Response of the Coptic Orthodox Church in the United Kingdom to the proposed 'Terminally Ill Adults (End of Life) Bill'

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The legalisation of assisted dying has been debated on a number of occasions in the United Kingdom. However, active consideration is now taking place to introduce a law which legalises the killing of another human. The Terminally Ill Adults (End of Life) Bill ("the Bill"), which Parliament is considering in November 2024, must be taken seriously and critiqued rigorously.

The first and most concerning aspect of campaigns for the Bill is the use of sanitised language to avoid reference to what is essentially assisted killing or, more precisely, assisted suicide or voluntary euthanasia. Despite the avoidance of such language however, it is clear that this is the issue at hand since the proposed Bill expressly legislates a carve-out from criminalisation under the Suicide Act 1961 to end the lives of terminally ill patients (section 24).

More importantly, continued debate on this matter highlights the terrible anguish and suffering people are experiencing around an issue which cuts deeply into the value and sanctity of human life, suffering and autonomy. Most significantly, the discussions pose a fundamental question that the Coptic Orthodox Church ("The Church") implores all to contemplate, and that is, 'Is there such a thing as a life not worth living?'

Our perspective is based not only on our Christian values, but also on our experience as a community constituted largely of practicing medical professionals in the United Kingdom, that is also connected to our international network of churches, including in the United States of America and Canada, where we can see the dangerous consequences of such policies.

Sanctity of Life

The Bill flies in the face of long-established jurisprudence concerning the sanctity of human life, dating back from the common law to Article 2 of the European Convention on Human Rights. The "Right to Life" is considered an absolute right without qualification. This principle and understanding is born out of moral, ethical and religious belief that every individual's life is precious and that the state is duty-bound to protect such life.

This cornerstone of governing laws is held dearly and deeply in the Orthodox Christian Faith, through which human life is viewed as a reflection of God's mysterious being, as "*God said. 'Let us make mankind in our image…'"* (*Genesis 1:26)*. Therefore, to

terminate or take one's own life is particularly significant because it is a profound violation of God's own image.

Therefore, The Church does not assess the value or worth of human life as contingent upon abilities, achievements or physical health but on the inherent dignity bestowed upon all as the depiction of God. Every individual is seen as an irreplaceable self-portrait of the Creator, whose value cannot be diminished by illness or suffering. The Church believes in the further elevation of humanity through the Incarnation of our Lord Jesus Christ, God the Logos, and as such, holds every human life as sacred and worthy of protection.

The Bill undermines this inherent dignity and value of life upon which governing laws lie. The dignified death that the Bill wishes to advance is unlikely to match the reality of what will occur. The value of life will further diminish, as it is inevitable that over time, the Bill and its remit to capture more individuals seeking to end their lives will increase. In time, there will be an extension to the six-month time limit, as has occurred in the Isle of Man, by those who will argue that there are also those suffering from terminal illnesses for whom the prognosis is longer than six months and therefore should be afforded the same rights set out in the Bill.

Under this proposed Bill, Assisted Suicide could potentially be considered legally discriminatory if other patient cohorts which are not terminal are excluded from accessing such assistance. For example, in the State of Oregon in the USA[1], the term 'terminal' has been expanded to include cases of anorexia and diabetes to permit access to assisted suicide. Canada has also passed a law[2] to have a sole diagnosis of mental health as grounds to offer assisted suicide, having formerly had the same strict criteria this Bill is proposing.

It is for these reasons that The Church opposes euthanasia and assisted suicide, but certainly not without recognising the immense pain and suffering people are experiencing, leading some individuals to contemplate taking such drastic and irreversible measures. It is a suffering that the Church wishes to address with deep empathy and compassion and where possible, action.

Fear of Suffering and Vulnerability

A primary argument for the legalisation of assisted suicide is rooted in compassion and the desire to alleviate suffering by ending life. While this perspective appeals to the human impulse to ease pain, modern medical advancements now provide effective means to manage physical suffering safely.

The focus of these discussions has shifted toward autonomy and the asserted right of individuals to determine the time and circumstances of their death. With increased

[1] Death with Dignity Act, 1997 as amended

[2] Medical assistance in dying (MAID), 2016 as amended

economic hardship and welfare pressures, individuals may well make decisions because they do not wish to burden their families or society. Such decisions will not only have motives that will be difficult for doctors to detect, but will also diminish the value of life. The data from the State of Oregon and from Canada highlights that there is a disproportionate number of individuals seeking to access assisted suicide who come from difficult financial and social backgrounds. This will therefore introduce a danger that those who seek assisted suicide may do so as a result of poverty or lack of support from society.

These fears and concerns highlight the need for a deeper exploration of the human experience, the meaning of suffering, and the value of interdependence within a spiritual and societal context. Dame Cicely Saunders (1918-2005), an English nurse, social worker, physician and writer who is noted for her work in terminal care research and her role in the birth of the hospice movement, emphasising the importance of palliative care in modern medicine, and opposing the legalisation of voluntary euthanasia, described this as having a profound fear of 'total pain', which encompasses physical, emotional, relational and spiritual aspects and addresses concerns over indignity and loss of independence.

Autonomy and Dependence

Suffering reveals the limitations of human autonomy and addresses a reality that demands us to release control. Through a proper understanding of the experience of suffering, we appreciate vulnerability and dependence on others, but most importantly, for those who believe, on God. In a culture that prizes independence, accepting one's reliance on others can be countercultural, yet it is profoundly human.

We are born as entirely dependent beings. As we grow, we see others depend on us, and as we progress in age, we find that we must rely on others once more. We have been designed to carry each other through the cycle of life, "*Carry each other's burdens, and in this way, you will fulfil the law of Christ" (Galatians 6:2).*

This shared journey of interdependence is not a source of shame but a reflection of God's design for humanity. To serve one another is a commandment requiring our obedience. A commandment that reaps blessings, strengthens our relationships, and nurtures love in our communities.

A Strain on Doctors and the National Health Service

The Bill places doctors into several difficult moral, ethical, and professional dilemmas. It requires doctors to go against the very essence of their profession, which is to save lives rather than to proactively end them.

Doctors will need to make a complex judgement and assessment of an individual's illness: that it is terminal and likely to end the patient's life within six months. It does not guide the doctor on how likely this should be and whether this depends on the availability of any other treatment that a patient does not wish to go through. There are various specialisations within medical health care, and the Bill does not indicate whether the two doctors who concur with the prognosis need to specialise in the specific illness classed as terminal.

The Bill also requires doctors to make a judgement affecting life or death for which they have no professional qualifications or training. Namely, to determine that the individual has reached a clear, settled and informed wish to end their own life and has made this decision voluntarily, without being coerced or pressured by any other person. This is a subjective 'judgement call', not associated with the doctor's profession, and without guidance as to what enquiries the doctor makes to satisfy themselves of this position.

While the Bill also tries to make provisions for doctors who do not wish to assist in ending life under Section 23 by providing that there is no legal obligation on any doctor to follow the Bill, this is not in fact the case. The Bill obligates a doctor who refuses or is unwilling to have such a discussion with an individual to make a referral to a doctor who is willing to do so, should the patient make such a request (Section 5(3)). In so doing, the doctor remains involved in the process of assisting in the death of an individual. Consequently, doctors who have a moral, ethical or religious dilemma with assisted suicide cannot conscientiously object to involvement in the process.

Not only does the Bill expect vulnerable people to conduct sound reasoning in a situation where they know they are terminally ill, but physicians are also permitted to raise the prospect of assisted suicide with their patients. That, in itself, risks intentional or unintentional coercion by the physician due to the power imbalance between a professional physician and vulnerable patients with a terminal diagnosis. Such an acceptance will have an irreversible impact on the doctor-patient relationships and trust upon which it is founded.

A Strain on the National Health Service and Legal System

In addition to the immense strain on doctors, the National Health Service is currently in a dire state, and the court system, which is also presently stretched, does not have the infrastructure to carry out the requirements of the Bill.

The Bill also states that doctors are required to stay with patients until they die. Evidence has shown that this could take days in some instances. This is just one aspect in which implementing this Bill would stretch the resources of the NHS and take away from an already overstretched system, severely impacting other life-sustaining care. Such measures can only escalate the suffering and pain of people whom society is trying to care for.

The Bill also seeks to implement further safeguarding measures by using High Court or Court of Appeal judges who face the same complex moral, ethical and professional dilemmas as the doctors. Within a legal system which is currently under extreme pressure, it is difficult to expect that judges will find the expedited time and space to listen to hearings carefully, summon individuals as necessary, and reach and publish reasoned decisions within the required time.

Palliative Care

The care for the vulnerable and suffering has been integrated into society through Palliative Care. Established by Dame Cicely Saunders in 1967, Palliative Care of the dying patient intends to neither accelerate the death process nor prolong it. It is, instead, to allow death to occur naturally and to concentrate on using the last few hours, days or weeks to the maximum. In the words of Dame Cicely Saunders, “You matter because you are you, and you matter to the end of your life. We will do all we can, not only to help you die peacefully, but also to live until you die.”

This was achieved by addressing the fear of ‘total pain’. Physical aspects were dealt with through the right balance of safe painkillers. Relations would be contacted, and relationships restored on behalf of patients. Emotional comfort was addressed through therapy, counselling, and friendship. Finally, spiritual comfort was addressed with a chapel at the centre of the first Hospice, St Christopher’s, enabling beds to be easily wheeled in at any stage of illness.

It is worrying and saddening that Palliative Care, which Britain was the first to pioneer and aided in the establishment of globally, is currently so underfunded by His Majesty’s Government, and is currently predominantly financed by charitable organisations. Accordingly, we would urge prioritisation across the United Kingdom for access to the Palliative Care system.

Pastoral Care

The Church serves its flock with a holistic approach, considering not only the spiritual wellbeing of a person, but often dealing with the various challenges that affect people on a number of levels: mentally, emotionally and financially, among others.

Pastoral care is core to the Church’s ministry, and it deals firsthand with those who have wished at times to end their lives for a variety of reasons. Those same people give testimony today of how thankful they are that they did not. We have numerous examples of people who now live vibrant and fruitful lives as a result of seeking and/or receiving support at the height of their pain and vulnerability. Pain is not always the enemy, and often leads to life-saving transformations that are not insignificant or to be ignored.

Dying Well

We must take time to contemplate the concept of dying well. It can be a time to receive and offer forgiveness, mend relationships and strengthen relations through the openness of the heart. It is an opportunity to be thankful for the smaller things surrounding our lives. Lastly, it is a time to prepare for and transition into the next step of our journey of life, with a focus on a joyous and pain-free life to come. It is for these reasons that the Church stands firm in its view that death in human beings should not be hastened, but left to take its natural course where it can.

This also gives the individual time to be ministered to, and to recognise that death is not to be feared. By the grace of God and His love for humankind, He has transformed death into a gateway to a new reality of everlasting life, remembering the words of Saint Paul, "…the time of my departure is at hand. I have fought the good fight, I have finished the race, I have kept the faith. Finally, there is laid up for me the crown of righteousness, which the Lord, the righteous Judge, will give to me on that Day, and not to me only but also to all who have loved His appearing" (2 Timothy 4:6-8).

Conclusion

This proposed legislation is being rushed without proper consultation or reflection on the consequences. Given its gravity, a private member bill should not be used to introduce such legislation without due time for consideration and debate.

Rather than offering expedited death as a solution, the Church advocates addressing the deeper issues in our society, as outlined by His Eminence Archbishop Angaelos, Coptic Orthodox Archbishop of London and Papal Legate to the United Kingdom, on this matter:

"Our society is in much need of solutions that support and promote wellbeing, health, and life as a whole. Our healthcare and legal systems are already stretched. People are working tirelessly in every facet of society to support their loved ones and the community at large, and so it is our individual and collective responsibility to speak robustly into the debate on assisted suicide.

We must strive to find ways to support people in their pain and to ease their struggles, rather than give in to the narrative that the ending of life is a solution, or indeed the only solution. If we do not reaffirm the sanctity of life at every opportunity, vulnerable people will inevitably be influenced to make irrevocable decisions that will undoubtedly lead to even greater loss to our already injured world. It is time to focus on what can be done better, and to spend greater effort and resources on the safeguarding of life itself."

We call for the strengthening of the understanding of the value of all human life, the encouragement of supportive communities, and investment in vital end-of-life care. We encourage people to hear, comfort and be present with those suffering at their most vulnerable time to alleviate suffering, rather than eliminate the sufferer.

The acceptance of assisted suicide and euthanasia is the acceptance of a life that is not worth living. For the reasons set out, we urge everyone to consider the seriousness, reality, implications and practicalities of what is being put forward. We pray that society does not succumb to the hopelessness in accepting a choice that leads to no more choices. Every life is worth living until it becomes a life well-lived.

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