YR EGLWYS yng NGHYMRU THE CHURCH IN WALES

Perspectives on Assisted Dying

Discussion Paper

April 2014

INTRODUCTION

The Science and Society group of the Church in Wales was invited by the Bench of Bishops and the Standing Committee to arrange a discussion and debate at the Governing Body [GB] meeting in April 2014, on 'assisted dying'. The objective of the debate is to open up for discussion a topic of considerable current interest, on which Christian theology, teaching and practise can contribute insight; and to offer the chance to explore some of the arguments in a Christian context. At the end of the debate, the GB will be invited to pass a motion recognising the importance of the issue and commending it to further prayer and study. Because this is a sensitive subject, and there is a range of views held by Christians, it is not intended that the GB motion commits the Church in Wales to a particular policy; it has been constructed as a 'take notice' debate.

The GB debate will be introduced by 2 invited speakers: Revd Professor Paul Badham; and Robert Preston, of the Living and Dying Well Foundation. Coming from both theological and health perspectives, they are acknowledged authorities on the subject, and well-known participants in the debate across the UK. In preparation for the GB debate, these background papers have been submitted by the external speakers; and they have had a chance to see one another's contributions in advance, so that they can address similar issues.

The papers do not cover every possible aspect of this complex subject, but we hope they will provide some background and

opening ideas. There are also suggestions for further reading, and other suggested resources.

This booklet has been circulated in advance to all GB members, and is available on the Church in Wales website. It is our hope that the debate and the associated materials will increase the confidence of Church in Wales members to talk about the important issue of 'assisted dying' in appropriate situations.

Revd Dr Sarah Rogers (Convenor, Science and Society Group) and Revd Carol Wardman (Bishops' Adviser for Church and Society)

March 2014

A Christian Context for Assisted Dying

Paul Badham

Religion matters to this debate because many people on both sides are motivated in the position they take by their religious beliefs. It is important to examine how their opinions are formed and how attitudes to medical care, life and death have been influenced by religious beliefs over the years and how these opinions have changed.

Another reason why it is important that religious people should think carefully about whether or not the law should be changed is because religious societies and leaders of faith communities have played a major role in opposing change. The last two attempts to change the law were defeated in part by a well organized Roman Catholic Lobby and also by the unanimous opposition of the Anglican Bishops in the House of Lords. In taking this stance Christian leaders were not speaking for all their members. Recent polls show that 78% of monthly worshippers want the law changed.[1] The figures are lower for more regular worshippers but a majority of them also want change. According to figures drawn from British Social Attitudes by Professor Robin Gill 61% of weekly Churchgoing Anglicans and 57% of weekly Churchgoing Roman Catholics would like the option of an assisted death.[2]

1 YouGov *Dignity in Dying Survey* 2013

2 Email from Robin Gill summarizing findings in his book, *Society shaped by Theology* Ashgate 2013

The importance of compassionate love and of Jesus' golden rule

This paper looks at assisted dying from the perspective of key Christian values. The most important of these is compassionate love. The Greco-Roman world was well acquainted with love in the form of eros (romantic or sexual love) and philia (the love between friends). Outgoing compassionate love (agape or caritas) was claimed as a distinctively Christian virtue. For St. Paul it was the supreme Christian value, more important than faith or hope or even of a willingness to accept martyrdom. For Jesus the whole of religious law and prophetic teaching could be summed up by the command to love God and to love your neighbour as yourself. His Golden Rule was that we should always treat others as we wish to be treated ourselves. These principles matter because they are at the heart of the current debate on assisted suicide.

Although theoretically anyone who assists another to die is liable to 14 years imprisonment, the Guidelines of the Director of Public Prosecutions make clear that no one will actually be prosecuted if the dying person had made a 'voluntary, clear, settled and informed decision to commit suicide' and if the relative or friend who gave assistance was 'wholly motivated by compassion' in helping them die.[3] These Guidelines were endorsed unanimously by the House of Commons on March 27th 2012.[4] Although MPs differed widely on the desirability of assisted dying, even those most opposed to it believed that criminal prosecution was wholly inappropriate in situations where people were acting out of compassionate love in the face of human suffering. Hence, in practice, assisted dying is

[3] *Policy for Prosecutors* DPP , February 2010 www.cps.gov.uk Section 45 paras 1 and 2

[4] *Hansard* 27th.March 2012 (available on-line)

already accepted when the assistance comes from relatives or friends and no one has actually been prosecuted for over six years.

However, the DPP has stated that any doctor or other health professional who assisted a person to die would be likely to face prosecution, as would anyone who sought to establish a British equivalent to the Swiss Dignitas organization. Lord Falconer‘s commission felt this was an incoherent position. For many doctors and nurses compassionate love for the well-being of their patients is their raison d’etre. Given that at least some dying people do have a ‘voluntary, clear, settled and informed wish to die’ and beg for help to do so, it is extraordinary that doctors and nurses alone are forbidden for giving them such help. The pressure group *Health Care Professionals for Assisted Dying* is campaigning for the law to be changed so that its members can give this help. They believe it is wrong that terminally ill British citizens should have to travel to Switzerland to get professional help to die. And they believe it is cruel to lay the burden of assisting a loved one to die on the shoulders of their nearest and dearest relatives.

Jesus’ Golden Rule is highly relevant to the current debate. As R.M. Hare argues in his *Essays in Bioethics,* ‘there is no moral question on which Jesus’ teachings have a more direct bearing than on euthanasia.’[5] It was Jesus’ teaching on treating others as you would wish to be treated yourself that led the Church of England Working Party *On Dying Well* to the conclusion that they could not say that euthanasia was always wrong. They admitted that, ‘there are bound to be cases where any of us who is honest with himself would wish to have our own deaths hastened so that the manner of them might be less

[5] R.M. Hare, *Essays in Bioethics* Oxford, Clarendon 1993 p.72

unbearable. Thus a direct application of the teaching of Jesus to these cases would legitimize at least some instances of euthanasia.'[6]

According to Dr. Michael Irwin, former Medical Director of the United Nations, 'many physicians and nurses have private arrangements that they will hasten each other's deaths should they ever be unfortunate enough to resemble the condition of some of their patients.'[7] Baroness Warnock and Dr. Elisabeth Macdonald have noted the same phenomena[8] and according to a Doctors Net Poll '66% of doctors are not opposed to the option of an assisted death for themselves if terminally ill and suffering.[9] A change in the law would enable such doctors to treat their patients as they wish to be treated themselves.

Why palliative care is not enough

It is of course true that many opponents of a change in the law are also deeply motivated by compassionate love. It is such love that has inspired the development of palliative care and the hospice movement, of which Christians are rightly proud to have contributed to. Like other members of *Dignity in Dying,* I strongly support palliative care and the hospice movement. I am convinced that in the vast majority of cases good palliative care is the best solution to the distress of terminal illness. There should be no conflict between support for palliative care and support for assisted dying. When Baroness Finlay introduced her Palliative Care Bill she did so because she believes that with good palliative care '95% of the pain in terminal illness can be and should be controlled'[10]. That would

6 Archbishop's Council, *On Dying Well* Church House Publishing 1975 & 2000 p.23
7 *Sunday Times* 20th July 1997
8 Mary Warnock and Elisabeth Macdonald, *Easeful Death* OUP 2008 p.122
9 Cited by *Campaign for Dignity in Dying* /01/ Winter 2012
10 Speaking in the House of Lords 23rd. February 2007

be a very welcome improvement on the present situation, but it would still mean that uncontrollable pain remained a significant feature of terminal illness. 95% success in controlling pain means a one in twenty failure to do so. If I found myself enduring uncontrollable pain in the final stages of my life, I would want the option of having help to end my life. Opinion polls show that at least 80% of the British population think the same way. However, the ending of pain is not the primary factor in people seeking an assisted death. Far more often it is a case of not wishing to go on living in a state of total dependency on others, or of being unable to control ones bodily functions, or the loss of sight, hearing or mobility.

Lord Falconer suggests that the only criteria for an assisted death should be that the patient is terminally ill with a probable upper limit of six months of life and that the patient found the suffering entailed by the dying process intolerable. In such circumstances I find it very hard to see how a Christian can deny them this request. When peoples' sufferings are so great that they make repeated requests to die, it seems a denial of that loving compassion, which is supposed to be the hallmark of Christianity, to refuse to allow their requests to be granted. If we truly love our neighbour as ourselves how can we deny them the death we would wish for ourselves in such a condition? We might also ask Baroness (The Reverend Kathleen) Richardson of Calow's searching question to opponents of euthanasia: 'By what moral judgement can we justify keeping alive those people who sincerely want to die, when their life is in their own eyes not worth preserving?'[11] Let us look at some of the arguments that have been used to justify turning down such requests.

[11] Mary Warnock and Elisabeth Macdonald, *Easeful Death* p.137

The sanctity of life argument

One argument frequently used against legalizing assisted dying is the claim that it denies the sanctity of human life at its most vulnerable and ignores the intrinsic value of every human being at every stage of existence. It also claims that to support assisted dying fails to recognize human life as a gift from God to be treasured. In response to such claims I would point out that from a New Testament perspective 'The Gift of God is Eternal Life'.[12] This gift of eternal life is not taken away by death. Christianity sees death as the gateway to a richer and fuller life with God. For those who believe this, death is not a disaster and there is no point in clinging on to a life that is no longer fulfilling to them. The early Christians certainly took this line. According to St. Athanasius 'the strongest argument for the resurrection of Jesus is that Christians have no fear of death but rush eagerly to meet it'.[13] One of the oldest Christian prayers is a prayer of St. Ambrose 'Grant to life's day a calm unclouded ending, an eve untouched by shadows of decay'. If it is right to pray for this it should also be right to ask a Christian doctor to help the prayer be answered. I also suggest that we best respect the dignity of the dying if we accept that in at least some cases people do have what the Director of Public Prosecutions describes as a 'voluntary, clear, settled and informed wish to die' and that they do sometimes seek compassionate help to enable them to do so.

The commandment 'Thou Shalt Not Kill'

For many evangelical Christians voluntary euthanasia and assisted dying are simply ruled out as forbidden by the sixth of the Ten Commandments 'Thou shalt not kill'. However, if we

[12] Romans 6.23
[13] St. Athanasius , *On the Incarnation* Mowbrays 1963 pp 57-59

look at the Old Testament law code of which this is part, we see at once that the command not to kill was never thought of as an absolute rule. It was subject to a bewildering range of exceptions. Not only was war enthusiastically supported but the death penalty was imposed for a bewildering array of offences ranging from consulting a medium to a variety of more or less trivial sexual offences. People could be killed for picking up sticks on the Sabbath day. A priest's daughter who had pre-marital sex was to be burnt alive.[14] It is clear from these and other exceptions that the Old Testament does not forbid killing as such, but what it does what it does do is to forbid murder and it is right to do so. The essence of murder is to take away an innocent person's life, against their will. That is quite different from responding to the request of a dying person to help them bring their own suffering to an end.

What is also significant is that the sixth commandment was never interpreted by the Old Testament as forbidding suicide when a person faced an undignified death. None of the suicides recorded in the Old Testament or Apocrypha are disapproved of. For example, we are told that Razis 'fell upon his own sword, preferring to die nobly than to suffer outrages unworthy of his noble birth.'[15] Clearly this is not a precise parallel with the assisted suicide of a person dying from terminal illness. On the other hand some of the factors in terminal illness that are thought unbearable by some dying patients include the loss of their dignity through the inescapable humiliations of the dying process. Hence their attitude is not wholly unlike that of those Old Testament heroes who sought a dignified death rather than falling into the hands of their enemies.

[14] Leviticus 20.6,10,13,17,18, Exodus 21.17; Deuteronomy 21.18; Leviticus 21.9
[15] 2 Maccabees 14. 41-42

Should only God determine the hour of our death?

One argument often used against assisted dying is that only God should determine the hour of our death. The difficulty with this is that today almost no-one consistently believes it. For example, if a person is seriously ill in hospital and suffers a cardiac arrest, we don't think that we should simply accept that this is God's will for that person. Instead we do everything we can to resuscitate that person and get the heart beating again. The whole ethos of modern medicine is rightly opposed to the idea that doctors should not intervene and today Christians very much welcome medical advances. This was not always true of Christianity. The earliest book on Christian ethics, *The Didache,* saw the taking of medicine as equivalent to sorcery.[16] In the Middle Ages the Church forbid the study of anatomy or dissection. In the 19th century some Christians opposed the use of anaesthesia. They also believed that to use quinine as a protective against malaria showed a lack of trust in God's providential care. The use of vaccination against small pox was seen as playing God. It is good that the Church has changed its stance on these issues and now thinks that medical intervention for human benefit is a great good. Today it is only in relation to stem cell research and assisted dying that the charge of playing God is still levelled.

Is it good for us to suffer?

However, some tensions remain. According to Pope John Paul II 'suffering, especially in the final stages of life, has a special place in God's plan of salvation.'[17] This view challenges both

[16] Didache 2.2; *NB* the Greek text includes a ban on *pharmakeuseis* (medicine). Oddly this has been left out of the English text in the Loeb edition.

[17] *The Declaration on Euthanasia of the Sacred Congregation for the Faith.* Rome 1980

palliative care and assisted dying and is, of course, very similar to what all Christians used to think about the pains of giving birth. According to the Bible 'women shall bring forth children in pain'.[18] That suffering too was seen as part of God's plan of salvation. But few Christians think like that today and women should be grateful that Queen Victoria insisted on her right to chloroform in childbirth and thereby changed the situation for all women.

The parallel between birth and death

There is another parallel too. At the beginning of the twentieth century almost all Churches opposed family planning, arguing that God alone should determine when a new human life begins. The Vatican still teaches this but almost all other Christian leaders now accept that it is right to plan one's family. This development is important for the euthanasia debate because Hans Kung has shown that the Papal Bull against euthanasia (*Evangelium Vitae)* uses the same arguments as those in the Papal Bull against contraception (*Humanae Vitae).* Kung believes the papal rulings are as catastrophically wrong in both cases.[19] Because I believe that it is right to seek medical help and assistance in the timing of birth and in the avoidance of suffering during birth I also think it right to seek medical help and assistance in the timing of death and in the avoidance of suffering while dying.

Our duty to the vulnerable and needy

Some opposition to euthanasia is based on the grounds that we should always seek to ensure that the legal system

[18] Genesis 3:16
[19] Hans Kung and Walter Jens, *A Dignified Dying.* SCM 1995 p.119

protects vulnerable and dependent members of society from unwelcome pressures. I totally accept this premise but not the conclusion derived from it. At present some vulnerable people often find themselves pressured by their families to accept burdensome treatments which may have little prospect of success. According to Hans Kung some terminally ill people are often exposed to 'intolerable suffering at the very point when their helplessness is at its greatest', but it is precisely the most vulnerable who should be allowed the means to ensure that their lives are not 'dragged out endlessly'.[20] Douglas Davies in his *History of Death* says that what really scares people about death today is their fear that they will be kept alive beyond sense and reason[21].

The peril of 'sliding down a slippery slope'

By far the strongest argument against changing the law is that it might have unforeseen consequences. During the 1960's Parliament legalized abortion, made divorce easier and decriminalized homosexuality. In all three cases the legislation was directed at 'hard cases'. Abortion was for when a mother's health was at serious risk, divorce was for when a marriage had irretrievably broken down, and homosexual reform was to prevent consenting adults being blackmailed. No-one imagined that within a generation we would have abortion on demand, 40% of marriages ending in divorce and homosexuality being seen as on a par with heterosexual relationships. So to it is argued once we 'cross a line' and allow assisted dying for the terminally ill, we might set ourselves on a course which could end with euthanasia being seen as the natural way for a terminal illness to be ended.

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[20] Hans Kung and Walter Jens, *A Dignified Dying*. London, SCM 1995, p.34 & 119.
[21] Douglas .Davies , *A Brief History of Death.* Oxford , Blackwell 2005, p.205

But are such fears justified? To answer that question we need to look at what actually happens in jurisdictions which allow assisted dying or voluntary euthanasia.

Does allowing Assisted Dying weaken health care provision?

The slippery slope argument assumes that allowing assisted dying would lead to a decline in health care and to a culture where 'a right to die would become a duty to die.' If such fears were justified we would expect them to be exemplified in Switzerland. This is because Switzerland has the most liberal law on assisted dying and has allowed it for seventy years. However, Switzerland has more hospital beds and more doctors per capita than Britain, spends more on healthcare, and has considerably better overall life expectancy and cancer survival rates. Indeed the average Swiss person lives two and half years longer than we do.[22]

What this comparison between Britain and Switzerland shows is that allowing assisting dying does not harm health care. It also shows that having a right to die does not in the slightest entail that people feel a duty to die. Instead the evidence indicates that a country which shows compassion to people who want assistance to die will be *more*, rather than *less*, likely to show equal compassion to others who want assistance to continue to live. This would seem supported by the consideration that while around 100 foreigners a year travel to the Dignitas Clinic in Zurich for an assisted death, 30,000 of foreigners a year travel to Swiss hospitals and sanatoria for the latest and best medical treatments.[23]

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[22] O.E.C.D. statistics on comparative health care as published on the webs

[23] http:www.swissinfo.ch/eng/swiss_news/Hospitals_target_wealthy_health_tourists.html?cid=29588036

Does allowing voluntary euthanasia weaken trust in doctors?

The Dutch have had experience of voluntary euthanasia for over forty years. However, initially it was highly controversial. 49% of the population were opposed, and no political party dared legislate for it. It came into being solely on the basis of a series of court cases. In those early years there were many atrocity stories told about what was believed to be happening and frightened Dutch people carried cards saying 'Don't kill me doctor'. Stories were told of people booking themselves into nursing homes outside the Netherlands to feel safer. The Royal Dutch Medical Association complained that opponents of euthanasia had succeeded in conveying a 'very inaccurate and unreliable impression of the true situation'.[24] Gradually however, the Dutch came to see that their fears were not justified and after 30 years experience of voluntary euthanasia the number of Dutch people opposed to it has dropped from 49% in 1966 to 10% by 1996.[25] In 2002 voluntary euthanasia was finally legalized by the Dutch parliament. In 2007 a survey found that the Netherlands is now the country in Europe where doctors are most trusted. Indeed a staggering 97% of the Dutch population declare their full trust in the medical profession.[26] This is because terminally ill patients are more willing to talk things through with their doctor when they know the doctor is free to help them whatever they decide. 79% of Britons say they would trust their doctors more or the same if euthanasia were legalized here.[27] The case for seeing

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[24] Margaret Otlowski, *Voluntary Euthanasia and the Common Law.* Oxford Clarendon 1997. p.437

[25] Ruurd Veldhuis, 'Tired of living and Afraid of Dying'. *Studies in Christian Ethics* 11.1, 1998. P.63-76, 70

[26] Z. Kmietovicz, Respect - Why doctors are still getting enough of it' *British Medical Journal* 2002. 324 (7328)

[27] YouGov Poll 1964 in Dignity in Dying The Report. London, Dignity in Dying, 2006, p19.

voluntary euthanasia in the Netherlands as beneficial is that the Dutch themselves have been convinced by experience that it is beneficial. The experience of the Dutch has also convinced the other 'Benelux' countries (Belgium and Luxembourg) to introduce comparable laws and more recently President Hollande has committed himself to legalizing assisted dying in France.

Does legalizing assisted dying weaken the demand for palliative care?

It is often claimed that allowing assisted dying would weaken the development of palliative care, but there is no evidence that this happens. On the contrary, the European Association on Palliative Care found that in the Netherlands, Belgium and Luxembourg palliative care has improved since voluntary euthanasia was legalized.[28] This has been most marked in Belgium where a universal right to palliative care was introduced at the same time as the legalization of voluntary euthanasia.[29]

A comparable effect has been found in Oregon. The Oregon Hospice Association, like Hospice associations everywhere, was passionately opposed to the *Death with Dignity Act* and fought it every step of the way. Then, when the Act became law in Oregon, the Hospice Association appealed to the United States Supreme Court to get the Act declared unconstitutional. But the American appeal system is notoriously slow and it took eight years for the case to reach the Supreme Court. Then, when that Court ruled that individual US states had the constitutional power to pass such a law, the Oregon Hospice Association put out a new position statement saying that they

[28] Lord Falconer; *Report of the Commission of Assisted Dying.* Demos 2011. p158
[29] Lord Falconer; *Report of the Commission of Assisted Dying*. Demos 2012. p220

were glad they had lost. This was because in the first eight years of the working of the Act 'absolutely none of our dire predictions has been realized'. Instead there had been an enormous expansion of Hospice care. In fact the percentage of Oregonians who died in hospices rose from 22% to 51% during those eight years.[30] Seeing how well the Act was working in Oregon the people of neighbouring Washington State voted for a similar *Death with Dignity Ac*t and the courts in Montana have made clear that they will no longer prosecute people who act in accord with such legislation. More recently The State of Vermont has become the fourth US State to legalize assisted dying.

Does legalizing voluntary euthanasia encourage non-voluntary euthanasia?

One of the strongest fears about a slippery slope is that legislating for voluntary euthanasia might lead to more involuntary euthanasia. But once again the empirical evidence does not support this. A report in the Lancet for the 11th July 2012 found that while cases of voluntary euthanasia before and after legislation remained comparable, (2.6% of all deaths in 2001 and 2.8 % in 2010) the number of cases of involuntary euthanasia had dropped from 0.7% in 2001 to 0.2% in 2010.

The Journal of Medical Ethics found that the evidence is that legalizing assisted suicide *decreases* the prevalence of involuntary euthanasia.[31] The British Medical Journal 29th Sept. 2007 found that people are more likely to be killed without their consent in European countries that forbid

[30] Ann Jackson, 'The Reality of Assisted Dying in Oregon: Draft notes of Compassion in Dying: All Parliamentary Group Meeting 19th.April 2006 p.11

[31] C.J. Ryan, 'The effect of new evidence on Euthanasia's slippery slope' Journal of Medical Ethics 24/5 pp.341- 4 October 98

euthanasia than in those that allow it. Likewise, the Journal of the American Medical Association found that the number of assisted deaths in Oregon, where is it legal, was lower than in other American states where it is not legal.[32] Although euthanasia is illegal in Britain a survey in the journal *Palliative Medicine 2009* found that 0.54% of UK deaths were instances of involuntary euthanasia.[33] This is a very low percentage but it is more than the 0.14% of assisted deaths in Oregon. A further recent survey found that 29% of UK doctors said that in treating terminally ill patients they sometimes acted 'with the expectation or intention to hasten the end of life.'[34] Such actions are not euthanasia, but to a lay person the distinction is a fine one.

Why this debate needs to be evidentially based

Whether or not legalizing assisted dying leads to a slippery slope is an empirical question on which we now have factual answers from the experience of the seven jurisdictions which have embarked on this process. As well as evidence about life expectancy and health care already cited, the Eurohealth Consumer Index ranks 34 European Countries using 42 indicators covering the five areas most important to patients.[35]

The top country in the Eurohealth Consumer Index by some way was the Netherlands followed by Denmark, Iceland, Luxembourg, Belgium Sweden and Switzerland. The UK was

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[32] Emmanuel Fairclough E. and Fairclough D. 'Attitudes and Desires Related to Euthanasia and Physician - Assisted Suicide among terminally ill patients and their carers. JAMA 284: 2460-2469 2000

[33] C.Seale 2009 'End of life decisions of UK doctors' *Palliative Medicine* 23/3 :198-204

[34] C.Seale 2009 'Hastening death in end of life care' *Social Science & Medicine* 69:1659-1666.

[35] The Eurohealth Consumer Index is freely available on the internet.

in twelfth place. The relevance of this is that the four countries which allow assisted dying were all in the top seven places in the league table of the Eurohealth Consumer Index. I hope that in the future Christian compassion will lead us to joining those countries which allow assisted dying as one small component of a comprehensive system of good health provision.

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'ASSISTED DYING'

Personal Morality or Public Safety?

Robert Preston, January 2014

Introduction

There are many dimensions to the complex question of whether what is being called 'assisted dying' should be legalised, including the law, clinical practice, social attitudes, ethics and international experience. One aspect, for some people, is religious faith. Another, which has implications for all of us, is public safety. I am not able to offer a professional opinion as to whether legalisation may or may not be compatible with religious conviction. This memorandum is largely about the public safety implications of legalisation. I will begin, however, by commenting on a couple of issues raised in Professor Badham's analysis of the faith dimension.

Faith Opinion

In his paper, Professor Badham states that "*religious societies and leaders of faith communities have played a major role in opposing change"* and that "*in taking this stance Christian leaders were not speaking for all their members*". Many of the latter, according to opinion polls, say they would support a change in the law. How can this apparent divergence be explained? And is it the case that faith-based organisations are a significant factor in the failure of 'assisted dying' legislation to commend itself to Parliament?

Legalisation of 'assisted dying' is a complex issue, and knowledge and understanding of its several dimensions and of

how they interact with one another is far from being common currency. There is perhaps a parallel here with opinion polling on other controversial subjects, such as immigration or membership of the European Union. In my experience few people know what the law on 'assisted dying' actually says and how it is applied. They hear suggestions that the law is oppressive and that individuals go in fear of prosecution for helping a loved one to die or, alternatively, that the law is not being enforced and that prosecutors do not have the stomach to press charges. But it is difficult for people leading busy lives to get at the truth and to understand what the real position is.

The way in which the subject is presented is also important. Campaigners for legal change do not refer to physician-assisted suicide, which is what their proposals amount to, but prefer to use the gentler-sounding term 'assisted dying'. Lord Falconer's Private Member's Bill, currently before Parliament, describes the lethal drugs which it would authorise doctors to supply to some of their patients as 'medicines'. More generally, the positioning of the debate within the context of health care surrounds the concept of 'assisted dying' with an aura of benevolence and compassion: if this is something that doctors would do for us, then it must in our best interests. That the majority of doctors, along with the Medical Royal Colleges and the BMA, have serious reservations about legalisation receives less emphasis.

Media reporting often focuses on the unusual or the exceptional - the traveller to Switzerland seeking assisted suicide or the instance of poor care at the end of life. In the same way, while the occasional air disaster makes the headlines, the hundreds of thousands of safe landings that take place every year go unreported. There is nothing surprising about this. What happens to most people and how the great majority of us live - and die - is simply not news. The

media focus is, moreover, often on individuals and 'human interest stories' rather than on issues and policies. As Professor Clive Seale has written, "*Journalists like to show ordinary people behaving like heroes or being 'victims' in need of rescue, in this case from the deterioration of their own bodies and from those who will not accede to requests for assisted dying, who are thereby constituted as 'villains'*[1]*.* Such 'human interest' stories have their place, but they can produce a distorted picture.

In these circumstances it is unsurprising if substantial numbers of people who declare themselves to be Christians (or of other faith persuasions) also say they support a change in the law. Most of us have neither the time nor the inclination to research carefully every subject that is presented to us. While we may be well-informed on a handful of issues of immediate concern to us, we tend to accept at face value what we read in the newspapers and what we see or hear on television and radio. Churchgoers read the same papers and tune in to the same radio and television programmes as the rest of us: they are not a separate caste.

Is opposition to legalisation by faith-based organisations frustrating a change in the law? Professor Badham refers in his memorandum to "*the unanimous opposition of the Anglican Bishops in the House of Lords"* as a significant factor in the failure of 'assisted dying' proposals to succeed in Parliament. In fact, when Lord Joffe's 'assisted dying' bill went to a Division in the House of Lords in 2006, just 14 of the 48 votes by which it was defeated were cast by the bishops: the bill would have been lost by a fair margin even without their intervention. Or, again, in 2009, when Lord Falconer proposed to amend the

[1] Seale, C: How the mass media report social statistics: a case study concerning research on end of life decisions, Social Science and Medicine (2010), doi: 10.1016/j.socscimed.201005.048

Coroners and Justice Bill to legalise assistance to be given to persons seeking assisted suicide overseas, only 5 of the 50 votes by which the amendment was defeated were cast by the bishops.

There is in any case a distinction to be drawn between, on the one hand, acceptance that an act which is regarded as reprehensible in general may not be so in highly exceptional circumstances and, on the other, arguing that a licensing system should be created for such acts. The law certainly makes this distinction with the discretion that Section 2(4) of the 1961 Suicide Act gives to the Director of Public Prosecutions not to prosecute where the circumstances do not warrant such action (see below). The question before us is not so much whether 'assisted dying' is moral or immoral in any individual instance. It is whether it should be licensed in advance by law. This brings us to the public safety dimension, to which I now turn.

Public Safety

Clarifying the issue. We need to begin by clarifying what legalisation of 'assisted dying' actually means. An 'assisted dying' law would license doctors to supply lethal drugs to some of their patients (under current proposals those who are terminally ill and mentally competent) in order to help them to commit suicide. In other words, it is physician-assisted suicide. The campaigning groups deny that this is assisted suicide. They argue that, as the recipients of lethal drugs under their proposals are expected to die shortly, supplying those drugs is assisting the dying process rather than assisting suicide. The logic here is beguiling but flawed. In law, as in the English language, if you end your own life, whatever your state of health, that is suicide; and a doctor or anyone else who

supplies you with the means to do so is assisting suicide. Law-making is a serious business, especially where lives are at stake. It needs to be based on language in which words mean what they mean, not what we might like them to mean.

Licensing physician-assisted suicide would represent no mere amendment of the criminal law but a major change to it. It would also run counter to social attitudes to suicide. While as a society we do not take the view that people who attempt suicide should be punished, we are clear that suicide is not something to be encouraged or assisted. The attempts to resuscitate people who have attempted suicide, the 'suicide watches' where persons are considered to be at risk of self-harm and the suicide prevention strategies that successive governments have developed are all testimony that public attitudes to suicide are no different today from 50 years ago when the Suicide Act was passed.

An 'assisted dying' law flies in the face of these attitudes. It says, in effect, that, while we should continue to try to prevent suicide for most people, those who have been diagnosed as terminally ill may actually be assisted to take their own lives. This may be seen, on the one hand, as conferring a right and a choice on one group of people or, on the other, as removing from one group of people the protection which the law now provides to all. Those who advocate an 'assisted dying' law argue that the law as it stands does not give adequate protection and that legalisation would include safeguards to regulate the practice. To assess the validity of this argument we need to understand what the law says and how it is applied and then to look at the alternative that is being suggested.

The Law

The law (the 1961 Suicide Act) may be summarised briefly. Attempting suicide is not a criminal offence but encouraging or assisting another person's suicide is, carrying a maximum penalty on conviction of 14 years imprisonment. However, the 1961 Act also provides that no prosecution may be undertaken without the consent of the Director of Public Prosecutions (DPP). The application of the law was clarified by a prosecuting policy, published in 2010, which lists some of the considerations which may incline the DPP either to prosecute or not to prosecute in any individual case. In his memorandum Professor Badham states that "*the Guidelines of the Director of Public Prosecutions make clear that no one will actually be prosecuted if the dying person had made a 'voluntary, clear, settled and informed decision to commit suicide' and if the relative or friend who gave assistance was 'wholly motivated by compassion' in helping them to die*". This is not so. The circumstances which Professor Badham lists are among those which the prosecuting policy designates as mitigating factors to be taken into account. It states clearly, however, that "*nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person*"[2].

The law's prescription of a maximum sentence and the requirement it places on the DPP to assess each case individually and to decide whether a prosecution is in the public interest reflects the reality that the offence of assisting suicide can cover a wide spectrum of criminality, from malicious assistance backed by coercion and designed to secure personal gain through to reluctant assistance given

[2] Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, Crown Prosecution Service February 2010

after much soul-searching, for wholly compassionate reasons and in response to earnest and persistent requests. In practice, the serious penalties that the law holds in reserve provide an effective deterrent against malicious or manipulative action. Less than 20 cases a year throughout England and Wales cross the DPP's desk. Thanks to the law's deterrent effect, these are usually at the compassionate end of the spectrum and prosecutions are rare.

The advocates of a physician-assisted suicide law argue that under the present law public protection comes too late, as cases of assisted suicide are investigated by the police and assessed by the DPP only after the death has taken place. An 'assisted dying' law, they argue, would provide 'upfront safeguards' by requiring two doctors to assess and approve a request for assisted suicide ahead of the act. It would, therefore, replace the current system of retrospective police investigation of the facts and circumstances with a prospective approval system based on subjective assessment.

Such a system places considerable reliance on the ability of a doctor not only to diagnose a patient's illness and to give an accurate prognosis of its course but also to detect what lies behind a request for assisted suicide - for example, whether the request has been carefully thought-through and represents a settled wish or whether it results from depression or despair (not uncommon in terminally ill people) or whether there are circumstances in the patient's personal and family life that might be influencing the request (for example, subtle pressure from others or a self-sacrificing wish to remove a care burden from the family).

In today's world of the multi-partner GP practice doctors often know little of their patients beyond the consulting room and home visits are rare. In the case of a request for assisted suicide this situation would be exacerbated by the

unwillingness of the majority of doctors to provide the service and the consequent need for the patients concerned to seek out, or to be introduced to, doctors who are willing to assess them and supply them with lethal drugs but have little or no knowledge of them beyond their case notes. It is fair to ask: just how much reliance could be placed on such a system? A police investigation may not invariably uncover all the facts and circumstances, but it is an evidence-based process focusing on facts. In contrast to this, the 'upfront safeguards' that are envisaged by campaigners for legalisation consist of subjective assessments by doctors who may have little first-hand knowledge of the patient concerned and who may have been approached as the result of a self-selecting process.

Moreover, an 'assisted dying' law would lack the 'teeth' of the current law. Under the law as it stands, anyone minded to aid and abet another's suicide must expect to have a spotlight shone on his or her actions and motivation, and any manipulative or malicious behaviour could well come to light as a result. Under an advance licensing system, on the other hand, the only risk being run by a potential malefactor is that the request might be rejected. We should not underestimate the part that deterrence plays in public protection.

Doctors and Patients

Supplying patients with lethal drugs with which to end their lives is currently not only illegal in most jurisdictions but also contrary to long-standing clinical ethics. What is being proposed, therefore, would represent a major change not only to the criminal law but also to the principles of clinical care. In the view of the Royal College of Physicians, a doctor's duty of care for patients "*does not include being in any way part of*

their suicide"[3]. Professor Badham quotes opinion polls to the effect that most Dutch people trust their doctors following legalisation and that a substantial majority of British people say they would do so too. Such opinion surveys may well record accurately what respondents say, but they are beside the point.

We trust our doctors, not because we have examined their qualifications or experience, but (at the risk of uttering a truism) because they are our doctors. It is unrealistic to expect that patients will uproot themselves and move to another country because 'assisted dying' in one form or another has been legalised where they are living. The doctor-patient relationship is, for most patients, an asymmetric one in that the doctor has a near-monopoly of knowledge and experience as regards the patient's health care. To recognise this is to recognise that the doctor is in a powerful position vis-a-vis the patient. As the Royal College of Physicians has put it, "*the trust afforded doctors and nurses gives their views considerable weight with their patients and the public*"[4]. In other words, because we trust our doctors we regard the advice they give us and the actions they take in respect of our health care as authoritative and we can all too easily read into that advice and into those actions meanings that are not there.

An important element in the doctor-patient relationship is the signalling, much of it unconscious, that takes place when illness and its treatment are being discussed. This is particularly so where patients are seriously ill and may have unresolved and unspoken fears and anxieties. A doctor who

[3] Letter from the Royal College of Physicians to the Director of Public Prosecutions, 14 December 2009

[4] Letter from the Royal College of Physicians to the Director of Public Prosecutions, 14 December 2009

agrees to take forward a request for assisted suicide risks sending a signal to the patient, however unintentionally, that the doctor concurs that the patient's condition and outlook is every bit as bad as the patient fears and that suicide is an appropriate course of action in the circumstances. For a small number of highly resolute and strong-minded patients such signalling may make little difference. But most seriously ill people do not fit this stereotype. They are apprehensive of what the future may bring, struggling to come to terms with their mortality and often veering between hope and despair. In a word, they are vulnerable.

In his memorandum Professor Badham writes that "*the DPP has stated that any doctor or other health professional who assisted a person to die would be likely to face prosecution*". What the policy actually says is that assistance with suicide given by a doctor or other health care professional to a patient who was *in his or her care* would be regarded as an aggravating circumstance (my italics). The words I have italicised are important. What we are seeing here is a recognition of the asymmetric nature of the doctor-patient relationship - that doctors are in a position of trust vis-a-vis their patients and that this trust, to quote again the words of the Royal College of Physicians, "*gives their views considerable weight*".

Conclusion

I would suggest that we need to keep in mind three central thoughts in addressing this difficult and often controversial issue. One is that, while a case may perhaps be made to justify an individual act of assisting suicide, there is a world of difference between that and setting up a licensing system for such acts. Licensing an act by law does not simply reproduce

the status quo in legal form. It changes the dynamic completely. The US State of Oregon, which legalised physician-assisted suicide for terminally ill patients in 1997, has seen a steady and continuing rise in the number of such suicide deaths. The number of persons who died in this way in 2012 was nearly five times the number in 1998. Oregon's 2012 death rate from physician-assisted suicide, if replicated in England and Wales, would lead to between 1,100 and 1,200 such suicide deaths here annually. In The Netherlands the number of cases of euthanasia or assisted suicide has risen steeply since legalisation. In 2012 1 in every 34 deaths in that country was the result of either physician-administered euthanasia or physician-assisted suicide.

Second, if Parliament is to be persuaded to approve a law which would allow doctors to involve themselves in bringing about the deaths of some of their patients, it needs clear evidence that the law as it stands is not working satisfactorily and that what would be put in its place would be better, not just for a minority of strong-minded and resolute individuals, but for all of us, and especially for the more vulnerable among us. No convincing evidence has been presented to date on either count.

Third, there is a need to conduct this debate against the background of the real world. Much of the argumentation in favour of licensing physician-assisted suicide assumes the existence of an ideal world - a world in which people who are terminally ill are clear that they either want or do not want to end their lives, a world in which doctors know their patients and their personal and family situations well and a world in which all families are loving. The real world is not like that. Serious illness often brings with it emotions and dilemmas that are difficult to resolve. Doctors are busy professionals who often know little of their patients beyond the surgery or the

hospital ward. While most families are loving and caring, some are not. We have criminal laws, not because most of us behave decently, but because some of us do not.

This is a complex and multi-faceted subject and this memorandum can do little more than scratch the surface and provide a basis for discussion. It is submitted as such.

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RESOURCES

There is a wealth of literature on this subject from a wide range of perspectives. The lists below represent a sample of what is available. There has been no attempt to numerically balance resources broadly aligned with opinions 'for' or 'against' assisted dying; items have been chosen for helpfulness and relevance to the debate.

Books

Some of these are dedicated to the subject; some are of more general application (eg Christian ethics or bioethics – marked) but include some treatment of 'assisted dying'.*

Paul Badham: *Is there a Christian Case for Assisted Dying?* SPCK (2009). ISBN 9780281059195

* Malcolm Brown: *Tensions in Christian Ethics*, SPCK (2010). ISBN 9780281058273

Church House Publishing: *On Dying Well* (2000). ISBN 0715165879

Cynthia B. Cohen and others: *Faithful Living, Faithful Dying*, Morehouse Publishing (2000). ISBN 0819218308

Julia Lawton: *The Dying Process,* Routledge (2000). ISBN 0-415-22679-1

Penney Lewis: *Assisted Dying and Legal Change,* OUP (2007). ISBN 978-0-19-921287-3

Brendan McCarthy: *Assisted Suicide: Drawing a Line in the Sand,* Grove Books Ltd, E155 (2009). ISBN 978185747375

*Gilbert Meilaender: *Bioethics,* Wm. B. Eerdmans (2005).
ISBN 9780802867704

Gilbert Meilaender: *Should we Live Forever?*
Wm. B.Eerdmans (2013).
ISBN 9780802868695

Mary Warnock and Elisabeth Macdonald: *Easeful Death,*
OUP (2008)
ISBN 978-0-19-953990-1

Michael Wilcockson: *Issues of Life & Death*,
Hodder Education (2009).
ISBN 9780340957752

Reports and Articles

(Lord Falconer's) Commission on Assisted Dying, Demos (2005)
ISBN 978-1-906693-92-3
http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm

'Assisted Dying for the Terminally Ill' Bill (House of Lords Report 86 (Session 2004-05)
www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm

The Parliamentary Debate, 27th March 2012:
www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120327/debtext/120327-0002.htm#12032752000002

Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, DPP Guidelines (2010)
www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

Christian Legal Centre and Christian Concern – various articles under ‘End of Life’: http://www.christianconcern.com/resources/downloads?page=1

Living and Dying Well Foundation – various articles: http://www.livinganddyingwell.org.uk/publications/our-reports/assisted-dying-and-the-law

Anscombe Bioethics Centre: www.bioethics.org.uk/index.php (especially http://www.bioethics.org.uk/article/1/Euthanasia)

Organisations and websites

Care Not Killing: www.carenotkilling.org.uk

Christian Concern: www.christianconcern.com

Dignity in Dying: www.dignityindying.org.uk

Healthcare Professionals for Assisted Dying: www.hpad.org.uk

Living and Dying Well Foundation: www.livinganddyingwell.org.uk

Samaritans: www.samaritans.org