

Baroness Meacher's Assisted Dying Bill: Analysis of the Second Reading Debate

The Assisted Dying Bill introduced to the House of Lords by Baroness Meacher received its Second Reading on 22nd October. The debate on the Private Member's Bill was attended by over 130 peers and brought to light many important arguments both for and against the legalisation of assisted suicide.

Contrary to press reports from Dignity in Dying, the Second Reading was not "unopposed". Throughout the debate, over sixty Peers indicated opposition to the Bill. The House is clearly divided on the topic but, as is convention, no division was called at the Second Reading.

During her opening remarks, Baroness Meacher implored Peers to ignore the evidence from Canada, Belgium, the Netherlands, Switzerland, Canada, Spain, Colombia and elsewhere as jurisdictions which have legalised the practice of 'assisted dying', suggesting they were not relevant. However, such legislation has profound consequences and the results from overseas are deeply concerning. The primary arguments proposed in favour of the Bill must be scrutinised against all available evidence, expertise and experience.

'Safeguards' and the Protection of Vulnerable Patients

Over a third of Peers who spoke in support of the Bill claimed that the legislation contains safeguards which are adequate for the protection of vulnerable patients. Baroness Meacher suggested that two doctors being required to independently assess the patient requesting assistance in suicide is an effective safeguard because, if either had doubts about a person's capacity to request assistance in suicide, the patient would be referred to an appropriate specialist. This fails to recognise that confirming capacity for such a major decision (to end one's life) is not an easy tick box exercise that can be undertaken at a single interview. People with impaired capacity may be able to make some autonomous decisions, but not others – as written, the Bill sets a minimalist criterion, which ignores cognitive distortions from the impact of illness, medication or neurodiversity.

Oregon's data, where a similar 'safeguard' is in place, reveals that the referral rate for such psychological assessment is far lower than would be expected, as research has shown that about estimated 1 in 6 patients who receive lethal drugs may meet the criteria for a diagnosis of depression¹, yet in 2020 only 1.2% of patients were referred to a specialist for psychiatric evaluation².

In Oregon, when a patient's request for assisted suicide is declined, the PAS campaign groups simply steer them to a willing prescriber from their lists of willing doctors. In Oregon in 2020, at least one doctor wrote as many as 31 lethal prescriptions³; the

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562435/>

² <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

³ <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

reporting process relies on simple forms filled out by the prescribing doctor, without any record of how their assessment was conducted⁴, making independent audit impossible.

The assessing doctors are expected to confirm that the request is without pressure or coercion, although it is almost impossible for a doctor to state this with legal certainty. Neither doctor could know what happens behind the closed doors of a person's life, whether that is perceived burdensomeness, persuasion, abuse, neglect or coercion. Such inquiry lies outside a doctor's role or powers of investigation. The College of Psychiatrists of Ireland has warned in a recent position paper that assisted dying is contrary to the efforts of psychiatrists and is incompatible with good medical care. Improvements in existing services should be deployed to manage issues such as fear of being a burden.⁵

The requirement that patients have a prognosis of six months or less is no safeguard at all. Studies show medical prognosis is highly unreliable⁶. This is also confirmed in Oregon's data, where in 2020, 9% of the lethal prescriptions ingested by patients had been prescribed in preceding years – eight patients are known to have outlived their 'six-month prognosis'⁷. Since Oregon's legislation was introduced, 4% of deaths from ingesting lethal drugs occurred in people who had already outlived their six-month prognosis.

The Bill's definition of 'terminal illness' is also problematic. According to Oregon's Death with Dignity Act, "anyone with a chronic illness who is likely to die within six months if they chose to stop treatment" is eligible for assisted suicide⁸. This would also apply to the definition given in Clause 2(1) of Baroness Meacher's Bill. Clause 2(2) could be interpreted, as Lord Morrow observed, to include insulin-dependent diabetics who have an illness which is "inevitably progressive" and whose treatment will never "reverse the condition". As the Bill is worded, a person who refuses treatment for a condition that is easily treatable and whose progression could be slowed so that the person can live for decades longer would still qualify for an assisted suicide. Thus, the criteria of a 'terminal illness' is far from a 'tight' safeguard.

At the end of Baroness Meacher's speech, she mentioned that "there are no legal safeguards for dying people who decide to end their lives early, whether by starving or, on occasion, shooting themselves. We propose a rigorously safeguarded system that would end these barbarous deaths and protect vulnerable people." This claim is without foundation and deeply misleading. The failure of safeguards is evident in the high number of suicides in countries that have changed the law. In Oregon, the overall suicide rate has risen by 24% since assisted suicide was legalised and remains one of the highest in the US.⁹ In the US, legalising assisted suicide has been associated with a 6.3% increase in total suicides (including assisted) and did not

⁴<https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/pasforms.aspx>

⁵ <https://www.irishpsychiatry.ie/blog/press-statement-college-of-psychiatrists-publish-position-paper-on-physician-assisted-suicide-and-euthanasia/>

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4999179/>

⁷<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

⁸ <https://drive.google.com/file/d/1xOZfLFrvuQcaZzfFudEncp2p2b18NrUo/view>

⁹ <https://www.oregon.gov/oha/PH/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx>

reduce non-assisted suicides,¹⁰ and the Netherlands has seen an increase in suicide rates in the last 10 years.¹¹ Safeguards to truly protect people at a vulnerable time in their lives and improve suicide prevention in the UK are missing entirely from this Bill.

As Lord Carlile stated in the debate, “parliamentary Bills founded on such fragile safeguarding and analysis, especially after years of trying to produce acceptable safeguards, should really not be troubling your Lordships’ House.”

Patient Autonomy

More than half of the Peers who spoke in favour of the Bill claimed that legalising ‘assisted dying’ promotes patient autonomy. The suggestion that patients’ choices in care are increased by assisted suicide legislation is flawed. The reality is that lethal drugs are cheaper than quality palliative care, and the legalisation of ‘assisted dying’ would infringe and impair patients’ ability to make autonomous end of life care decisions.

Every day in the UK, over 320 patients fail to get the palliative care they need¹². The Government currently funds only around one-third of hospice palliative care costs¹³, and Hospice UK says the current funding model for palliative care is unsustainable¹⁴. Based on a 2014 report by the Nuffield Trust, an average 14-day stay in hospice costs approximately £5,600¹⁵.

Evidence from some jurisdictions where assisted dying is legal suggests that such legislation is underpinned by financial incentives. Reports from Canada suggest that ‘medical assistance in dying’ may reduce Canada’s annual health care bill by up to \$138.8 million¹⁶. In Canada, less than half of patients who participate in assisted suicide or euthanasia see a specialist palliative care team¹⁷ and only 15% of Canadians have access to publicly funded palliative care at home¹⁸. In New Zealand, the proposed fee-for-service for a doctor delivering ‘assisted dying’ is \$1087 (equivalent to about £553) plus travelling expenses, acting as an incentive to process requests.

It is inevitable that cost would become a factor in a person’s decision to take lethal drugs, placing pressure on them to accept a premature death. Canada has shown that some patients, denied the social care support they need, are repeatedly offered ‘assisted dying’. For them, hastening death is not one end of life care choice among many but becomes the only feasible option.

Assisted Dying and Palliative Care

¹⁰ https://nottingham-repository.worktribe.com/output/981903/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide%22%20%5Ct%20%22_blank

¹¹ <https://www.cbs.nl/en-gb/news/2019/26/fewer-suicide-deaths-in-2018>

¹² <http://www.hospiceuk.org/docs/default-source/What-We-Offer/publications-documents-and-files/hospice-care-in-the-uk-2016.pdf?sfvrsn=0>

¹³ <https://londoneconomics.co.uk/blog/publication/modelling-demand-and-costs-for-palliative-care-services-in-england-march-2021/>

¹⁴ <https://www.hospiceuk.org/latest-from-hospice-uk/jenga-funding-model-undermining-capacity-hospices>

¹⁵ <https://www.nuffieldtrust.org.uk/files/2017-01/end-of-life-care-web-final.pdf>

¹⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5250515/>

¹⁷ <https://www.cfp.ca/content/66/11/833>

¹⁸ <https://www.cihi.ca/sites/default/files/document/access-palliative-care-2018-en-web.pdf>

Several Peers supporting the Bill claimed that “assisted dying” legislation complements the development of palliative care. In her opening speech, Baroness Meacher stated that she is passionate about “achieving the best possible palliative care across the country” yet she fails to recognise the practical and ethical contradictions between the promotion of palliative care and assisted suicide.

Evidence from jurisdictions where assisted suicide is legal reveals that ‘assisted dying’ legislation does not lead to the sustained development of palliative care services¹⁹. An analysis of specialised palliative care services in European countries over the last 14 years reveals that the average growth in palliative care services in countries with ‘assisted dying’ is slower than countries without such legislation. Notably, Belgium and the Netherlands have experienced no growth in palliative care services since 2012²⁰.

In Canada, the provision of MAID has been detrimental to the quality of palliative care. Clinicians report that assisted dying complicates patient symptom management, feeling they must withhold medication which could alleviate patient distress in order to maintain MAID eligibility. They also find open communication and trust are harmed within the physician-patient relationship; introducing the topic of MAID can be misinterpreted as an invitation to request it. Since the legalisation of MAID, many patients fear palliative care and assisted dying are synonymous. This burdens patients at a vulnerable time in their lives and can erode families’ trust. Clinicians also report that the practicality of providing assisted dying is time consuming and can result in the reallocation of staff and resources away from the care of other patients²¹.

Based on the concerns of patients and practitioners, some hospice facilities in Canada refused to incorporate the practice within the scope of their services. These hospices have had their statutory funding threatened or withdrawn²².

Oregon’s data from those who had physician assisted suicide provides no reassurance. Over the past 23 years, on average, ‘inadequate pain control or concern about it’ has been cited by 27%, but rose to 33% in the last two years (2019/2020).

Assisted Dying and Suffering

Many Peers who supported the Bill argued that Assisted Dying legislation is needed in order to prevent patient suffering (by 37% of Peers who spoke in favour of the Bill). Baroness Meacher stated, “the sole aim of this Bill is to reduce unnecessary and unbearable suffering”.

Data from Oregon, however, reveals that the main concerns of those seeking assisted suicide are principally social, rather than medical. In Oregon in 2020, 53% of patients who died by assisted suicide stated that they were concerned about being a burden on their families, friends, or caregivers.²³

¹⁹ <https://pubmed.ncbi.nlm.nih.gov/32519584/>

²⁰ <https://pubmed.ncbi.nlm.nih.gov/32519584/>

²¹ <https://journals.sagepub.com/doi/10.1177/0269216320968517>

²² <https://www.ctvnews.ca/health/standoff-between-b-c-and-hospice-refusing-to-offer-assisted-dying-1.4773755>

²³ <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

We must also remain aware of financial exploitation and coercion of the sick and dying. According to a 2017 national survey, almost 10% of older people in the UK say that they are being abused, with financial abuse frequent²⁴. In reality this is likely to be a higher number because basic data on the scale of elder abuse in the UK are lacking, creating “systematic invisibility.”²⁵

Only 10% of Palliative Care consultants, who deal with the most severe of patient symptoms in those who are terminally ill, are willing to actively participate in assisted suicide, according to a recent BMA poll.²⁶ Only 6% would be prepared to administer euthanasia.

Palliative Care is an approach that improves the quality of life for both the patient and the family, providing relief from pain and other distressing symptoms by means of early identification and impeccable assessment and treatment of pain and other problems whether physical, psychosocial and spiritual, using a team approach. It affirms life and regards dying as a normal process, neither intentionally hastening nor postponing death, helping patients live as actively as possible until death and their family to cope during the patient's illness and in their own bereavement. Palliative care professionals across the world remain concerned that legalising assisted dying is incompatible with providing specialist palliative care, as evidenced in Canada.

If assisted suicide were legalised in the UK, it is inevitable that those who feel a burden on their family and carers, or feel isolated and lonely,²⁷ would request assisted suicide. The question is, simply, whether it is acceptable to implement legislation that encourages assisted suicide and euthanasia.

The role of the court

As Lord Gold observed, the role of the court is not defined in this Bill. He stated, “The Bill is silent on whether the court will appoint an amicus curiae to argue the case or whether the judge is to act in an inquisitorial capacity, himself quizzing the applicant’s counsel and perhaps the doctors. The intention might be that the application will simply be on paper, with no opportunity for the court to challenge the evidence or quiz the doctors unless something looks suspicious. This is wholly unfair on the judge and, more significantly, on the unwell applicant, whose interests and well-being are paramount.”

Further, the Court based legal scrutiny of decisions had not been considered with any care, had not been discussed with the cadre of judges named, and failed to recognise that, in the system of scrutiny proposed, the sheer number of cases would overwhelm the courts named.

²⁴ <https://www.caremanagementmatters.co.uk/epidemic-of-elder-abuse/>

²⁵ <https://www.bmj.com/content/375/bmj.n2828>

²⁶ <https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf>

²⁷ In 2019 in Canada, 18.6% of MAiD recipients cited isolation or loneliness when describing the nature of their suffering that led to their request for assistance to end their life

In her letter to Peers following the debate, Baroness Meacher admitted that, in fact, the Courts had not been consulted about her Bill.

Expansion of the Law

International evidence shows clear evidence of expansion of similar and near-identical laws when in place. Baroness Meacher's is not a "modest Bill based on tried and tested laws from overseas".

We would draw attention to Canada, which legalised assisted dying for terminally ill adults in 2016²⁸. Not long after, in 2019, the Superior Court of Quebec declared the "reasonably foreseeability of natural death" criterion unconstitutional, and their House of Commons passed an Act in March of 2021 to remove this requirement. Other amendments to the law have been brought forward, including one to allow assisted dying for individuals suffering from mental illness alone and written arrangements that allow individuals to request 'assisted dying', should they lose their decision-making capacity²⁹.

In the Netherlands, euthanasia and assisted suicide was legalised for adults over 12 years old in 2001³⁰. In 2015, the Dutch Paediatricians' Association recommended that children under 12 should be eligible for euthanasia³¹. In 2020, a law was tabled to allow ending the life of elderly people who view their life as 'complete'³².

The latest report to the Dutch Parliament suggests that 'assisted dying' should be available to anyone aged over fifty-five³³. In Belgium, a survey found that a quarter of cases of euthanasia were involuntary - illegal under Belgian law³⁴. In Switzerland, 21% of those dying at Dignitas do not have a fatal illness³⁵. In other jurisdictions, widening interpretation of legislation is seen in the incremental rise in cases of such deaths year on year.

Baroness Meacher's Private Members' Bill is particularly open to interpretation over the administration of lethal drugs, through case law, to expand assisted suicide into euthanasia. Oregon's law has not extended to direct euthanasia, because it is prohibited by USA Federal Law, which curtails State Law. But even in Oregon a slackening of the required cooling off period has been passed.

Several campaigners, and some in the debate, have already called for the criteria for "assisted dying" to be extended, suggesting that the current proposals are a steppingstone towards far slacker controls.

²⁸ <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>

²⁹ <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

³⁰ <https://wfrtds.org/dutch-law-on-termination-of-life-on-request-and-assisted-suicide-complete-text/>

³¹ <https://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands>

³² <https://www.dutchnews.nl/news/2020/07/euthanasia-law-proposed-for-healthy-over-75s-who-feel-their-lives-are-complete/>

³³ <https://www.rijksoverheid.nl/documenten/kamerstukken/2020/01/30/kamerbrief-over-aanbieding-onderzoek-doodswens-bij-55-die-niet-ernstig-ziek-zijn>

³⁴ <https://www.nejm.org/doi/full/10.1056/nejmc1414527>

³⁵ https://www.researchgate.net/publication/23441990_Suicide_Assisted_by_Two_Swiss_Right-to-Die_Organisations