Assisted Suicide: ...a 'minefield' of harm

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The Jersey Government will be debating the important issue of "Assisted Dying" in the Autumn. As a retired doctor (GP) and one of the Pastors of Freedom Church, I have significant concerns on the dangers of permitting this, from medical and ethical viewpoints...

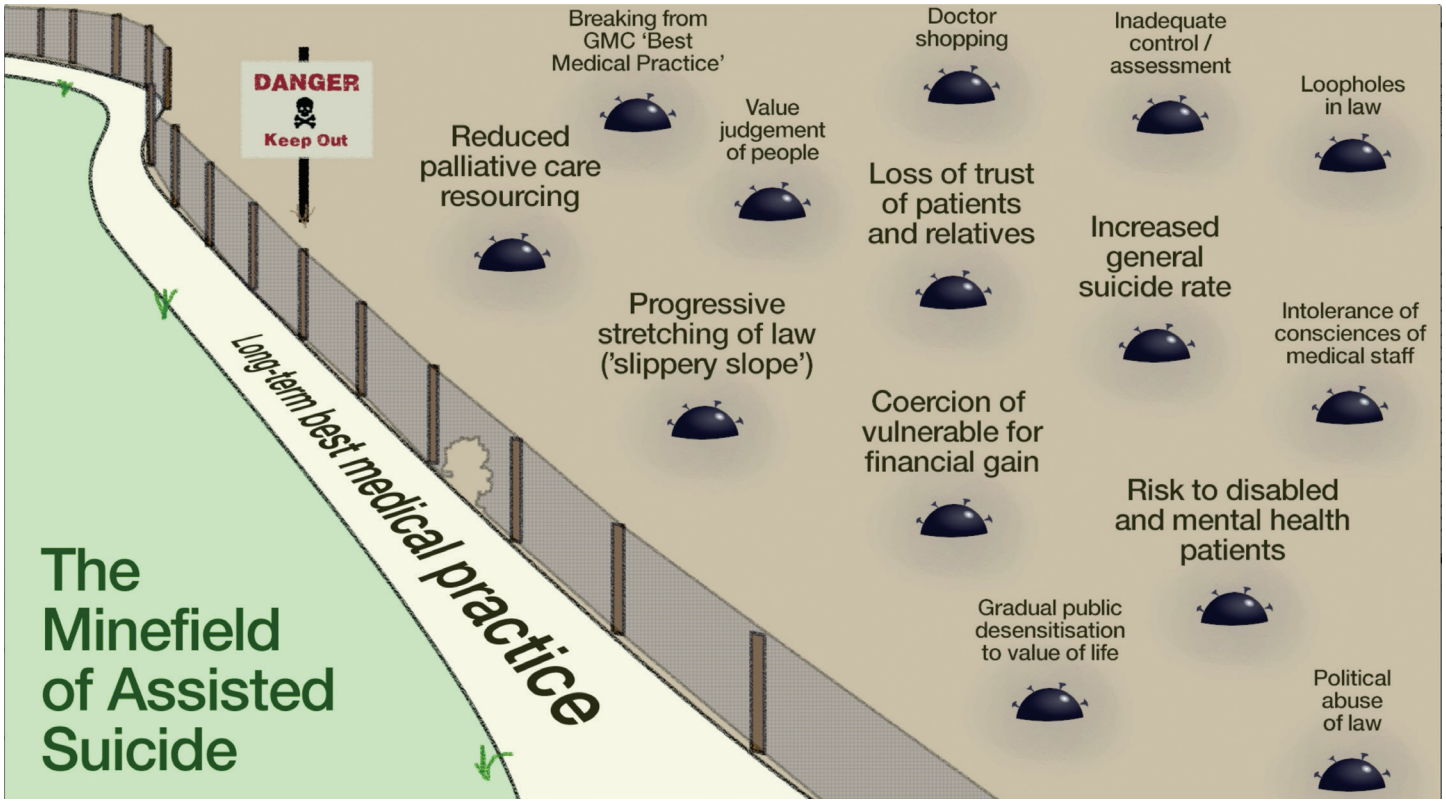
The Minefield of Assisted Suicide

The term 'euthanasia' has been softened to be called 'assisted dying' or 'assisted suicide', or physician assisted suicide (PAS). The present law protects those who are vulnerable in our society, including people with disabilities, dementia and during terminal illness, when so often those unwell do not wish to be a burden to others.

It is important to acknowledge that this is a complex and sensitive issue for many, particularly for the family and friends of those who have been through a difficult time during the death of a loved one, with subsequent negative memories, though they would have a sense of privilege to have been through that journey with them. Over the 37 years as a family doctor, I have had the privilege to be with many patients during their final illness and subsequent death as well as their loved ones.

Assisted suicide, as in other jurisdictions would 'open up' a minefield of harm and danger with:

- Progressive stretching of law once introduced ('slippery slope')
- Coercion of the vulnerable for financial gain
- Loss of trust of patients & relatives regarding care
- Increased general suicide rate / 'normalising suicide'
- Reduced palliative care resourcing
- Risk to disabled & mental health patients and those suffering from depression



Minefield of Assisted Suicide (continued)

- A value judgement of people
- Gradual public desensitisation to the value of life
- Intolerance of consciences of medical staff who are opposed to Assisted Suicide
- Loopholes in law & inadequate safeguards
- Possible political abuse of the law.

(1) Vulnerability & Capacity

In 2015 a bill to legalise assisted suicide was defeated in the House of Commons by 330 votes to 118, when MP's who had particular concern that the change in the law would put vulnerable people at risk.

Vulnerability to coercion by others is a very real risk when someone is already feeling a burden to others. It is possible that a relative with an interest in an earlier death of the person for the sake of an inheritance or a larger inheritance, may be considering the cost and therefore the disadvantage of paying of care over a prolonged period of time.

A change in the law allowing for 'assisted dying' would greatly increase the risk of vulnerable persons being subject to a 'value assessment'. This has happened in countries or States where 'assisted dying' has been legalized. Instances of unilateral decisions to terminate patient's lives has been done for patients with dementia, clearly showing that a value judgment of a patient's life has been made.

There can be vulnerability even in persons who are considered to have 'mental capacity'. For instance, a person with suicidal ideas can have mental capacity, and yet still be vulnerable. Mental health professionals will do whatever they can to protect the person from outworking those thoughts of self-harm during such periods of vulnerability. In the Netherlands where euthanasia has been legalized since 2001 there has been an instance of a person age 29 years who persuaded her doctor to kill her because she suffered with mental illness.

During a terminal illness, a person is also extremely vulnerable as it has been shown that over 50% of people have expressed that they do not want to be a 'burden' to others at such a time. What they need at such times is reassurance both verbally and practically through expressions of love and care. They need reassurance from their carer or relative, at such a time, that they are not a burden. This is needful in order that they feel highly valued. Treatable depression occurs during end-of-life care in a similar way that depression is generally treatable when there may be thoughts of self-harm or a wish to hasten death (WTHD). Psychiatrists in Jersey have both training and experience in helping people with depression during their final illness.

Mental Health & Increase in General Suicide rates:

In Oregon where PAS has been legal since 1997, figures showed in 2019 that there was a 35% higher general suicide rate than USA average. In the Netherlands, between 2007-2019 there was a 33.8% increase in suicide rates, despite the fact that suicides have been falling in neighbouring countries, and, over last 10 years deaths due to Euthanasia have increased by 150% and 'General' suicides by 35%. This could be due to what is called suicide contagion or Werther Effect:
https://www.carenotkilling.org.uk/events-reports/experts-outline-assisted-suicide-risks-to-mps/

Withdrawal of treatment:

There is no allowance in the Jersey Capacity Law to allow 'Assisted Dying', whether one has 'capacity' or not. There is already provision in the law for people to make advance directives and these can be to refuse life sustaining treatment. So, if someone really wants to die and they have capacity they can already choose this route.

People refuse treatments legally under these circumstances and die. It is legal to request medication to assist in pain relief but not to sustain life. It should be noted that the 'Jersey Mental Health Law' overrules or carries more weight in law that the 'Jersey Capacity Law'.

(2) Autonomy

One of the main arguments in favour of PAS is personal autonomy. There cannot be complete autonomy for any of us, as our actions can result in affecting the autonomy of others. There are laws in place that may affect our autonomy, but they are there for the protection of other people or ultimately protecting ourselves.

The recent pandemic restrictions either by guidelines or laws that were instituted by our own government in Jersey, and other countries around the world, were for the protection of the whole community and for us as individuals. There are many other examples in law for the ongoing protection of all, for example, a speed limit is in place for the obvious reason of preventing harm to others as well as the driver themselves. The present law exists to prevent harm to others that could and would result from introducing euthanasia in any form.

(3) Value judgement of a person's life

There is a strong voice against the various forms of euthanasia within communities that have adults and children with some form of disability. Disability groups have expressed their deep concern over the introduction of Physician Assisted Suicide (PAS).

In the USA the National Council of Disabilities (NCD) is an independent federal agency of the United States Government Headquartered in Washington D.C.

Quotes drawn from a recent NCD report and extracted from an article in Disability News Worldwide 14th October 2019: *"Many national disability rights organizations oppose the legalization of assisted suicide. All national groups that have taken a position are opposed." The report finds that safeguards are ineffective and that there is little oversight of abuses and mistakes. ''Closely examining the experience in Oregon, where the practice has been legal for 20 years, NCD found that the list of conditions eligible for assisted suicide has expanded considerably over time, including many disabilities that, when properly treated, do not result in death, including arthritis, diabetes, and kidney failure.'*

'Scope', *a disability charity in the UK, did a survey which showed that 'twice as many disabled people said they would be concerned by a change in the law (64%) as those who would not (36%)'.*

Professor Theo Boer, *a regulator for euthanasia / assisted suicide in the Netherlands for nearly 10 years (2005 – 2014) –* ***in the following video he expresses his change of view:***

https://www.youtube.com/watch?v=c0PTHL9mD74

Video (3 minutes 44 seconds)

Initially he thought that it was a 'good' euthanasia law but now actively speaks out against it, because of:

Increasing problems of conscience where increasingly people saw euthanasia as a right with a corresponding duty of the doctor to act with the doctor's autonomy being over-ruled. Those doctors who refuse to do euthanasia are seen as 'rule breakers'.

He gives the tragic example of a person with autism, who laid off from his job

Professor Theo Boer
Regulator for Euthanasia/Assisted Suicide in the Netherlands

because of his age, and could not cope without having the daily routine of his job, and at his request received euthanasia.

Extract from article by Professor Theo Boer:

In 2001 the Netherlands was the first country in the world to legalize euthanasia and, along with it, assisted suicide. In 2007 I wrote that 'there doesn't need to be a slippery slope when it comes to euthanasia.

A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia.' Most of my colleagues drew the same conclusion.

But we were wrong – terribly wrong, in fact. In hindsight, the stabilization in the numbers was just a temporary pause.

He has seen the results of what he has described as a very 'slippery slope' of extension of the law.

He stated at the World Medical Association that it was a mistake to introduce the law.

Quote: "Once the genie is out of the bottle it is not likely to go back in again."

A gradual public desensitisation to the value of life can and does occur, with extreme discrimination being expressed against people with disabilities.

Lionel Roosemont, a Belgian father of a 20-year-old disabled daughter, explained what he and his family sometimes have to put up with from fellow Belgians whilst out in public.

"We were walking with our child in a wheelchair and we would have people that we did not know, and they would come towards us and they would ask us, 'Why don't you have euthanasia with that child?' "

"…If today you go through Belgium, you will not see many young children that have a handicap, because they were not left to be alive."

https://www.youtube.com/watch?v=YAVq1pFJbHc

(4) Pain Relief and Palliative Sedation

The aim of palliative care is to provide the best possible care for patients and their families during what is such an important time for all involved. Pain management has improved significantly over recent decades. Newer slow-release oral medications, as well as pain relief medications (analgesics), have been developed. The use of the 'Syringe Driver' for slow infusion of analgesic drugs, sedation, and anti-sickness medications has been a major development and has been in use for several decades, thus avoiding the need for frequent injections with increasing dosages.

'Intolerable/unbearable pain': Those who express support for PAS refer to 'intolerable pain' as a supporting reason for its' introduction and this can aggravate or instil fears of dying in severe pain in those who hear such claims.

In the Irish Times Newspaper 10 November 2020:

'Dr Twomey said that, while he couldn't speak for everyone, based on the experiences of the members of the Irish Palliative Medicine Consultants' Association (IPMCA) who have cared for thousands of highly complex palliative care patients with severe symptoms over many decades, it was "an extremely rare event" that extreme pain and distress could not be managed.' (end quote)

The Association for Palliative Medicine (APM) in 2009 stated: *"There is a misconception that morphine related drugs and sedative drugs bring about death more quickly and that doctors both know this, and in some way condone their use with the double effect. The APM refutes this claim: it knows of no credible research evidence to suggest that a patient's life is shortened either by opioids or sedatives when used in line with accepted palliative care practice."*

'The same can be said for palliative sedation. In guidance published in 2009, which was reviewed again in 2012, the Association of Palliative Medicine clearly stated: *"Rarely, patients may experience distress when symptoms cannot be controlled even after exhaustive attempts with specific interventions. In these circumstances some patients may require sedating medication to diminish awareness of their suffering. If medication is sedating in its effect, the dose should be monitored in order to ensure that it is the minimum required to relieve the patient's distress. Medication used in this way does not shorten life.'*

The statement also contained a crucial qualification: *"Sedation in palliative care is thus sedation while the patient dies and is not sedating the patient to death."*

Those most closely involved in the end-of-life care of the terminally ill are the Palliative Care doctors who are strongly against the law being changed:

''Position Statement on a doctor's involvement in actions intended to end life (Assisted Suicide and Euthanasia – September 2020)

The Association for Palliative Medicine (APM) represents over 1200 palliative medicine doctors working in hospices, hospitals and the community in Great Britain and Ireland.

The APM opposes any change in the law to license doctors to supply or administer lethal drugs to a patient to enable them to take their own life.

The majority (85%) of our membership do not support a change in the law, and a similar percentage would refuse to participate in assisted suicide or administer euthanasia."

(5) Historical/Political Concerns

There are precedents, even in the last century, of the value judgement of people with certain medical conditions, such as epilepsy, people with disabilities or even people groups, ethnicity, or race, who have been seen of no value by dictatorships who have extreme views. This has resulted in affecting the worldview of their country's population. The value of human life in law is one of the most important protections against such an extreme. A value judgement according to a person's ability to contribute to society's needs in general, can result in progressive change in attitudes in a population. This could happen even in countries without leaders with extreme political views. Also, the financial cost of longer-term care, could eventually affect policies and decisions made by governments.

Historically, the Hippocratic Oath, which originated in the 5th century B.C. and explicitly ruled out both euthanasia and PAS. 'I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them. I will not give poison to anyone

(Continued on back page)

though asked to do so, neither will I suggest such a plan…'

(6) Inadequate Governance of Laws or Safeguards in Jurisdictions with PAS & PAE and stretching of the law once introduced

There is clear evidence that there is inadequate governance of laws in jurisdictions where Physician Assisted Suicide (PAS) and Physician Administered Euthanasia (PAE) exists, with significant 'stretching' of the law once introduced, to include people with non-terminal illness and laws that have even included children. This has happened in Canada after only 5 years of them introducing 'MAiD' (Medical Assistance in Dying) Law. Prior claims are made that instituting safeguards for vulnerable people will be in place and followed but this does not occur in practice once PAS or PAE is introduced into law. Another example is in Belgium where a person with poor eyesight, plus hearing loss, plus chronic tiredness is now considered sufficient reason for being a candidate for euthanasia and assisted suicide. Research carried out by Belgian academics based at Ghent University found a combination of everyday conditions associated with old age, known as "poly-pathology", accounted for a significant number of assisted deaths in 2019. The study found that it was given as the reason for over 17 per cent of all reported euthanasia and assisted suicide cases in 2019, and a 47 per cent of all "non-terminal" euthanasia cases.

(Quote) 'In the 18 years since the passing of the law, much has changed. We argue that in Belgium a widening of the use of euthanasia is occurring and that this can be ethically and legally problematic. This is in part related to the fact that several legal requirements intended to operate as safeguards and procedural guarantees in reality often fail to operate as such.

These are just two examples of several jurisdictions that once introduction of a law that allows PAS/PAE that there is poor governance so that the law has been extended to other groups of people not envisaged at the time of introduction. This has even been extended to include children.

(7) Religious belief and PAS

Our Western moral outlook is built, whether we like it or not, on a Judeo-Christian ethic which is foundational to our culture. Even those among us who do not profess a religious belief broadly accept its' guiding principles, including that we do not deliberately take or aid and abet the taking of human life.

In a joint letter sent by UK faith leaders in 2015 to express concern over Rob Marris MP's 'assisted dying' bill of that year'. They write that:

"Our concern is rooted in a profoundly human and profoundly sacred calling to care for the most vulnerable in our society, a concern shared by people of all faiths and none' and that "in the UK some 500,000 elderly people are abused each year, most by family members, often for financial reasons" and that "a change in the law would result, not in greater comfort, but in an added burden to consider ending their lives prematurely, a burden they ought not be asked to bear."

This is a shocking UK statistic, and the equivalent would be that 800 people per year in Jersey suffer 'Elder Abuse'. This shows the degree of increased risk to the elderly by those close to them should there be a change in the law.

In an article in the Economist 22nd August 2018, 'Liberals and Atheists Can Also Oppose Assisted Dying' Kevin Yuill, writes that:

'Opposition to assisted dying is usually derided as being religious in nature, which is easier than confronting hard questions or inconvenient truths. It is easier to shut down "religious bigots" than to consider what they say, just as it is easier to use the term "assisted dying" instead of the more accurate but controversial "assisted suicide." …'Anyone who looks closely and critically at the issue will see past the emotive stories and simplistic assumptions used to justify the push for legalisation.' …'We currently place equal moral weight on human life and do not measure it by years left or physical ability. Instituting assisted dying threatens that moral precept.' His concluding statement is ***'A wise government will, like the British parliament in 2015, refuse to make assisted dying legal.'***

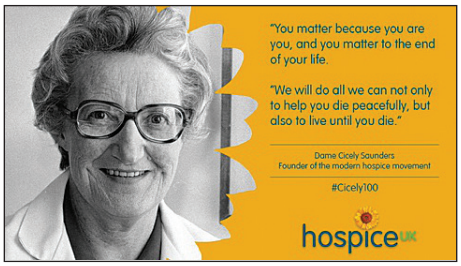
The Way Ahead

Greater investment and continued development of Palliative Care is the answer. This is of great importance rather than introducing any change in the law, to introduce Physician Assisted Suicide / Assisted Dying.

Dame Cicely Saunders, the founder of the modern hospice movement is often quoted as saying:

"You matter because you're you, and you matter to the end of your life. We will do all we can not only to help you to die peacefully, but also to live until you die."

This quote encapsulates the essence of palliative care.



Dame Cicley Saunders
Founder of the modern hospice movement

Palliative care has improved enormously over the last 40-50 years, but there is always room for further improvement and development as well as greater investment in Palliative Care services. There is a continual need for improvement in all care including end-of-life care and this should be an ongoing aim in Jersey. This is the responsibility of us all, and especially for those who represent us politically, ensuring that there is further investment in palliative, medical and social care.

Dr John Stewart-Jones
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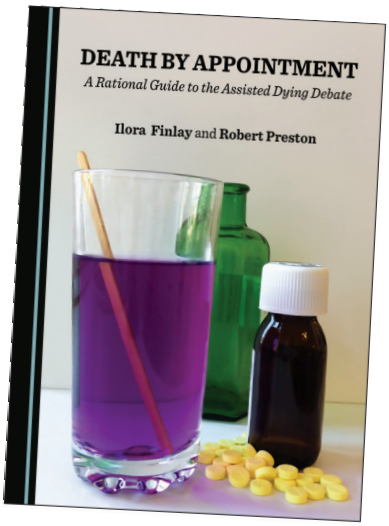

I would like to recommend the book

'Death by Appointment'

by Robert Preston and
Baroness Ilora Finlay.

There is a special reduction of 50% on the cost of these if purchased directly from the publishers, Cambridge Scholars, which cost £10 if a special code is added to the order. This can be found on the Living and Dying Well website:

https://livinganddyingwell.org.uk