



HOUSE OF COMMONS

LONDON SW1A 0AA

5th October 2021

Dear Colleague,

We are writing to you as the former Chair of Hospice UK and the Chair of the APPG for Dying Well, to alert you to the serious dangers of Baroness Meacher's Assisted Dying Bill, which will have its Second Reading in the House of Lords on Friday 22 October.

The Bill proposes to license doctors to supply lethal drugs to terminally ill patients who are thought to have six months or less to live, and who seem to them to meet certain broadly worded conditions.

In our view this measure is dangerous, for the following reasons:

1. Evidence from countries where assisted dying is legal reveals that most patients who receive lethal drugs are concerned about being a burden on their family, friends or caregivers.¹ The option of an assisted death creates the real threat of pressure on disabled, elderly or frail people to relieve their family of what can be an expensive, time-consuming and distressing responsibility, by minimising the need to spend on palliative care. There is depressingly no shortage of evidence of elder abuse, neglect and exploitation, as well as discrimination and prejudice against disabled people, in our country. It is significant that no disability rights organisation supports a change in the law, and an overwhelming majority of doctors who care, day in and day out, for terminally ill and elderly people oppose any change and would refuse to participate in the practice.²

2. Disabled, elderly or frail people are also sometimes considered a burden on health services. In some jurisdictions, such as Canada, it has been openly declared that by averting the need for expensive end-of-life care assisted death will reduce costs for the state.³ This fact has been cited as a potential benefit of assisted death in the United Kingdom.⁴ We should be very wary of the effect of such an incentive to cost-cutting in the NHS.

3. The safeguards against abuse that have been included in the Meacher Bill are impossible of effect. They are little more than aspirations for how things would work in a perfect world. In reality it is notoriously difficult for a doctor to give an accurate prognosis of death; there are many instances of people given six months to live surviving for years longer. It is not reasonable to expect a doctor, on the basis of what could well be a single short meeting, to judge the capacity of an individual to make a decision independent of family pressure or mental ill-health or incapacity. (It is unlikely that a request for lethal drugs would be considered by a patient's regular doctor.

¹ Oregon Health Authority. Oregon Death with Dignity Act 2020 Data Summary. February 26, 2021.
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

² British Medical Association. Physician-assisted dying survey. Updated September 14, 2021.
<https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey>

³ Trachtenberg, Manns. Cost analysis of medical assistance in dying in Canada. *CMAJ*. January 23, 2017.
<https://www.cmaj.ca/content/189/3/E101.abstract>

⁴ Shaw, Morton. Counting the cost of denying assisted dying. *Clinical Ethics*. March 10, 2020.
<https://doi.org/10.1177%2F1477750920907996>



In jurisdictions with assisted suicide, 'doctor shopping' generally occurs, whereby people seek out or are referred to a willing doctor to whom they have been introduced specifically for the purpose and who know nothing of them beyond their case notes.⁵⁾

4. Once the principle has been declared that people have a 'right' to assisted death, every 'safeguard' is in fact a limitation of that right, and the basis of discrimination. Why should only people with six months to live be eligible to receive lethal drugs, but not those with chronic conditions or disabilities which they (or others) feel make their life not worth living? Why should only people who are physically able to administer lethal drugs to themselves qualify, while others who need someone else to do it for them are excluded? The expansion of the 'right' to people with years of life ahead of them, and the short step to euthanasia, are implicit in the Meacher Bill, and indeed declared as the intended destination by many of the campaigners for it.⁶ This is certainly the experience of countries which have legalised assisted death, in every one of which the original scope of the law has been expanded to make assisted death less tightly regulated and more widely available.⁷

We feel that these arguments - the danger of family pressure, the incentives to cost reduction in the NHS and the atrophy of palliative care, the weakness of the safeguards in the Bill, and the inevitability of expanding its scope once such a bill reaches the Statute Book - are compelling reasons to oppose the Meacher Bill.

We understand and share the very real concern that people have about themselves or their loved ones dying over a prolonged period in pain and distress. This concern should prompt us to invest more in proper end-of-life care. The UK is the home of the modern hospice movement and has been acknowledged in international surveys as having the best quality of care of the dying. Analgesic science - the medical management of pain - has advanced dramatically in this century, to the point where almost no one need die in severe physical pain. However, the provision of high-quality palliative or end-of-life care in the UK is scandalously patchy and greater investment is needed in this branch of medicine whose services almost all of us will need in due course.⁸

Rather than changing the law to allow the prescription of lethal drugs, we should be putting all our energies into improving access to the best possible care. This is not compatible with the option proposed in the Meacher Bill.

In every country where assisted death is legalised, investment in palliative care either declines or does not keep up with its growth in other countries.⁹

⁵ National Council on Disability. The Danger of Assisted Suicide Laws. October 9, 2019. https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf

⁶ My Death, My Decision. "What We Want". <https://www.mydeath-mydecision.org.uk/what-we-want/>

⁷ Mroz, Dierickx, Deliens, Cohen, Chambaere. Assisted dying around the world: a status quaestionis. *Annals of Palliative Medicine*. March, 2021. <https://apm.amegroups.com/article/view/50986/html>

⁸ Davies, Sleeman, Leniz, Wilson, Higginson, Verne, Maddocks, Murtagh. Socioeconomic position and use of healthcare in the last year of life: A systematic review and meta-analysis. *PLoS Med*. Apr 23, 2019. doi:10.1371/journal.pmed.1002782.

⁹ Arias-Casais, López-Fidalgo, Garraida, Pons, Rhee, Lukas, de Lima, Centeno. Trends analysis of specialized palliative care services in 51 countries of the WHO European region in the last 14 years. *Palliative Medicine*. <https://doi.org/10.1177/0269216320931341>



We very much hope you will agree with us that the future need not be widespread euthanasia of the elderly and disabled. The future should be high quality, compassionate, dignified care for all.

Please consider attending the Second Reading debate on 22 October. We would be grateful if you could let us know if you intend to do so.

With best wishes,

A handwritten signature in black ink, reading "Richard Harris".

A handwritten signature in black ink, reading "Danny Kruger".

Rt Hon Lord Howard of Lympne, Chair of Hospice UK, 2010-18
Danny Kruger MP, Chair of the All-Party Parliamentary Group for Dying Well

P.S. Please see the APPG website www.dyingwell.co.uk for more information about the reality of assisted death in other countries, and the implications for it in the UK.