

## BMA neutralised: on assisted suicide and euthanasia

Review by **Mark Pickering**  
CMF Chief Executive

**'Doctors Drop Opposition to Assisted Dying'** were the predictable headlines when the British Medical Association (BMA) narrowly voted to move from 'opposition' to 'neutrality' on 'assisted dying, including physician-assisted dying' (PAD), at its online Annual Representatives' Meeting (ARM) on 14 September.<sup>1</sup>

The vote was incredibly close, with just four votes (one per cent) in it; 302 voted, with 149 for, 145 against with eight abstentions. This represents just over one per cent of those voting in the BMA's 2020 member poll on PAD, where almost 29,000 responded. The poll itself showed marked diversity, with support for assisted dying most popular (40 per cent), ahead of opposition (33 per cent). However, that headline is misleading.<sup>2</sup> Students and retired doctors (who do not care for patients) were most in favour of PAD, whilst those in palliative care, oncology, geriatrics, and general practice (who routinely discuss end of life care with

patients) were most opposed. The closer people get to 'assisted dying', the more they tend to recoil.

Strikingly, due to a loosely worded motion, the BMA is now not only neutral on assisted suicide (which had significant support in the members' poll), but also neutral on euthanasia (which did not). The vague catch-all campaign phrase 'assisted dying' covers both.

This slim margin is predictably being trumpeted as a major victory by campaigners. Excellent speeches against the motion, including some by CMF members, made the point that the only thing this really achieves is to hand a simple, seductive soundbite to campaigners as they press on to Parliament, where Baroness Meacher's Bill is due for debate on 22 October.

Much better would have been to focus Parliament's attention on the details of the BMA's poll, with nuanced data on where support for assisted dying actually lies (and does not lie) within the medical profession.

The idea that the BMA must be 'neutral' in order to represent diversity is patently false – delegates also spent a whole hour in closed session, debating how the BMA can represent members' diverse views, irrespective of their overall position on PAD.

There is much to do. But there were some clear encouragements from this year's ARM. CMF members were able to pass policy on Clinically Assisted Nutrition and Hydration, on conscience and moral injury, and on reducing sexual abuse of children. It was incredibly heartening to see members and allies working together to be salt and light in this challenging environment.

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## Reforming the Mental Health Act giving a more personalised approach

Review by **Ruth Butlin**, a retired medical missionary & member of the *Triple Helix* committee

**T**he involuntary detention of people with serious mental illness is currently controlled by the Mental Health Act of 1983, as amended in 2007 (MHA 1983/2007).<sup>1</sup> An Independent Review of the Mental Health Act<sup>2</sup> grappled with balancing patient autonomy against the protection of individuals and communities. It also addressed the fear associated with the MHA 1983/2007 in patients' minds. The review panel reported in 2018, but COVID-19 delayed the Government's response, now published as a white paper,<sup>3</sup> a public consultation on which closed in April.<sup>4</sup>

The government is ready to accept most of the recommendations of the Independent Review. In particular, to utilise the framework of four proposed principles, namely Choice and Autonomy, Least Restriction, Therapeutic Benefit and the Person as an Individual. Most of the proposed changes will be in the direction of stricter criteria for detention, more right to appeal against involuntary treatment, more control for detained patients over who

can act on their behalf and more support for all patients with mental illness in the form of specialist advocacy services (for voluntary as well as detained patients). There is a marked emphasis on the non-discriminatory application of the legislation, given the evidence that the impact of MHA 1983/2007 has fallen disproportionately on people of Black, Asian, or ethnic minority backgrounds. The new criteria for imposing detention or community treatment orders will require evidence of a higher level of risk to self or others. The duration of detention will be more tightly controlled. Learning disability,<sup>3</sup> or autism alone will no longer be justification for detention.

Until now, each detained patient's 'nearest relative' (as defined in the MHA 1983/2007) had certain rights to object to or appeal against detention, as well as a right to be kept informed. This role will be replaced by a Nominated Person (NP), who the patient can choose. Many patients whose family members are not their closest confidantes have welcomed this change.

Under the new Act, neither a police cell nor

a prison can be classified as a 'Place of Safety' for a person detained under the MHA. Imprisonment happened all too often to the detriment of the patients concerned.

More controversial will be the proposals for Advance Choice documents, which would give patients opportunities to specify their preferences for future management. These would be somewhat similar to Advance Directives, but it is unclear why a different system is needed.

We need to pray for the Government to make the right decisions as they draft this new Mental Health Act, which affects some of our most unfortunate and marginalised citizens.

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## Vaccine tyranny?

*Covid vaccine controversies rage on*

Review by **Jennie Pollock**  
CMF Head of Public Policy

At the time of writing, Westminster has just dropped its 'vaccination passport' plans for crowded venues in England,<sup>1</sup> but has rolled out a voluntary vaccination programme for twelve to 15-year-olds.<sup>2</sup> Meanwhile, vaccine passports will be introduced in Scotland from 1 October,<sup>3</sup> and Westminster's ruling that all care home workers must be fully vaccinated by 11 November is still in place. Workers who are not exempt needed to have their first dose by 16 September to be fully protected in time.<sup>4</sup>

In addition to these statutory plans, some universities, airlines and businesses are starting to make vaccination a condition for education, employment and social interaction.<sup>5</sup>

While many of those at greatest risk from the coronavirus remain, understandably, anxious about restrictions easing even as hospital admissions continue to rise,<sup>6</sup> others are urging governments to help us move to a phase of learning to live with the virus responsibly.

In a culture that sets a high value on personal autonomy, it was heartening to see how readily we obeyed the 'Stay home' mandate in March 2020. However, there is a growing sense that the Government is now overstepping the boundaries of what is reasonable and necessary for the protection of the public. Concerning the vaccine rollout for children, for example, the risk vs reward data remains unclear,<sup>7</sup> and many are concerned that we are putting our children at risk for the sake of adults.<sup>8</sup> The fact that children deemed 'Gillick competent' can overrule their parents' decision on the vaccine<sup>9</sup> has also raised concerns.<sup>10</sup>

Fear, mistrust and an overload of complex information make it very hard for anyone to see the intricacies of the vaccine debate clearly, and the harder the Government pushes, the more entrenched resistance is likely to become. Meanwhile, across the world, millions are still waiting for access to the vaccine, while the UK and US are throwing away hundreds of thousands of expired doses.<sup>11</sup> With the autumn booster

job programme already starting,<sup>12</sup> Covid vaccines look set to be a contentious issue for quite some time.

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## NHS data grab

*betraying confidence?*

Review by **Steven Fouch**  
CMF Head of Communications

Data is the new gold – the most valuable commodity in the digital world, and the NHS holds a vast amount of this asset. Data about almost every British resident's medical history, demographics, and healthcare interactions. This information is estimated to be worth nearly £10 billion, according to Ernst & Young.<sup>1</sup>

In May, the Health Secretary issued a legal direction to every GP in England to upload their patient records to a central database.<sup>2</sup> The plan was for this data to be made available to private companies and research bodies, albeit 'pseudo-anonymised'. But the campaign group openDemocracy, fearing this would breach GDPR, issued a legal challenge in June.<sup>3</sup>

Only at this point did most of us become aware of what some called the 'NHS patient data grab',<sup>4</sup> or more officially, the General Practice Data for Planning and Research scheme (GPDPR).<sup>5</sup> The subsequent outrage from patient groups, Royal Colleges, and others caused the implementation date to

be pushed back from 1 July to 1 September. That date has now been postponed indefinitely, as over a million people living in England have opted out. The government is now about to go into an extended consultation process with all those involved.<sup>6</sup>

Data mining of patient records is nothing new – in fact, it goes on all the time. It is invaluable in medical research and health service planning.<sup>7</sup> Even then, it remains controversial, despite access being restricted and anonymised.<sup>8,9</sup> GPDPR would have centralised data in a way that is useful but would have arguably weakened the link between patient and GP.

The principle of confidentiality is central to all healthcare. Patients share the most intimate details of their lives with health professionals, especially GPs. And we do so on the understanding that it will only be used for the purposes of our care and treatment. This widely shared value is also profoundly biblical. As the Scriptures remind us, we are not to 'betray another's confidence'. (Proverbs 25:9-10)

The marketability of our personal data drives commerce, social media and most of the Internet. We should be wise in how we approach utilising this data. Trust is essential, and the lack of consultation, transparency, and public awareness of the implementation of GDPR has dented that trust. This is another area where we will need to maintain vigilance in the coming years.

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