Response ID ANON-D24X-6HZJ-4

Submitted to Assisted Dying - Private Members' Bill
Submitted on 2023-01-26 15:18:28

Introduction

1 What is your name?

Name:
Alejandro Sanchez

2 What is your email address?

Email:
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3 Are you responding on behalf of an organisation?

Yes

4 If you answered "yes" to the previous question please state which organisation

Organisation:
National Secular Society

5 Are you responding as an individual or a group?

Group

6 Are you resident on the Isle of Man?

No

7 May we publish your response?

Yes, you can publish my response in full

Support for Proposal

8 In principal, do you agree or disagree that assisted dying should be permitted for terminally ill adults on the Isle of Man?

Agree

Please explain the reasons for your response:

We believe that patient autonomy includes the right of mentally competent adults to make a voluntary and settled decision regarding the time, setting and manner of their death. We recognise there is scope for reasonable disagreement on the eligibility criteria for accessing assisted dying.

87% of Islanders support a change in the law on assisted dying.

The vast majority of terminally ill patients do not avail themselves of assisted dying, even in jurisdictions where it has been decriminalised. As such, assisted dying should be correctly understood as complementary to, rather than in competition with, high quality palliative care. It is entirely consistent to believe that assisted dying should be legal while well-funded, gold-standard palliative care should be available to all.
But is it undeniable that even the best palliative care cannot alleviate all suffering in all cases. This suffering can come in many forms, including but not limited to: physical pain, nausea, immobility, incontinence and indignity.

It is well known that, even where access to high quality palliative care is available, serious illness is associated with a higher risk of suicide. A 2022 Office for National Statistics analysis found, for example, that the suicide rate in English patients with low survival cancers was 2.4 times higher than the general population. There is no reason to believe this data would not be replicable in Jersey.

Marjorie Wallace CBE, chief executive of mental health charity SANE, has said traditional suicide prevention measures "are not an appropriate response" for those who are nearing the end of life and wish to ease the dying process, because their motivation is "to shorten death, not shorten life".

The potential criminalisation of assisted dying increases the risk of botched suicides amongst this group. Without the assistance of a medical professional, these individuals lack the means and expertise to end their lives in a peaceful and dignified manner. Furthermore, the lack of an explicit legal framework exposes those who might seek to assist such patients, even when motivated entirely by compassion, to prosecution.

Those with substantial financial means may elect to travel to Dignitas in Switzerland to receive medical help in ending their lives. Indeed, since 2002,

almost 500 Britons have resorted to travelling to Dignitas in Switzerland. At an average cost of £10,000, however, this option remains out of reach for many.

Accessing assisted dying abroad is not only problematic because it excludes the less well off in our society: travelling to Dignitas necessarily requires an individual to be at a stage in their illness where they are still physically able to travel. This means some patients will feel forced into availing themselves of assisted dying abroad earlier than they otherwise would were it legal domestically.

Thus, the current law is pressurising patients into ending their lives prematurely in an alien setting, away from their home, family and friends.

By contrast, assisted dying was legalised in Oregon in 1997 for terminally ill, mentally competent patients. Available evidence suggests it has been implemented safely and effectively. Of the 36,498 deaths in Oregon in 2017 only 143 resulted from assisted dying. It has not, as opponents have suggested, lead to "widespread euthanasia".
Indeed, in 35% of cases, individuals prescribed aid-in-dying medication did not ultimately use it. Rather it served as peace of mind that it would be available were their suffering to become intolerable – a form of so called "emotional insurance".
And, as of 2018, Disability Rights Oregon, a state-based disability advocacy group, had not received a single complaint of actual or attempted abuse under the Oregon Death with Dignity Act.

Furthermore, the implementation of a safe and effective assisted dying framework has not come at the expense of high quality palliative care. In 2019, the Center to Advance Palliative Care ranked Oregon's palliative care system 12th in the country with an A grade, scoring of 88.9 out of a possible 100.

9 Do you think that there should be a limit on their life expectancy?

Not Sure

10 Do you support the provision of assisted dying for someone who has a condition which causes unbearable suffering that cannot be alleviated by other means but which may not give a terminal diagnosis?

Not Sure

11 If they are unable to take oral medication should a health care professionally be permitted to administer medication intravenously to achieve death?

Not Sure

Eligibility

12 Do you agree that assisted dying should be available only to people over the age of 18 Years?

Not Sure

13 Should they have to be permanent residents of the Isle of Man?

Not Sure

14 If you agree they should be permanent residents please state for how long.

Other

If you have ticked "Other", please provide some details:
The National Secular Society does not have a position on whether individuals wishing to avail themselves of assisted dying on the Isle of Man must be permanent residents.

Process

15 Do you agree with the proposal that two different doctors should meet with the person independently and establish they are mentally competent to make an informed decision without pressure or coercion?

Yes

16 Should any health professional be able to conscientiously object to being part of an assisted dying programme?

Yes

17 Do you agree that if either doctor is unsure about the person's capacity to request an assisted death, the person should be referred to a psychiatrist for a further capacity assessment?

Yes

18 Do you agree that the two doctors should ensure that the person has been fully informed of palliative, hospice and other treatment and care options?

Yes

19 Do you support the proposal that the person signs a written declaration of their request, which is witnessed and signed by both doctors?

Yes

20 Do you agree that there should be a waiting period of 14 days from this time to the provision of life ending medication to allow the person to reconsider their decision?

Not Sure

21 Do you feel that this period should be shortened to 7 days if the person is expected to die within 30 days?

Not Sure

22 Should the person themselves or a relative be able to collect the relevant medication from a designated pharmacist?

Not Sure

23 Should this be able to be stored securely in the person's home until they decide whether they want to take it or not?

Not Sure

24 If they change their mind should the medication be returned to the pharmacy immediately?

Not Sure

25 Should a health care professional be required to be with the patient once they have taken the medication until they are certified to have died?

Not Sure

26 Should an annual report be produced regarding the number of people who have taken advantage of assisted dying, and be published?

Yes

27 Should it be possible to include the provision of assisted dying in a "living will" or advanced directive?

Not Sure

28 Do you have any comments on the process to provide Assisted Dying which will be included in the draft Bill

Any other comments...:

The NSS believes everyone should have their say when it comes to assisted dying reform. However, religious dogma should not be considered a rational, compassionate, or legitimate basis for policy making. It is not for the state to impose religious dogma on citizens. Furthermore, religious groups should not resort to fearmongering and misinformation in their efforts to oppose assisted dying.

The Isle of Man Broadway Baptist Church states in its opposition to assisted dying reform: "A concern for personal autonomy regarding end of life choices needs to be weighed against care for people who live with disabilities, physical and mental impairments, or people with obvious or hidden vulnerabilities."

This, deliberately or otherwise, fails to acknowledge that support for assisted dying reform amongst the disabled community exceeds that amongst the general population. Furthermore, individuals with "mental impairments" which deprive them of the capacity to make decisions about assisted dying would not be able to avail themselves of it under the proposed changes.

They continue: "a change in the law would in some cases lead to a greater concern for relieving the family's suffering (or bank balance) than for the best interests of their elderly relative."

The law as it stands contains no prospective safeguards for those considering assisted dying. By contrast, the proposed changes would ensure two independent doctors were satisfied that the patient's decision was capacitous and volitional. Thus, a change in the law would serve to increase rather than diminish the safety of patients.
The Church states that there is a "well documented trend" in Oregon of people ending their lives to "relieve burden on others" but have failed to produce any evidence to support this claim.

They also invoke theological 'sanctity of life' arguments: "We believe that all human life is a sacred gift from God". The religious views of some, however sincerely held, should not restrict the freedoms and choices of others.

The Church says it supports “the ethos of the Hospice and palliative care movement”, as if palliative care and assisted dying are mutually exclusive. As discussed in question 8, this is inaccurate.

The Christian Institute has also sought to mispresent the efforts of proponents of reform, labelling them “pro-euthanasia activists”. Euthanasia and assisted dying are discrete medical and ethical concepts. To wilfully conflate them is disingenuous. Similar language has been employed by Grace Baptist Church.

Not Dead Yet UK is nominally a group for UK disability activists who oppose assisted dying. Per research by Dignity in Dying, however, they are actually a front for the charity Christian Concern. This was revealed in a lecture by an outgoing member of the Christian Medical Fellowship, Peter Saunders:

“This was a demo that was fronted, you can see virtually entirely by disability rights campaigners. But actually, everything was put together by one of the groups involved in Care Not Killing, that was Christian Concern, who provided the financial support, made the placards, came along, got the disabled people along to the event and were completely invisible in doing it, because they realised it was better for disabled people to be fronting it.”

It is, at best, disingenuous and, at worst, exploitative to use disabled people to covertly promote a religiously motivated message.

Regarding Isle of Man’s proposed reforms, Not Dead Yet UK said: “There is no safe system of assisted suicide and disabled people want help to live, not to die”. We have countered these claims in question 8.

The law concerning assisted dying should seek to uphold the right to exercise a genuinely autonomous choice. The religious views of some, however sincerely held, should not restrict the freedoms and choices of others.

We recognise that there is scope for reasonable disagreement on this issue and welcome intellectually honest debate around it. We urge the Tynwald to be mindful of theological opponents of assisted dying obfuscating their language, motivations and funding.