

## Assisted Dying Bill – Second Reading Briefing

July 2014

The Second Reading debate on Lord Falconer's Assisted Dying Bill will take place in the House of Lords on Friday 18<sup>th</sup> July.

### **1. Introduction**

1.1 The Assisted Dying Bill proposes a radical innovation in UK Law: individuals are to be permitted *actively* to participate in ending other individuals' lives. The Bill is *not* about a person's 'right to die', but about one person's freedom to help end another person's life. Affirming the intrinsic value of life and caring for vulnerable individuals are important ethical principles that help us to shape a cohesive and compassionate society in which individuals are respected and valued. It is often not a simple matter to see how these principles may best be applied to end of life dilemmas, but we believe that they form important touchstones by which both legislation and practice may be evaluated.

1.2. The current law and the attendant DPP guidelines address situations where a person wishes to end his or her life and gains assistance from another person in doing so. They strike a fine and workable balance between promoting respect for life and protecting vulnerable individuals on the one hand and respecting autonomy and protecting compassionate individuals who assist a suicide on the other. The Supreme Court in its judgment of 25<sup>th</sup> June 2014 has recognized the need for a compassionate, yet safe, response to individuals who experience 'unbearable suffering' and who wish to end their lives. It has suggested that the current law and its application might require further fine-tuning. While recognizing the good intentions of the Bill's proponents, we do not believe that the Assisted Dying Bill represents an acceptable means of achieving this.

1.3. The Bill is fundamentally flawed in five main areas:

- (i) its use of 'terminal illness' as a primary criterion for assisted suicide,
- (ii) its determination of what constitutes 'a clear and settled intention',
- (iii) the burden it places on doctors,
- (iv) its failure to address the wider implications of such a radical change to the Law, and
- (v) its failure to incorporate workable safeguards in primary legislation.

## **2. ‘Terminal Illness’**

2.1 The Supreme Court has contended that if compassion for individuals who are facing unbearable suffering is the stated motive for changing the law on assisted suicide, there is no intrinsic reason for restricting assisted suicide to terminally ill patients. Indeed, as the cases before the Court illustrated, some of the most difficult legal, ethical and compassionate dilemmas arise not where someone is in the final stages of cancer or heart failure but has a degenerative condition that robs them of the ability to end their life without the involvement of someone else. It is not unreasonable to ask if one effect of incorporating this restriction in the Bill will be to make it acceptable as a first step towards a more comprehensive change in the law in the future.

2.2 It is a matter of *fact* that predicting life-expectancy in terminal illnesses is fraught with difficulty and is frequently wrong. A meta-analysis of various methods used by oncologists to estimate life-expectancy in advanced cancer patients (Journal of Supportive Oncology, June 2013) has shown accuracy levels as low as 20%, rising to 60% at best, with 39% being wrong by *at least* one month. Estimating life-expectancy in end-stage congestive heart failure patients is even more uncertain with 50% of such patients surviving for more than a year after diagnosis with others living for only a few months (Heart, May 2007). The Bill’s intention to make assisted suicide available to people who are ‘reasonably expected to die within six months’ has no justifiable medical basis.

## **3. ‘Clear and Settled Intention’**

3.1 It is important to safeguard those suffering from clinical depression since decisions that one might make while experiencing the symptoms of depression might not be the same as when these symptoms are absent. One study suggests that 24% of terminally ill patients suffer from clinical depression (European Journal of Cancer Care, October 2001)) and clinical depression is not uncommon among those suffering other serious life shortening conditions, not least where ability to participate in common daily activities is already severely impaired.

3.2 If ‘clear and settled intention’ is to be a key test it is essential that it can be defined in a way that is workable. It is hard to see how this can be established in the case of a terminally ill person who is close to death when it can take several months to diagnose clinical depression (NICE Guidelines CG90). The Bill’s provisions with regard to six months life expectancy and a ‘clear and settled intention’ are, therefore, unworkable.

3.3 If the scope were widened beyond the terminally ill the problem of guarding against the more or less subtle coercion of vulnerable individuals, particularly elderly people and those living with severe disabilities, would then need to be faced. The Supreme Court has recognized this difficulty though and has suggested that a judicially supervised process may be worth exploring. Clearly further work needs to be done on this.

3.4 It is important to note by way of background, however, that Action on Elder Abuse states that some 500,000 elderly people are abused in England each year. The majority of this abuse is perpetrated by friends or relatives with financial gain being a prime motive in around half of all cases.

3.5 Abuse includes emotional pressure and neglect which can lead to feelings of isolation, lowered self-esteem and purposelessness. These can all become contributory factors in leading a vulnerable person to consider assisted suicide without any obvious signs of pressure or coercion being evident. Outwardly an individual might appear to have a clear and settled mind, but in reality the decision to request assisted suicide has been born from neglect or abuse. Equally problematic is unintentional pressure that might be placed on vulnerable persons who, for various reasons, might perceive themselves as being burdens to their families or to society. It is extremely difficult to safeguard vulnerable individuals; the Assisted Dying Bill fails to do so.

#### **4. The Burden on Doctors**

4.1 The Assisted Dying Bill places the onus on two doctors to assess the physical, mental and social health of anyone requesting assisted suicide. It is difficult to see how such a complex decision can safely be made by professionals who are not specifically trained in all three areas of expertise. In any event it would be a fundamental and chilling development in terms of the ethos of the medical profession if doctors became the gatekeepers for assisted suicide. The Supreme Court judgment helpfully suggests that, *if* the law were to be changed at some point to provide some means by which the incapacitated could seek help in the preparations for ending their lives without exposing their relatives and others to risk of prosecution it would be preferable, as in other extreme situations where fundamental rights and safeguards are at stake, to place a decision before the courts which could hear a range of expert opinion.

4.2 Most doctors do not want to play a role in assisted suicide as the BMA and the Royal Colleges have made clear. If the Assisted Dying bill were to become law it would inevitably lead to ‘doctor-shopping’, a problem already encountered in jurisdictions that permit assisted suicide.

#### **5. Wider Implications**

5.1 Any change in the law as radical as that proposed by the Assisted Dying Bill must be scrutinized for its wider consequences on society. What effect, for example, might a change in the law have on suicide intervention initiatives? Might a law that is designed to assist a few individuals become a ‘default’ means of dealing with terminal illness? There is evidence that this has become the case with terminal cancer patients in the Netherlands. How might a change in the law affect the nature of doctor-patient relationships if doctors are seen both as agents of healing

and agents of hastening death? At the very least, validated research *within the UK* is necessary before a change in UK law ought to be considered.

5.2 The Assisted Dying Bill also raises issues with regard to the sort of society we wish to nurture and build. A compassionate, cohesive society requires fine balancing of laws, customs and shared moral principles. The Church of England has considerable experience of helping to deliver end of life care through hospital and hospice chaplaincy and through pastoral ministry in parishes; we are aware of how easily this fine balance could be upset. The ‘law of unintended consequences’ suggests that a change as fundamental as that represented by the Assisted Dying Bill deserves measured public consideration and debate in a non-adversarial environment. There is nothing to be gained by Parliamentary scrutiny of legislation hot on the heels of an important Supreme Court judgment which points in a very different direction from this bill and which requires a fresh study of options in the light of this landmark ruling before any decision is taken to embark on a legislative process. Any such process needs to start from the sort of serious and careful analysis of options that cannot realistically be achieved at the committee stage of a bill that begins in completely the wrong place

## **6. Workable Safeguards**

6.1 The Supreme Court expressed a core problem for anyone considering a change in the current law: *The question requires a judgment about the relative importance of the right to commit suicide and the right of the vulnerable, especially the old and sick, to be protected from direct or indirect pressure to do so. It is unlikely that the risk of such pressure can ever be wholly eliminated. Therefore the real question is how much risk to the vulnerable is acceptable in order to facilitate suicide by others who are free of such pressure or more resistant to it.*

6.2 This is a profoundly complex issue and, if a change in the law were to be effected, it ought only to occur if and when genuinely effective measures to protect the vulnerable had been identified and agreed by Parliament. It is not sufficient for such safeguards to be left to regulations which the Secretary of State may introduce, as proposed in the Assisted Dying Bill.

## **7. Conclusion**

7.1 We recognize that the Assisted Dying Bill is a genuine attempt to address compassionately the aspirations of a relatively small number of people who might wish to have assistance in ending their lives. The Supreme Court has suggested that this is an issue Parliament ought to address in the context of wider considerations. For the reasons set out above, however, we do not believe that the Assisted Dying Bill provides the right starting point for this investigation and we call on Lord Falconer to withdraw his bill to facilitate further parliamentary consideration of the issues to which we trust all interested parties would be committed.

This paper was written by Rev. Dr Brendan McCarthy, Medical Ethics and Health and Social Care Policy Adviser for the Archbishops’ Council. It was produced by the Mission and Public Affairs Division and Parliamentary Unit of the Church of England, at Church House, Westminster.

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