

GENERAL SYNOD**Assisted Suicide and Palliative Care****Summary**

The Palliative Care system in the United Kingdom is based on a strong foundation of innovation and development largely pioneered by Dame Cicely Saunders. The appropriate use of palliative care medication and the concept of “Total Pain”, where addressing psychological, social, emotional and spiritual issues is understood to be as important as considering the physical factors causing pain, are among her strongest legacies. Over 200 independent hospices have developed over the past 70 years providing high quality in patient and community based palliative care. But they are underfunded with only 37% of their funding coming from Government sources. A significant increase is needed to a level of 70% to prevent hospice closures and maintain standards. Out of perceived deficiencies in palliative care to alleviate suffering at the end-of-life, demands have grown to allow Assisted Suicide currently prohibited by the 1961 Suicide Act. There have been four failed attempts to navigate a change to the law through the Parliamentary system. Any change to the law could threaten the welfare of many groups including those who have lost mental capacity, the mentally ill, those with learning disabilities and those who are physically disabled. Also, the nature of medical practice would be fundamentally altered by any change in the law. Canada provides an example of a country where the introduction of altered legislation has resulted in progressive change and a rapid growth in the use of Assisted Suicide. This motion appeals to us all to recognise the potential dangers inherent in altering the current Suicide legislation and to uphold the importance of the Christian belief in the sanctity of life.

The Motion

That this Synod

- a) Appreciate the enormous and untiring efforts of health professionals, including healthcare chaplains, in constantly developing and maintaining the excellence of palliative and end of life care provision in this country;
- b) Call on Her Majesty’s Government to guarantee and expedite the adequate funding and resourcing of palliative care services within the NHS to ensure that the highest possible standards of care are achieved and made universally accessible;
- c) Affirm that the current legislation in relation to Assisted Suicide referenced in Section 2 of the Suicide Act 1961 (and its application through the DPP guidelines) should remain unchanged.

1. Palliative care and the Hospice movement.

1. The origins of the modern Hospice movement in this country owes much to the legacy of Dame Cecily Saunders through her pioneering work in palliative care during the 1960s and 1970s. In particular 3 aspects of her work stand out:
 - a) The establishment of St Christopher’s Hospice in 1967 in South London as a centre for research, training and excellent practice in palliative care.

- b) Her pioneering work in the use of morphine as a single agent for pain relief rather than the use of fixed dose combinations of medications such as the Brompton Cocktail.
 - c) Developing the concept of “Total Pain” where understanding and addressing psychological, social, emotional and spiritual issues can be as important to a patient’s management as the prescription of pain-relieving medications for the physical pain being experienced. As a result, specialists from a wide range of disciplines can effectively contribute to the well-being of patients, not least Hospice Chaplains seeking to address patients’ Spiritual needs.¹
2. The foundational work of Cecily Saunders has been built upon by many others including Dr Robert Twycross in Oxford who helped to establish the principle of titrating doses of diamorphine as a means of providing better pain relief ² and Dr Patrick Russell who first described the use of a syringe driver to provide subcutaneous pain relief when taking oral medication had proved impossible.³ These same principles have subsequently been applied to the whole range of medications used to manage the varied and difficult symptoms that can occur during the last weeks of life.
 3. As a result, over the last 70 years the hospice movement has grown and flourished into a network of over 200 charitably based institutions as well as specialist palliative care services becoming embedded in both hospital and community care settings.

2. The problem of funding

1. Currently the levels of funding of independent hospices who are commissioned to provide much of the palliative care provision in this country are inadequate. In March 2021 the *Sue Ryder* foundation published a review of the levels of funding that hospices were currently receiving from their local health care commissioners and attempted to project the costs involved in the next 10 years.⁴ It is estimated that the total cost would be on average £947 million per annum. Different funding scenarios were explored:
 - a) If there was no change to the current level of Government funding for palliative care only 37% of Hospice sector costs would remain covered. In absolute terms this amounts to £350 million annually. The level of charitable funding needed to finance the deficit is not sustainable in the long term.
 - b) If the Government were to cover all the charitable sectors clinical costs and a contribution towards support services this would require a 70% funding level at an additional cost of £313 million per year.
 - c) If 100% of the charitable sector’s costs were to be covered an additional £597 million would be required.

While all this has tried to take into account the impact of Covid 19 this might yet be a factor that makes these estimated costs inaccurate.

On reviewing their analysis, the authors felt that the 70% funding level would be that required to sustain the Hospice infrastructure and avoid the very real risk of local hospice closures in the medium term.

To perhaps get this into perspective, the Government in May announced a £1.3 Billion package of military support to Ukraine.

2. *Hospice UK* produces an annual report on the UK state of hospice funding throughout the United Kingdom.⁵ The 2021 report highlights two further hidden factors:

- a) While on average hospice funding nationwide stands at 37% of total costs, for smaller hospices with a turnover of less than £2 million annually this level falls to only 20%.
- b) There is considerable regional variation in support which is at its lowest in the South of England covering only 25% of total costs.

The conclusion of both these reports is that without the necessary Government funding the current Independent Hospice movement risks collapse.

3. Assisted Suicide

1. For clarity the definitions of terms used in discussions about Assisted Suicide need to be considered:
 - a) Assisted Dying is used by many to refer to the prescription of life terminating drugs, usually large doses of barbiturates, for self-administration to mentally competent patients within a strictly defined terminal prognosis usually of 6 months. This is the term applied to the legalised practice in a number of USA states, some Australian States and New Zealand.
 - b) Assisted Suicide is a broader term where those with longer term progressive illness as well as the terminally ill are given assistance to die by the prescription of drugs that are self-administered. This is permitted in Switzerland.
 - c) Voluntary Euthanasia is the term used where a physician directly administers drugs to end a patient's life at their request where there is a clinical indication. This is currently permitted in Belgium, Luxembourg, the Netherlands and Canada.

Within the terms of the current legislation in the United Kingdom Assisted Dying and Assisted Suicide are described as Assisted Suicide and prohibited under Section 2 of the 1961 Suicide Act while Voluntary Euthanasia is regarded as either manslaughter or murder.⁶

2. One of the consequences of an inadequately funded palliative care system is that it can be perceived as failing to deliver when needed and this can lead to increased pressure from those seeking relaxation of the legislation on assisted Suicide. The call to change the 1961 Suicide Act to allow Assisted Suicide has become particularly strong in the 10 years since this issue was last debated at General Synod in 2012. In Parliament four attempts have been made during that time to bring about change:
 - a) In 2013 Lord Falconer sought to introduce an Assisted Dying Bill into the House of Lords. This failed to proceed beyond the committee stage in 2015.
 - b) In 2015 an Assisted Dying Bill (No 2) was introduced by MP Rob Marris based on Lord Falconer's Assisted Dying Bill. This was debated in the House of Commons and defeated by a majority of 330 to 118 votes.
 - c) Baroness Meacher introduced a fresh Assisted Dying Bill which was debated in the House of Lords on 22 October 2021 with contributions from a number of our Bishops. This failed to proceed beyond the Committee stage due to the proroguing of Parliament at the end of April 2022.
 - d) On 16 March 2022 an attempt was made by Lord Forsyth to introduce an amendment to the Health and Care Act 2022 which was under debate but this was defeated by a majority of 179 to 145 votes in the House of Lords. The use of an amendment to try to reintroduce the debate about Assisted Dying in this way drew considerable criticism from commentators.

3. There are a number of reasons why this motion seeks to resist any change to the legislation on Assisted Suicide.
- a) Above all there is the Christian understanding of the sanctity of life. The bible reminds us in many places of God's gift of life to us including:
- Genesis 2:7 God breathed into his nostrils the breath of life, and the man became a living being.
 - Psalm 139:16 All the days ordained for me were written in your book before one of them came to be.
 - Psalm 31:15 My times are in your hands.
- b) There are several groups for whom any change in the law would constitute a particular threat:
- Those no longer having mental capacity. There are currently over 5 million active Lasting Powers of Attorneys (LPAs) and this is growing annually with at least 25% of these LPAs covering Health and Welfare. A change in the law could run the risk of these LPAs being used to prematurely end people's lives.
 - Those suffering from mental illness. Depression and anxiety are well recognised complications of terminal illness. Often with appropriate support and medication a person's feelings of hopelessness can be transformed. With a change in the law a number might well choose Assisted Suicide before receiving that help.
 - Those with learning difficulties who become seriously ill might find themselves vulnerable to any change in legislation being unable to fully comprehend what is being suggested to them if Assisted Suicide was being discussed.
 - Those with disability or progressive degenerative conditions might be drawn into the criteria of any altered legislation and could potentially feel covertly pressurised into accepting Assisted Suicide to unburden those caring for them.
 - Those who are terminally ill may feel pressure from relatives to end their own suffering. This could arise from a range of motives from the relatives genuine difficulty watching a loved one progress through a difficult terminal illness to the more unscrupulous eyeing increasing care costs eroding their inheritance. It may also be that patients themselves might feel motivated to seek Assisted Suicide in the belief that they would be easing their relatives' distress and to reduce the economic impact of their illness on the family. Certainly, in Oregon where Assisted Suicide has been legal for 25 years over half those seeking it cite being a burden to family or caregivers as one of the contributing factors in their decision.
- c) The effect on medical practice:
- Those working in palliative care may feel their role is compromised. While there has always been the recognition that increasing doses of medication used for palliation of symptoms can possibly lead to problems like altered consciousness and respiratory depression hastening death, the intention has always been to alleviate symptoms not deliberately and prematurely end life. A change in the law could dramatically alter this approach.
 - Even with a conscientious objection clause as with current abortion legislation, doctors might find this difficult to negotiate with an unsympathetic hospital trust management or other employer.
 - There may be strong pressure from relatives, complaint or even threat of legal action where the views of relatives clash with those looking after a patient. Certainly, there is precedent for this in countries who have legalised Assisted Suicide.

- There is the risk of Doctors colluding. The requirement for two signatures is no guarantee of a safety net with the possibility of a Doctor's application merely being countersigned by a second Doctor who is a close colleague.
- The genuine difficulty in the healthcare system meeting the demands changed legislation would bring. Each patient would need a detailed Psychiatric assessment for which there currently is no available capacity while over 90% of those seeking Assisted Suicide would be likely to do so through their General Practitioner, a service that is already under extreme pressure.

4. Medical opinion remains divided over the issue of Assisted Suicide.

- a) The Royal College of General Practitioners (RCGP) remains opposed to any change in the legislation.⁷
- b) The Royal College of Physicians (RCP) has moved to a neutral position despite the fact that the majority of members oppose Assisted Dying.⁸
- c) The British Medical Association (BMA) has moved to a similar position despite the majority of GP members, on whom the burden of prescribing lethal medication would fall, being opposed.^{9 10}

However, all three surveys had very low response rates: the RCP 20%, the BMA 19% and the RCGP 13%. It therefore remains uncertain how the majority of doctors feel about the issue. Opposition to any change in the law was strongest amongst those working in Palliative Care.

5. Canada provides an example of the impact of changing Suicide legislation. In 2011 Canada was in a very similar situation to that in the United Kingdom at present. But following legal challenge and after 5 years of constitutional debate, in 2016 legislation was passed resulting in the Medical Assistance in Dying Bill (MAID) passing into law allowing both Assisted Suicide and Euthanasia. Initially the legislation was intended to be restricted to those over 18, being mentally competent, suffering from a serious physical health condition and in an advanced state of decline whose natural death was reasonably foreseeable. Through a variety of subsequent legal challenges this has now removed the need for someone to be terminally ill and a natural life expectancy of up to 10 years has been accepted. From 17 March 2023 people with mental illness as their sole underlying medical illness will have access to MAID and there has been increasing pressure to apply the legislation to those under 18 by parents of sick and terminally ill children.¹¹ There would be every prospect that any change in the Suicide Act in this country could lead to similar consequences.

4. Conclusion

1. There needs to be an honest admission that some perceive palliative care to be failing at times to deliver its best.
2. The logical response to this is to seek ever improving excellence in our palliative care services through training and investment.
3. Changing existing Assisted Suicide legislation would place many vulnerable groups at risk, fundamentally change the nature of medical practice and challenge the central Christian belief in the sanctity of life.

Jesus said "I have come that you may have life and life in all its fullness". I believe Jesus meant this to apply to the whole of our lives, even the difficult and testing days that can come as our life draws to a close.

References

1. Richmond C. Dame Cicely Saunders. *British Medical Journal* 2005 331: 238.
2. Twycross RG. Choice of strong analgesic in terminal cancer: diamorphine or morphine? *Pain* 1977 3: 93-104.
3. Graham F and Clark D. The syringe driver and the subcutaneous route in palliative care: the inventor, the history and the implications, *J Pain and Symptom Management* 2005 29:32-40.
4. England's Palliative Care Funding Challenge. Sue Ryder Foundation 2021.
5. Hospice Accounts Report Hospice UK 2021.
6. Best J. Doctor's Organisations, neutrality, and the assisted dying debate. *British Medical Journal* 2021 374:2075.
7. <https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx>
8. <https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral>
9. <https://www.bma.org.uk/news-and-opinion/bma-physician-assisted-dying-survey-results-published>
10. <https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf>
11. <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>