Submission to House of Commons Health and Social Care Committee Inquiry into 'Assisted Dying' (Euthanasia and Assisted Suicide)

Submitted by Professor David Albert Jones on behalf of the Anscombe Bioethics Centre

Summary

0.1 Legal approval of 'assisted dying' – euthanasia or Physician Assisted Suicide (PAS) – would not be a minor modification of the current law but would be a radical and unprecedented change. It would cross a 'bright line' in law and medical ethics.

0.2 Once this line is crossed, the logic of PAS for those with a terminal illness would seem to many people to justify PAS for those who suffer much longer with chronic physical or mental health conditions, and to justify voluntary euthanasia for those who are not physically or psychologically capable of PAS, and ultimately, to justify non-voluntary euthanasia for those who are not physically or psychologically capable of requesting euthanasia or PAS.

0.3 The evidence from jurisdictions with euthanasia or PAS confirms that the logic of these proposals leads to abuses in practice: expansion of use and eligibility criteria over time and widespread intentional ending of life outside the scope of the law, including, most concerningly, 'life-terminating acts without explicit request'.

0.4 Legal approval of PAS would also undermine a fundamental principle of suicide prevention, that 'every suicide is a tragedy'. There is strong evidence that where PAS is legalised, self-initiated death increases significantly and there is evidence that unassisted suicide also increases significantly.

0.5 Citizens' assemblies while ostensibly exercises in 'participatory democracy' represent an abnegation of responsibility by Parliament which, in the United Kingdom, is the summit of democratic legitimacy.

The present submission

1.1 The Anscombe Bioethics Centre (formerly the Linacre Centre for Healthcare Ethics) was established in 1977. It is named after the philosopher Elizabeth Anscombe, who is well known for her work on intentional killing. She contributed to the Centre's 1982 report on euthanasia (reproduced in Gormally 1994).

1.2 David Albert Jones is Director of the Anscombe Bioethics Centre, Fellow at Blackfriars Hall, Oxford and Professor of Bioethics at St Mary's University in Twickenham. His publications include *Euthanasia and Assisted Suicide: Lessons from Belgium* (Jones *et al.*, 2017), and articles on the 'logical slippery slope' (Jones 2011), on assisted dying and suicide prevention (Jones

2018), and on assisted suicide and suicide rates (Jones and Paton 2015, Jones 2022a, Doherty et al. 2022).

1.3 Professor Jones has submitted written and / or given oral evidence to Parliamentary committees in Scotland (2014/2015), Canada (2015); New Zealand (2016/2017 and 2018); Ireland (2021) and New South Wales, Australia (2021). He was one of three academics who provided content advice for the Jersey Citizens' Jury on Assisted Dying (2021). He was an interviewee and an external peer reviewer for the POSTbrief on assisted dying.

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

2.1 It is a terrible thing to take someone's life. It is to take what cannot belong to another and what cannot be restored. For a private citizen (abstracting from questions of war or capital punishment) intentional homicide is wrong for deep reasons relating to human dignity and human equality. This a 'bright line' in law, ethics and human rights. The prohibition shows respect for our common humanity and not only the contingent wishes or feelings of the victim and thus consent to be killed does not give another person the right to kill.

2.2 To take one's own life is not equivalent to killing someone else and the Suicide Act 1961 does not prohibit people from attempting suicide. However, it does prohibit others from 'encouraging or assisting' suicide. There is no human right to assistance in suicide (Finnis 2015). On the contrary, it could be argued that people have a right to be protected from committing suicide (Herring 2022). This is easiest to see in an institutional context such as a prison or a training centre where the failure to take reasonable steps to prevent someone's suicide may be a violation of that person's human rights.

2.3 The legal prohibitions of intentional homicide and of encouraging or assisting suicide are in harmony with a longstanding tradition of medical ethics. For doctors to end life intentionally would be contrary to their role as healers. This understanding of medicine is attested to from the Hippocratic Oath to the World Medical Association's Declaration on Euthanasia and Physician-Assisted Suicide. No Medical Royal College advocates a change in the law on homicide or assisted suicide (POSTbrief, p. 16).

2.4 Once it is decided to give permission in advance for intentional killing by, or with the assistance of, a doctor, then it seems difficult to justify restricting this to PAS for those with a terminal illness. If PAS can be justified for those who have only a short time to live then how can PAS reasonably be denied to those who face a longer period of suffering with chronic physical or mental health problems?

2.5 Again, if PAS can be justified for those who are capable of taking their own lives, how can voluntary euthanasia reasonably be denied to those who would find PAS physically or psychologically difficult?

2.6 Finally, if voluntary euthanasia is justified to eliminate the suffering of those who are capable of requesting it, how can it reasonably be denied to those who are evidently suffering but who are not capable of requesting death? If 'assisted dying' is deemed to be part of normal

end-of-life medical care then like other forms of care it can be and should be provided on the basis of a best interest judgement even in the absence of a request. (Jones 2011, Keown 2021, Keown 2018, ch. 6)

2.7 The rationale of PAS or euthanasia laws also has an impact on patients. It forces people who experience physical or mental health problems and who would be eligible for an assisted death to have to justify their continued existence. It encourages the feeling that those who persevere in living are a burden on others (Stainton 2022).

2.8 The legal approval of PAS also weakens a fundamental principle of suicide prevention, that 'every suicide is a tragedy' (WHO 2014, p. 2). Approval of PAS implies that, for at least some categories of patient, it is good that they die by their own hand. PAS creates an exception to the universal commitment to suicide prevention and thus potentially encourages suicide more widely, by 'suicide contagion' or the 'Werther effect' (Niederkrotenthaler et al. 2010, Jones 2018).

2.9 It has been argued that the term 'physician assisted suicide' is misleading as the characteristics of those seeking PAS are different from the typical image of someone who attempts suicide. However, people who seek PAS and those who attempt suicide without medical assistance have it in common that they seek death because life no longer seems tolerable. Many also share physical or mental health conditions (Friesen 2020). In Switzerland, the Netherlands and Luxembourg, where PAS is legal, the ordinary term for this practice is 'assisted suicide' (Jones 2021) and this terminology is accepted by the POSTbrief (p.4, p.7).

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

3.1 Worldwide, euthanasia or PAS is legal in only twelve countries (the figure of '27 jurisdictions' (POSTbrief, p. 5) comes from counting US States and Australian States separately). Only five countries have sufficient experience to provide meaningful evidence of impact: Switzerland, the Netherlands, Belgium, the United States (principally Oregon), and Canada. Of these, Canada is the most similar to the United Kingdom in its legal and healthcare system, and after only seven years already has the highest numbers of assisted deaths of any country.

3.2 There are some features that are common to these jurisdictions. In all jurisdictions deaths continue to rise dramatically. Thus from 2010 to 2019 officially reported assisted deaths increased in the Netherlands by 103%, in Belgium by 167%, in Oregon by 189% and in Switzerland by 427%. In Canada from 2016 to 2021 deaths increased by 889%, from 1,018 to 10,064 (for sources of these data see this Evidence Guide). For those with concerns about the practice, these seemingly inexorable increases are alarming. The increases do not themselves demonstrate that the practice is malign but they show that the practice cannot be limited to a small number of people. Over time it will be 'normalised' (Jones *et al*. 2017, ch. 13).

3.3 The reason most commonly cited for seeking assisted death is not fear of pain or other physical symptoms but loss of the ability to engage in enjoyable activities. In Oregon, a majority (54% in 2021), cite fear of becoming a 'burden on family, friends/caregivers' as a reason for

seeking death. In Canada this reason is cited by more than a third and one-in-six cite 'isolation or loneliness'. In 2021, this last reason was cited by approximately 1,720 people.

3.4 Where it is legal, there is an increase in the proportion of euthanasia or PAS for non-terminal conditions. In Belgium an increasing proportion have 'polypathology' (Raus et al. 2021). This term is used to cover many common maladies of old age such as arthritis, impairment of hearing and vision and memory loss. The expansion of euthanasia for non-terminal conditions happens both within the law and by changes to the law. In 2021, Canada removed the restriction of 'Medical Assistance in Dying' to those whose death was 'reasonably foreseeable'.

3.5 Where both PAS and euthanasia are available the overwhelming majority of patients prefer that doctors administer the fatal dose (96.9% in the Netherlands, 99.9% in Belgium and Canada). Two thirds of the countries that have legalised assisted dying have legalised euthanasia (Colombia, the Netherlands, Belgium, Luxembourg, Canada, Spain, New Zealand and Australia). As yet no US State has shifted from PAS to euthanasia but there have been attempts to do so, most recently by a court case in California.

3.6 There is clear evidence that non-voluntary euthanasia is widespread in the Netherlands and in Belgium where such acts are termed 'life-terminating acts without explicit request'. These amount to hundreds of deaths a year. The fact that the number of assisted deaths without explicit request remains 'strikingly high' was cited in the Irish case of *Fleming v. Ireland* [2013] (para 104) as a reason to keep the present law. Since 2013 there has been further evidence of non-voluntary euthanasia. In Belgium, 'terminal sedation' is being used as a means of euthanasia, sometimes without consent (Jones et al 2017, ch. 5, ch. 14). In the Netherlands a recent case has extended the law to people with dementia who have previously requested euthanasia, even if at the time the person resists being euthanised and has to be sedated and held down for the lethal injection to be administered.

3.7 In relation to suicide rates, there have been several studies published in 2022 on the impact of PAS or euthanasia on rates of self-initiated death and on suicide rates (Canetto and McIntosh 2022, Girma and Paton 2022, Jones 2022a) including a systematic literature review (Doherty et al. 2022). All show large increases in self-initiated death (euthanasia or PAS plus unassisted suicide) and when measured this increase is always significant. Studies on unassisted suicide also saw increases in deaths but smaller and not always statistically significant. Nevertheless, the most recent study to examine these data found that 'Looking at unassisted suicides only, the total policy effect of assisted suicide laws remains *statistically significant* and positive' (Girma and Paton 2022, p.9 emphasis added, see also Jones 2022b).

3.8 The evidence in countries where assisted dying/assisted suicide is legal shows that the ethical concerns are fully justified. The rationale of the practice creates a pressure that pushes towards further expansion: first to those with non-terminal conditions; then to those with mental health conditions; and finally to those who have not asked for death. More people come to seek death because they feel they are a burden to others and more end their lives whether by assisted or unassisted suicide. If such laws are passed then some people will have their lives ended reluctantly or even without their consent and some will die by unassisted suicide who might have lived.

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

4.1 By longstanding convention, controversial ethical issues such as euthanasia or physician assisted suicide are matters for Private Members' Bills. There is no general duty on the Government to provide time for such legislative proposals, especially where Parliament has had the opportunity to debate a Bill on the issue in the relatively recent past and has rejected it (as it did in 2015 by 330 to 118 votes).

4.2 The Inquiry's online form asks individuals whether a referendum or a Citizen's Assembly on this issue would be helpful. In relation to a referendum, the convention in the United Kingdom is for matters of criminal law to be decided by Parliament and referenda to be reserved for significant constitutional matters such as Scottish Independence or leaving the European Union.

4.3 In relation to a Citizens' Assembly, the Committee should consider the recent experience of Jersey which established a 'Citizens' Jury' to consider 'assisted dying'. The 'jury' was selected to reflect public opinion on assisted dying, as assessed by previous opinion polls. As a result, the majority of members selected held strong views at the outset, with 83% in favour of a change in the law (Citizens' Jury Report, p.10). At the end most retained the opinions they began with (78% in favour; Citizens' Jury Report, p.26). Note that though the group was termed a 'jury', a jury in English law is selected to be unbiased and to exclude those with strong prior views. Furthermore, juries are asked to determine matters of fact not matters of law.

4.4 After the process was complete, consideration of the outcomes focused, almost exclusively, on the final votes of this group. Having set up the process, Members of the Jersey States Assembly felt bound to accept the majority view of the 'jury' as far as possible. For this reason the proposed legislation includes both PAS and euthanasia, both for the terminally ill and for the chronically ill, administered either by a doctor or nurse practitioner. The proposed law would also provide 'regulation-making power allowing the Assembly to amend the eligibility criteria or the assisted dying process' (see Consultation Report, p. 13), with the intention to revisit the age limit (p. 16).

4.5 Those conducting this process did so conscientiously and efforts were taken to ensure that the evidence presented to the 'jury' was balanced. What was most problematic in this process was not primarily the bias in the selection of the 'jury' nor the decisions that it reached, extreme as these were. The key flaw was the exaggerated authority given to the votes of this group. The elected representatives effectively ceded the decision to a non-expert non-elected body instead of taking responsibility for the decision and reviewing the evidence themselves.

4.6 A Citizens' Jury / Assembly is effectively a sustained focus group which could reasonably inform understanding of public opinion, (but by analysis of its reasoning rather than by 'votes' which are meaningless from the perspective of qualitative research). However, it does not seem reasonable or responsible to give such a body the task of deciding the shape of the criminal law.

4.7 Citizens' Assemblies / Juries, whilst ostensibly exercises in 'participatory democracy' represent an abnegation of responsibility by Parliament which, in the United Kingdom, is the

summit of democratic legitimacy. The most appropriate mechanism for further democratic consideration of such questions prior to a specific Bill being tabled is the Parliamentary one of a Cross-Party Committee, as indeed exemplified by the present Inquiry.

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