

Revd Dr Brendan McCarthy, the Church of England's National Adviser on Medical Ethics, Health and Social Care Policy, sets out the Church of England's response to calls for 'doctor assisted dying'

The representatives of ‘a new religious alliance in support of doctor assisted dying’ have stated that they wish to counter ‘the impression being conveyed that all faith groups are implacably opposed to changes in the law to help people longing to die on their own terms, without discomfort, indignity, or extreme pain.’

The Church of England does not oppose enabling people to die well; that is a goal shared with every palliative care professional, hospice worker and healthcare chaplain. Its opposition is to a change in the current law on assisted suicide.

This distinction is not a matter of semantics; it is a legal imperative.

The writers assert that on this issue, Church leaders are out of touch with their members and cite opinion polls to that effect. The arguments for and against assisted suicide are complex and cannot be addressed in an opinion poll. The Church of England debates serious issues with serious intent, not least through its elected, representative bodies at deanery, diocesan and national level.

The General Synod has voted unequivocally, to oppose a change in the current law on assisted suicide. Correctly, policy is decided by informed debate, not by opinion polls.

The appeal to Biblical ‘proof-texts’, employed by the authors is not indicative of Anglican hermeneutics in which a respectful, reasoned reading of the texts illuminates the narrative and theological arcs and motifs contained in the Scriptures. From these (not proof-texts), emanate core beliefs and principles. These principles reflect Christian theological beliefs, but can be shared by people of other faiths or of none.

In the context of this brief response to the authors’ article, the principle of caring for the vulnerable requires considered examination though it is also the case that any shift in the law or societal norms that undermines our egalitarian commitment to the intrinsic value of every human life or anything that lessens our relational and societal bonds with one another is deeply flawed.

The authors speak of ‘safeguards’ to ensure that vulnerable people are not put at risk and reference the provisions of the ‘Meacher Bill’.

Safeguards on paper, however, are worthless unless they can be consistently, universally and comprehensively translated into practice.

It is a tragic irony that on the day the authors’ article was published, news headlines were dominated by the deaths of three vulnerable adults in Care. In spite of every written policy, protocol, and approved practice, their reality was tragically different.

These were not isolated incidents; we have only to think of the hundreds of avoidable deaths in the Mid-Staffs hospital scandal, abuse of residents with learning disabilities in Eldertree Lodge and ‘systemic biases contributing to unequal mortality outcomes in ethnic minority women and women facing multiple problems and deprivation’.

We can add to this, the recent experience of many elderly care home residents in the early months of the COVID-19 pandemic who were given

DNACPR notices without proper protocols being followed.

Human lapses and failings build upon one another until catastrophic outcomes ensue...a process that, in too many instances, no amount of assumed monitoring or paper safeguards has been able to capture, never mind stop.

What can possibly give us confidence that similar safeguards will provide a better outcome if the law on assisted suicide were to be changed?

The authors point to the experience of the Oregon Death with Dignity Act, but Oregon gives us no grounds for confidence at all. Far from being a model of good practice (as is often claimed), over twenty years of experience in Oregon indicates, inter alia, an alarming failure to maintain rigorous reporting and monitoring information , failure to pursue adequate psychiatric evaluation and failure to evidence physician presence at ingestion.

The authors stress the need for uncoerced consent to be gained before any process begins that might lead to an ‘assisted death’, but it is not possible to ensure that this can be consistently and effectively guaranteed for vulnerable, terminally ill people.

The charity Hourglass (formerly Action on Elder Abuse) affirms that some 500,000 elderly people are neglected or abused in the UK each year, often for financial reasons. It is naive in the extreme to believe that some of these would not fall prey to pressure to end their lives prematurely if the law were to be changed.

The authors state that ‘there is nothing holy about agony’. While many Christians might suggest that the crucifixion of Jesus indicates otherwise, it is essential that people are given high quality physical, mental and spiritual care at the end of life...and most are. Some 600,000 people die each year in the UK and while every instance of suffering is tragic, mercifully very few die in the sort of ‘extreme pain’ that lies at the heart of appeals to change the law on assisted suicide. Better palliation, not assisted suicide, should be our goal.

We must acknowledge that there are many vulnerable people involved in any discussion of end of life care: those who wish to end their lives, their families, healthcare professionals, those who wish to live, but who are prey to covert or overt pressure...all of us who live with the consequences of changes in societal mores.

Sadly, it is not possible to meet the aspirations of all and we have to face that fact openly and honestly.

In such circumstances, we must act to protect and care for as many vulnerable people as fully as possible. The aspirations of a very small number of individuals seeking a change in the law, whose needs and concerns are nonetheless genuine, must not endanger the very large numbers of people who will be put at grave risk by any such change.

In failing to pass previous ‘Assisted Dying’ Bills, both Houses of Parliament have recognised this.

We must not gamble with vulnerable people’s lives in the hope that somehow, against all evidence to the contrary, we will get it right this time.

*This article was first published as a 'rapid response' on the BMJ website to an article in the BMJ by Lord Carey and Rabbi Jonathan Romain.*

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