's 'right to die' would impose on the doctor a duty to assist. Any notion of the sanctity of human life would be undermined and the physician’s conscience coerced and compromised.

Palliation - the better way

Good palliative care, whether in the community or in hospices, has demonstrated that it is possible to control discomfort and distress effectively – killing the pain, not the patient. In 2010 the British Medical Association, recognising that requests for assisted suicide and euthanasia are very rare when patients are being properly cared for, called for better training of doctors and education of the public about palliative care.[8] Our appeal to the Human Rights Committee is to give preference to investment in these areas in its Comments, rather than sanction assisted suicide.

[8] https://www.cmf.org.uk/news/?id=185

[1] Ganzini, L et al. 'Oregon physicians' attitudes about and experiences with end of life care since passage of the Oregon Death with Dignity Act', Journal of the American Medical Association 2001; 285, pp. 2363 – 2367.
[2] Emanuel ,EJ et al. 'Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers', JAMA 2000; 284, pp.2460-8.
[3] Levene, I and Parker, M. 'Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review', Journal of Medical Ethics 2011; 37, p.205
[4] Oregon Revised Statutes 127.800.127.995, 127.825 §3.0.
[5] Increase in assisted suicide cases sends warning to Britain. Care Not Killing, 16 April 2012
[6] Van der Maas PJ et al. Euthanasia and other medical decisions concerning the end of life. Lancet 1991;338:669–74
[7] Van der Maas PJ et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. NEJM 1996; 335:1699–705
[8] Groenewoud JH et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. NEJM 2000; 342:551–6
[9] Keizer B in Ross W. Dying Dutch: Euthanasia spreads across Europe. Newsweek, 12 February 2015