Submission to the House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill (HL Bill 17 Session 2003 04)

By Jonathan C Garvey, MA, MB, BChir
General Medical Practitioner, Chelmsford Essex

I have been qualified since 1976, and practising in town-centre and a suburban practice of 12-14,000 since 1980. Though my full-time work is mixed general practice, I maintain a close interest in medical ethics. In my career, I have only come across two incidents of "assisted dying", as opposed to the ethically non-controversial issue of judicious withdrawal of medical management. Both these incidents raised issues relevant to the proposed bill.

- The first was during my probationary year, when another houseman stated his intention to give an overdose of morphine to a newly-admitted terminally ill patient, despite the protestations of those who overheard him. The next morning, the patient was dead and it is likely that the doctor had carried out his intention. In this case the patient was critically ill from cancer, and from my present experience would probably have died within a day or two anyway. But he was not in distress, and was too ill to be in a fit state to voice his wishes – he certainly had not made a "living will" as such things did not exist then. The doctor involved knew nothing of the clinical or social situation, and had been qualified less than 6 months.

  If indeed the doctor did kill the patient this was illegal then, and would be under the proposed new law. But the case shows the impossibility of properly regulating such a difficult matter. It is hard to see any checks and balances that would not rapidly be bypassed by doctors with inadequate maturity, pecuniary motives or simply a more active view of euthanasia than the law envisaged.

- The second incident was also in my early career, when a baby with Downs Syndrome was rejected by its parents at birth, and a decision was taken by the consultant paediatrician to withdraw the usual care of food and fluid, presumably with some idea of the baby's life not being worth living if the parents were not around. There were no medical problems of note. The child starved to death after a month or more, during which "necessary" drugs were given to alleviate the distressing symptoms caused by withdrawing "unnecessary" food and water. Had he lived, he would have been roughly the same age as other Down's sufferers currently enjoying national success in the acting profession, for example.

  My main point here is that the doctor most closely involved was the senior house officer, whose own conscience was deeply troubled by this management, but whose sense of duty and career considerations forced him to go along with what he saw (and I see) as the murder of a human being mentally incompetent (because of age) to insist on his right to life.

In the years since I have not come across any case which in the least tempted me to compromise my core belief that a doctor's calling (not to mention that of every human) is to preserve life, not to end it. I am certain that I am in a large majority

within the medical profession which holds that view (a straw poll on a national medical website puts the ratio at more than 2:1 against the proposed law).

This is my personal position, but my main submission is that the passage of this, or other, euthanasia laws will have more deleterious effects than most of their more balanced proponents envisage. (I use the word "euthanasia" for "assisted dying" advisedly, as I believe that any ethical distinction between "doctor-assisted suicide" and "deliberate killing" is philosophically untenable: the intention of the action is the touchstone).

The reason is that experience has shown that all the moral and legal changes made within our society in recent decades on the basis of "autonomy" or "individual choice" have not led to an increase in options, but merely a change in the prevalent view. Put simply, it is impossible for a society to support both those who believe euthanasia to be right, and those who believe it to be wrong. Society can only decide to abandon one underpinning moral stance for another.

The abortion issue is sufficiently parallel to illustrate this. The 1967 Act got through Parliament by promising to avoid dangerous illegal abortions (whose number was grotesquely exaggerated to make the case). The medical profession opposed it, and few intended it to allow abortion on demand. Legally it still does not, but no discussion at any level nowadays can deny that "demand" is the sole ground for termination. Evidence for this:

- No successful prosecution has ever been brought for misusing the Act.
- The commonest medical grounds given by doctors completing the necessary form is "depression", which is not only at odds with the epidemiological evidence but is a diagnosis gynaecologists and abortionists are simply unqualified to make.
- Gynaecologists and to some extent GPs who refuse to authorise terminations have their career prospects seriously damaged.
- Termination is the only surgical procedure in which doctors who oppose it, in any particular case, are required by law to get a second opinion from someone who will not oppose it.
- The number of legal terminations vastly outweighs those ever done illicitly in the past.
- I am now compelled by local policy to refer all TOP requests to an agency with an overtly "abortion on demand" philosophy.

Less obvious upshots of the law are the well-publicised (and from my experience depressingly common) situations of post-abortion trauma, which the prevalent "freedom of choice" climate simply renders invisible. "I cannot complain, because I chose it – though it feels like I was pressured, lied to, abused and eventually cursed for what I allowed myself to do."

For myself, I feel marginalised into some freaky "pro-life" compartment simply for subscribing to the Judaeo-Christian and Hippocratic traditions that have underpinned our society and my profession for their entire history.

This would be far more radically true were assisted dying to be permitted in law. For all that, no doubt, I would be able to decline to perform euthanasia on conscience

grounds, society's disapproval of this would be shown by insisting that I refer to a less "biased" practitioner – bias being defined arbitrarily as adherence to a "sanctity of life" position rather than a "sanctity of choice" one.
It is not hard to envisage how much junior staff's careers would suffer by evoking the conscience clause, because the 1967 Abortion Act proves it.

Were "assisted dying" to be restricted to specialist centres, then once more the doctor's conscience clause would, in effect, be useless once the regulations insisted on the patient's "right" to be referred there. I find it hard to predict how I will feel after knowing a patient their whole life, fighting to help them in their last illness, and having then to sign their death warrant against my will, against my conscience and against what I believe to be the duty of a civilised society. However, I find it even more worrying (and so should you!) to consider what kind of doctor would gravitate towards, and be produced by, "assisted dying centres". Their salary would, of course, depend on their doing their lethal job well – so what chance would there be of avoiding a pecuniary bias in their decisions?

If practitioners misused the act, would there be any greater chance of prosecution than under the Abortion Act, where it is nil? Who would the witnesses be that granny's death was less than voluntary?

And finally, if relatives or others involved were deeply troubled in conscience – as many would be since there is no more deeply ingrained ethic in human existence than the sanctity of human life – then what counselling would calm their conscience? Society's message would be that such scruples are plain wrong.

In 1982 I wrote an article in a medical magazine in which I posited a gradual drift towards euthanasia, and the marginalisation of those who opposed it, as a result of the 1967 Abortion Act. The correspondence I got said that the article was amusing, but that the prediction was incredible. I ask the Select Committee to ponder why, when palliative care has advanced by leaps and bounds, my "incredible" prediction has become the subject of the Committee Stage of a parliamentary bill. You will not recognise, or like, the society that gradually develops from this Act if it is passed into law.

Jon Garvey
19th August 2004