House of Commons Health and Social Care Committee Inquiry into Perspectives on Assisted Dying/Assisted Suicide

Response from Christian Medical Fellowship, January 2023

Introduction

This submission is on behalf of the Christian Medical Fellowship (CMF). We are happy for the submission to be published and attributed to CMF. We would also be pleased to contribute oral evidence.

The Christian Medical Fellowship is an association of around 4,500 doctors, medical students, nurses and midwives in the UK that exists to unite and equip them to live and work for Jesus Christ. Many of our members work in palliative care.

Terms of Reference

Q1. To what extent do people in England and Wales have access to good palliative care? a) How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying/assisted suicide?

The UK has been a world leader in the hospice movement, building on the foundations laid by pioneers like Cicely Saunders who famously said: *'You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.'*

The need for palliative care and end of life care is due to increase up to 42% in the next 20 years, as predicted by Marie Curie UK. One in four people in the UK are currently unable to access the palliative care they need, as estimated by Hospice UK. Over the past 16 years, the proportion of people dying at their usual place of residence has been steadily increasing, according to a 2022 survey from the Nuffield Trust. It is clear that demand is already outstripping supply and that a significant increase in investment in palliative care services will be required to meet the growing need.

Our appeal is that priority be given to training a new generation of palliative care specialists and to multiplying palliative care units and symptom control teams. There is enormous benefit to families where hospice-type care is locally available, and this also encourages 'ownership' by local communities, which helps generate income through fund-raising and legacies.

People often have fears or misunderstandings about what can be offered by way of end-of-life care; giving palliative care services a reasonable chance to alleviate the situation should be a pre-requisite.

However, evidence[1] shows that '*palliative care and assisted dying do not, and cannot, co-exist harmoniously. They do not rise and fall together because they are not complementary but are diametrically opposed both in theory and practice. One can truly flourish only at the exclusion of the other.*'

To most people, the term 'assisted dying' suggests 'providing hospice-type care to people who are dying' or 'giving people who are dying the right to stop futile life-prolonging treatment.' It is not generally understood to mean the giving of a lethal dose. Only 42% of those questioned in a July 2021 UK survey[2] realised that it refers to giving lethal drugs to a patient to end their life intentionally.

In summary, we are sceptical that palliative care services will receive the additional investment required at the same time as introducing assisted dying. Raising public awareness of the true nature of assisted dying – the giving of a lethal dose – should precede any move to legalise it.

Q2. What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?

Legalising assisted dying reduces the incentive to invest in palliative care services

Before permitting assisted suicide in 1997, Oregon, for instance, was comparatively advanced in palliative care provision, ranked highly in the US for hospice utilisation, hospital ICU utilisation, pain policy and advance care planning policy. After 2000, palliative care funding and provision stagnated as assisted suicide, encouraged by health insurers, took hold.

A similar pattern of diminution in palliative care has been observed since 2012 in the Netherlands, where investment is a third less than in the majority of European countries which prohibit assisted death. The same has occurred in Belgium since 2008 where promised increases in palliative care failed to materialise while the workload in doctor-assisted deaths climbed incrementally, sparking mass departures of palliative care specialists angry that their units were being turned into 'houses of euthanasia' and their functions reduced to preparing patients and their families for lethal injections.

Legalising assisted dying undermines compassion and hardens societal attitudes

We are concerned that legalising assisted dying would inevitably strengthen the perception that people with certain types of disease or disability have lives 'not worth living', that they would be 'better off dead', and that the costs of their care would be better directed towards healthcare provision for the more socially or economically 'productive' members of society.

The long-term effect on doctors and nurses themselves could be equally damaging. They could become hardened to causing death, and even begin to see their most vulnerable patients as 'disposable.' Such patients might then decide not to ask for medical help, for fear that they be encouraged to consider assisted dying by doctors whom they feel they can no longer fully trust.

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[1] Caldwell S. Palliative care and assisted dying – never the twain shall meet. Published in Conservative Woman, 19 November 2021. https://www.conservativewoman.co.uk/palliative-care-and-assisted-dying-never-the-twain-shall-meet/

[2] https://www.dyingwell.co.uk/wp-content/uploads/2021/09/Survation-Assisted-Dying-Survey-July-2021-Summary-3.pdf

Lord McColl of Dulwich described this change in medical conscience as ‘chilling’. In a speech in the House of Lords in 2003, reporting on a visit to the Netherlands, where euthanasia had been legalised, he said: *'Noble Lords will be aware that the Select Committee visited Holland. When we inquired of a doctor what it was like doing the first case of euthanasia, he said, “'We agonised all day. It was terrible.'” But he said that the second case was much easier and the third case – I quote – “‘was a piece of cake.” We found that very chilling indeed.’*

The risk of incremental extension in scope and scale

There is evidence from all the jurisdictions where assisted suicide or euthanasia have been legalised of incremental extension in application. In the example of Oregon, details of patients dying under the Act show a substantial number do not have terminal illnesses, even though the Law was intended to extend only to that category of patients. In 2013, 16.9% of those receiving assistance to die under the Act did not have cancer, heart disease, chronic lung disease or motor neurone disease but were classified as having ‘other illnesses.’ A footnote in the 2013 Oregon Public Health Division report on compliance with the Act explains that this ‘includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s disease, and Huntington’s disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease’. Whilst many of these conditions might be considered life-shortening, it is not credible that all these cases were terminal. They fell outside the terms of the Oregon Act.

In 1984, the Supreme Court in the Netherlands established a set of criteria that should be followed for a physician to cause the death of a person by euthanasia without fear of prosecution. From 1984 to 2002 a series of legal decisions led to a widening application of euthanasia for the hard cases, including people living with chronic depression (mental pain) and children who were born with disabilities. This led in 2001 to the Dutch Parliament officially legalising euthanasia, the law coming into effect in April 2002. Over the next decade the rate of euthanasia deaths increased three-fold. By 2007, voluntary euthanasia (1.7%), non-voluntary euthanasia (0.4%) and terminal deep sedation accompanied by withdrawal of nutrition and hydration (8.2%), accounted for around one in ten Dutch deaths.

In the same year (2002), Belgium’s law came into effect permitting euthanasia for those in a ‘medically hopeless’ situation – the ‘hard’ cases. Over the next ten years the rate of euthanasia in Belgium increased eight-fold. In 2010, 954 Belgians died by euthanasia; in 2019, the figure had risen to 2,655. Today, Belgium has some of the world’s most liberal euthanasia laws, which are not restricted to the terminally ill or to competent adults. Children of any age are also eligible, as long as they ask for it themselves and have the agreement of parents, and people with psychiatric conditions are also eligible.

Despite the extent of the laws already in place, lawmakers in The Netherlands are currently inquiring into how further to expand legislation in order to permit euthanasia based on having a ‘completed life,’ allowing people to be killed if they are tired of life and feel it is complete but have no serious illness.

The situation in Canada is even more alarming. The rate of increase in the proportion of deaths involving medical assistance has been faster than in any other jurisdiction. The number of cases of

MAiD (medical assistance in dying) in 2021 represents a growth rate of 32.4% over 2020. All provinces continue to experience a steady year over year growth.

In practice, once any so-called 'right' is established in law, experience shows that incremental extension takes place over time. There is a steady increase in absolute numbers of cases and a gradual inclusion of those who are outside the stated boundaries of the law. There is also pressure to extend the law as activists bring new cases to the courts using the same general arguments of autonomy and compassion. There is no reason to assume that the outcome would be any different in the UK. It has proved impossible to draft legislation that can adequately safeguard vulnerable people.

The right to end one’s life becomes the duty to end one’s life

The pressure on vulnerable people to end their lives, to ‘do the decent thing’ perhaps in order to relieve the burden of care from, or liberate finances for, other members of the family, or to relieve pressure on a beleaguered health system, becomes almost irresistible in an environment where assisted suicide becomes normalised.

Pressure and ‘coercion’

It’s not just the patients who might be put under pressure. The obvious danger is that the economic pressure to cut costs will determine clinical priorities and inevitably place systemic pressure on clinical commissioning groups to prematurely end the lives of patients. Are we to believe that pressure will not be present when the choice could be between a few hundred pounds for a lethal cocktail or £100,000 for an extended period of palliative care?

Q3. What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?

Introducing ‘assisted dying’ would mark a fundamental shift in the purpose of medicine – from preserving life to ending it. It would inevitably result in an equally fundamental change in the nature of the doctor/patient relationship. We are concerned that trust – the essential element in that relationship – would be irreparably damaged.

Doctors, who enter the profession with a vocation to improve the lives of their patients, will instead be asked to end those lives. It is not surprising that palliative care physicians are those most opposed to changing the law.

Freedom of conscience

Nobody should be required to participate in procedures that conflict with their sincerely held beliefs, religious or otherwise. To coerce a doctor (or any person) to act against their conscience is unethical, contrary to human rights legislation,[3] and causes moral injury and harm.

Requiring those who conscientiously object to refer a patient on to a colleague who does not share those beliefs makes them complicit. This appears to be understood by the General Medical Council whose guidance does not require ‘effective referral’ provided the patient has the information they

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[3] https://www.equalityhumanrights.com/en/what-european-convention-human-rights

need to access the services they seek. The World Medical Association has recently voted to protect conscientious objection for medical personnel concerning assisted suicide and euthanasia by excluding a provision that would mandate 'effective referral' in its International Code of Medical Ethics.[4]

This is not true simply where involvement is direct. The same complicity and moral harm results from indirect involvement of all kinds, whether for medical, nursing or support staff. **The issue should not turn on the threshold of involvement but on the threshold of objection**. For example, one person's conscience would be troubled by providing administrative support for appointments with doctors assessing eligibility for assisted dying. For another, whose conscience is calibrated differently, only direct involvement in the delivery of the dying substance might trigger objection. People vary in the thresholds at which they experience moral complicity and thus moral injury. It is simply not possible to draw up tidy categories – these activities represent 'direct' involvement and thus qualify for conscience rights to be respected, whereas those activities represent 'indirect' involvement and do not qualify – and we suggest that no survey will be able to draw lines that are workable in practice.

If assisted dying is legalised, we strongly urge that:

1. a *statutory* right of conscientious objection be included, that will apply equally to all healthcare professionals, and cover both direct and indirect involvement, rather than relying on the guidance published by professional regulatory bodies;

2. an *institutional* right of conscientious objection, so that individual hospices etc can decide not to provide assisted dying, without risking their funding. If this is not present in draft legislation, it would place an intolerable strain on the ethos of many existing services.

Q4 What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?

CMF believes that 'assisted dying' is unnecessary, unethical and unsafe. The solution does not fit the problem. In all but a tiny minority of cases, high quality palliative care is an effective means of providing end-of-life care. The problem is that high quality palliative care is not widely accessible in the UK. The solution is not to eradicate the patient, but to invest in training and provision of more excellent palliative care services.

Q5. What protections could be put in place to protect people from coercion and how effective would these be?

The best way to protect against coercion would be not to change the existing law. We believe it is not possible to put effective safeguards in place to protect vulnerable people from coercion that is often subtle and complex.

These are internal levers of coercion. Experience in other jurisdictions shows that the most common reasons given by people who request help to end their lives are not fear of pain but loss of control,

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[4] https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/

value and dignity. Loneliness, weariness and a desire not to be a burden to others. A sense of hopelessness and a fear of dependence.

External levers of coercion include pressure from relatives (who might stand to gain from the early death of a family member) and pressure from official bodies (eg, in Canada, where folk struggling with homelessness, poverty or disability, and who have been unable to access the help they need, in desperation are considering the option of assisted suicide as their only means of escape[5] [6]).

At the heart of the hospice movement is the commitment to help people 'live until they die.' **Kindness, compassion, company and communication can restore a sense that life is worth living, that a loss or productivity does not mean a loss of value, that dependence on help from others is a normal part of the human condition, and that dignity is conferred on vulnerable people by giving them time, love and tender care**. Along with expertise in symptom-control, these things can transform end-of-life experience, for patients and care givers alike.

Q6. What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?

It is our conviction that assisted dying/assisted suicide should not be introduced at all.

If it is introduced, consent would need to be fully informed. We believe that should include:

- a clear explanation of the process, including the imbibing of an unpleasantly tasting lethal draught, the risk that it may be regurgitated, or take a long time to act, or simply not be effective, and what is likely to happen in these circumstances;
- a clear explanation of the option of palliative care;
- a period or reflection lasting not less than four weeks;
- the offer and recommendation of non-directive counselling.

Q7. What capabilities would a person need to be able to consent to assisted dying /assisted suicide?

We reiterate that we do not believe the law should be changed to make legal the option of assisted dying/assisted suicide.

Assessment of capacity must include a full assessment of mental health by fully qualified and clinically experienced (a minimum of five years) mental health professionals. Existential angst is the most common reason given for requesting assisted dying. Conditions like anxiety and depression are amenable to treatment. Without qualified assessment of capacity, it is inevitable that some patients who could have been successfully treated will instead be helped to die.

Discussion with family members/close friends can assist healthcare professionals in assessing capacity when it may not be immediately clear. Family doctors may also have had experience of the person over a longer time and their perception of the person's capacity could be helpful.

Q8. What should the Government's role be in relation to the debate?

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[5] Raikin A. No Other Options. Published in the New Atlantis, Issue 71, Winter 2023 https://www.thenewatlantis.com/publications/no-other-options.

[6] https://www.ctvnews.ca/politics/paralympian-trying-to-get-wheelchair-ramp-says-veterans-affairs-employee-offered-her-assisted-dying-1.6179325

It is our opinion that the Government should uphold the law as it stands, and invest in high-quality, widely accessible palliative care.

As part of this, it should review the impact of section 21(1)(h) of the Health and Care Act 2022 to ensure that it is delivering the intended improvement in consistency of palliative care provision.

Any vote in Parliament must be a free vote that respects the consciences of those on all sides of the House.

RJT January 2023