Space in the City: Winchester: 8 February 2012.

Double vision: the ethics of assisted suicide and euthanasia.

On Thursday January 5th this year, The Times ran its main Leader on the subject of Dying with Dignity. It was in response to a report written by an independent commission which had been supported by what used to call itself the Voluntary Euthanasia Society, but which is now known as "Dignity in Dying". That commission was chaired by Lord Falconer of Thoroton, a former Lord Chancellor, committed to changing the law in the UK, a law which, as you will be aware, currently does **not** allow assisted dying, and it was funded by Sir Terry Pratchett, himself also committed to a change in the law.

It was the latest in a series of reports and articles which, from time to time, erupt into the media on this difficult and controversial subject.

What I am hoping to do in this talk is to throw as much light as possible on the subject, but I recognise that to try to do so in just thirty minutes is a tall order.

So, where shall I begin?

It's always important in a debate about this topic to have some common and clear definitions.

Definitions.

The word "Euthanasia" derives from the Greek, and simply means "a good death". But it has come to be used in a more specialised way to refer to a death brought about by an individual at the instigation and request of a person who is suffering.

I was a member of an international group of bishops and lay-people at the 1998 Lambeth Conference which gave considerable and careful attention to the ethics of this subject. Having looked at a number of available definitions we agreed that the following set of words was the most accurate and unambiguous that we could construct:

Euthanasia is **"the act by which one person intentionally causes the death of another who is terminally ill, or seriously ill, in order to end the other's pain and suffering."**
The Official Report of the Lambeth Conference, Morehouse Publishing, 1998, pg 103

There are other definitions, such as this one, which do not include any concept of suffering as a part of the definition:

"The intentional killing by act or omission of a dependent human being for his or her alleged benefit."
www.euthanasia.com

Or, this one:

*"*Medical assistance or action which is intended to end a human life."
"The challenge of euthanasia", in "Euthanasia and the Churches", ed. Robin Gill, Cassell 1998, pg 16

Or, this one:

"Euthanasia refers to one person's deliberate killing of another, not because they are threatening injury or have committed a crime, but because their lives are not reckoned worth living."
Aiming to Kill: Nigel Biggar: D.L.T. 2004. Basic Terms. Pg 1

We could spend quite a while looking at the subtle differences between each of those definitions; for example, Robin Gill's definition introduces the word "medical", but is that really a necessary and defining categorisation? Is it not possible to conceive of a situation in which the person bringing about the other person's death does not have any medical training or expertise but out of deference to the other person's wishes, ends that person's life?

What each of the definitions seems to have in common is what we might call "intentionality". The person who does the killing is acting with the intention of bringing about death: the person who asks to be killed intends that his or her life should be ended by someone other than himself or herself.

It's at this point that we need to add an important caveat. Where someone kills another person for that person's alleged benefit it is important to recognise that the word "Voluntary" needs to be included somewhere. If it is not included, if we are not careful, we shall create a definition which might stray into the territory of murder or manslaughter. So, let's take a brief look at a definition of Voluntary Euthanasia.

At the Lambeth Conference in 1998 we offered this definition:

Voluntary euthanasia is an act in which a competent, informed person asks another to end his or her life and whose request is then carried out.
See: The Official Report of the Lambeth Conference, Morehouse Publishing, 1998, pg 103

There are other definitions, for example:

"When the person who is killed has requested to be killed"
www.euthanasia.com

Or this:

"Euthanasia that is voluntary is conducted at the request, or with the consent, of the person to be killed."
Aiming to Kill, Nigel Biggar ,D.L.T. 2004. Basic Terms. Pg 1

In these definitions, one of the characteristics that an act must have if it is to be considered "Euthanasia", is that the act shall be carried out by someone other than the person who is requesting to be killed, and that it should have, in both the one who requests and the one who fulfils that request a strong element of freedom. In other words, there should be no coercion of any kind.

The difference between Euthanasia and Assisted Suicide is that whereas in Euthanasia another person does the actual killing, in Assisted Suicide the person who wishes to die takes

an action to kill themselves, though the means to carry out the suicide might have been provided by another person.

Here then is a possible definition of assisted suicide:

"Assisted suicide is an act in which a person takes his or her own life with the help and/or the means provided by one or more other people".

Now what is already clear, I am sure, is how very difficult it is to achieve a definition which is absolutely solid and agreed upon. And, in passing, therefore, I need to point out that when you try to draft legislation, definitions are of the essence. It is not at all an easy or simple matter.

What then is the current state of play in English law relating to euthanasia and assisted suicide?

It is currently not lawful to commit euthanasia, nor is it lawful to assist someone to commit suicide.

But all of this has a bit of history behind it and is subject to further debate; more of this in a moment. But let me just spell out where we actually are in relation to Assisted Suicide.

The Suicide Act was changed in 1961; up to that point in this country it was considered a crime to commit suicide. The 1961 Act changed that, introducing a more compassionate note into our legislation. Nevertheless the 1961 Act makes it a statutory crime "to aid, abet, counsel or procure a suicide or attempted suicide and the offence carries a penalty of up to 14 years' imprisonment."
Select Committee on the Assisted Dying Bill 2005, pg 13.

As I said in my brief introduction, there is a strong move to change the law on assisted suicide and if you want to hear the arguments they were most clearly put by Lord Falconer in an article in The Times in 2009 when he was trying to bring an amendment to the Coroners and Justices Bill then before Parliament: "...the law as it stands should reflect current practice and ethical standards. Nobody who has any sensitivity, who understands what families must be going through, wants to see prosecution in these cases… My amendment (to the Coroners and Justice Bill) is designed to give protection to people who accompany their loved ones to a clinic abroad and then gives support in the last moments of life… I am motivated by a situation in which the law does not work… Parliament must act. We need the law to reflect our values and to reflect real situations. No one, no matter how wise, should decide whether to enforce criminal law. We all know why the DPP has made his judgement in these cases- because no-one has the stomach to prosecute people under the current law…"
The Times, June 3rd, 2009.

What Lord Falconer was referring to was the Debbie Purdy case in which she wanted clarity about whether or not her husband would be prosecuted if he helped her with her decision to go to Switzerland to commit suicide. And it also referred to all those "… previous cases of people travelling to Switzerland who have not been prosecuted for accompanying their loved ones in the assisted suicide process. As the Law stands at the moment the Suicide Act is applicable when a substantial part of the aiding, abetting, procuring or counselling of the

suicide occurs in England or Wales." *(CPS Press Release 23/09/2009)* The suicide itself can occur in any country.

But on the 23rd September, 2009, a consultation document was issued by the DPP, Keir Starmer, seeking views about the policy. There were responses from nearly 5000 people to the consultation that he had inaugurated.

There were those who argued that the consultation document was itself flawed. Amongst them were, Lord Carlile, Lord Mackay and Baroness Butler-Sloss. They argued that the document changed the role of the DPP from an enforcer of law to an arbitrator, and considered that to be possibly a breach of Parliament's role in creating legislation. What is more they argued that compassionate grounds are difficult to determine and said that many cases of abuse occur in families where, no doubt, the phrase "loved one" might be used.

Following the Consultation the DPP issued his Assisted Suicide Policy on Feb 25th, 2010. Keir Starmer said: "The policy is now more focused on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia. It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not.
…Assessing whether a case should go to court is not simply a question of adding up the public interest factors for and against prosecution and seeing which has the greater number. It is not a tick-box exercise. Each case has to be considered on its own facts and merits.
…As a result of the consultation exercise there have been changes to the policy. But that does not mean prosecutions are more or less likely. The policy has not been relaxed or tightened but there has been a change of focus."

He outlined sixteen public interest factors which should be taken into account if there were to be a prosecution. Those sixteen public interest factors ***in favour*** of prosecution are:

- The victim was under 18 years of age.
- The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.
- The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
- The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
- The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
- The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim.
- The suspect pressured the victim to commit suicide.
- The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
- The suspect had a history of violence or abuse against the victim.
- The victim was physically able to undertake the act that constituted the assistance himself or herself.

- The suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.
- The suspect gave encouragement or assistance to more than one victim who were not known to each other.
- The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.
- The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.
- The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.
- The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

Having outlined the public interest factors that needed to be taken into consideration when bringing a prosecution, he then outlined six public interest factors ***against*** prosecution. They are, as follows:

- The victim had reached a voluntary, clear, settled and informed decision to commit suicide.
- The suspect was wholly motivated by compassion.
- The actions of the suspect, although sufficient to come within the definition of the crime, were of only minor encouragement or assistance.
- The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
- The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.
- The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

The DPP makes absolutely clear that the policy does not in any way permit euthanasia. What is not clear to me, however, is how one can determine

1. Whether a person assisting suicide was truly and wholly motivated by compassion.

2. Whether the person committing suicide really had reached an informed and voluntary decision.

The debate continues… but it is not only a debate between lawyers. I believe we always need to ask about any proposed change in legislation questions such as these: what effect is it likely to have on the most vulnerable …? Will it protect or will it make it easier for such a person to be manipulated or abused? What message is it giving to society about what constitutes human value and worth?

So, let me summarise thus far. In England it remains an offence to assist someone to commit suicide, but under the guidelines issued by the DPP there is now a good deal more clarity

about the factors that ought to be taken into account when deciding whether or not to prosecute someone who has helped a person to commit suicide.

The state of the Law concerning assisted suicide and/or euthanasia in other jurisdictions.

1. The Netherlands

Euthanasia is allowed and so is assisted suicide**.** The legislation was passed in 2001/2. There have been a number of studies of the take-up of Euthanasia and Assisted Suicide . For example, in the New England Journal of Medicine, (Nov 28th 1996) a study by P.J. van der Maas et al discovered that approx. 2.3% of all deaths in the Netherlands were defined as Euthanasia and about 0.45% of deaths were by Assisted Suicide. 0.7% of patients did not give their concurrent, explicit permission. A study in the Lancet in August, 2007 (vol 362, Issue 9381) argued that the evidence showed that the demand for Euthanasia/ Assisted Suicide had not risen since previous surveys had been taken, but that a degree of reluctance amongst physicians and patients seemed to be emerging.. A further study by A van der Heide et al , published in the New England Journal of Medicine in May 10th 2007, revealed that in 2005 only 80.2% of all euthanasia cases had been reported. It also revealed that the take-up of euthanasia etc had dropped from2.6% in 2001 to 1.7% in 2005. However, it also discovered that 0.4% of deaths were not with the explicit consent of the patient.

It is worth reading carefully the following numbered paragraphs which are taken from the House of Lords Select Committee report. They provide an outline of the state of play in The Netherlands.

"170. The 2002 law is not limited to adults. Nor does an applicant for euthanasia have to be terminally ill. As Dr Legemaate put it, "the main basis is hopeless and unbearable suffering; it has nothing to do with your life expectancy". He added however that "in actual practice I think that our law is very close to your Assisted Dying Bill, in the sense that 95% or 98% of the cases… are patients within the last days or weeks of their life… But we do not exclude the rather exceptional situations in which, for instance, somebody who is 55 and has a very severe but incurable mental illness – which relates to a situation of hopeless and unbearable suffering – asks for assisted suicide. We have had these cases every now and then. Not many, but they are not excluded" (Q 1285).

171. Approximately 16 million people live in The Netherlands, of who around 140,000 die every year. We were told that some 9,700 requests for euthanasia are made annually. About 3,800 of these actually receive euthanasia, of which some 300 are assisted suicides. Euthanasia therefore accounts for around 2.5% and assisted suicide 0.2% of all deaths in The Netherlands. **In addition to these, there are about 1,000 deaths a year (0.7% of all deaths) where physicians end a patient's life without an explicit request.**

172. Under subsection 2 of the 2002 Act a Dutch physician who carries out euthanasia is exempt from prosecution if he fulfils a number of specified criteria of "due care" and notifies the coroner. There are six such criteria. The patient must have made a voluntary and well-considered request to die; his suffering must be lasting and unbearable; he must have been informed about his medical condition and prognosis; both the doctor and the patient must be satisfied that there is no other reasonable solution to the situation; the doctor must consult at least one other (and independent) physician, who must visit the patient and give his written

opinion of whether the requirements of due care have been met; and, finally, the doctor must terminate the patient's life with due medical care. The "second opinion" is now increasingly provided by a team of SCEN (Support Consultation Euthanasia Network) doctors" *Assisted Dying for the Terminally Ill Bill, Vol 1 Report. April 2005.*

It is also worth adding that the Select Committee were told that Dutch doctors preferred Euthanasia to assisted suicide, because they could be more certain about the effectiveness of the processes. *(see ADTI Report, Para 168)*

Once the patient has died**:**

And what happens after the patient's death? The procedures are as outlined in the ADTI report:

173. Once the patient has died, it is the doctor's responsibility to report the death to the coroner and to complete a report. The coroner visits the place of death, performs an external medical examination of the patient and notifies the public prosecutor and the civil registrar. He then compiles his own report, noting the cause of death, and forwards this, together with the doctor's report and, if necessary, the patient's medical notes, to one of five regional assessment committees.

174. The committees were set up under the 2002 law. We were able to discuss their operation with the committee covering The Hague. Its chairman, Mr Jan Suyver, told us that "the committees investigate each reported case and assess whether or not the criteria are met with. It is black or white, not grey. However, in its written explanation on its judgement the committee is entitled to mention all the relevant circumstances and dilemmas… If the committee finds all the criteria fulfilled, then the case is over – end of the story. There are no further investigations, no prosecution. If not, the committee must also notify the public prosecution service and the health inspectorate. The committees do not give advice on whether or not to prosecute or to bring the case before a disciplinary tribunal. Those are the exclusive decision powers of the prosecution service and the health inspectorate" (Q 1439). The committees do not have a role in monitoring euthanasia practices. Dr Gerrit Kimsma, the physician member of the committee, told us that they "have data on the variety in numbers [of euthanasias performed] between physicians, but we do not keep track" (Q 1455). There is thus no routine procedure which would show whether some physicians are performing significantly more euthanasias than others, though it would be possible, we were told, to "put it a query" and extract this information (Q 1457).
House of Lords Select Committee, ADTI Report, 2005.

2. Belgium

Euthanasia became legal in Belgium in 2002. It was passed by a vote in the Lower House : 86 in favour, 51 against, 10 abstentions. In the first year of operation 203 people received help from a doctor to die. The distinction that we draw in the UK between Assisted Suicide and Euthanasia does not seem to be part of the discourse in Belgium.
A research group at Brussels Free University found that in a random sample of 6,202 death certificates in the Flanders region, (total pop. approx. 6 million,) between June and November 2007 there were 118 cases of euthanasia. (*Associated Press 09/09/09*). This represents a rising trend towards 2%.

Patients must be under constant and unbearable physical or psychological pain resulting from accident or incurable illness.

Minors cannot seek assistance to die.

3. Luxembourg

Legislation to legalise euthanasia and assisted suicide was passed in Feb 2008. 30 voted in favour, 29 against.

The patient must be suffering from a terminal or incurable illness; make repeated requests; the consent of a panel of experts and two doctors is required.

4. Oregon

In Oregon only Assisted Suicide is allowed in law. The person who seeks physician assisted suicide must be 18 years of age or above; a resident of Oregon; capable of making their own health care decisions; have a terminal illness which will lead to death within six months.

The Act came into force on October 27, 1994. It was decided by a ballot of the citizens: 51% voted in favour and 49% voted against. An attempt to get rid of the Act by ballot in Nov 1997 resulted in 60% voting to keep the legislation and 40% voting to repeal it.

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications.

The material which follows comes from the Oregon Public Health Division website.

The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2010 are listed below. The numbers of prescriptions written and deaths contained in this report are based on paperwork and death certificates received by the Public Health Division as of January 7, 2011. Because there is sometimes a delay between a death and receipt of the follow-up questionnaire and death certificate, it is possible that additional participants that received the medications in 2010 have died, but the Public Health Division has not yet received the paperwork or the death certificate. For more detail, please view the figures and tables on the web site at www.oregon.gov/DHS/ph/pas/

• As of January 7, 2011, 96 prescriptions for lethal medications had been written under the provisions of the Death with dignity act (DWDA) during 2010, compared to 95 during 2009 (Figure 1). Of the 96 patients for whom prescriptions were written during 2010, 59 died from ingesting the medications. In addition, six patients with prescriptions written during previous years ingested the medications and died during 2010 for a total of 65 known 2010 DWDA deaths at the time of this report. This corresponds to 20.9 DWDA deaths per 10,000 total deaths

• Two of the patients who took the medications during 2010 did not die after ingestion, but died later from their underlying illness. Twenty of the patients who received prescriptions in 2010 did not take the medications and died of their underlying illness. Status is pending for

15 patients: two have died but we have not received the follow up questionnaire, and for 13 we have neither the death certificate nor follow up questionnaire (Figure 2).

• One of the two patients who awoke after ingesting the medication regained consciousness within 24 hours after ingestion and died of their underlying illness five days later; the other gained consciousness 3 ½ days after ingestion and died of their underlying illness three months later. Regurgitation was reported in both instances.

• Fifty-nine (59) physicians wrote the 96 prescriptions written in 2010 (range 1-11).

• Since the law was passed in 1997, 525 patients have died from ingesting medications prescribed under the Death with Dignity Act.

• Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65 years; the median age was 72 years. As in previous years, most were white (100%), well-educated (42.2% had a least a baccalaureate degree), and had cancer (78.5%).

• Most (96.9%) patients died at home; and most (92.6%) were enrolled in hospice care at time of death. Most (96.7%) had some form of health care insurance, although the number of patients who had private insurance (60.0%) was lower in 2010 than in previous years (69.1%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (36.7% compared to 29.6%).

• As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (93.8%), decreasing ability to participate in activities that made life enjoyable (93.8%), and loss of dignity (78.5%).

• In 2010, one of the 65 patients was referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for six (9.4%) patients compared to 20.3 in previous years.

• Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for only 32 of the 65 deaths in 2010. Of those 32 patients, time from ingestion until death ranged from 5 minutes to 2.2 days (53 hours).

• During 2010, one referral was made to the Oregon Medical Board for failing to wait 48 hours between the patient's written request and writing the prescription

I find this material very helpful and it is good that it is published on the Net, but I suggest that there are a number of issues which are troublesome. The first relates to patients who tried to commit suicide but who regained consciousness a few days later. What must this experience have done to them and their families? Secondly, where the physicians were present at only 9.4% of the deaths – how can anyone be certain that the person committing suicide was not under any duress in the other 90.6% of cases? Thirdly, is it possible to be certain that those who had the medication in their bedside lockers but did not ingest it for some period of time were not under duress when they did finally take it? Fourthly, what degree of safety should

surround the storage of lethal medications in the home? And fifthly, what provision is there for either inquest or post-mortem to establish whether or not there had been any foul play?

5. Washington.

New legislation came into effect in the State of Washington in Feb 2009. It is based on the Oregon legislation.

The person must be 18 years of age or older. They must be suffering from a terminal illness which will lead to their death within six months. They must be a resident of the State of Washington. They have to make two oral requests 15 days apart and submit a written request witnessed by two people, but those witnesses must not be heirs, relatives or the attending physician. Two doctors must certify that the patient has less than six months to live.

In the first ten months of the new legislative processes 63 people obtained prescriptions, of whom 47 actually died, 36 with the help of an overdose, and the rest through natural causes. One fifth of those who died said that they were worried that they were a burden on their family. The doctor who prescribed the overdose was present in only three of the 36 cases when the drug was taken…
(Ed Pilkington. The Guardian, 05/03/2010.)

More statistics are now available on the website, but it seems to me that the concerns I have raised about the Oregon procedures apply also to the Washington situation.

For information, the following are the instructions issued by the Washington State Department of Health.

Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act.

Washington's Death with Dignity Act (RCW 70.245) states that "...the patient's death certificate… shall list the underlying terminal disease as the cause of death." The act also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

1.The underlying terminal disease must be listed as the cause of death.

2.The manner of death must be marked as "Natural."

3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
a. Suicide
b. Assisted suicide
c. Physician-assisted suicide
d. Death with Dignity
e. I-1000
f. Mercy killing

g. Euthanasia
h. Secobarbital or Seconal
i. Pentobarbital or Nembutal
The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act. If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued. (Revised April 8, 2009)

You will notice that the death certificate has to refer to "natural causes". But where is the provision for ensuring that the person choosing to die was not under duress and/or was not forced to consume the medical poison…?

6. Montana

The Montana Supreme Court ruled in December 2009 that doctors would not be prosecuted if they helped a terminally ill patient to commit suicide, but the Court avoided making a decision about whether or not their decision gave the citizens of Montana a right to have physician-assisted suicide. There remains a good deal of confusion about the current state of the law in Montana.

7. Switzerland

In Switzerland only assisted suicide is allowed. Euthanasia is forbidden. A person can be prosecuted if for "selfish reasons" they have helped someone to commit suicide, but if no "selfish reasons" are involved it is unlikely that they would have been held to break the law.

The following two numbered paragraphs explaining the law in Switzerland are taken from a paper produced for the House of Lords Select Committee (03/02/2005) by Professor Christian Schwarzenegger and Sarah Summers of the Faculty of Law in the University of Zurich.

1. If the act carried out by the person who assists directly causes the death of the victim (i.e. injection of barbiturate), the act no longer constitutes an assisted suicide in the sense of Art. 115 Penal Code. It is rather a case of direct active euthanasia, which is an intentional killing on request according to Art. 114 Penal Code.

2. If the act is carried out by the victim himself or herself, the case falls under Art. 115 Penal Code. The person assisting in the suicide can only be held criminally responsible, if he or she acts for selfish reasons (i.e. pecuniary profit, publicity, to receive the inheritance). Assistance provided by Swiss organisations such as EXIT or Dignitas do not usually fall within the realm of criminal liability, because of the absence of this selfish motive. Thus, the assistance is legal.

There is considerable debate in Switzerland about whether or not an individual who is suffering from long-term mental illness also has a right to be helped to die, with the debate centring on whether the patient has the capacity to make a reasoned decision notwithstanding their mental illness.

It is also known that 21% of people receiving help from Dignitas and 65% of women receiving help from EXIT did not have a terminal illness at the time of their death.

What are the arguments for and against Euthanasia and Assisted Suicide?

Arguments for

1. Personal autonomy: the exercise of choice.

One of the most frequently used arguments in favour of changing the law in this country centres on the philosophical concept of personal autonomy and, in particular, on the importance of autonomy in exercising choice.

Personal autonomy was defined by John Harris, Professor of Bioethics in the School of Law, University of Manchester, in the evidence he gave to the House of Lords Select Committee, as "The ability to choose and the freedom to choose between competing conceptions of how to live" (Assisted Dying for the Terminally Ill, Vol. 1. Report, 2005, p. 20). "It is only by the exercise of autonomy that our lives become in any real sense our own. The ending of our lives determines life's final shape and meaning, both for ourselves and in the eyes of others. When we are denied control at the end of our lives, we are denied autonomy*." (ADTI Vol. 1, p. 20)*

The importance of exercising choice as a part of our personal autonomy is expressed by Sarah Wootton, CEO of Dignity in Dying, in this way:
"An overwhelming majority of us want more choice about where we die, pain relief, access to quality health care and not to have life prolonged against our wishes… ultimately, each individual decides what they believe is a dignified death."
Sarah Wootton, A Charter for Dignity at the End of Life. 2008 p. 3.

Lord Warner, a government minister in the previous administration, a member of Lord Falconer's independent commission and a supporter of Dignity in Dying, places the issue of choice in an even bigger context:
"Choice and Personalisation are central to the current debate about the future of the NHS."
Lord Warner, A Charter for Dignity at the End of Life. 2008 p.1.

The importance of personal autonomy has been highlighted on a number of occasions by Baroness Warnock; for example:
"…we have a moral obligation to take other people's seriously reached decisions with regard to their own lives…seriously, not putting our judgement of the value of their life above theirs…"
Mary Warnock, The Observer, October 19, 2008.

2. Personal autonomy: Ownership.

The arguments based on personal autonomy are not solely about the exercise of choice, they are also connected with the concept of ownership. It was expressed very clearly by Sir Terry Pratchett in a letter he wrote to The Times in 2009:

"There can be nothing wrong in requesting that one's life should be brought to a dignified end. There can be no possible reason to object to this…We are not slaves. We own our lives."
Sir Terry Pratchett, The Times, March 9, 2009.

3. Principled autonomy:

A subtle but important caveat in the arguments based on personal autonomy is one in which it is argued that the rights of the individual have to be considered in the context of the rights of others, and of society as a whole.

In his presentation to Lord Falconer's Commission the Revd. Professor Robin Gill of the University of Kent argued that there are three principles which need to be taken into account in the debate around medical ethics: autonomy, compassion and liberation, but he then qualified what he said:

"Taken on their own these three values or principles of autonomy, compassion and liberation do seem to suggest a positive answer to my question, 'why should society not permit compassionate assistance to die for those autonomous individuals who are facing the prospect of a burdensome death?' However my question was prefaced by the conditional clause, 'If no one else is affected'. A fourth value or principle, variously identified as the common good, solidarity or social justice, points beyond individual people's lives (however deserving of our compassion) to society more broadly. This principle suggests a revised question: 'In seeking to change the law to facilitate assisted dying for autonomous individuals in need of compassion and liberation from an otherwise burdensome death, can we be confident that life will not become more burdensome for other vulnerable people who also need our compassion?"
The Revd Professor Robin Gill, January 19th, 2011.

4. Moral force and compassion.

There are those who argue for a change in the law on the grounds of compassion.

In a leader in The Times an argument was put forward for a change in the law relating to Assisted Suicide appealing to our sense of fairness and compassion: "…the sheer fortitude of those who go through with assisted suicide despite the logistical obstacles and the efforts of friends and families to talk them out of it."
The Times December 11, 2008.

Lord Falconer has argued that a change is needed in British law to ensure that the relatives of those who travel to Switzerland to help a loved one to die do not face the rigours of the law.

"In such cases the relatives who accompany a loved one abroad can be reported to the police… the police are then duty bound to investigate which clearly causes a great deal of distress to the bereaved family members... the law as it stands should reflect current practice and ethical standards. Nobody who has any sensitivity, who understands what families must be going through, wants to see prosecutions in these cases."
Lord Falconer, The Times June 3, 2009.

A C Grayling, Professor of Applied Philosophy, Birkbeck, University of London also appeals to compassion:
"The motive to have physician assisted suicide legalised is a simple one: it is a humane impulse of kindness, based on the realisation that we are kinder to our pets than to our fellow human-beings…refusing them denies their autonomy, and is at least unkind and at worst, cruel." *Professor A.C. Grayling, The Times, March 31, 2009.*

5. Public Opinion.

A fifth argument in favour of changing the law appeals to "Vox Pop" Opinion polls, and is based on the assumption that what the public wish to have they should then get.

"…easing the law on assisted suicide would win broad public backing without necessarily increasing its use. Three quarters of Britons believe that doctors should be allowed to help the terminally ill to end their lives, according to the British Social Attitudes Report."
The Times December 11, 2008.

6. Duty To Die?

A sixth argument put forward by Baroness Warnock suggests that we ought to consider the possibility that we have a moral duty to die:
"If you're demented you are wasting people's lives – your family's lives – and you're wasting the resources of the NHS."
Mary Warnock, The Daily Telegraph, Sept 18, 2008.

In other contexts sacrificing oneself for one's family would be considered good. I don't see what is so horrible about the motive of not wanting to be an increasing nuisance…"
Mary Warnock, The Observer, Dec 12, 2004.

7. Equality.

The seventh argument is based on the premise that the right to die should be available to all, regardless of class, creed, wealth, or income.

It is possible, says this argument, for wealthy people to make the arrangements to go to Switzerland to die; should this not also be an option for those who do not have the wealth or ability to do so? In other words, should we not make provision in this country to assist people who wish to kill themselves and spare their relatives the business of travelling to a foreign country?

"The two-tier death service forecast by Baroness Warnock is now a reality. Access to assisted suicide for Britons is far more a matter of means… than of the condition and prognosis of the patient. This cannot be right. Neither is it humane, even for those who can afford the fees…"
The Times, Leader, December 11, 2008.

What are the arguments against changing the law?

1. Personal autonomy is an inadequate description of human purpose.

It is simply inadequate, blinkered and bleak to describe the exercise of personal autonomy as the highest moral good we humans can exercise. We live not as atomistic individuals but as members of families, friendship groups and society. John Donne's words from the 17th century echo as true now as when they were first written:

"No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as

well as a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee."
Meditation XVII; 1624.

It is possible, of course, to debate whether there is actually a hierarchy of moral values, but it does not call into question that debate if one says that moral values such as love and truth seem to have been held in very high esteem by humanity across the centuries. Is not love, amongst the most important moral values we know? And does not love, by definition, involve someone other than my atomistic self?

Do we not also recognise that courage, for example, is an important virtue, and honour those who sacrifice their own lives or well-being for the good of others?

2. Personal autonomy: choice.

Whether we like it or not, individual decisions have moral, social consequence.(Is this not what much of the debate about Green issues centres around?) Whilst the exercise of choice is enjoyable, may there not be situations in which my individual choice has potentially catastrophic consequences for others? For example, I may choose to drive my car at speeds in excess of one hundred miles per hour on a public highway but to do so could involve risking the lives of others.

Similarly, if the law were to be changed in favour of assisted suicide, and I exercised my choice to commit suicide, what effects might this have upon the ways in which society regards other people, particularly the old and vulnerable?

Lord Turnberg, in the debate in the House of Lords on Lord Joffe's proposed "Assisted Dying Bill" (May 2006) said this:

"My Lords, I have thought long and hard since our previous debates on the Bill, but I am sorry to have to say to the noble Lord, Lord Joffe, for whom I have enormous respect and whose motives I admire enormously, that I cannot support the Bill. I say that not because I am against the principle that we should do all we can as a society in general, and as doctors in particular, to relieve a patient's suffering, especially the type of heart-rending cases that we have heard about today. Where they are terminally ill, I am not against easing their passage from this life as best we can by palliative care; how could I, as an ex-practising physician, not support that principle? All my feelings and emotions are in favour of those who speak for the Bill. I am not against the Bill because of the religious convictions that I may have, because I do not wish to inflict those convictions on others who do not hold them. I am against the Bill for entirely practical reasons – the unintended consequences of acceding to one patient's desire for assisted suicide when the risks entailed for others seem, to my mind, too great. The probability of a risk to the aged, the disabled and the depressed, who will feel a burden to others despite the safeguards in the Bill, seem to me too high. The finality of that risk, the termination of a person's life, is too severe. When mistakes are made they will be fatal, and mistakes seem inevitable. Some mistakes, such as a wrong diagnosis or a misdiagnosis of depression, will go undetected"

It is a gentle warning about the effect of changing legislation in which giving the highest status to the exercise of personal autonomy could have serious consequences for vulnerable people in society.

Law exists to balance the rights of individuals with the rights of others and society. It's a difficult and fine balance to achieve and where personal choice becomes enshrined in law the downside risks, it seems to me, are considerable.

If you wish to read a succinct summary of the arguments around personal autonomy and choice it is worth looking at Professor Onora O'Neill's comments to Lord Falconer's commission. (Professor O'Neill is a philosopher based at the University of Cambridge.) She comes to a very sober conclusion. The following is an extract from her evidence. Lord Falconer asks her a question:

LF: … Do you feel able to put what your conclusions are on autonomy and assisted dying and safeguards; can they be put together in one conclusion? For example, I don't think your autonomy should stretch to assisted dying; or I think it should subject to safeguards; I believe is the area. Which would it be?

OO'N: I do not believe that it is possible to draft adequate safeguards without invoking misleading and unrealisable fantasies about individual autonomy.

LF: So what would your conclusions be about how the policy of the law should deal with it?

OO'N: Whatever one thinks about the legitimacy of assisted suicide, it's not legislatable; not safely legislatable.

3. The Doctor- patient relationship.

One of the foundation principles in health care in this country rests upon a profound and trusting relationship between the patient and the doctor. Would not a change in the law jeopardise this?

If the law were to be changed so that the GP could prescribe treatments either to assist with suicide or with euthanasia, how could the patient ever be completely certain that the doctor was working in the best interests of the patient?

To see this at its starkest, picture a ward round in which the physician says to a patient: "These are the treatment options… but I also have to tell you that one of your options could be to peacefully terminate your own life …" What kind of pressures might this put upon a patient who "does not want to be a nuisance"? Might they feel obliged to accept the Doctor's offer?

4. Pressures on the doctor.

If the law were to be changed it would give the terminally ill patient the right to demand and require that the Doctor provide the means for that patient to kill themselves.

Is it acceptable for an individual to be given that degree of power over another? By what right as a patient should I be able to impose my will in those circumstances upon another?

Could we be certain (notwithstanding any safeguards that might be built in to the legislation), that a doctor could freely and *without harm to his/her career* exercise a right of conscience and refuse to help a patient who wished to commit suicide? Such evidence as we have over conscience clauses in abortion legislation does not inspire confidence that safeguards in assisted dying legislation would be any more successful.

5. Prognosis.

The problems of prognosis in people who are terminally ill are widely known within the medical profession. Is it possible to create legislation which will be dependent on the accurate prognosis of a terminally ill patient without opening up all kinds of legal counter challenges to any decision reached?

"I have come across instances in which an apparently firm resolve to die proves nothing of the sort. In 1991, a young man, a father of three children, was crystal clear in his repeated requests to me for euthanasia. His clinical outlook was bleak. Against all predictions, he did not die. Eleven years later his wife died, leaving him to bring up their three children."
The Times, April 1, 2009,Barones Finlay of Llandaff, Professor of Palliative Medicine at Cardiff University

In a moving speech to the House of Lords on May 12, 2006, Baroness Symons of Vernham Dean said:

"My Lords, just over 14 years ago, I sat every day and most nights at the bedside of a man in his 30s who had been diagnosed with a very advanced case of the most aggressive and virulent form of leukaemia. He fulfilled the criteria in the Bill of the noble Lord, Lord Joffe, to legislate for his assisted dying. He had been given a less than 20 per cent chance of survival and was likely to die within weeks – on some days, he was likely to die before the end of the afternoon. His physical pain was excruciating. Indeed, it was unbearable – so much so that administering any form of pain-killer was initially almost impossible. His mental anguish was constant and acute.
As his treatment began – there were four rounds of huge doses of chemotherapy, each round lasting for 13 days – he was absolutely clear-minded, but his will to fight became blunted. He said repeatedly that he could not go on. But he had to, and I am glad.
Fourteen years later, I am happy to say that he is thriving and I am so glad that the Bill of the noble Lord, Lord Joffe, was not on the statute book. I fervently hope that it never will be."
House of Lords Weekly Hansard, column 1223, 12 May, 2006

6. Social Pressures for the ending of a patient's life.

It is possible to imagine a scenario in which an old person not wishing to be a burden on the family, and wishing to ensure that the family received their full inheritance would feel under a kind of moral obligation to seek assisted suicide. At the moment that possibility is prevented by law. If the law were to be changed would the "right" to die begin to morph into the "duty" to die?

And, another echo of this – how can legislation be drafted which would ensure, without a scintilla of doubt, that the patient had not succumbed to family pressure in asking for Assisted Suicide?

7. Health care rationing.

At a time of health-care rationing, is it possible that a change in the law might lead to pressure on the elderly, for example, to sacrifice their own lives for the good of society?

8. Vulnerable people.

If legislation were to change , might this give the impression to the most vulnerable that they had lesser value than other people and ought therefore to, cease to exist. Or, less melodramatically, might it lead to them being considered to be a drain on society?

In the May 2006 debate in the House of Lords, Lord Mackay of Clashfern, a former Lord Chancellor and the chairman of the Select Committee said:

"… We took evidence from a great number of people. Among the witnesses were severely disabled people who expressed anxiety about the Bill. However, I felt that they may have misunderstood it and I said to one particular person, whom I remember very well, that this Bill – of course, when I spoke of "this Bill", I was talking about the previous Bill introduced by the noble Lord, Lord Joffe – did not contain any threat to her or her colleagues because it dealt only with terminal illness. Terminal illness was defined in that Bill as being of a limited time but it was expressed a little more ambiguously than in the present Bill, where the time limit is defined as six months.

I tried to understand why the lady felt that the Bill was a threat. I hope that I summarise fairly when I say that she took the view that, if doctors could properly help to end a heavily burdened life in the circumstances described in the Bill, that involved a judgment on the value of a heavily burdened life. She felt that she was in the category of having a heavily burdened life, which accentuated the burden..

There are many more disabled people – some of them heavily disabled – in this country than there are likely to be beneficiaries of this Bill, if the evidence from Oregon on which it is founded is to be relied on. I feel strongly that I do not wish to add to the burden of heavily burdened lives lived by those who may be disabled. I do not wish to add to their burdens while they live a heavily burdened but successful and challenging life, which challenges all of us in what they can achieve in the face of their disabilities. We have had the privilege in this debate of hearing from people who are disabled. The message from them seems to be rather the same as that which I took from the evidence of the disabled lady."
Lord Mackay of Clashfern, House of Lords Weekly Hansard, column 1277, May 12, 2006.

9. Slippery slopes?

There are those who argue that a slippery slope would **not** be created if legislation were to change. It is worth pointing out, in answer to this, a statistic from the experience in the Netherlands:

"There are around a thousand instances every year in the Netherlands of a patient's life being ended by a doctor without an explicit request"
ADTI Report Vol 1, p. 64

Lord Carlile of Berriew in a letter to The Times expressed his concerns in a beautifully constructed phrase:

"Already, in advance of another Assisted Dying Bill, we are hearing suggestions that people with dementia should consider whether they are a burden to their families. The slippery slope is no fiction. It is already well-polished."
Lord Carlile of Berriew, The Times, November 5th , 2008.

10. Psychological concerns.

The diagnosis of clinical depression amongst those who are terminally ill is a matter of some debate in medical circles. Baroness Finlay, a professor of Palliative Care in Cardiff makes this point, based on her extensive experience:
"Many move during the course of a terminal illness from hope to despair and back again. Depression is a common feature of terminal illness, and, as worrying research from Oregon shows, doctors cannot be relied on to detect it before issuing lethal drugs to potential suicides."
The Times, April 1, 2009, Baroness Finlay of Llandaff, Professor of Palliative Medicine at Cardiff University.

In other words, if a patient is suffering from depression and that depression is not treated nor taken into account in considering the patient's request for assisted suicide, can we be certain that they have made a balanced and reasoned request?

10. Sanctity of life.

There are a number of arguments based on the concept of sanctity of life; in brief, that life is God-given and that we do not have the right to reject or to interfere with that divine gift. But those arguments are weakened when it is recognised how successful medicine has been in its interventions in human lives over the past century. Many of us are alive today as a result of them. If it is morally right to intervene to *prevent* suffering, what should prevent us from intervening to *end* suffering?

There are those who argue that the gifts which humankind has developed in medicine are a direct result of God's creative generosity in sharing his Being with ours, but with those gifts comes also the burden of having to make difficult moral decisions.

In spite of the apparent weakness in the sanctity of life arguments it would be worth exploring in greater depth what it is about human life that gives rise to the concept in the first place? Is there some essential, irreplaceable thing about our humanity which can only be described as being derived from the divine?

10. Justice and social relationships.

The creation of law is not only about making a careful balance between the rights and needs of individuals and the rights and needs of society, it is also about trying to provide a foundational set of axioms or principles which apply to all people everywhere at all times.

In his statement to the House of Lords Select Committee, Lord Detchant who had chaired the 1993/4 Select Committee on Medical Ethics, referred to "society's prohibition of intentional

killing, a prohibition which is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal."
ADTI Bill Report, Vol 1, pg 24.

Professor John Finnis of the University of Oxford sees this law as a "bright line". "Though like other laws, it is not invariably respected, it is not in the least artificial or brittle: it rests on a rational principle that a person's life is the very reality of the person."
ADTI Bill Report, Vol 1, pg 24

If that is a fundamental axiom then to dismantle it is a very serious step and not one to be taken lightly.

11. Control of medication.

And finally…a practical question, but one with a number of ramifications.

In Oregon, where assisted suicide is legal, "Through to the end of 2003 there were 265 prescriptions actually written and 117 people who actually chose to use them".
ADTI Bill Report, Vol 1,pg56.

Could there be any guarantee in legislation that lethal drugs issued would not fall into the wrong hands and be used to commit a crime against a patient?

A Christian response.

There can be no denying that the subject of Assisted Dying will continue to dominate public discussion in the years that lie ahead. As Christians, we have some insights which we have a duty to share widely.

At the 1998 Lambeth Conference, a number of lay people and bishops from across the world spelt out what we described as five bedrock principles which should undergird all discussion of euthanasia and assisted dying. The principles are these:

1. Life is God-given and therefore has intrinsic sanctity, significance and worth.

2. Human beings are in relationship with the created order – a relationship characterised by such words as respect, enjoyment and responsibility.

3. Human beings, while flawed by sin, nevertheless have the capacity to make free and responsible moral choices.

4. Human meaning and purpose are found in our relationship with God, in the exercise of freedom, critical self-knowledge and in our relationships with one another and the wider community.

5. This life is not the sum total of human existence; we find our ultimate fulfilment in eternity with God, through Christ.

Those bed-rock principles are, of course, open to debate but unless we can establish such bed-rock principles we might not get our voice heard.

We might phrase things in a different way –

In a General Synod debate about assisted dying and euthanasia held in July 2005 I was asked to lead with an opening speech. In it, I said this:

"There is one question which has haunted and shaped society for thousands of years. It underlies all human relationships. It underlies all ethical decisions. The question is: 'Am I my brother's keeper?' The answering of that question has led, throughout history, to the righting of major injustices, like the abolition of the slave trade. But the usual answer to that archetypal question may be about to be rewritten in the United Kingdom. The answer 'yes' is about to be replaced by the answer 'no'.

Let me put it another way: 'Can I be my brother's killer?' For thousands of years the answer has been 'no'; but in legal terms, in the UK, the answer 'yes' is being seriously proposed: 'Yes, you may kill your brother in certain defined circumstances.'

It was a way of grabbing attention but it had a serious moral purpose which was to highlight the fundamental shift that might occur in our society if assisted suicide reached the statute book.

There are those Christians, however, who argue that there is another serious strand within our Christian tradition which we ought to take into consideration on this subject. It can be summarised in the biblical text: "Greater love hath no man than this, that he lay down his life for his friends". In other words, it might be considered part of a Christian's duty to sacrifice his or her own life for the well-being of others.

One might also argue that we are made in the image of God. However, we have also been given the moral freedom by God to debate and to create ethical systems. In exercising that gift might we not have the duty to re-visit old conceptions of morality and create new ones to meet changed human circumstances?

There is not time or space today to debate these things but it would be unhelpful to conclude without giving even the briefest attention to what is implied by the Incarnation. God enters our human condition in all its fragmentation and uncertainty and brings to us all in Christ the gift of hope and reconciliation. In this debate the spirit of Christ is also at work. After all, nothing is outwith Christ) and part of our task is surely to listen with great care to the voice of God in Christ in Scripture, in the tradition and in our reasoned discourse with each other to see how we might become wiser in our thinking and decision making…for the sake of truth and the common good.

PS. This paper is much longer than the actual talk I gave at the Space in the City meetings held in Winchester during January and February 2012, but I thought it important to stimulate further debate by offering a longer, albeit unfinished paper.