

QUB CATHOLIC CHAPLAINCY

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END OF LIFECARE- A CATHOLIC PERSPECTIVE

The Assisted Dying for Terminally Ill Adults Bill is due to be debated in the House of Commons on 29th November. The Bill is only for England and Wales but given that Scotland is already considering a Bill and the Republic of Ireland have voted to note a final report by a committee on assisted dying, which calls on the government to legalise assisted dying in certain restricted circumstances, the focus is likely to shift to Northern Ireland should the Bill pass.

Assisted Dying in law is assisting suicide and any change in the law would require an amendment to the Suicide Act 1961 to no longer make it an offence to *"aid abet counsel or procure the suicide or attempted suicide of another person"* In practical terms the law presently follows Guidance ironically drafted by Sir Keir Starmer as Director of Public Prosecutions which gives a residual discretion as to whether to prosecute or not. There are approximately 20 cases of Assisted Suicide that are reviewed by the DPP annually few, if any, of which result in prosecution.

By Assisted Dying I mean action by a medical practitioner that provides to a legally competent person some means to use in assisting suicide. This needs to be distinguished from withholding or withdrawing or refusing treatment which may be an ethically correct thing to do, and the actual killing of the patient by the doctor which is euthanasia, and which is presently a criminal offence. I argue that once Assisted suicide is permitted a whole range of new questions arise which may be an unintended consequence of the initial decision but in essence change the entire health culture, which will affect not only how we as individuals think but also how government make fiscal decisions.

Definitions matter. In a 2021 poll of British adults, just over half thought that the term assisted dying meant providing hospice care to people who are dying (10%) or giving

people who are dying the right to stop life prolonging treatment (42%). It is regularly suggested that polls support assisted dying but a more accurate reading reveals that the public themselves are confused about what is actually being proposed.

**While I hold to a Catholic perspective on this issue our experience of other hot button issues such as abortion reinforces the importance of approaching the issue in the public square with rational arguments that can be supported by those of all persuasions believer and non-believer alike.

It is however critical to appreciate that those who have advocated for Assisted suicide are highly effective at raising emotive or highly relatable stories in the media. But underlying the campaign is a philosophy which may be highlighted as the right to die or respect for the sovereignty of autonomy. That the law should respect a patient's right to decide the time and manner of their death at least if they are terminally ill and or experiencing unbearable suffering.

But there are obvious limits to the principle of autonomy

It is timely to remember the foundational principle of the inviolability (we may say sanctity) of life that prohibits the intentional killing of the innocent. As the preamble to the UN Declaration of Rights puts it

“Recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom justice and peace in the world”

While we enjoy a right to life, we also live in a society which recognises the scourge of suicide as a tragedy and a scourge Look in Northern Ireland at the number of charities and groups directed towards preventing suicide particularly in those with mental and physical health issues. Why do we think suicide is the answer to suffering?

Throughout our history the concept of assisting someone to end their life struck at the heart of the values we held as a society. Physicians undertook to care and do no harm and the development of the hospice movement was a response to the

importance of easing the suffering of terminal illness and helping people to die with dignity. Within just a few decades the focus has shifted. In bioethics the principle of respect for personal autonomy has become the defining argument and suddenly even the word dignity has been changed in meaning.

Growing pressure to yield to new philosophy based on what one philosopher referred to as adopting a principle of indifference to an acute form of vulnerability in order to get *"a few independent folk to get others to kill them on demand"*

To solely consider at bodily autonomy which is a persons expressed wishes about what should happen to their body is overly reductionist There is more to this area of ethics than just autonomy and such a narrow view does not do justice to the complexity and enormity of what it means to be human. One of the things we really value about human life is that it is intrinsically relational As the poet John Donne said

*No man is an island,
Entire of itself;
Every man is a piece of the continent,
A part of the main.*

The fact is that we cannot sever the principle of the common good from that of autonomy What we seem to have lost in the clamour for personal autonomy is any idea of the common good or the unintended consequences of legislation aimed at shortening death, but, in reality, opening up a Pandoras Box where the prevailing culture is changed and it suddenly become acceptable and financially expedient in a healthcare context to discuss euthanasia and assisted suicide as solutions to complex problems. In Canada you will have to wait 6 months for an urgent mental health referral but Assisted suicide is available immediately

Once the principle has been conceded the Rubicon has been crossed. There is no going back and inevitable further pressure for easing the safeguards

Let us consider 3 examples:

Canada

The rapid expansion of euthanasia and assisted suicide in Canada has led to the point where guidance recommends that Medical Assistance in Dying (“MAID”) should be raised in conversation with all those who might qualify and where such a suggestion would align with their values. The power imbalance in the patient doctor relationship coupled with the intrinsic trust that a healthcare provider will only suggest the best options for their health makes the physician raising option dangerous. The Fourth Annual Report on Medical Assistance in Dying in Canada records that 4.1% of all deaths in Canada in 2022 were MAID deaths. Regional variations were even higher and yet this does not seem to have been the subject of critical interrogation or reflection by those who promised that the legislation was intended for a small group of people in the terminal stages of life whose suffering was truly acute.

Netherlands

In the Netherlands the law has since 2002 permitted euthanasia and assisted suicide. The focus is on “unbearable and hopeless suffering but has gradually developed to include those with non-terminal disabilities including intellectual disability and autism. Hughes and Finlay¹ state:

In the Netherlands it has become normal to ask for and receive an assisted death when you find that your suffering is hopeless. The fact that one in 20 Dutch people now have an assisted death means that many people will have experience of an assisted death within their own social circle. Growing number so people will be conscious of the realistic option of receiving euthanasia for non life limiting conditions. It is inevitable that people with life long disabilities will ask for it too.

Once euthanasia for disability related reasons is acceptable it becomes much more likely for that option to be put on the table as a possibility

¹ The Reality of Assisted Dying. “Understanding the Issues” Ch 6

Oregon

Oregon is often advanced as a jurisdiction where the law has not changed and as a model for those who wish to uphold stringent safeguards. Research from the BMJ revealed significant gaps in the data and indices which would not support the argument of stability.

They analysed the data in every annual report from 1998 to 2022, specifically looking at the numbers of patients prescribed lethal drugs under the legislation, their insurance status, reasons for wanting an assisted death, and the qualifying illness.

Some 2454 people died an assisted death during this period. Their average age was 72. In 1998, 24 prescriptions were written for lethal drugs and 16 patients died as a result. **On average, the number of lethal drugs prescribed under the legislation increased by 13% each year**, with the annual number of assisted deaths rising by 16%. In 2022, 431 prescriptions were written, and 278 patients died as a result.

The proportion of those with private health insurance fell from 65% to 20% over the 25 years; most (80%) had government (Medicare or Medicaid) health insurance in 2022.

In the first 5 years of the legislation, nearly a third (30%) of participants were concerned about being a burden. Since 2017, this has been cited by around half of those opting for an assisted death: 46% in 2022.

Cancer has remained the main qualifying diagnosis, although this fell from an average of 80% in the first 5 years of the legislation to 64% by 2022. But since 2010, various other diagnoses have qualified, including non-terminal illness, such as arthritis, complications from a fall, hernia, and anorexia nervosa.

The length of the doctor-patient relationship reduced over time, the review shows, falling from 18 weeks, on average, in 2010, to 5 weeks in 2022.

And referrals for psychiatric evaluation also steadily declined. In the first 3 years of the legislation doctors requested psychiatric assessment in an average of 28% of cases. By 2003 this had dropped to 5%, and in 2022, just 1% of participants underwent psychiatric evaluation.

The reduction in doctor-patient time “may have made it more difficult to identify treatable factors influencing the wish to die,” suggest the researchers, noting a lack of recent data on how many participants had treatable depression—a factor known to influence a person’s wish to die.

There was also a worrying lack of data on those who didn't take the lethal drugs they were prescribed, and how they were advised and counselled in the first place, note the researchers.

And information on complications, including those whose death was prolonged or who regained consciousness, was often missing. These data were absent for 206 out of the 278 (74%) assisted deaths in 2022.

Emphasis Added

It is difficult to resist the conclusion that stringent safeguards are illusory. This is not surprising. Once the line is crossed and one adheres to the view that personal autonomy is paramount why should the State stop at those with a terminal illness who have less than 6 months to live and wish to end their own lives? The next step to extend the prerogative to those with incurable illnesses who may well have years to live but who feel that life is not worth living. Pressure is already being brought to bear by influential commentators like the retired High Court Judge Sir Nicholas Mostyn who suffers from Parkinson's and who wish such conditions to be included in the Bill. If the Bill passes How long will it be before the next step is demanded as has almost invariably been the case in other jurisdictions that have changed the law.?

In fairness having reviewed the legislation, the proposed safeguards have been drafted with a view to address the main arguments against and are an attempt to assuage concerns (especially the mandatory reference to the High Court). There remain aspects of the bill which lead to inevitable subjectivity including:

- (i) The 6 months before death stipulation appears to me to be extremely difficult to assess and gauge. The temptation to construe widely and generously will be difficult to resist and the importance of personal autonomy as a factor will inevitably be the subliminal influence. I note that there has already been pressure to remove the same limit in New Zealand which introduced assisted suicide 2 years ago..
- (ii) I would like to see a stronger and more specific conscience clause although no person is under any duty to provide assistance² (section 23).

² In 1967 the Abortion Act had a conscience clause which was limited only to participating doctors by the decision of the Supreme Court in *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68

- (iii) There does not appear to be a statutory waiting period or pause after a decision has been taken.
- (iv) Once a person meets the qualifying criteria, (clear settled intention and a progressive illness where death can reasonably be expected within 6 months) there is a detailed process and checks to ensure qualifying criteria met but little of actual substance. No question or inclusion of “unbearable and hopeless suffering” or other criterion which might induce further caution. The stress is on “clear and informed wish” Once you remove the 6 month limitation (pressure has already started) the way is open to assisted suicide on demand once anyone develops a progressive illness that is incurable.
- (v) The ability of a registered medical practitioner to raise the subject of their own volition with a patient is deeply concerning given the power imbalance of the patient/doctor relationship. (section 4(2))
- (vi) Apart from protection from financial conflicts of interests (5(3)) the lack of Guidance means there is no stipulation as to how well the doctor knows the patient or how much time they need to spend with a patient. The thought of a doctor initiating a conversation with a vulnerable elderly person who may well be *compis mentis* is chilling. I accept that the reference to the High Court is a protection but the lack of detail on how and when these conversations can occur is worrying.
- (vii) There is no direct mention or specific prohibition of psychiatric difficulty or mental disorder being excluded which given the expansion to these conditions in other jurisdictions seems an obvious omission.
- (viii) For all of its sinister expansions the Dutch system has a requirement of formal review and reporting which is unique and praiseworthy. The monitoring provisions in section 9 are generalised focused on process. Guidance is needed which should include not just the number of requests but data which would allow for review. How for instance do you discover the number of people who feel they are a burden etc?

I think that any fair reading of the evidence from other jurisdictions leads one inexorably to the conclusion that to change the present law and to abandon the principle is to open the possibility of much greater abuse and legal lassitude in the future. It is surely telling that much of the most effective opposition has emerged from those living with disabilities who fear that the change in law means that their lives are

less valued. If the Canadian laws are adopted, then any acute suffering *per se* is potentially a valid ground. Many disabled people identify with the Canadian army veteran, offered medical assisted suicide as a solution to her problem of obtaining a home wheelchair ramp.³ Are we really saying that it could in any circumstances be legitimate for society to offer assisted suicide to children or euthanasia for the mentally disordered. Yet that is what has happened in some jurisdictions, and it is naive to believe that similar sorts of debate will not happen in the UK in the future should the resent legislation pass.

What we seem to have lost in the clamour for personal autonomy is any idea of the common good or the unintended consequences of legislation aimed at shortening death, but, in reality, opening up a Pandora's Box where the prevailing culture is changed and it suddenly become acceptable and financially expedient in a healthcare context to discuss euthanasia and assisted suicide as solutions to complex problems.

At present where end of life care is prioritised with the provision of high-quality palliative care many of the concerns of those suffering from a terminal illness can be addressed. No one is arguing for a form of vitalism where people are being kept alive at all costs. There already exists protocols and pathways that allow for suffering to be eased or treatment to be withdrawn where the overall benefit is not justified.

Post modernism has elevated the principle of personal autonomy as paramount. It is at root a Christian principle, but one that is distorted when its relationship to the common good is severed. The task for legislators is to ensure that the common good is not lost and that the vulnerable are protected. The evidence from other jurisdictions reveals that when assisted suicide and euthanasia are permitted there is a commensurate change in culture which allows questions that should never be asked to become normalised.

I end with the beauty and clarity of the pastoral letter from Bishop Alan:

³ <https://www.cbc.ca/news/politics/christine-gauthier-assisted-death-macaulay-1.6671721>

Our Catholic faith proclaims that every human life possesses infinite dignity – a dignity that remains constant regardless of circumstance or condition. A society reveals its character through its treatment of its most vulnerable members: the terminally ill, people living with disabilities, and those approaching life’s end. We all deserve care at every stage of life, and those who are dying have the right to holistic accompaniment that honours their dignity.

Those who advocate for assisted suicide often speak from genuine compassion, seeking to end suffering. Some argue that assisted suicide simply respects individual autonomy over one’s life. However, when life is taken away, autonomy ceases entirely. It’s important to note that the Church has never insisted on using extraordinary means to prolong life, nor does it require patients to accept unduly burdensome treatment. Yet, deliberately ending life prematurely eliminates any possibility of growth or healing and represents a failure of hope. As life draws to its close, spiritual care becomes paramount – which is why assisted suicide can never be the answer and must be firmly rejected by all God’s people.

At this time we face challenging discussions about life and death. We are invited to hold fast to our faith in God’s unconditional love and our belief that every life, at every stage, has meaning and purpose.

In season and out of season, students must challenge the prevailing philosophy and seek to uphold the inviolable dignity of all human beings.

Deacon Brett Lockhart