

## Countering the Arguments for Assisted Dying

Argument	Counterarguments
Public opinion is in favour of a change in the law	<ul style="list-style-type: none"> <li>• Only 46%, although agreeing in principle, think a change in the law would be practicable or safe</li> <li>• As the public becomes more informed, opinions change</li> <li>• The public wants better access to good end-of-life care</li> </ul>
People want choice (respect for autonomy)	<ul style="list-style-type: none"> <li>• A law that allows one person choice, must be safe for everyone (this one would not be)</li> <li>• Respect for our autonomy is always within the context of the autonomy of others</li> <li>• That is, we must think in terms of relational autonomy</li> </ul>
I should be able to decide for myself, not have anyone else decide for me	<ul style="list-style-type: none"> <li>• The effects of my decisions on others (especially if they have an impact on people who haven't enough care and support in their lives) must be considered</li> </ul>
"Assisted dying" allows people to die with dignity	<ul style="list-style-type: none"> <li>• Assisted suicide does not always provide a "dignified" death, e.g. if the medication causes side effects, if its effects are delayed, or if it does not work; or if it distresses family and friends</li> <li>• A dignified death is a well-supported death: our services are not yet fully developed and not yet easy to access</li> </ul>
Numerous horror stories of bad deaths	<ul style="list-style-type: none"> <li>• Horror stories point to the need to develop better care and support</li> <li>• Hard cases make bad law</li> </ul>
31 jurisdictions and 450 million people have access to "assisted dying" in the world	<ul style="list-style-type: none"> <li>• 289 jurisdictions and 7.75 billion people do not have "assisted dying".</li> </ul>
Compassion dictates that assisted suicide should be an option	<ul style="list-style-type: none"> <li>• Everyone in this debate is guided by compassion</li> <li>• Palliative care is an example of compassion in practice</li> </ul>

<p>Religious views are divided on this issue</p>	<ul style="list-style-type: none"> <li>• Most mainstream religions are against assisted suicide</li> <li>• Religious arguments are not the issue</li> <li>• This debate is about how public services support everyone humanely regardless of means</li> </ul>
<p>There's a distinction between "suicide" and "assisted dying"; they are very different, the latter is not shortening life but shortening death</p>	<ul style="list-style-type: none"> <li>• "Suicide" in public discourse (e.g. law) and etymologically means self-killing; "assisted suicide" is self-killing, but with assistance</li> <li>• Suicidal inclinations and the possible underlying causes of such inclinations (e.g. depression, loneliness, pain, feeling a burden) can be the same in both suicide and assisted suicide</li> <li>• Shortening the process of dying is to shorten life</li> </ul>
<p>We need to help people who are in pain</p>	<ul style="list-style-type: none"> <li>• This is the work of palliative care and specialist pain clinics, both of which are under-resourced</li> </ul>
<p>We need to help people to have a good death as well as a good life</p>	<ul style="list-style-type: none"> <li>• This is the work of palliative care which needs to be better resourced and joined up with care and support</li> </ul>
<p>Palliative care does not help everyone (evidenced by (a) House of Commons Health and Social Care Committee Report <i>Assisted Dying/ Assisted Suicide</i>; and (b) OHE Report <i>Unrelieved Pain in Palliative Care in England</i>)</p>	<ul style="list-style-type: none"> <li>• The OHE Report notes that 'referral of palliative care patients to specialist pain clinics is rare in the UK' (p. 12): let's improve this!</li> <li>• The OHE report talks of "unrelieved pain", not "unrelieved agony" as suggested by Polly Toynbee (<i>The Guardian</i> 26 July 2024); the word "agony" is not used</li> <li>• Important to note that "unrelieved" in the OHE Report does not mean "severe" or "intolerable"; the severity of pain was not assessed</li> <li>• Palliative (end-of-life) sedation is allowed under the current law</li> <li>• More research on end-of-life care is required</li> </ul>

<p>The House of Commons Health and Social Care Committee Report concluded that “jurisdictions which have introduced AD/AS on the basis of terminal illness have not changed the law to include eligibility on the basis of “unbearable suffering”.”</p>	<ul style="list-style-type: none"> <li>• In Canada the original law in 2016 was for those whose deaths were “reasonably foreseeable”</li> <li>• In 2021 the law removed the requirement to be “reasonably foreseeable”</li> <li>• In Oregon, we have seen expansion of the eligibility criteria: no need for the “cooling-off” period; no need for residency requirement</li> <li>• Also, we see <i>de facto</i> expansion of the eligibility criteria by allowing that people with non-terminal conditions who refuse treatment thereby become terminal</li> <li>• In Oregon and in other countries, there are accounts of assisted suicide (or euthanasia) for people with “terminal” anorexia, whereas anorexia is not considered “terminal” in any usual sense of the word</li> <li>• The same would be true of other mental health conditions</li> <li>• There may be tactical reasons why in Oregon they have not moved away from terminal conditions, i.e. in order not to put off other States from joining those who already have assisted suicide.</li> </ul>
<p>The House of Commons Health and Social Care Committee Report asserts at paragraph 142: “In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/AS; indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions”</p>	<ul style="list-style-type: none"> <li>• This is contradicted by studies which show a drop in the rankings of almost all countries in terms of palliative care where assisted dying is legalized</li> <li>• See: The 2015 Quality of Death Index: ranking palliative care across the world. London: Economist Intelligence Unit, 2015</li> <li>• And: Finkelstein, E.A., Bhadelia, A., Goh, C. et al. (2022) Cross country comparison of expert assessments of the quality of death and dying 2021, <i>Journal of Pain and Symptom Management</i>, 63(4): e419–29; <a href="https://doi.org/10.1016/j.jpainsymman.2021.12.015">https://doi.org/10.1016/j.jpainsymman.2021.12.015</a></li> </ul>
<p>It will all be all right if safeguards are in place</p>	<ul style="list-style-type: none"> <li>• The sort of safeguards suggested are actually no more than criteria, because there are no mandatory procedures to ensure that they are true safeguards</li> <li>• All of the so-called safeguards raise problems in real-life contexts</li> </ul>

<p>The Leadbeater Bill will only be for people with a terminal diagnosis and less than 6 months to live</p>	<ul style="list-style-type: none"> <li>• Diagnosis is inaccurate in 30% of cases</li> <li>• Prognosis is inaccurate in 50% of cases</li> </ul>
<p>There would be no expansion in the Leadbeater Bill of the criterion beyond terminal illness</p>	<ul style="list-style-type: none"> <li>• Section 2(2) of the Leadbeater Bill [‘For the purposes of subsection (1), treatment which only relieves the symptoms of an inevitably progressive illness, disease or medical condition temporarily is not to be regarded as treatment which can reverse that illness, disease or condition’] means that Type-1 Diabetes could be considered “terminal”, showing that “terminal” already expands to include conditions which would normally be regarded as non-terminal. Similarly for Anorexia Nervosa.</li> <li>• In any case, there will be pressure to expand the eligibility criteria on grounds of equality and to avoid discrimination under the European Convention on Human Rights</li> </ul>
<p>In the Leadbeater Bill coercion must be excluded as a safeguard</p>	<ul style="list-style-type: none"> <li>• The Leadbeater Bill ignores the possibility of internal (internalized societal) coercion</li> <li>• The Leadbeater Bill ignores the reality of 400,000 cases of domestic abuse each year in England and Wales and the implication that there will be examples of overt, conscious, malign coercion, which might nevertheless be difficult to pick up (in the same way that cases of coercive control are hard to pick up and to prosecute)</li> </ul>
<p>In the Leadbeater Bill the person must have full decision-making capacity</p>	<ul style="list-style-type: none"> <li>• But this will be judged by a non-specialist, where in marginal cases, e.g. in the vulnerable and frail, this can be very difficult and involves value judgements; and those involved in these assessments are likely to be inclined to presume the person has capacity. Moreover, under the Mental Capacity Act 2005 (MCA), the person must be assumed to have capacity, all practicable steps must be taken to help them to make a decision (and it should be noted that this could potentially amount to a form of possible coercion).</li> <li>• Furthermore, the MCA states that the action or decision taken should be the least restrictive of ‘the person’s rights and freedom’; but if the action or decision results in the person’s death it is hard to see how this helps the person’s rights and freedom</li> </ul>

	(since there is no right to die, only a right to refuse treatment).
In Section 4(4)(c) the Leadbeater Bill says that the medical practitioner must 'explain to and discuss'... 'any available palliative, hospice or other care, including symptom management and psychological support'	<ul style="list-style-type: none"> <li>• But the Bill does not give enough weight to what might be achieved by properly funded palliative care and by appropriate funding for end-of-life research</li> <li>• The discussion with a non-expert about palliative care is not sufficient and compares poorly to either an assessment and discussion with a specialist or the actual experience of palliative care</li> </ul>
The Leadbeater Bill cannot be compared with countries where there is euthanasia, because it only sanctions the person him or herself taking 'the final act'	<ul style="list-style-type: none"> <li>• Yet in Section 18 (6c) it states the coordinating doctor may 'assist that person to ingest or otherwise self-administer the substance'</li> </ul>
The Leadbeater Bill provides for conscientious objection	<ul style="list-style-type: none"> <li>• Yet in Section 4 (5) it states: 'A registered medical practitioner who is unwilling or unable to conduct the preliminary discussion mentioned under subsection (3) must, if requested by the person to do so, refer them to another registered medical practitioner whom the first practitioner believes is willing and able to conduct that discussion'</li> <li>• This makes it illegal for a doctor to refuse to have anything at all to do with the process</li> <li>• Meanwhile, there is no conscience clause for a judge who does not wish to participate in the process</li> </ul>
Life is not sacred; suffering is not sacred	<ul style="list-style-type: none"> <li>• <u>Lord Walton in 1994</u> said : the prohibition of intentional killing is the cornerstone of law and of social relationships</li> <li>• This is a secular expression of the inviolability of life</li> </ul>
We shouldn't keep people alive when they will suffer, it's against their will and they're dying anyway	<ul style="list-style-type: none"> <li>• It is basic to palliative care, neither to hasten nor postpone death</li> <li>• People can also come to terms with their suffering, especially with the right psychological and social support</li> </ul>

<p>We don't let our pets suffer in the way we do humans: vets euthanize animals out of compassion</p>	<ul style="list-style-type: none"> <li>• We treat human beings differently to animals because of our awareness of the inherent difference between humans and animals, which reflects inherent human dignity</li> <li>• We also kill animals for food and hunt them – showing that our treatment of animals is accepted by society to be different to our treatment of human beings</li> <li>• Some pets are put down for financial reasons, rather than purely for reasons of compassion</li> </ul>
<p>We are looking away from the reality (or status quo) that thousands of people with terminal diseases are killing themselves (several hundred a year are blowing their brains out, as described by Kit Malthouse MP) because they are in agony</p>	<ul style="list-style-type: none"> <li>• Unassisted suicides don't go down after “assisted dying” legislation, they <u>go up</u></li> <li>• The rate of suicide increases during the 12 months after a diagnosis of a severe health condition, but the numbers are relatively small</li> <li>• In the latest report from The National Confidential Inquiry into Suicide and Safety in Mental Health, run by Manchester University, there is no mention of terminal conditions being a significant cause of suicide (the words “terminal” and “cancer” do not appear), even if a quarter of all suicides have "a major physical illness"</li> <li>• However, the main risks for suicide are psychological and social, including feeling a burden</li> <li>• Gunshot suicides account for about 2.5% of all suicides, but only about 29% of those in people aged over 55 years have a known malignancy or neurological condition, suggesting (in England and Wales) out of the 6,000 suicides a year about 44 would be caused by gunshots (not several hundred)</li> </ul>
<p>The system as it stands is unregulated, whereas once a law is passed it will be regulated</p>	<ul style="list-style-type: none"> <li>• Doctors are regulated in numerous ways in the UK</li> <li>• Evidence from other countries, including Oregon, show that regulation of PAD/PAS/ euthanasia is poor with, for example, under-reporting and very little auditing</li> </ul>
<p>Medication for pain already shortens people's lives anyway</p>	<ul style="list-style-type: none"> <li>• The evidence does not support this assertion: pain medication relieves pain</li> </ul>

<p>The involvement of doctors emphasizes that assisted dying simply continues the therapeutic relationship of doctor and patient in a last act of compassion</p>	<ul style="list-style-type: none"> <li>• Often the doctor will not be the person's family doctor, therefore there is no therapeutic relationship</li> <li>• Medical involvement is not necessary and would be detrimental to the doctor-patient relationship</li> <li>• The task of providing medication could be undertaken by a technician outside of healthcare</li> <li>• It is better to keep the medical profession clear of intentional killing</li> </ul>
<p>The involvement of a judge ensures that people will be protected and that safeguards will be maintained</p>	<ul style="list-style-type: none"> <li>• This would only work if the judge had full investigative powers, with the parties having proper representation, with all that this means in terms of time, costs and complexity – this might mean that less well-off people would be excluded</li> <li>• We cannot always depend on courts e.g. to make the right decision in cases of coercive control or rape: courts can err</li> <li>• When the Court of Protection is making decisions about issues such as capacity, they can routinely take literally years</li> <li>• Of course courts can deal with emergencies quickly, but if there were hundreds (or thousands) of such cases, how would they cope?</li> <li>• Sir James Munby has estimated that, at best, the High Court would require an additional 34,000 hours of court time (currently there are only 19 judges in Family Division of High Court, allowing 19,000 sitting hours a year)</li> <li>• There are no rights of appeal in the whole process</li> <li>• Family members have no right to be informed of proceedings, which might allow a challenge or appeal</li> <li>• In theory, the High Courts involvement could be based solely on paper</li> <li>• For many aspects of many cases, the judge would have to rely on the expert opinion of the medic in front of him or her, but this medic might well be a non-expert</li> <li>• People presumed to be "experts in mental capacity" have often been found to have erred in their assessments – following detailed examination by a court – but if the non-specialist doctor says that the person does not require a capacity assessment, a palliative care assessment, or a mental health assessment, how would the judge be</li> </ul>

	<p>able to be sure? While the judge could make an assessment him or herself of capacity, the judge would not be able to assess the need for palliative care (in any case, the person only needs to be informed about palliative care options, not experience them), or the need for a mental health assessment</p> <ul style="list-style-type: none"><li>• And we know that GPs and other non-specialist healthcare professionals frequently miss psychiatric diagnoses</li></ul>
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