

Written evidence submitted by The Orders of St John Care Trust (ADY0423)

The Orders of St John Care Trust (the 'Trust') is one of the UK's leading not-for-profit care providers. We are a Christian charity who offer care to all faiths and none. We operate across over 60 locations and our offering to older people includes specialised dementia services, intermediate or respite care, respite, day care and expert nursing. Our sole purpose is to provide the best possible care to those who live with us – some of the most vulnerable people in society.

On behalf of the Trust, we submit the below evidence to the Inquiry, which relates primarily to our experience in the field of social care. For clarity, we are not expressing views on behalf of our residents.

We start from a position of agreement with the current law on this issue in England and Wales and our comments relate to the specific changes which would follow if the law permitted Assisted Dying as defined by the Parliamentary Office of Science and Technology briefing (i.e. Healthcare professionals would be actively involved in the provision or direct administration of lethal drugs, at the patient's request).

Providing healthcare professionals with an ability to accelerate the death of a person creates real challenges for our residents:

- Many residents move into our homes for End of Life care, expected to live for only a very few weeks. Determining prognosis of an individual's condition and judging how long they have left to live are inevitably difficult and prone to error. We regularly see that when a sense of self-worth, place, and belonging are restored, the therapeutic value can be greater than all medicine. Loving care can vastly improve quality of life and change individual outlooks.
- Whilst there would be strict eligibility criteria, there will be inevitable scope creep, and areas of poor or differing practice. Many of our residents sadly already see themselves as a burden. This can be financial, or just because they are now reliant on those who once relied on them. This makes them vulnerable to making a decision for the 'wrong' reason, or to exploitation.
- For those already living in care homes, a change in the law may unintentionally create a constant burden of deliberation, additional pressure through witnessing the choices of fellow residents to opt for assisted dying and potentially a stressful environment where residents perceive they are being continuously assessed about whether they qualify. A change in law may erode the trust placed in medical professionals by our residents.
- Many residents do not have capacity to make specific decisions in the last months of their lives. This is an area of acute concern.
- We can foresee a time when it is our colleagues who find themselves giving information/evidence /documentation in cases where a request has been made by someone who lives with us. This might place a huge emotional burden on colleagues who join the Trust largely to extend and enhance the lives of those in our care. The relationships formed by social care professionals are often entirely different to the ones formed by medical professionals whom residents may only see once or on occasion. We cannot be drawn into giving advice (whether this be formally to medical professionals or informally to residents or their families) as this would open us to all sorts of legal challenges as well as emotional ones, and direct conflicts of interest.
- We have concerns about the potential for incremental extension of eligibility criteria once legalised. Where access to Assisted Dying is already permitted, there are clear examples where countries have subsequently widened their qualifying criteria. There is no basis on which to assume the UK would be any different.
- Precedents elsewhere suggest that conscientious objection safeguards are primarily limited to individuals and not institutions. As a faith-based organisation, we would find ourselves unable to facilitate Assisted Dying. Any change to the law could place us and others like us in an

irreconcilable position if the law were to require such facilitation from us. For care providers with large local-authority funded resident bases, the possible imposition of a contractual obligation to facilitate Assisted Dying could pose an existential threat to the Trust and reduce the number of beds available for Local Authority purchasing. As a minimum, any proposals should allow both organisations and their staff members to claim exemption. In any event, we foresee that pressure would be exerted upon “dissenting clinicians” to refer residents requesting drugs to end their lives to a clinician who will assent.

- We are concerned for those around the periphery of the process, especially our staff in an organisation with a Christian ethos, who may be expected to play a part, albeit in the background, with the process without being able to opt out in any meaningful way.
- Finally, what impact would a change in law have on the value of the lives of older people, and might this have a consequential impact on the provision of services and care that give purpose to and quality of life? There is not yet enough research into the societal impacts of a change in legislation in jurisdictions where the law has already been changed. Our concern is that the value of the lives of older and disabled people will be diminished and this could adversely affect healthcare decision making in the longer-term, eg investment in palliative or end of life care services.

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