# Submission from the Joint Ethico-Medical Committee of The Catholic Union of Great Britain and the Guild of Catholic Doctors to The House of Lords Select Committee considering the Assisted Dying for the Terminally Ill Bill

The Joint Ethico-Medical Committee is composed of members drawn from the two parent bodies. The Catholic Union is an organisation of the Catholic laity which is not affiliated to the hierarchy but which represents the Catholic viewpoint, where relevant, in Parliamentary and legislative matters. The Guild of Catholic Doctors represents Catholic Medical Practitioners in the United Kingdom.

## General Comments

Euthanasia, as understood by the Catholic Church, is an act or omission which of itself or intention causes death with the purpose of eliminating suffering. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used. Assisted suicide is included in the definition of euthanasia.

It is noteworthy that the definition of "assisted dying" given in clause 1(2) includes direct killing, ie direct euthanasia, of those unable to commit suicide. It is dishonest to give the bill a title of 'assisted dying', when it is intended to allow direct euthanasia.

It is a reality that we will all die. Modern medicine has allowed most of us to live into old age, but there will come a point, whether by direct illness or by the frailty due to the degenerative process of old age, when death will be inevitable. Many accuse those who feel strongly about the sanctity of life of requiring that everything must be done to keep patients alive at all costs. This has never been a position adopted by the Catholic Church. We accept that medical procedures, which are disproportionate to any expected results or which impose an excessive burden on the patient and his family, can be refused or withdrawn so long as the normal care due to the sick person is not interrupted

The Church has always taught that man has free will; that is the freedom to choose between what is right and what is wrong. In secular understanding free will is frequently translated as personal autonomy. However personal autonomy is not absolute. The nature of man is that we live in relationships with one another. Our actions and choices in many ways have an effect on others. Suicide by an individual affects others in many ways. This fact was recognised by the Supreme Court of America, in its memorable and rare unanimous decision of June 26 1997, where it held that the US Constitution did not protect the right to suicide. It manifested a particular sensitivity to the fact that rarely are all those facing disability or terminal illness in equivalent situations. It said '*The State's interest goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and sociological indifference*'.

This Bill implies we are totally autonomous individuals and that our real value lies in our ability to act and choose. By contrast, the Christian understanding assumes we are essentially not isolated individuals but persons in relationships. Indeed we are persons only in and through our relationships with other persons. Our ability to relate to and act in support of others is part of our very humanity. Appropriate medical care, supported by the moral teaching of the Christian churches, urges that life does not have to be prolonged at all costs. Individuals who competently choose to commit suicide are not legally prohibited from doing so. In respecting the freedom of an individual to commit suicide the physician has no duty to assist them. To do so would destroy the solidarity which the medical profession should have with its patients, offering them care and support during their times of difficulty.

Some years ago the Roman Catholic and Anglican Churches submitted a joint statement to the House of Lords Select Committee on this subject; '*Neither of our churches insists that a dying or seriously ill patient should be kept alive by all possible means for as long as possible. On the other hand, we don't believe that the right to personal autonomy is absolute. It is valid only when it recognises other moral values, especially the respect to human life as such whether someone else's or not.*'

There is little evidence of demand from doctors for legalisation of euthanasia. The most recent large survey was done by Doctors.net, regarded as the foremost medical Internet company in the UK. 986 medical practitioners completed it over a two-week period from March 26th to April 9th 2003. A total of 9000 doctors were approached over this period, selected at random, and the company was assured that an 11% response rate was typical of this type of Internet study. It revealed that a majority of doctors are not in favour of either euthanasia (61%) or assisted suicide (60%). Only 22% of doctors were in favour of euthanasia and only 25% were in favour of assisted suicide. A significant number (13%) were undecided, mainly because they were not directly involved in the decision-making process. Most doctors would refuse to perform either euthanasia (76%) or assisted suicide (74%) if it were legalised.

The case for the decriminalisation of euthanasia has been reduced by the success of the hospice movement. 98% of terminal pain can now be relieved. The emphasis of the proponents of euthanasia and assisted suicide has therefore shifted to the other forms of suffering experienced by some at the end of life. Surveys have shown that most people who request assisted suicide are lonely and not always terminally ill. (New England Journal of Medicine 1999: 340; 577-583.)

We have seen in the *Dianne Pretty* judgement in 2003, that there is no "right to die", least of all at the hand of another. All the judges were unanimous, at appeal, in the House of Lords and in Strasbourg, in denying the applicant's request that her husband be not prosecuted for assisting her suicide. Their reasons are voluminous and we trust that the select committee will review them.

## Specific Comments

### Opening paragraph.

This includes the phrase "*…and to make provision for a person suffering from a terminal illness to receive pain relief medication.*" Symptom relief is part of normal medical care, and

has been since medicine was first practised in ancient times. Its inclusion in this Bill implies that doctors are being negligent in not providing adequate care. There is absolutely no need for such a phrase to appear in any new legislation, and especially not in any legislation relating to euthanasia.

## Clause 2 (Qualifying conditions)

Prognosis is not an exact science and there can be no such certainty regarding prognosis as the Bill presumes. Even diagnosis can be uncertain, as has been shown repeatedly in post mortem studies worldwide, where the cause of death given on the death certificate was found to be incorrect in around 25% of cases.

Unbearable suffering cannot be objectively assessed and is therefore a subjective assessment. Furthermore acceptance by a physician that suffering is unbearable and sufficient to warrant euthanasia is tacit recognition that a patient's life is no longer of value. Such value judgements of the worthiness of an individual's life will do great harm to the relationship of trust and caring that must exist between patients and their doctors.

## Clause 3 (Offer of palliative care)

We are not persuaded that *bona fide* professionals in the field of palliative care would undertake the tasks envisioned, given that one outcome is the antithesis of their ethic. Last year the World Medical Association in its Washington conference advised all doctors to avoid co-operating with euthanasia, even in jurisdictions where it is legal.

## Clause 4 (Declarations made in advance)

Despite the conditions, there is no way to ascertain that the patient is making the request freely and that they are not being coerced to do so by relatives or others. The medical profession can experience difficulty assessing a patient's mental state, so how is a solicitor to determine that a patient is of sound mind?

## Clause 7 (Duties of physicians, and conscientious objection)

This clause, despite its wording, does not grant conscientious objection. It is recognised in law that a person who commissions another to commit a crime is not innocent but guilty by their complicity. So it is morally. A person who cannot perform an act, but passes the patient onto others in the knowledge that they will perform the act is morally equally culpable of that act. Those who hold convictions about the immorality of euthanasia will be unable to comply with this Act as they will not be able, in conscience, to refer the patient onto other willing physicians. To refer a patient to another physician for euthanasia would be acting against one's conscience. The right to practise in accordance with one's conscience or religious belief is protected under article 9 of the Human Rights Act.

## Clause 8 (Psychiatric referral)

A single psychiatrist cannot resolve the question of competence, in the manner suggested. The *Mental Capacity Bill* makes this abundantly clear. Capacity varies with time and the nature of decision under consideration.

## Clause 10 (Protection for physicians and other medical personnel)

We read this whole section with great anxiety as it seeks to protect medical teams and doctors rather than the patient. It is the complete reverse of current good practice. It would in many ways put the doctor outside legal control. We fear that this is one of the purposes of the whole Bill, to protect the doctor and not the patient.

## Clause 11 (Offences)

Given the other weaknesses in the Bill, we are not convinced that these provisions are as protective as they seem, for example diagnosis and prognosis are notoriously difficult, and assessment of the unbearability of suffering is subjective. What are the criteria to be used for judging that a declaration was false? As we have seen with the 1967 Abortion Act doctors "acting in good faith" can lead to almost any falsification. Who really believes that the 180,000 women who annually have abortions on psychiatric grounds were suffering from the stated depression or neurotic illness given as the medical reason for their abortions'?

## Clause 15 (Administration of drugs to patients suffering severe distress)

This clause is completely unnecessary. Not only is this practice lawful, it is standard medical practice for doctors to ask their patients about pain and distress, and give appropriate medication.

## Clause 16

The powers given to the Secretary of State to make regulations would give scope for far reaching variations, well beyond the intentions of parliament. As the outcome of changes to such regulations will control the outcome of death for individuals, it is inappropriate that any such changes should be exercised by Statutory Instrument. The reality is that any changes would be recommendations of an appointed unelected commission, all of whom would favour euthanasia.

## Conclusion

We sincerely hope that the committee will examine the reasons put forward, by the House of Lords Select Committee on Medical Ethics in 1994, against euthanasia and reach the same conclusion. The conclusions of the 1994 report of the House of Lord Select Committee on Medical Ethics are equally valid today as then.

Signed

Dr Michael Jarmulowicz FRCPath., MB.BS., BSc.
Chairman, Joint Ethico-Medical Committee.
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