Terminally Ill Adults Bill

On Wednesday, 16th October 2024, Kim Leadbeater MP (Labour) introduced her 'Terminally Ill Adults (End of Life)' Bill which would make it legal for over 18s who are terminally ill to be given assistance to end their own life. The second reading of the Bill is scheduled for Friday, 29th November.

The requirements are:

- They must be resident in England or Wales and be registered with a GP for at least 12 months
- They must have the mental capacity to make the choice and be deemed to have expressed a clear, settled and informed wish, free from coercion and pressure
- They must be expected to die within six months
- They must make two separate declarations, witnessed and signed, about their wish to die
- Two independent doctors must be satisfied the person is eligible
- A High Court judge must hear from at least one of the doctors and can also question the dying person, or anyone else they consider appropriate. There must be a further 14 days after the judge has made the ruling

Under the bill, a doctor could prepare the substance, but the person must take it themselves.

Though Leadbeater's Bill will limit assisted dying to those who are terminally ill, there are reports that 50 MPs support a bill not only for those who are terminally ill but for all those in 'intolerable suffering' (this could include those with physical disabilities, depression, anorexia, dementia, or autism).

General Synod

Importantly, General Synod has recently voted twice on the legalisation of assisted dying, each time Synod has overwhelmingly voted against (2012 and 2022). Theologically the opposition to assisted dying is rooted in a concern for the most vulnerable in society, for the widow, the orphan and the stranger: for older people, those living with dementia or in poverty, those whose disability puts them at risk, and those in coercive relationships. More broadly, the opposition to assisted dying seeks to recognise every human person as a gift. There is no point at which a person stops being a gift, stops being valuable. Neither illness nor suffering diminish the value of human life, nor can they diminish the image of God in which human beings are created. As St Paul says, nothing can separate us from the love of God (Rom. 8:38-39). The role of the Church as it cares for those approaching the end of life is, therefore, to recognise and celebrate the giftedness of every human being at every moment in their life, to minister to the sick and to prepare the dying for their death.

International comparators

There are a number of jurisdictions which have legalised assisted dying. These include: Netherlands, Belgium, Luxembourg, Switzerland, Portugal, Spain, Austria, Canada, Oregon (USA), New Zealand and Australia. The two most frequently cited examples in the public debate are Oregon and Canada.

In 1997 Oregon legalised assisted dying for those who are terminally ill under the Death with Dignity Act. Oregon is the jurisdiction most favoured by advocates of assisted dying because it

has not expanded the law to include 'intolerable suffering'. However, since 1997 Oregon has expanded the diseases which Oregon allows assisted dying for, now including diseases which are not generally considered terminal (e.g. arthritis, diabetes, and liver disease). In practice therefore there has been an expansion of eligibility criteria. Worryingly, Oregon has also seen a significant increase in people who elect for assisted dying saying that they feel like a burden: from 12% in 1998 to 43% in 2023. The example of Oregon suggests that the legalisation of assisted dying can *make* people feel like a burden.

Canda has had the most concerning legalisation of assisted dying, with a clear example of a 'slippery slope'. Medical Assistance in Dying (MAiD) was introduced in 2016 for those whose natural death was foreseeable. A challenge in the courts expanded this, making anyone with a 'grievous and irremediable medical condition' or disability eligible for MAiD. Worryingly, this has included two cases of people with severe skin allergies who were unable to afford housing which did not aggravate these allergies. These cases have become emblematic of the significant expansion in eligibility criteria, as well as the intersection between assisted dying, poverty, and disability. In short, it appears that people are electing assisted dying in Canada because they have insufficient medical, social and emotional support.

Arguments against legalising assisted dying

The key arguments against the legalisation of assisted dying are:

- **Transforming people into burdens**: in Oregon, almost half of people who elect for assisted dying say that they feel like a burden. Amidst, a crisis of funding in adult social care in the UK there is a real threat that people may elect for assisted dying because they do not want to be a burden to friends or families, and because of financial pressures. Indeed, data from Oregon lists financial pressures as a reason why people elect assisted dying. Canada's MAiD program does not record data on financial pressures; however, that poverty is a factor in people electing assisted dying is reflected in case study evidence. Polling has indicated that this is the most powerful argument in changing public opinion on assisted dying.

- **Impact on the most vulnerable**: research shows that there is significant abuse of older people in the UK. Legalising assisted dying would put people over the age of 65 under additional risk of life-threatening coercion and control. Similarly, a third of female suicides are linked to intimate partner violence. For those who are most vulnerable assisted dying creates a huge risk of coercion and control.

- **The doctor-patient relationship**: there are also significant worries that the legalisation of assisted dying would undermine the doctor patient relationship. Professor of Medicine, Farr Curlin talks about the principle of 'do no harm' as the boundary which allows those in palliative care to trust their doctor. Were assisted dying to be legalised, doctors would have to present this as a 'treatment' option to patients. In other countries we have seen examples of people who are terminally ill, or disabled, approach doctors anticipating medical care and instead being offered 'assisted dying'. This can severely undermine trust in doctors and related institutions. It is relevant that only 10% of palliative care doctors surveyed by the BMA say they would participate in assisted dying were it to be legalised.

- **A better death**: Professor of Palliative Care, Baroness Finlay has powerfully made the case that palliative medicine can manage death better than assisted dying. While the UK hospice sector needs more funding, the quality of care that it delivers is world-leading. Were palliative care, mental health, and community support services to be properly funded, then a 'good' death would be within reach for everyone.

Response to arguments for legalising assisted dying

- **People should have a choice about the end of life**: People do not make choices in the abstract, they make them in the context of relationships and amidst very real funding restrictions. The prevalence of abuse, manipulation and control amongst vulnerable groups will significantly impact the choices they make. Making assisted dying a possible choice risks opening these groups up to significant abuse. Moreover, given the funding challenges facing adult social care, and the hospice sector, legalising assisted dying risks introducing choices which could create disastrous financial and structural incentives.

- **The current law is unsafe**: advocates of assisted dying argue that the current law is unsafe because it 'compels' people who are in 'intolerable suffering' or who are terminally ill to attempt suicide in an unmedicated and uncontrolled environment. Any suicide or attempted suicide is tragic and society must do all it can to support those who are in despair and at risk. It is important to note though that the legalisation of assisted dying does not reduce the un-assisted suicide rate. Indeed, in some jurisdictions the un-assisted suicide rate has increased following the legalisation of assisted dying.

- **Assisted Dying is the compassionate response**: It is completely understandable to want to end suffering. Where pain can be treated medically, palliative care is excellent at managing it. No doubt palliative care's proficiency in treating pain could be further enhanced through additional research. It is worrying that almost half of the people who have used life-ending drugs in Oregon said that they felt like a burden to friends and families. This emphasises that the end of life is not only a medical reality, but a social, emotional and spiritual one. A good death will require a response to the end of life which recognises and caters for these varied dimensions. The most compassionate response must be the one which protects the most vulnerable in society, and will require the proper funding of palliative care, mental health and community support services. The policies we pursue for the end of life must be those which engender hope, and which work towards a good death for everyone.