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March 3, 2025

United Kingdom Parliament
House of Commons
Westminster
London
SW1A 0AA
United Kingdom

Re: The Terminally Ill Adults (End of Life) Bill 2024-25

Honorable Members of the House of Commons:

1. **Summary**

a. On behalf of The National Catholic Bioethics Center (NCBC USA), the Catholic Medical Association (CMA USA), the National Association of Catholic Nurses, USA, (NACN-USA) and the National Catholic Partnership on Disability (NCPD USA), we provide you with documentation of the hazards to health care, society, and human life when effective Palliative and Hospice Care is abandoned for the euphemism of "Death with Dignity" or "Medical Aid in Dying" (Physician Assisted Suicide-PAS).

b. In the United States there are ten legal jurisdictions that provide legal immunity for health care providers who assist patients to actively kill themselves. Our four organizations have members practicing or being served in such jurisdictions. NCPD USA serves thousands of persons with disabilities, and those who minister to them, fostering inclusion in Church and society. NACN-USA represents nurses involved in direct care, and the education and administration concerning such care, to thousands of persons including those with disabilities or terminal illness. CMA USA is the largest association of Catholic individuals engaged in healthcare in the United States. These professionals have witnessed not only the erosion of options presented to patients and families for quality palliative care, but also the erosion of conscience rights of objecting healthcare providers, with the legalization of PAS. The National Catholic Bioethics Center (NCBC USA) was established in 1972 to address the ethical issues arising in health care and the life sciences, as technological advances were outpacing the ethical analysis needed to assure the protection of vulnerable populations. Its educational programming, leading to two graduate degrees, publications, and most importantly its consultation services attest to the fact that a utilitarian approach to persons with terminal illness or disabilities can lead to a denial of certain health care

services, which this proposal will continue to foster. On behalf of NCBC USA, NCPD USA, NACN-USA, and CMA USA we are writing in opposition to the *Terminally Ill Adults (End of Life) Bill* 2024-25, whose passage precedent has shown leads to discrimination, coercion and, thus, non-consensual death to persons whom society is abandoning through such proposals.

2. Examples of International Data

a. A number of countries have legalized PAS, and some have extended this to euthanasia, including for non-terminal conditions, such as mental illness, as well as for children. One of the most significant and negative trends has been identified by Anne M Doherty (University College, Dublin, Ireland), Caitlyn J Axe (University of Washington, Washington, USA), and David A Jones (St Mary's University Twickenham, UK).[i] They concluded: "The findings of this review do not support the hypothesis that introducing EAS [euthanasia and assisted suicide] reduces rates of non-assisted suicide. The disproportionate impact on older women indicates unmet suicide prevention needs in this population."[ii] Oregon, the USA state with the longest history of allowing PAS, demonstrates that general suicides rise dramatically once assisted suicide is promoted as a "good."[iii]

b. One of the most concerning sociological trends has been documented on the impact on quality care, as discussed by Dr. Doherty, cited above, and Miriam Colleran (St Brigid's Hospice, Crotanstown, Kildare, Ireland). In Ireland's consideration of legalizing PAS, Colleran and Doherty cite the alternative need for person-centered and compassionate care, with equitable access to primary and specialist palliative care and mental health care, and support for caregivers allowing patients to die naturally with optimized symptom control. Furthermore they identify the risks to vulnerable populations: "Given the complexity of assessing coercion, the risks to persons in vulnerable groups (including older persons, persons with mental health conditions and persons with disabilities), the progressive expansion of eligibility for EAS [Euthanasia and Assisted Suicide], the lack of safety and the undermining of suicide prevention strategies, the current law is most protective of persons in vulnerable groups in the interest of social justice."[iv]

3. USA Experience

a. Oregon (USA) Health Authority has gathered data annually since 1998.[v] The primary reason terminal patients have given for requesting aid in dying is not pain but loss of autonomy (90.4%). Most significantly 44.2% fear being a burden to family/care givers. Of note is that Oregon data indicate that 53.9% of victims of PAS are either widowed, divorced, or never married. Tragically, this coupled with the fear of loss of autonomy represents a fear of abandonment, when one is less able to engage in self-care. These are the same threats to human flourishing faced by those with disabilities, whom we serve.

b. Even though *The Terminally Ill Adults (End of Life)* proposal, on its face, addresses those with terminal illness, in the USA, and likely in the United Kingdom, there is a porous line separating terminal illness from disabling conditions.[vi] While USA state laws protect all other persons from engaging in suicide, those with a terminal diagnosis, who by its very nature are facing a disabling condition,[vii] are deemed less worthy of such protection. The illnesses certified as "terminal" have expanded, including ailments commonly associated with aging. The state (USA) of Oregon, with

the longest experience with PAS, cites diagnoses of arthritis, anorexia (a psychological condition), diabetes, "benign" tumors, and "others." [viii]

c. If such threats exist for those with terminal illness, as well as those with disabilities, society must do all it can to alleviate such threats, not eliminate the person who is the victim of those threats. The same societal obligations exist both for those with terminal diseases and those with disabilities.[ix] Otherwise all persons are subject to a culture that sees the answer to human suffering as to eliminate the sufferer – another bias perpetrated on those with disabilities.

4. Implications: The implications for all persons whom we serve, especially those with disabilities or who are terminally ill, and those who have a Hippocratic obligation to care for them, are real:

a. Healthcare professionals may run the risk of becoming less focused on providing care and comfort to those deemed less "worthy" of societal protections.

b. Oregon data indicate that 61.3% of victims of PAS have government insurance (Medicaid or Medicare) available for those impoverished or elderly. Furthermore, evidence exists of government and insurance companies denying expensive treatments, even if palliative;[x] There is growing evidence with reimbursement policies that providing the drug for enabling physician assisted suicide will be funded when treatment protocols are not.[xi]

c. In Oregon (as well as in the state of Washington), the prescribing physician frequently is not present when the drugs are ingested (Oregon 27.3%), and rarely at the time of death (Oregon, 13.9%).[xii] Thus, the prescriber cannot know whether the patient was seriously ill, competent, or acting voluntarily at those critical times. But he or she can sign the death certificate, which lists death by the underlying pathology. Thus, PAS laws generally encourage or require doctors to falsify on death certificates the cause of death.

d. Pressures will grow to make health care providers get involved in assisting suicide directly or by referral as happened in Vermont.[xiii]

e. Assisted suicide is a recipe for abuse of the elderly and disabled because it can put lethal drugs in the hands of abusers. The states of Oregon and Washington have authorized distribution of about 2,000 lethal drug overdoses that remain unaccounted for.[xiv]

f. Timeframes for predicting death for aid in dying are notoriously fallible, creating arbitrary standards for applicability for *The Terminally Ill Adults (End of Life)* provisions.

5. Conclusions

a. Persons with terminal illnesses or disabilities whom we serve report that they often are discriminated against by judgments that deem them not to have a "quality of life." This is particularly true as persons age and experience increasing disability of body and cognition. This labeling has an extremely dangerous impact on the care and wellbeing of the human person, an impact frequently reported to our organizations by those we serve. The discussion of quality of life should never suggest that the life of the patient has less value than that of others. Life itself is an

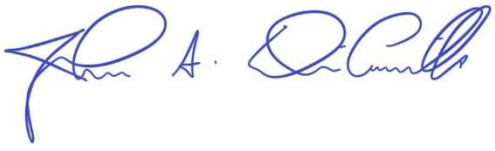
intrinsic good and always possesses value. The problem arises when the value of the person is called into question by those who would say that life becomes diminished in value when it is not of sufficient quality, often meaning that the patient has lost some or all of the higher cognitive abilities.

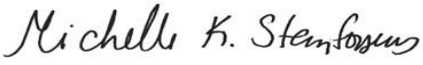
b. Any law that allows the government, through legislation, to decide that some individuals' lives are not eligible for its protections is discriminatory. When government secures such rights for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying: this class deserves less care and protection; its members deserve fewer safeguards of their human rights. In other words, they deserve less respect because in some way they are less human. Such discriminatory processes, as fostered by *The Terminally Ill Adults (End of Life)* proposal, must be opposed.

c. Again, when the government decides that some lives contemplating suicide should be saved, yet others can be helped to kill themselves, there exists a discriminatory double standard.

d. On behalf of the thousands of persons served by the National Catholic Partnership on Disability, The National Catholic Bioethics Center, the Catholic Medical Association, and the National Association of Catholic Nurses, USA, we urge you to oppose *The Terminally Ill Adults (End of Life)* Bill 2024-25.

Sincerely yours,





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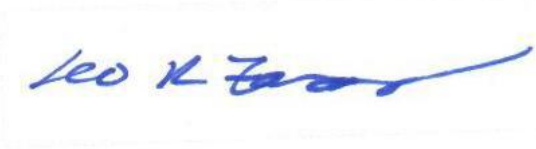

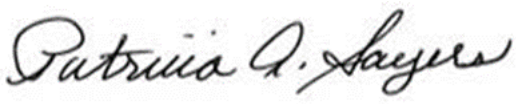

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ANNEX: REFERENCES

[i] Anne M Doherty, Caitlyn J Axe, and David A Jones, "Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: systematic review," *BJPsych Open* (2022 Jun 3;8(4):e108. doi: 10.1192/bjo.2022.71).

[ii] *Ibid.,* "Abstract: Conclusion."

[iii] Nancy Valko, "Why are suicide rates climbing after years of decline?" *Linacre Quarterly*. 2017 May; 84(2): 108–110.

[iv] Miriam Colleran and Anne M Doherty, "Examining assisted suicide and euthanasia through the lens of healthcare quality," *Ir J Med Sci* (2024 Feb;193(1)) 353-362. doi: 10.1007/s11845-023-03418-2. Epub 2023 Jun 10.

[v] Pain is not one of the top reasons for such a request. See, Oregon Health Authority, Public Health Division, Center for Health Statistics, *Oregon Death with Dignity Act 2023 Data Summary* (March 20, 2024). NB: However, everyone agrees that dying in pain is unacceptable, but nearly all pain is now treatable.

[vi] See, 42 U.S.C. §§12102(1)(A) (*Americans with Disabilities Act*). As physical impairments that substantially limit life activities, terminal conditions are disabilities.

[vii] The *Americans with Disabilities Act* may apply if you have a physical or mental problem that greatly limits one or more of your usual activities. See, American Cancer Society, "Americans with Disabilities Act: Information for People Facing Cancer" (last revised, September 2023). https://www.cancer.org/cancer/financial-insurance-matters/health-insurance-laws/americans-with-disabilities-act.html.

[viii] U.S. Conference of Catholic Bishops, Secretariat of Pro-life Activities, "Assisted Suicide Laws in Oregon and Washington: What Safeguards? Executive Summary," *USCCB* (Updated January 2024). See, https://www.usccb.org/resources/assisted-suicide-laws-oregon-and-washington-what-safeguards.

[ix] *See Glucksberg*, 521 U.S. at 730-31 ("Research indicates… that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.") (Citations omitted).

[x] Bradford Richardson, Insurance companies denied treatment to patients, offered to pay for assisted suicide, doctor claims, *The Washington Times* (Wednesday, May 31, 2017). https://www.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/.

[xi] *Ibid.*

[xii] Oregon Health Authority, Public Health Division, Center for Health Statistics, *Oregon Death with Dignity Act 2023 Data Summary* (March 20, 2024).

[xiii] *Vt. All. for Ethical Healthcare, Inc. v. Hoser*.

[xiv] *Op cit.,* U.S. Conference of Catholic Bishops, Secretariat of Pro-life Activities.