



Assisted Suicide

By Rick Thomas

Everyone hopes for a good death. But in a world of changing cultural values and complex technological healthcare, what does it mean to die well and to die faithfully as a Christian believer?

Many people fear that during a final illness they will suffer uncontrollable pain, or indignities, or be 'kept alive' by technology longer than they would wish. So the thought that they could 'call time' on their struggle before they lose control will appear understandably attractive. They see the prospect of assisted suicide as offering them the hope of retaining control over the manner and timing of their deaths.

Euthanasia (having one's life actively ended) and assisted suicide (being helped to kill oneself) are both still illegal in this country, though one or both have been legalised in some European countries (notably Belgium, the Netherlands and Switzerland) and also in certain states in the USA (Oregon, Washington and Vermont). The Suicide Act 1961 decriminalised suicide and attempted suicide, in England and Wales (in Scotland it was never a crime). However, it remains illegal to assist or encourage another person to commit suicide, a crime punishable by up to 14 years in prison. At the time the Suicide Act was passed, the desire to commit suicide was considered a sign of illness, requiring treatment and care, and not something to be facilitated. Fifty years later, the cultural landscape has change significantly.

The case for assisted suicide

Today, those advocating a change in the law believe they are reflecting a trend in public opinion. Doesn't individual autonomy imply the right of any mentally competent person to end his or her own life or to receive assistance to end it?

Is there really any significant moral difference between being given painkillers and sedatives during end of life care in a hospice and taking a lethal dose of prescribed barbiturates at home? Former Archbishop of Canterbury George Carey recently argued: 'The current law fails to address the fundamental question of why we should force terminally ill patients to go on in unbearable pain and with little quality of life.'¹

Doesn't compassion demand that people with disabling and incurable conditions be able to end their suffering when they feel they have had enough? Campaigner Tony Nicklinson, who eventually died with 'locked-in syndrome' after an unsuccessful attempt to change the law, put it starkly: 'My life is dull, miserable, demeaning, undignified and intolerable... I should be able to decide how and when I end it'.²

Is not the continuing care of severely demented people a waste of resources? Bioethicist Baroness Warnock remarked: 'If you're demented, you're wasting people's lives – your family's lives – and you're wasting the resources of the National Health Service.'³

These are the three principal arguments used to support the legalising of assisted suicide – autonomy, intent and compassion. We consider a Christian response to each of these below, following reviews of attempts to change UK law and the experience of those jurisdictions where the law has already changed.

UK 'on the brink'

There have been a number of attempts to change UK law on assisted suicide both in British parliaments and in the courts (see box). Parliaments have so far rejected proposals to change the law, primarily out of concern for public safety.

A succession of highly publicised cases of terminally ill patients requesting permission to receive assistance to end their lives keeps the issue in the public eye in UK. In February 2010, the Director of Public

Parliamentary attempts to change the law

- **2006 Assisted Dying for the Terminally Ill Bill – Lord Joffe**
Defeated in House of Lords by 148 to 100.
- **2008–9 Coroners and Justice Bill**
Lord Falconer's amendment to permit enabling or assisting a person to travel to another country where assisted suicide is legal, was defeated in House of Lords by 194 to 141.
- **2010 End of Life Assistance Bill – Margo MacDonald MSP**
Defeated in Scottish Parliament by 85 to 16.
- **2014–15 Assisted Dying Bill – Lord Falconer**
Ran out of Parliamentary time in House of Lords but is expected to be reintroduced after the 2015 general election.
- **2015 Assisted Suicide (Scotland) Bill – Patrick Harvie MSP**
Currently being considered by Scottish Parliament.

Prosecutions (DPP) published guidelines that are now used by the Crown Prosecution Service (CPS) to decide if it is 'in the public interest' to prosecute a suspect for encouraging or assisting a suicide in a given case. Some of these criteria – for example that the suspect was 'wholly motivated by compassion' – have been criticised as opening the door for exploitation and abuse.

Experience in other countries

In practice it can be extremely difficult to predict accurately who will and who won't survive for six months, as proposed in Lord Falconer's Assisted Dying Bill. The Oregon experience illustrates this.⁴ Some patients prescribed lethal drugs for the purpose of assisted suicide, on the basis that they were not expected to live for more than six months, had still not taken those drugs three years later.⁵

Also, many who *appear* to have a settled wish to die do not have a terminal illness but actually seek assisted dying because they feel their lives are worthless and they'd be better off out of the way. In Oregon in 2013, such existential reasons were by far the most common ones given for seeking assisted suicide – 93% cited 'loss of autonomy', 89% 'loss of enjoyment of life' and 73% 'loss of dignity'. Similarly, in Washington in 2013, 61% of people opting for assisted suicide gave the fear of being a burden to family, relatives and caregivers as a key reason.

In one multi-site study in the US, half of those with terminal illness who had initially considered seeking assisted suicide changed their minds over the subsequent few months.⁶ In another study, in Oregon, 26% of those seeking assisted suicide met the criteria for depression. Less than 3% of such patients were referred for formal psychiatric assessments. In the same study, researchers found that 2–17% of those in Oregon and the Netherlands, who died by assisted suicide, had been suffering from clinical depression at the time.⁷ Over time, there has been a dramatic fall in the number of individuals receiving assisted suicide in Oregon who are first referred to a mental health professional on the grounds that a suspected mental disorder may be impairing judgment. In 1999, the figure was 37%; the number in 2010 was 1.5%.⁸

A frequently heard argument is that assisted suicide gives patients the chance of dying a 'good death'. However, the reality can be very different. Dutch research shows that distressing complications can occur. For example, in 18% of cases the patient failed in the attempt and doctors had to intervene and kill the patient – assisted suicide became, in effect, euthanasia.⁹

Incremental extension

Many of those who currently seek assisted suicide are suffering, not with terminal illness, but with long-term neurological or other chronic conditions that would not fall within the terms of Lord Falconer's bill. Were it to be passed pressure to extend the scope of its provisions to include such cases on grounds of 'equality' would be inevitable. This has been seen in every European country and US state where assisted suicide and euthanasia legislation has already been passed.¹⁰ There is clear evidence from the Netherlands that at least one thousand

patients, including the elderly, incapacitated, those suffering emotional distress, the disabled and even children and newborn babies, are being killed every year without their expressed consent.^{11 12 13} As Dr Karel Gunning, a Dutch General Practitioner, states: 'Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.'¹⁴

Lord Falconer's Assisted Dying Bill has been modelled on the Oregon legislation. Thus it seems likely that any change in UK law to allow assisted dying would produce the same effect of placing pressure on vulnerable people to end their lives – a 'right to die' would rapidly become a 'duty to die'. Of course, supporters of the bill point to its 'safeguards' against abuse, such as limiting the application of assisted dying to certain categories of people. Similar claims were made when David Steel introduced the 1967 Abortion Bill. In practice, once any so-called 'right' is established in law, experience in other jurisdictions shows that incremental extension takes place over time. There is both a steady increase in absolute numbers of cases and also inclusion of those who are outside the stated boundaries of the law. There is also pressure to extend the law as activists bring new cases to the courts using the same general arguments of autonomy and compassion.

Financial cost is another driver of incremental extension – it's much cheaper to kill than to treat. At a time of national financial restraint, and with the high cost of in-patient care, the temptation for authorities to 'stretch' the scope of application would be ever-present. It costs on average £3,000 to £4,000 a week to provide in-patient hospice care, but just a one-off cost of around £5 to pay for the drugs which would help a person commit suicide. Cancer treatments like chemotherapy, radiotherapy or surgery cost much more. Do we really wish to place that temptation before families, NHS managers and health ministers?

The Hippocratic tradition

It is significant that doctors and palliative care workers are amongst the most vigorous opponents of moves to legalise assisted suicide. They study and work to preserve lives, not to end them; to be purveyors of health, not death. The vast majority of UK doctors are opposed to changing the law,

along with the British Medical Association (BMA), the Royal College of Physicians, the Royal College of General Practitioners, the Association for Palliative Medicine and the British Geriatric Society. A law making them responsible for assisting suicide would be against the Hippocratic tradition that has guided doctors for over 2,000 years (see box).

Trust is crucial to the doctor–patient relationship. The patient's confidence that the doctor will always act in such a way as to do no harm is foundational to that relationship. Giving doctors the power deliberately to end the lives of their patients will inevitably redefine the nature of the relationship and risks undermining that essential trust and confidence. Doctors could eventually become hardened to causing death, and begin to see their most vulnerable patients as 'disposable'.¹⁵ Such patients could decide not to ask for medical help, for fear that they be encouraged to consider assisted suicide by doctors who they feel they can no longer fully trust.

In a speech in the House of Lords in 2003, Lord McColl of Dulwich reported on a visit to the Netherlands which illustrated well this change in medical conscience: 'Noble Lords will be aware that the Select Committee visited Holland. When we inquired of a doctor what it was like doing the first case of euthanasia, he said, "We agonised all day. It was terrible". But he said that the second case was much easier and the third case – I quote – "was a piece of cake". We found that very chilling indeed.'¹⁶

Autonomy is not absolute

The most strident voices calling for a change in the law to allow assisted suicide are those that trumpet the autonomous rights of the individual.¹⁷ Of the four commonly quoted principles advanced as guides to bioethical debate and practice (namely respect for autonomy, beneficence, non-maleficence and justice¹⁸), autonomy has taken centre stage. But if understood as 'the right to do what I like', autonomy is a mirage – it fails to recognise that my choices affect yours and vice versa.

We live in a highly individualistic culture where there is much emphasis on an individual's rights, but much less about responsibilities and less still about restrictions. The truth is that we are not just individuals but individuals living in community, whether that community

Oaths and declarations

- **Hippocratic Oath (c.400 BC)**
'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.'
- **Declaration of Geneva (1948)**
'I will maintain the utmost respect for human life from the time of conception; even under threat I will not use my medical knowledge contrary to the laws of humanity.'
- **International Code of Medical Ethics (1949)**
'A doctor must always bear in mind the importance of preserving human life from the time of conception until death.'
- **Declaration of Oslo (1970)**
This declaration reaffirmed the 'utmost respect for human life from the time of conception'.
- **Statement of Marbella (1992, and reaffirmed in 2013)**
'Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.'

is a family, neighbourhood, workplace or society. A right exercise of autonomy will recognise the implications our decisions will have for others. It will balance rights with responsibilities and forgo some freedoms out of respect for others' rights and the common good (as with the observance of speed limits and smoking restrictions). We all accept that in a democratic society there are limits to personal freedom – that is why we have laws.

The person exerting her autonomy by taking her own life ignores the profound effects of her action on those who have to live through the tragedy – she has effectively removed those very same autonomous rights from the survivors.

Ironically, the autonomous rights of elderly, confused, disabled or depressed persons would be threatened, not protected, by the introduction of assisted suicide legislation. Spoken or unspoken pressures on such vulnerable people can mean that legislation intended to provide the opportunity to choose death, in practice imposes an obligation to do so. When assisted suicide becomes a cheap treatment option, the danger is that sick or vulnerable people can be subtly steered toward choosing suicide out of a felt sense of duty not to be a financial or emotional burden upon others. This is why all the major

disability rights organisations in Britain oppose any change in the law, believing it would lead to increased prejudice towards disabled people and increased pressure on them to end their lives.

Assisted suicide, by definition, is not a private act – it requires the involvement of another person, often a doctor. The patient's autonomous decision therefore impinges on the autonomy of the physician – the patient's 'right to die' would impose on the doctor a duty to assist. The doctor (or more than one) would be obliged to make a value judgment about whether a patient's *quality* of life was such as to preserve or terminate it; any notion of the *sanctity* of human life would be undermined.

Intent is important

There are many examples of the importance that society and the law attach to intent. Take for instance the distinctions we draw between negligence, manslaughter, crimes of passion and murder. Judicial sentencing reflects the measure of intention behind the deed. We make special allowance for those with diminished responsibility. We do not concern ourselves simply with outcomes, but also with motives and intentions.

Allowing terminally ill patients to die from their illnesses when there is no longer anything to be gained by more active treatment or intervention has long been part of good medical practice. Good symptom relief during those final days will sometimes include the use of medications to control pain and/or anxiety that may incidentally also shorten the patient's remaining life, although in skilled hands this is extremely rare. This 'double effect' is deemed legally and ethically acceptable where the doctor's clear *intention* is to relieve distressing symptoms, not to shorten life.¹⁹ In assisted suicide, however, the prescribing doctor's clear intention is to end the life of his patient. He has crossed an ethical Rubicon that has guided doctors for almost 2,500 years since Hippocrates.

Compassion is costly

Those who advocate assisted suicide often argue for it on the basis of compassion – it's kinder to kill than to care! Of course, it is not usually expressed in such terms. More commonly heard is the notion that dying with dignity is kinder than living with incurable suffering. The kind motives underlying such sentiments are not in

question. This was the position taken by Archbishops Carey and Tutu over the Falconer bill. Lord Carey admitted that, for him, 'the old philosophical certainties have collapsed in the face of the reality of needless suffering'.²⁰ Compassion, he seemed to be saying, means that we must intervene to end suffering, even if it means ending a life. But the true meaning of 'compassion' is not to end suffering but 'to suffer with'. We may not always be able to cure a condition but we can always exercise compassionate care – we can 'walk with' others in their suffering.²¹

The following medical aphorism is attributed to Dr Edward Trudeau (1848–1915): 'To cure sometimes, to relieve often, to comfort always.' The public misconception that modern medicine holds the answer to all illness can create a level of expectation that doctors cannot possibly meet. Doctors can be tempted to feel a sense of failure when faced with relentless, incurable disease in their patients. But the truth is, doctors are not called to cure all – they are called to care for all. Compassion does not mean that they should intervene to end the lives of those they cannot cure.

Compassion is what has motivated many Christians to engage in palliative and hospice care. Good palliative care, whether in the community or in hospices, has demonstrated that it is possible to control discomfort and distress effectively – killing the pain, not the patient. In 2010 the BMA, recognising that requests for assisted suicide and euthanasia are very rare when patients are being properly cared for, called for better training of doctors and education of the public about palliative care. Whilst some effects of disease, such as paralysis, might not be reversible, with effective care people are still able to lead meaningful lives. The love and support of family, friends and clinical staff will affirm their value, regardless of the limitations of their condition.

Of course, there is a significant cost to such care, and society must decide to value highly its sick, demented, disabled and dying members if it is to meet that cost. Legalising assisted suicide would inevitably strengthen the perception that vulnerable people have lives 'not worth living', that they would be 'better off dead', and that the costs of such care would be better directed towards healthcare provision for the more socially or economically 'productive'

members of society. The quotient of compassion in the caring professions and in society at large would inevitably ebb.

Cross-shaped care

The power of the arguments from compassion and autonomy for Christians is that they are half true. We are called to treat all people with Christ-like compassion but that does not involve killing them, and we are called to respect individual freedom and accountability but that is not the same as 'autonomy'.

Christians believe that human life has intrinsic value because it is the gift of God, created in his image (Genesis 1:27). The inviolability of human life is based on this intrinsic dignity and sanctity, and is independent of capacity or productivity.

The intentional killing of an innocent person is forbidden in the Ten Commandments (Exodus 20:13) and uniformly condemned throughout Scripture. In the Old Testament, God permitted killing in three situations: in the context of a holy or 'just' war (Deuteronomy 20), for certain capital offences (Genesis 9:5–6) and in proportional self-defence (Exodus 22:2). All of these situations have clearly defined conditions. There is no provision for so-called 'compassionate killing' and no recognition of a person's 'right to die'.

In the New Testament, Jesus 'raised the bar' in his teaching, affirming the importance of obedience to 'the law' but also calling for right attitudes of heart – to Jesus, intent is important (Matthew 5:17ff). He taught that true liberty, prosperity and fulfilment, for individuals and societies, is discovered, not through the pursuit of autonomous rights, but in submission to his benevolent rule (eg Matthew 6:33).

Christians should know how to die. For Christians, death has lost its 'sting' (1 Corinthians 15:55) and is but a gateway to a more glorious existence in a new heaven and new earth (Revelation 21:4). Their confident hope gives them an eternal perspective on suffering in this life. It gives them strength to endure their own struggles without fear (1 Peter 1:6–7; 2 Corinthians 4:17) and to comfort and encourage others going through similar trials (2 Corinthians 1:3–4). Christian doctors recognise that man's greatest need is to be able to approach death having made peace with God, and so will be concerned to provide spiritual care alongside

symptom relief and emotional support.

Christ not only robbed death of its victory, he demonstrated the cost and nature of true caring. The key element in Christian caring is empathy, the readiness to stand alongside those cared for, to suffer *with* them, as God in Jesus has suffered with us. Such compassion is self-giving, incarnational; it is cross-shaped, willingly dying to self in giving self to others who are dying; it is hope-bringing and empowering.

There is mystery here – somehow reflecting in care for one another the cosmic and transforming power of the cross of Christ to turn tragedy into blessing, suffering into redemption and despair into deep joy. Few who receive such selfless, costly and compassionate care will continue to contemplate or seek assisted suicide.

Rick Thomas is a specialist in Respiratory Medicine and CMF Public Policy Researcher.

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