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Introduction

Friends,

At the General Assembly meeting in Keele this year, we put forward a motion on assisted suicide. The Assembly, in its wisdom, referred the matter back with a call for more time to understand, discuss and reflect upon the issues raised.

Many people within the Unitarian movement have openly supported this cause; others are opposed to it and some do not think it a suitable subject on which to have a Unitarian position. So, this is clearly an issue that will be difficult to discuss and for some it will bring back memories that have been both painful and tragic.

However, we at Fulwood Old Chapel do believe that it is an important issue of social justice and that we, as Unitarians, should consider our position, personal or otherwise, and be able to contribute to the public debate that is already going on.

We have endeavoured in this document to provide an unbiased, balanced and comprehensive view of the subject, bringing together facts, arguments, personal testimonies and spiritual reflections so that every congregation, district and affiliated society may have the opportunity to discuss and express its views before a motion is represented at next year's General Assembly.

As a result of this document and the discussions around it, we very much hope, if nothing else, that Unitarians will become the best informed and thoughtful group of people on this subject. Specifically, I urge you all to read the information on living wills which, although not part of the debate, is something that everybody should consider doing for themselves today!

We are grateful to all those who have contributed and hope you will find this helpful in your discussions.

Robert Ince

Fulwood Old Chapel, July 2012

Robert Ince is chairman of Fulwood Old Chapel, Sheffield; President of the Sheffield and District Association and a member of the Executive Committee of the General Assembly of Unitarian and Free Christian Churches

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Organisations

Essex Hall, Dignitas Clinic, Zurich, Dignity in Dying, London

Facts and Arguments

Definitions

The terms “Assisted Suicide”, “Assisted Dying” and “Euthanasia” are often used interchangeably in normal conversation with many people not recognizing any difference in meaning. It is sometimes important to acknowledge distinctions between these terms in order to debate the issue accurately and fairly. If it is felt helpful to the discussions, please refer to page 47 in the reference section.

The Law in the United Kingdom

Suicide Act 1961(for full text see page 47 in the reference section)

This Act amended the law of England and Wales [3rd August 1961]. It is quite unusual in that section 1 determined that suicide would cease to be a crime, but section 2 made it a criminal offence to be complicit in another’s suicide, so that a person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, is liable on conviction to imprisonment for a maximum of fourteen years. The other important part of section 2 is that no proceedings can be instituted except by or with the consent of the Director of Public Prosecutions.

The Purdy case

Debbie Purdy, who suffers from multiple sclerosis, instituted civil proceedings which eventually went to the House of Lords in order to determine whether her husband would be prosecuted for assisting her commit suicide. In passing judgement in 2009, the Law Lords instructed the Director of Public Prosecutions to publish the guidelines for prosecutors

Summary of Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (for full text see page 48 in the reference section)

The guidelines seek to differentiate between malicious acts and compassionate acts. There are no absolutes in the guidelines, but ……

factors tending toward prosecution would be: age under 18, lack of mental capacity, no clear, voluntary settled decision, no clear communication of the decision, no seeking of encouragement, outside pressure, the suspect had a history of violence or abuse, the suspect was unknown to the victim or gave encouragement to more than one victim, the suspect was paid, the suspect was a healthcare professional or professional carer.

Factors tending against prosecution would be a clear, voluntary settled and informed decision, suspect wholly motivated by compassion, only minor encouragement of assistance, the suspect had sought to dissuade, full co-operation with the police.

Legal difficulties with the present law in the UK

The following contributions were made to the Falconer commission and have been selected to highlight some of the problems with the existing law and the associated DPP guidelines

Dignity in Dying - The prosecuting policy cannot provide sufficient safeguards to protect people, because all the checks take place after a person has died, when it is too late to prevent potential abuse. In contrast, the assisted dying legislation that we propose would provide ‘up front’ checks and safeguards when someone requests help to die

Professor Penney Lewis - Without having any restriction on the victim's condition or experience, for example his or her experience of suffering, the policy is now more liberal than most permissive regimes and fails to distinguish between on the one hand a terminally ill victim who is experiencing unrelievable suffering and a victim who is suffering from depression.

DPP - We thought that if the law remains unamended and in that form, it was important to distinguish between as it were one off acts of support and compassion and those that were engaged in the delivery of professional services or a business that would routinely, or more likely to routinely bring them into conflict with the law, because of the broad prohibition on assisted suicide…it's one thing to say, 'this is a one off compassionate act' compared with 'this is the provision of a service or a business', which inevitably involves a breach in the law.

Nursing and Midwifery Council - The issue for us is that you are a registered nurse and there are particular clauses within the code that certainly require you to uphold the law under any circumstances, but they also require you to uphold the good standing of the profession, whether you are on duty or not. So it's an important emphasis to make that you can't just switch that off and say 'Well, I'm not nursing now, I'm down the pub, I'm going to do something outrageous, I don't care.' Well if that brings the profession into disrepute, we might well take a view on it and there are a lot of very different circumstances that will be taken on.

General Medical Council - The principle in Good Medical Practice is that doctors need to follow the law so the fact that the DPP doesn't prosecute does not mean that the doctor has not acted unlawfully.

PAVA UK - There is a general issue throughout this matter that relates to 'vulnerable adults' who are 'the suspect' as opposed to 'the victim'. Adults with learning disability, a sensory impairment of a mental health problem could be put into a position of 'assisting' someone else commit suicide without being fully aware of what they are doing while lacking the capacity to understand if fully informed.

About a recent case in NE England - The two people who accompanied him are still on police bail, 6-8 months later. Although they, I think, won't be prosecuted, it's very hard to grieve for somebody when you have had your house turned over and you're on police bail for something

Alan Cutkelvin Rees - The police took my DNA, my photograph and my fingerprints and I'm now in the process of trying to get them removed from the database because I consider that I'm not a criminal and I've done nothing wrong.

The Law in Other Countries

- ## US States of Oregon and Washington

Oregon (1997) & Washington (2008) – and currently being proposed in Montana

An individual who is 18 years of age or older who is capable, is a resident of Oregon or Washington, and has been determined by a physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner. A valid request for medication under this Act must be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, the physician must refer the patient for counselling. No medication to end a patient's life in a humane and dignified manner can be prescribed until the person performing the counselling determines that the person is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner. No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

- ## Switzerland

The Swiss penal code of 1937 maintains that assisted suicide is not a criminal act if the person assisting is motivated by altruistic considerations and the person assisted is a competent adult. Physicians have no special status and are therefore at liberty to play a part in assistance, particularly as a doctor's prescription is needed if lethal medication is required. Direct, active euthanasia (deliberate killing in order to end the suffering of another person) is forbidden. By contrast, both indirect, active euthanasia (the use of means having side-effects that may shorten life) and passive euthanasia (rejecting or discontinuing life-prolonging measures) – while not governed by any specific statutory provisions – are not treated as criminal offences provided certain conditions are fulfilled. Since the 1980's, right to die societies such as Dignitas, have played a prominent role in providing assistance

- ## Netherlands

In the Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* took effect on April 1, 2002. It legalizes euthanasia and physician assisted suicide in very specific cases, under very specific circumstances. The procedures codified in the law had been a convention of the Dutch medical community for over twenty years.

The law allows medical review board to suspend prosecution of doctors who performed euthanasia when each of the following conditions is fulfilled:

- the patient's suffering is unbearable with no prospect of improvement
- the patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness or drugs)
- the patient must be fully aware of his/her condition, prospects and options
- there must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above
- the death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present
- the patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents)

The doctor must also report the cause of death to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act. A regional review committee assesses whether a case of termination of life on request or assisted suicide complies with the due care criteria. Depending on its findings, the case will either be closed or, if the conditions are not met brought to the attention of the Public Prosecutor. Finally, the legislation offers an explicit recognition of the validity of a written declaration of will of the patient regarding euthanasia (a "euthanasia directive"). Such declarations can be used when a patient is in a coma or otherwise unable to state if they wish to be euthanized.

Euthanasia remains a criminal offense in cases not meeting the law's specific conditions, with the exception of several situations that are not subject to the restrictions of the law at all, because they are considered normal medical practice:

- stopping or not starting a medically useless (futile) treatment
- stopping or not starting a treatment at the patient's request
- speeding up death as a side-effect of treatment necessary for alleviating serious suffering

Euthanasia of children under the age of 12 remains technically illegal; however, Dr. Eduard Verhagen has documented several cases and, together with colleagues and prosecutors, has developed a protocol to be followed in those cases. Prosecutors will refrain from pressing charges if this Groningen Protocol is followed. Source: WikiPedia

- **Belgium**

The "Euthanasia Act" legalized euthanasia in Belgium in 2002, but it didn't cover assisted suicide.

In 2006, Belgium legalized partial euthanasia with certain regulations

The patient must be an adult and in a "futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated"

- Patient must have a long-term history with the doctors, resulting in euthanasia/physician assisted suicide only being allowed for people residing in the country
- There need to be several requests that are reviewed by a commission and approved by two doctors. Source: WikiPedia

- **Luxembourg**

Euthanasia and assisted suicide were legalized in April, 2009, after failing to get royal assent. In December 2008 Luxembourg's parliament amended the country's constitution to take power away from the Grand Duke of Luxembourg. Euthanasia is allowed for the terminally ill and those with incurable diseases or conditions, only when they asked to die repeatedly and with the consent of two doctors and a panel of experts

- **Northern Territories, Australia**

The Northern Territory passed the Rights of the Terminally Ill Act in 1996. The Act was similar in scope to the Oregon and Washington, but was overturned by the Australian Parliament in March 1997 after only 9 months operation.

The Position of Medical Profession

The Royal Colleges in the UK have generally rejected calls for a change in the law as incompatible with their oath to protect life, whilst recognising that a significant proportion of their members hold an alternative view. The Royal College of Nursing has moved to neutral position on this and there is an organisation called Healthcare Professionals for Change actively promoting a change of view within the medical profession.

To see the details of the positions of the Royal Colleges, please refer to page 54-57 in the reference section

The Hippocratic Oath

The Hippocratic Oath is an oath historically taken by physicians and other healthcare professionals swearing to practice medicine ethically. It is widely believed to have been written by Hippocrates, often regarded as the father of western medicine, or by one of his students. The oath is written in Ionic Greek (late 5th century BC), and is usually included in the Hippocratic Corpus. Of historic and traditional value, the oath is considered a rite of passage for practitioners of medicine in many countries, although nowadays the modernized version of the text varies among them.

The Hippocratic Oath is one of the most widely known of Greek medical texts. It requires a new physician to swear upon a number of healing gods that he will uphold a number of professional

ethical standards. In reality, these days, few doctors in the UK actually swear any oath and only one medical school currently insists upon this.

Modern version

A widely used modern version of the traditional oath was penned in 1964 by Dr. Louis Lasagna, former Principal of the Sackler School of Graduate Biomedical Sciences and Academic Dean of the School of Medicine at Tufts University:

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not", nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death? If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, be respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Medical Ethics- What are the moral issues inherent in Assisted Dying?

By Ella Lewis Jones

I cannot but have reverence for all that is called life. I cannot avoid compassion for all that is life. That is the beginning and foundation of morality.

Albert Schweitzer: Reverence for Life

Most of us, were we to be given the choice, would choose a 'good death', that is an end to our life that was dignified, without fear and undue pain. Unfortunately, for far too many, their passing is often marked by intolerable physical and mental suffering, with their relatives and loved ones feeling helpless and inadequate to relieve the suffering. In his book 'Health is for People', written more than fifty years ago, the author the Rev Dr Michael Wilson suggests, and I paraphrase, 'it seems that within the Medical Profession today there is a strong belief that the worst thing that can happen to a man is that he should die'. In the years that have followed more and more resources have gone into prolonging life, seemingly regardless of its quality, so much so that even if we accept that individuals have a right to their life, even in the most dire physical or mental condition, we have to ask ourselves, in the face of what often appears to be overzealous treatment 'do we not also have a right to die'? There are many who believe that there is an important moral difference between 'act and omissions' in medical care that is a difference, between killing and 'not striving to keep alive'.

If, as I have implied, there are circumstances in which it is morally right to help to end the life of someone who wants to escape a life which to them is intolerable, then the question is whether the law could be changed to make this not only morally right but legally permissible.

Although every society subscribes to some principles which prohibit the taking of life there are great variations between cultural traditions as to when the taking of life is considered to be wrong. It was Judaism and the rise of Christianity which contributed substantially to the general feeling that human life has sanctity and as such must not deliberately be taken. 'The Sanctity of Human Life' principle has many supporters, not all religious, and it is based on the view that it is always better to be alive than dead even if one passionately wants to die. It is the sanctity of human life argument which is used predominantly by those who wish to prohibit any change in the law to permit assisted death.

There are two primary reasons which are given for the moral permissibility of assisted death which are motivated by compassion for hopelessly ill and suffering patient(s) and/or out of respect for individual autonomy and a person's right to end their life if they so wish. The meaning of autonomy is making one's own laws, and adopting one's own principles. The principle of autonomy is generally regarded as the basis upon which those who wish to see a change in the law base their case.

Medical students today are taught about the principle of patient autonomy in their compulsory ethics courses. The principle of autonomy is one of the four which are considered to be at the root of medical ethics. The four principles are *beneficence* (the doctor must be well-intentioned towards his patient and aim to do good): *non-maleficence* (the doctor must avoid harming his patient): *autonomy* (the doctor must treat his patient as a rational human being capable of making choices and possessed of free will): and *justice* (the doctor must distribute resources, including time and skill, fairly between his patients. (Beauchamp & Childress 1994) These principles e.g. autonomy and justice can be in conflict when financial resources are finite and expensive drug treatments are given to one patient which leaves less resources for other patients. Doctors are taught these principles so that when they cannot decide what they ought to do in the best interests of their patient they have an ethical framework within which they can consider their decision.

In cases of extreme pain which is impossible to alleviate a doctor whilst administering pain-relieving treatments can unintentionally bring about death. This is termed, a 'double effect'. The doctrine of 'double effect' can be crudely stated as the view that it may be permissible to perform a good act with some unforeseeable bad consequences, but, and this is what causes many doctors a serious moral dilemma, that it is wrong to do a bad act for the sake of good consequences that will follow. In practice, this doctrine has been cited as the reason for doctors withholding pain relief for fear of killing the patient. Although a doctor's training forbids the termination of a patient's life the interpretation of the patient's 'best interest' has evolved and now takes into account, at a much more fundamental level, the notion of the patient as a person with a right to decide on important matters concerning his/her own health.

However, even for doctors who support the primacy of patient autonomy, there have to be legitimate limits to patient choice. A patient, for instance, cannot force a doctor to give him the treatment of his choice, if in the doctor's judgement the treatment will be futile. Nor can the patient's preferences outweigh the doctor's superior professional knowledge and expertise. Moreover a Doctor should have the right, if conscience dictates, to decline involvement in euthanasia or assisted suicide, in the same way as conscientious objection to participate in abortion has been respected. The difficulty lies in determining precisely where the limits of the doctor's involvement should be drawn. Doctors are committed to saving life, sometimes, for a variety of reasons some patient(s) may wish to die.

One of the considerable concerns, which to date has not been resolved to the satisfaction of either the legal establishment or many members of the general public, which even those who accept the need for a change in the law on compassionate grounds recognise, is the genuine concern that any legislation which is formulated, however humane the intentions, could, in the future, be abused by the unscrupulous. These arguments against any relaxation in the law on assisted dying are described in ethical terms as the "Slippery Slopes". The slippery slope is a variant of the well-known principle of

the dangerous precedent. In other words, in relaxing the law so that those who wish to end their life on compassionate grounds can be allowed to die we will also be opening the legal 'gates' so that those who have not asked to die could have their lives deliberately ended. There are a number of potential problems which are often cited in "Slippery slope" arguments. To give some examples: If the law on assisted dying is changed, will the funding and research on Palliative Care be considered unnecessary or be reduced? Will children, impatient either for their inheritance or simply for relief from the burden of care, put pressure on their relative(s) to seek an early death? Will anyone who has an incapacitating or intractable physical or mental condition be pressured into seeking their own death to lessen the burden on society? Or will trust between a patient and their Doctor be eroded if Doctors are permitted to assist death?

Recent evidence has shown that in both Oregon and the Netherlands where euthanasia is permitted, rates of assisted dying show no evidence of heightened risk for several vulnerable groups, notably the disabled, the elderly, and those with a psychiatric illness. Thus, where assisted dying is already legal there is no current evidence for the claim that legalizing assisted dying will have a disproportionate impact on vulnerable patients and put them at risk of undue pressure to agree to end their lives. Nevertheless, regardless of the fact that many of the above arguments are speculative, it behoves us to ensure that any legislation which permits assisted dying should, in so far as it is humanly possible, contain sufficient legal safeguards to protect the individual and ensure that the law is not abused.

References

Beauchamp T.L & Childress J.C. (1994)	**Principles of Biomedical Ethics** OUP	
Glover J (1990)	**Causing Death and Saving Lives**	Penguin
Harris J (1991)	**The Value of Life**	Routledge
Singer P Edt (1993)	**A Companion to Ethics**	Blackwell
Warnock M & Macdonald E (2009)	**Easeful Death**	Oxford
Further Reading		
Arditti M (2010)	**The Enemy of the Good**	Arcadia

Ella Lewis Jones has an MA in Medical Ethics and is a member of the Aberdare congregation

Research

It would be impossible include all available research into this section. Details of some of the available research are on websites listed in the References section of this document. We have concentrated on giving key facts and conclusions that may be of interest.

Uptake of assisted dying in countries where the law allows it

The availability for the option for assisted dying is considered by far more people than actually use it. The Oregon Hospice Association reported in 2007 that of the 30,000 people who died in Oregon that year, almost 10,000 considered seeking an assisted death, around 1,000 spoke to their doctor about getting a prescription, 85 received a prescription and only 49 people actually went on to have an assisted death.

Activities outside the Law

A major Dutch nationwide study was undertaken in 1991 and repeated again in 1995 and 2001 that is before the implementation of the Euthanasia Law. Known collectively as the Remmelink Committee reports, after the Prof Jan Remmelink who headed the original committee, they were also the subject a report in the Lancet which is often quoted as indicating that 1,000 deaths happen each year outside the law.

This report points out that many deaths occur 'outside the law'. That is deaths where the medical profession cause people to die without their consent or request. Reviews have consistently shown that approx. 1,000 deaths each year (0.8% of deaths) were as a result of 'life terminating acts without explicit or persistent request'. On the face of it, that is rather damning evidence.

However, the Lancet report, which contained these statistics, also pointed out:

Sometimes the death of a patient was hastened without his or her explicit and persistent request. These patients were close to death and were suffering grievously. In more than half such cases the decision had been discussed with the patient or the patient had previously stated that he would want such a way of proceeding under certain circumstances. Also, when the decision was not discussed with the patients, almost all of them were incompetent.

Whether it is true today in the UK today is the issue. Many people claim to be aware of this, others deny it happens. One result of the change to the law in the Netherlands may be that doctors are now more prepared to admit what is going on because it is more socially and legally acceptable.

Depression

Research into depression in terminally ill patients has concentrated on diagnosis and treatment rather than the recognition that this is a fundamentally spiritual situation where people contemplate the inevitability of their own mortality and the unknown that lies beyond this. Yet practitioners still recognise the spiritual aspects of this situation and the ability of those with spiritual training to significantly impact upon the quality of people's lives.

A level of rational depression or 'appropriate sadness'[1] is considered normal in terminally ill patients approaching the end of their life. The existence of depression does not mean that a person lacks capacity; it does not necessarily impact on a patient's ability to make a rational decision about choosing assisted dying.

Research conducted in Oregon by Ganzini *et al*[2] demonstrates that whilst some patients who requested assisted dying and then died as a result of prescribed medications had symptoms of depression *all had mental capacity* and were capable of making rational decisions. 1 in 4 who requested assistance had symptoms of depression. 1 in 6 who died had symptoms of depression. The tool used to assess the presence of depression could be called into question as lack of appetite-type questions were used as an indicator of depression and lack of appetite is frequent in those approaching the end-of-life.

A study, conducted in the Netherlands and Oregon, by Battin *et al*[3] found no evidence for the claim that legalized physician assisted dying or euthanasia will have disproportionate impact on patients in vulnerable groups - such as people with psychiatric or mental illness.

In a study conducted in the Netherlands Marcoux *et al*[4] found that patients with mental clarity and fewer mental health issues go through with the assisted dying procedure more than those with mental health issues.

Further research is needed to investigate a) the impact that depression has on patients' end-of-life decisions b) the difference between clinical depression from the range of normal sadness and fear that can be acknowledged and explored, but not necessarily treated[5].

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[1] Ganzini L, Dobscha S (2003) If it isn't depression…*Journal of Palliative Medicine* 6(6): 927-931

[2] Ganzini L, Goy E, Dobscha S (2008) Prevelance of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey *BMJ* 27 October

[3] Battin MP, van der Heide A, Ganzini L, van der Wal G and Onwuteaka-Philipsen BD (2007) Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups *Journal of Medical Ethics* 33: 591-97

[4] Marcoux I, Onwuteaka-Philipsen B, van der Weide J, van der Wal (2005) Withdrawing an explicit request for euthanasia or physician-assisted suicide: a retrospective study on the influence of mental health status and other patient characteristics *Psychological Medicine* 35: 1265-1274

[5] Quill TE (2008) Suicidal thoughts and actions in cancer patients: The time for exploration is now *Journal of Clinical Oncology* 26(29): 4705-4707

Dignitas

From: Robert Ince

Sir Terry Pratchett
"I feel embarrassed that people from this country have to go, cap in hand, to die in Switzerland."

I visited Dignitas in Forch (near Zurich) in the middle of May, because I happened to be there for family reasons. It seemed a good opportunity to understand things from their perspective. Well, if you want to understand, really understand, you will need to do what I had to do. Throw away all you preconceived ideas, even if you have read a lot about it…….it simply isn't like that!

Dignitas has its offices in small village outside of Zurich. No markings, just like so many other small office buildings. Here I met Silvan Luley, assistant to the General Secretary and founder, Ludwig A. Minelli.

Why was Dignitas created and what do they actually do?

Dignitas terms itself an 'end of life society', of which there are four major ones in Switzerland, but only two of them, Dignitas and EX International will respond to foreigners. Dignitas are the bad guys, always pushing the limits and up until recently have had a bad press. Last year there was a vote in the Canton of Zurich on two initiatives, one aiming at entirely prohibiting assisted suicide and the other intending to bar individuals from outside of Switzerland and outside of the Canton of Zürich to have access to such option. The majorities against both propositions were so unexpectedly overwhelming that the press stopped most of it attacks and the Swiss government shelved its plans to severely tighten the law.

Dignitas is not primarily about assisted dying (they prefer the term 'accompanied suicide') it's about listening to those who have reached a low point in their lives and trying to help. The majority of people they deal with are real suicide cases, people who have no life threatening medical condition, just a desire to end their lives. They get counselling much in the same way as the Samaritans in the UK would provide. Their approach is to be non-judgemental and not to be paternalistic. They certainly don't get drugs to help them commit suicide, because that is against the law and Dignitas, if nothing else, is driven by Swiss and international Law. A few people who come to them do have a life threatening medical condition and for those people, if they are so determined, there can be help to prescribe life ending drugs. These are a small part of Dignitas's daily care.

When we talked about the mechanics of what happens with accompanied suicide an unexpected ethical issue came to light. It is a matter of unshakeable morality that the person themselves must administer the drug and be of sound mind, otherwise it would be killing (voluntary or even involuntary euthanasia) and that is unacceptable as well as illegal

Article 115 of the Swiss Criminal Code relating to inciting and assisting suicide was in place already from the start of this Code in 1937, but about 30 years ago, lawyers recognised that if altruistic help were offered to those in need, the law said that was not illegal. Dignitas in particular has been active in pushing the limits of the law and its interpretation. This continues today, aided by the European Convention on Human Rights. Mr. Minelli, who is a lawyer, believes that the best way to bring about change is through interpretation and further development of the law rather than political pressure. Whether he is right or not, is another matter; but he has been very successful in bringing about change.

Dignitas is an NGO, a 'not for profit organisation'. Mr Minelli does not need the money; he was a successful journalist and lawyer for many years and, now close to his eighties, he dedicated his life to a cause he believes in so much. Interestingly enough, because of the lack of need to court personal popularity, Dignitas can appear to have a very cold and clinical approach to the end of life. This may also be as a result of Mr Minelli's avowed atheism. Mr. Luley, on the other hand, declares himself to be agnostic, but I found a very sympathetic Unitarian soul and our conversations over the spiritual side of dying revealed this as something he wished to think more about.

Palliative Care as an alternative

From: Professor Bee Wee

Dying is rarely easy, both for the person who is dying and for family and friends who love that individual and value being with them. For some, it can be a time of closeness and growth; for many, it is a roller-coaster time, fluctuating between hope and despair, happiness and sadness; for a few, it is unmitigated misery. There is no doubt that legalising assisted dying would allow the autonomy of a number of individuals to be respected. But there is also no doubt that the risk to others is extremely high – for example, as a doctor, I meet some people who feel that they are a burden on their families, practically, emotionally and in many cases, financially. It would be a tragedy if such individuals were to feel obliged to hasten their death for the sake of others.

Palliative care has much to offer in terms of alleviating suffering related to physical and psychological problems, and of providing support in the social and spiritual aspects of the life of a dying person. But it needs to remain securely within the context of a constant search to improve the quality of life of the dying person, not to deliberately cut short that life.

There are a number of myths about palliative care that are worth dispelling. One is that palliative care is only available for those who suffer from cancer. It is not. Even in the early days, its focus was on both cancer and neurological conditions. Nowadays, palliative care is provided on the basis of need, neither the underlying disease nor age. Because of this myth, some patients are still not seeking (or offered) referrals to specialist palliative care services when they could benefit from these.

A second myth is that pain is always present towards the end of life, and that it can only be controlled by rendering the person unconscious. In some dying people, pain might not exist at all or only mild pain might be present. Most pains can be diminished or eliminated. Pain management is an art which draws on an understanding of the science of pain and of the medication and other techniques that are available to help improve pain, as well as the ability to ask the right questions, listen and hear the person's responses and, together, work out a way of controlling (or at least diminishing) the pain in a way that the person finds acceptable. The more we work at this, the better we get. Moreover, pain is not just a physical phenomenon. Emotional distress and spiritual pain are much more difficult and medication alone is rarely effective. A good palliative care physician understands this and does not simply try to offer more pain killers, but takes a much more holistic approach. The same is true when helping to deal with other physical and psychological symptoms.

We can be rightly proud of palliative care in the UK but much more remains to be done. In some parts of the country, there is still insufficient palliative care physicians, specialist nurses, occupational therapists, physiotherapists, social workers and chaplains, all of whom play a critical role in helping dying people to 'live until they die', to quote Dame Cecily Saunders, the founder of the modern hospice movement.

Not only do we need adequate manpower to provide the care that is needed, we also need to invest in teaching other professionals to deliver better palliative care, teaching the dying person's family some of the basic practical skills that we professionals take for granted so that they can feel more confident in the assistance they give the person, and research so that we can improve the quality and effectiveness of what we do.

As a practising palliative care physician, I find the focus of attention on the legalisation of assisted dying immensely frustrating. It distracts from the day to day business of providing and constantly trying to improve the quality and 'reach' of palliative care to those who are dying right now. There has been some suggestion that if euthanasia/assisted dying were to be legalised, it should be linked to palliative care. I think this would be a highly dangerous move. The confusion between our core work of helping people 'to live until they die' and a move towards hastening death would cause alarm, anxiety and distress amongst many of the dying people who already feel vulnerable. It could

very well foster a damaging distrust in the very people (and medication) who are trying to help them, and their families, through this difficult time.

Professor Bee Wee is the Academic Director of the Oxford International Centre for Palliative Care and Senior Tutor in Medicine at Harris Manchester College. Dr Bee Wee is also head of the WHO Collaborating Centre for Palliative Care, a Trustee of Marie Curie Cancer Care, and President of the Association for Palliative Medicine of Great Britain and Ireland.

The Slippery Slope (The erosion of safeguards)

In the report of the Falconer Commission, they established eight principles for framing safeguards

- Provide a decision making model involving the assessment, advice, support and independent judgments of two independent doctors with support from other health and social care professionals where necessary
- Provide a safeguard to ensure the person has been fully informed of all other treatment and end of life care options that are available and still wishes to proceed
- Ensure that the eligibility criteria have been met
- Ensure that the person has a settled intention to die
- Ensure the safe storage and transportation of lethal medication
- Ensure that the person has a reliable and supported assisted death
- Ensure that assisted deaths are reported correctly
- Provide monitoring and regulatory oversight by a national monitoring commission with powers to investigate cases suspected of non-compliance retrospectively

Whilst these proposals deal with the practical issues and clearly represent a huge challenge in the development of the law, arguments surrounding the potential for the erosion of safeguards once a change to the law is implemented also fall into two other categories, and get entangled with moral judgments often using emotive phrases designed to alarm without supporting evidence or reason.

Social attitudes will soften and the law will change even further

The first question is, of course, the desirability of social change and the judgment as to whether that might be a good thing. It depends upon your moral and ethical standpoint. Undoubtedly social attitudes do change in response to a change in the law. Often the law changes in response to a change in social attitudes. The British Social Attitude Survey (See page 23) has shown that 82% of people do support a change to the law, but Parliament is currently resisting change.

In the countries where the law allows assisted dying or euthanasia of some sort, laws have not, thus far, been softened over time or indeed changed since their original conception.

This argument is encapsulated in what was meant as critical comment made on the DPP Policy by one particular faith group

'To tolerate assisted suicide under certain conditions or legalise euthanasia would bring about profound changes in social attitudes to illness, disability, death, old age and the role of the medical profession'

The nub of the issue is whether this is viewed as a bad thing or a good thing

People will be put under increasing social pressure to conform to the opportunities any new law might offer.

The arguments here encompass the threat to disabled people and those with mental illness, either temporary or more permanent, and the feeling of older people to be a burden on their relatives and on society in general.

The threat to those with disabilities, particularly those associated with some limited mental capacity is of major concern to Disability charities but whether it constitutes a credible threat to those of sound mind is debatable. In theory they should be no less able to resist social pressure than anybody else although they may feel more of a target.

Every country that allows some form of assisted dying has explicitly excluded those with a mental illness, temporary or more permanent. However, one difficulty does occur with people who make living wills when they are of sound mind which specify treatment to be withheld in specific clinical circumstances, which may include the loss of mental capacity. So when an Advance Decision was made they were mentally capable, but when this Advance Decision needs to be put into practice they are mentally incapable. That situation already exists in the UK.

The question of feeling a burden to family and to society is more difficult, because it raises some philosophical or moral questions. If a person of sound mind logically concludes that he or she is a burden to those around them, is that not an acceptable conclusion from an educated mind? Is society to say that a person is not entitled to draw that conclusion?

One of the other sides to the 'burden' argument is that being a burden is often one of many reasons that, taken together, would draw somebody to the decision to end their life. Other associated reasons typically might be loss of dignity, loss of quality in life and intolerable suffering.

Positions of Faith Groups and others

In this section we tried to include as many positions of faith groups as possible. If the General Assembly were to decide to support calls for a change to the law, it would be the first faith group to publically do so in the UK. Some faith groups have established a specific position against any change and have expressed in detail their reasons for doing so. Many other have no positions at all, whilst others are still contemplating the subject. It does seem that even where there is a firmly stated position, many others within that faith take an opposing view.

Christian Views

A Roman Catholic view

Based on views expressed in the CTS Explanations booklet "Euthanasia" by Philip Robinson

Beliefs that underpin the Churches teaching on Suicide and Euthanasia

The objective moral Law
The truth the Church proclaims is that morality is not a human invention, nor a social convention but an unchanging and binding law. It teaches that the difference between right and wrong is something that is given; it is not something that is invented but something that is discovered. The moral aw is part of the very nature of what makes us human. The Church holds that even those who do not believe in God are capable of recognizing the objective and binding force of the moral law. Neither the believer, nor the non-believer can escape its demands.

The value and inviolability of every human life
The Church teaches that the inviolability of every human life is a truth of the natural law; so it ought to be possible to commend it on the basis of reasons which even a non-believer could accept. The truth that the Church expresses when it says that man is made in the image of God is widely recognized. It is the truth that the difference between humans and even the highest animals is not a mere difference in degree but a difference in kind.

Every human being is a person
The Church profess that all human beings are persons who share the same right and the same dignity as individual members of the human race.

We are stewards not owners

The Church rejects the idea that the right to self-determination is one that must include the right to end one's own life, primarily because it does not believe that man's power over his own life is a power due to ownership but rather a power attached to stewardship. That is to say the life belongs to man in the way that children belong to their parents. The child is not property but their special charge.

The meaning of suffering
The Church rejects the idea that suffering is always evil and something that human beings must avoid at all costs. While it is true that suffering is an evil, which we often have a duty to combat, it can become a means of sanctification and a source of solidarity

The Churches teaching on suicide and Euthanasia

Suicide

The Church has always taught that suicide, understood as the ending of one's life by a course of conduct with that end in view, is seriously wrong. Having said that, the Church does not condemn individuals who commit suicide because it recognizes that often there are social and psychological pressures that may well mean that the person is not fully responsible for his or her actions.

Euthanasia

Pope John Paul II saw advocacy of euthanasia in contemporary society as rooted in two attitudes which are widespread in our age: the view that human lives can cease to be meaningful and worthwhile, and the view that human beings are completely free to dispose of their lives as they will: the view that we enjoy completely autonomous control over our lives. The first view is incompatible with recognition of the dignity which belongs to every human being simply in virtue of the fact that he or she is a human being. The second view is incompatible with recognition of the fact that our lives are gifts of God of which we are stewards, not owners.

The Church of England

In his response to the Falconer Commission report, Rev Dr Brendan McCarthy, Medical Ethics and Health and Social Care Policy Adviser to the Church of England, presents the Anglican view of the assisted dying issue. To be fair, this is a specific response to the report rather than a general statement of the Church's position on euthanasia, but it demonstrates a rejection of the proposals made by Lord Falconer without offering any moral or ethical position that underpins this view.

Much of the rationale is an academic rejection of both the Commission's integrity and the strength of its arguments, but there are no belief statements made. The risk to vulnerable adults is considered sufficiently great as to override any compassion for those with an intolerable existence. The idea (of the Falconer Commission) that those with less than 12 months to live should be allowed assisted dying is dismissed as a statistical lottery.

Much of the Church's concern, however, rests upon the difficulties of achieving sufficient safeguards to protect the elderly from undue coercion and a recognition of the abuse that already takes place.

The response concludes with the statement: "The Commission on Assisted Dying set itself a bold objective: to find a safe way of amending the law to permit some forms of assisted suicide. In spite of its labours, it has manifestly failed to do so."

The question that must be asked is whether the Anglican Church has any moral objections to assisted dying as well as practical ones?

An Alternative Christian View

The Reverend Professor Paul Badham *A Christian Case for Assisted Dying*
(Excerpt from a presentation to a conference on assisted dying held at St. Michael's Hospice in Harrogate on Apr.24 2012
For full text – see Reference Section page 57)

The relevance of the teaching of Jesus

For any Christian what we want for ourselves is an important consideration in making moral judgments. This is because Jesus taught that the whole of religious law and prophetic teaching could be summed up by saying that we should love God and love our neighbour as ourselves. His golden rule was that we always treat others as we wish to be treated ourselves. According to R.M. Hare, a former Professor of Moral Philosophy at Oxford, 'there is no moral question on which these teachings have a more direct bearing than on euthanasia. '[i] It was this consideration that led the Church of England Working Party *On Dying Well* to the conclusion that euthanasia was not always wrong. They said that 'there are bound to be cases where any of us who is honest with himself…would wish to have our deaths hastened so that the manner of them might be less unbearable. Thus a direct application of the teaching of Jesus to these cases would legitimize at least some instances of euthanasia.' [ii] However the working party did not go on to recommend the legalization of euthanasia because they believed that the law should not be changed for a few 'hard cases' but must rather consider the wellbeing of the large majority whom they believed would be at risk. Writing in 1975 they thought that if euthanasia were allowed it would put health care at risk, weaken trust in doctors, and hold back the development of palliative care. I shall explore later in my paper whether or not these fears are justified by looking at what has actually happened in jurisdictions which have changed their laws. But first let me examine some specifically religious arguments against changing the law.

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 appears not to see 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'[iii] and the gift of eternal life is not taken away by death. Christianity has always seen 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. 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. Under the present guidelines such help cannot be given by a British health professional but can only be given by a relative or friend unless the dying person is able to go to Switzerland for professional help.

The commandment 'Thou Shalt Not Kill'

For many 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 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 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 trivial offences For example consulting a medium, for reviling one's parents, for homosexuality, adultery or incest, or having sex while the woman is menstruating. Parents had the right to complain to the elders of the city that their son has become a disobedient glutton and a drunkard and could have him stoned to death. People could even be killed for picking up sticks on the Sabbath day. A priest's daughter who had pre-marital sex was to be burnt alive. [6] 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

[6] Leviticus 20.6,10,13,17,18, Exodus 21.17, Deuteronomy 21.18 Leviticus 21.9

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 in any way. 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.'[7] 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

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 but is good that in many areas of medical practice a close bond now exists between doctors and clergy.

Is it good for us to suffer?

However some tensions remain. According to Pope John Paul 2, 'suffering especially in the final stages of life has a special place in God's plan of salvation'.[8] This view challenges both 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.[9] That suffering too was seen as part of God's plan of salvation. But no Christian thinks like that today and all women should be grateful that Queen Victoria insisted on her right to anaesthesia in childbirth and thereby changed the climate for every other woman.

The parallel between birth and death

There is another parallel too. At the beginning of the twentieth century all Christian 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 right to plan one's family. Birth statistics in Italy Spain and Poland show that most Catholic couples also believe this. 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)* and that it is as catastrophically wrong in both cases.[10] 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 Christian opposition to euthanasia is based on the grounds that we should always seek to ensure that the legal system 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

[7] 2 Maccabees 14.41-42
[8] *The Declaration on Euthanasia of the Sacred Congregation for the Faith* Rome 1980
[9] Genesis 3:16
[10] Hans Kung and Walter Jens, *A Dignified Dying* SCM 1995 p.119

people are exposed to 'intolerable suffering at the very point when their helplessness is at its greatest'. It is precisely the most vulnerable who should be allowed the means to ensure that their lives are not 'dragged out endlessly'.[11] 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. [12]

Rev Prof Paul Badham is Emeritus Professor of Theology at Trinity Saint David University (Lampeter Campus).

A summary of the Christian view

From: Rev Tony McNeile

It has been difficult to establish a Christian moral view on assisted dying - because Christianity is a faith of many parts. The Roman Catholic view is that life is sacred - the soul a gift from God who calls it back when he requires it. The pain and suffering of dying at the end of life is part of the process of salvation. Papal bulls have forbidden euthanasia, just as they have forbidden contraception. Both are seen as interfering with God's will.

However as Emeritus Professor of Theology, Paul Badham writes in the Christian case for Assisted suicide, we have moved on from the days of Leviticus when so many laws demanded the death penalty for what we would consider trivial offences. Even in the Old Testament, the warrior Raziz is praised to falling on his sword rather than suffer death by his captors in a suffering way.

The professor also points out that the medical profession is committed to saving life and preventing death, rather than standing back and allowing God to take a soul that could be saved. He also says that we should consider God's gift of life as being eternal life and not simply temporal life.

Those who take the view that God is immanent in the world would accept that many of the changes since Old Testament times have been beneficial to humankind - the advances in medicine, the abolition of slavery, the emancipation of women, the abolition of the death penalty, advances in education - and that the immanent God has been working his purpose out year by year.

It could be argued that the immanent God drives the wisdom of humankind and it is down to them also to create the kingdom on earth.

Changes come because the perceived wisdom is advancing and where humankind has taken the step, the consequences are good and benefit the people.

Where assisted dying has been legalised, there has been an increase in trust in doctors - especially in relation to palliative care. The healthcare of the society has been better because of this trust and in dealing compassionately with people who would otherwise face an end of life in intolerable pain. The professor says that in Switzerland, the Netherlands and the State of Florida which all have legislated to allow for assisted dying, it has led to more understanding, more comfort for the end of life patients and more confidence in doctors - and an improved healthcare system generally. The present law insists that doctors do prolong life even though it may cause more pain and suffering simply because they are not allowed to follow the wishes of those who seek a dignified end to the suffering.

I feel that the moral dilemma for Christians is to decide whether the change that is occurring in some countries and the current debates are part of God's immanence being worked out through the wisdom of humankind.

It would seem sensible to continue the debate, work through the worries and concerns that people have and build a system that protects us from our worst fears but allows our dearest wishes to be fulfilled if we are approaching the end of life in fear and unbearable pain - or do we hang on to the Old Testament law of Leviticus?

Rev Tony McNeile is a retired Unitarian Minister and a member of Bolton Interfaith Council

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

A Moslem View

From: Moulana Faruk Ali,

In Islam, the soul of a person is a gift from Allah which only Allah can take back. If a person takes their own life, they have abused this gift from Allah and so they face punishment in the hereafter.

However, if the person who takes their own life is not in proper control of their senses, through pain or mental health, then they will be forgiven.

Moulana Faruk Ali is an Imam, a local community leader and chair of the Bolton Interfaith Council.

A Buddhist View

From: Graham Woodhouse

HH Dalai Lama in his book 'The Meaning of Life'

Question: Please say something about euthanasia, which can be performed by withholding active treatment or by giving an active drug that kills a person in a few minutes.

Answer: Again, there may be exceptional situations, but in general it is better to let persons die in their own time. What we undergo is due to our own past actions, and we have to accept what our karma has impelled toward. Initially, we have to do what we can to avoid suffering, and then if nothing will relieve the problem, the suffering should be understood as the unavoidable result of former actions.

Educating Compassion by Thanissaro Bhikkhu

If you have any friends or family members who are sick or dying, I know of no one who would tell you to treat them in a hard-hearted way. Everyone would agree that you should be as compassionate as you can. The problem is that there's little agreement on how compassion translates into specific actions. For some people, compassion means extending life as long as possible; for others it means terminating life — through assisted suicide or euthanasia — when quality of life falls below a certain level. And neither of these two groups sees the other as compassionate at all. The first sees the second as criminal; the second sees the first as heartless and cruel.

For those of us trying to negotiate the murky territory between these two extremes, there's not much reliable guidance. Ours is a culture that doesn't like to think about illness and death, and as a result, when faced with someone who's sick or dying, we're at a loss as to what to do. Some people will advise you simply to do what feels right, but feelings have a way of turning slippery and devious. Some things feel right simply because they make you feel good, regardless of whether they're genuinely right for the other person. A desire to extend life may mask a deeper fear of your own death; a desire to terminate a miserable illness may rationalize your distress at having to witness suffering. Even if you're told to act from a place of mindful presence, you may find that what seem to be your spontaneous inspirations are actually conditioned by hidden, unexamined assumptions about what life and death are all about.

This is why the simple injunction to be compassionate or mindful in the presence of a sick or dying person isn't enough. We need help in educating our compassion: specific advice on how to think

through the implications of our actions in the face of life and death, and specific examples of how people who have contemplated these issues thoroughly have actually acted in the past.

With this thought in mind, I searched through the Pali canon — the oldest extant record of the Buddha's teachings — to see what lessons could be drawn from the Buddha's example. After all, the Buddha often referred to himself as a doctor, and to his Dharma as medicine for the sufferings of the world. From his point of view, we're all sick and dying on a subtle level, so we all deserve continual compassion. But what sort of advice did this doctor give when face-to-face with the flesh and blood suffering of illness and death? How did he treat people who were physically sick or dying?

You probably know the story of how, together with Ven. Ananda, he once found an unattended sick monk lying in his own filth. After washing the monk, he assembled the other monks, chided them for abandoning their brother, and gave them strong incentive to follow his example: "Whoever would tend to me," he said, "should tend to the sick." He arranged that monks nursing their fellow monks should receive special allotments of food, to encourage them in their work and help lighten their burden. But he didn't subscribe to the notion that medical treatment should try to extend life at all costs. The Vinaya, his monastic discipline, imposes only a minor penalty on a monk who refuses to care for a fellow monk who is sick or dying, or who totally abandons a sick monk before the latter recovers or dies. And there's no penalty for withholding or discontinuing a specific medical treatment. So the rules convey no message that the failure to keep life going is an offense of any kind. At the same time, though, a monk who deliberately ends the life of a patient, even from compassionate motives, is expelled from the monkhood and can never reordain in this life, so there's no room for euthanasia or assisted suicide.

This means that the middle ground is where true compassion can be exercised. The Buddha sets out some guidelines for this area in his definition of the ideal nurse. You're qualified to tend to the sick if (1) you know how to prepare medicines; (2) you know what's amenable to the patient's cure, taking away whatever's unamenable and providing things that are amenable; (3) you're motivated by compassion and not by material gain; (4) you're not squeamish about cleaning up urine, excrement, saliva, or vomit; and (5) you're competent at encouraging the patient at the proper times with talk on Dharma.

Of these five qualifications, the one most discussed in the Pali canon is the fifth: What qualifies as a helpful and compassionate talk on Dharma to a person who is sick or dying? What doesn't?

Here again, the *don'ts* mark off the territory for the *do's.* The Vinaya cites cases where monks tell a sick person to focus his thoughts on dying, in the belief that death would be better than the miserable state of his life. The sick person does as they advise, he dies as a result, and the Buddha expels the monks from the monkhood. Thus, from the Buddha's perspective, encouraging a sick person to relax her grip on life or to give up the will to live would not count as an act of compassion. Instead of trying to ease the patient's transition to death, the Buddha focused on easing his or her insight into suffering and its end.

This is because he regarded every moment of life as an opportunity to practice and benefit from the Dharma. It's a well-known principle in all meditation traditions that a moment's insight into the pain of the present is far more beneficial than viewing the present moment with disgust and placing one's hopes on a better future. This principle applies as much at the end of life as it does anywhere in the middle. In fact, the Buddha encouraged his monks to reflect constantly on the potential imminence of death at every moment, even when in ordinary health, so that they could bring a sense of urgency to their practice and give the present moment their full attention. If you learn to treat all moments as potentially your last, then when your last moment does come you will face it prepared.

Transcribed from a file provided by the author.

Quaker and Liberal Jewish View

So far as can be ascertained, whilst individuals hold a range of personal views, there is no publically stated position from either Quakers of Liberal Jews.

A Pagan View

From: Yvonne Aburrow

As Paganism is non-creedal, different Pagans can think what they like but I suspect most would agree that assisted dying should be allowed, provided that appropriate safeguards are in place to prevent over hasty decisions and people being pressurized into it.

Yvonne Aburrow is Editor of 'The Unitarian'

The Humanist View

Written Evidence to the Commission on Assisted Dying from the British Humanist Association (BHA), April 2011

Humanists are non-religious people who live by moral principles based on reason and respect for others, not obedience to dogmatic rules. They promote happiness and fulfilment in this life because they believe it is the only one we have. Humanist concern for quality of life and respect for personal autonomy lead to the view that in many circumstances assisted dying, or voluntary euthanasia, is the morally right course.

People should have the right to choose a painless and dignified end, either at the time or beforehand, perhaps in a 'living will'. The right circumstances might include: extreme pain and suffering; helplessness and loss of personal dignity; permanent loss of those things which have made life worth living for this individual. To postpone the inevitable with no intervening benefit is not a moral act. Individuals should be allowed to decide on such personal matters for themselves; if someone in possession of full information and sound judgement decides that her[2] continued life has no value, her wishes should be respected.

While humanists generally support assisted dying and voluntary euthanasia, they also uphold the need for certain safeguards. These may include counselling, the prevention of pressure on patients, clear witnessed instructions from the patient, the involvement of several doctors, no reasonable hope of recovery – measures which would prevent involuntary euthanasia.

Some religious people maintain that there is a moral distinction between acts which cause death (active euthanasia) and omissions which cause death (passive euthanasia), only the second being morally permissible. Many humanists think they've got it the wrong way round, because the first is quicker and thus kinder for everyone involved, though both are probably painless for the patient.

Many of the medical profession and politicians have also accepted this traditional distinction. It might be easier for doctors to withdraw or withhold treatment than it would be for them to administer a lethal drug – but this does not necessarily make it right. It would be wrong to force doctors and nurses to do things that they consider morally wrong, but patients wishing assistance in dying should be allowed to seek a doctor who will help them.

Some think that suicide is wrong because of the great pain it often causes to those left behind. If one believes suicide is wrong, then assisted suicide, seemingly, must be wrong too. However, the death of a terminally ill and suffering patient would probably be a merciful release for everyone involved and so is very different in its effects from other suicides. There is no rational moral distinction between allowing someone to die and actively assisting them to die in these circumstances: the intention and the outcome (the death of the patient) are the same in both cases, but the more active means is probably the more compassionate one. The BHA supports attempts to reform the current law on assisted dying and voluntary euthanasia.

The British Social Attitudes (BSA) survey

In the 26th report (2009-10) the question was asked:

Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life, if the patient requests it?

Results

51.9 %	**Definitely should be allowed**
30.1 %	**Probably should be allowed**
8.0 %	**Probably should not be allowed**
7.1 %	**Definitely should not be allowed**
2.8 %	**(Don't know)**
0.1%	**(Refusal)**

To read more about the British Social Attitudes Survey, please refer to page 58 of the reference section

Personal Testimony

It doesn't make sense!

From: Rev. Celia Cartwright

In the late 1980's our beloved red setter, Rosie, began behaving strangely and became increasingly confused. Eventually she was often incontinent and her deafness didn't help. I think it was Christmas 1990 or '91 when things came to a head. As usual we had gone to my parents but Jodie was so distressed I took her home on Boxing Day. A couple of days later the vet's verdict was in. She had dementia and the only kind thing to do was to put her to sleep. When the children came home a couple of days later there was much sadness in our house. We kept Rosie for a week and lavished love and attention on her. Saving images and the feel of her in our hearts and minds. We all went with her to the vet and stayed with her till she was at peace.

In the late 1990's my dad was diagnosed with dementia and during the following few years he became increasingly confused and depressed and he developed strange habits. By 2000 he could no longer figure out how to do even simple tasks. The man of great intellect, purpose and vision was gone. In his place was an increasingly difficult person who talked incessantly, who followed his elderly wife round and round giving her little peace - and he was becoming doubly incontinent. Social services were few and it seemed that as we were 'coping' that was fine. Mum and I took antidepressants and kept going with my daughter's help.
In 2005 during the Christmas break a duty Community Psychiatric nurse came at my insistence to see him. Appalled, she found a place for him in a well-run nursing home. 18 months later he died in hospital after his multi-infarct dementia put him in a coma. Only then was palliative care deemed the right thing.
Now here's the thing I don't understand. If I had allowed my dog to suffer the way my dad suffered I would have been guilty in law of cruelty. However, had I helped my dad as I helped my dog I would have been guilty in law of at least manslaughter. It doesn't make sense at all.

Celia Cartwright is the Minister at Unitarian Chapel, Kendal

Can medical science solve everything?

From: Robert (and Susie) Ince

When I proposed the motion at the 2012 General Assembly meeting in Keele, I referred briefly to the experience my wife and I had watching our own parents die. I made that point for two reasons; firstly to demonstrate a personal involvement and secondly to show how widespread the problem is. It was not appropriate in that speech to go into detail, but I think the story does highlight quite a few different issues and perhaps this is the time tell the story in detail.

My mother, having spent 6 years as a widow where she searched hard to find a purpose in her life, eventually recognized she could no longer live on her own and came to live with us for, what turned out to be, the last two weeks of her life. She had given up fighting and just wanted a time of peace with her family. This time was very precious to me because she was able to talk in way she never did before. Hers was a generation that didn't reveal too many feelings to the outside world. She had seen the horrors of war and didn't want to talk about it. Suddenly, she was at peace with it all and was ready to move on. This she did, peacefully without pain, at home, with those she loved.

My father, who never really had a day's illness in his life started with problems at the age of 78. Nobody knew what it was. It took months of tests to determine he had a brain tumor, by which time the tumor had grown so large it was inoperable. And so began six months of waiting for the inevitable. After 3 months, the pressure on Dad's brain had reached a point where he was unable to

hold a conversation because thinking was too painful, yet painkillers rendered him comatose. His body meanwhile was failing to respond to the simplest of activity and so he lay there for 3 months with nurses attending to his bodily functions and not be able to think or communicate properly until it all came to a natural end.

My father in law, meanwhile, developed vascular dementia – a series of mini strokes that progressively turns off parts of the brain –he started to lose his memory and became aggressive, so ended his days in a secure home. It was clear that, whilst his memory had all but disappeared, he somehow responded to those closest to him. In the end, he lost the ability to swallow and a decision was taken not to force feed with tubes. That meant he would starve to death. We are all still convinced that it was the right decision, yet feel ashamed that it took 5 painful days for his body to finally give up the fight.

My mother in law was a tribute to the National Health Service. Her medical records were wheeled round the hospital in 3 supermarket trolleys and many parts of her had been replaced over many years. She had had open heart surgery and a pacemaker. She also had severe vascular problems which eventually lead to her losing one leg. The doctors suggested her amputation be carried out under local anesthetic, but she refused, insisting she have the general anesthetic which they warned could kill her. She survived only to be told that the operation was not successful and she would have to go through it all again. She survived that too, but the pain in her missing leg continued and no amount of painkillers would remove it. Indeed, morphine and similar powerful painkillers actually made her more ill. It was at this point she begged for help to end her life on numerous occasions and we felt totally helpless. Eventually her other leg failed, but she refused any operation knowing that would lead to gangrene and death. That was her conscious decision to end it.

What are we to make of these stories? Well, I think a recognition that medical science has come a long way but will never solve every problem, because there comes a point at the end of many people's lives where the love and compassion of their family and friends is more important than what is provided by medicine. The final days are rarely without pain and we can only reflect with hindsight that people reach a point where the spirit is what is most important. For many there truly is a Gift of Death.

Fulwood Old Chapel, Sheffield

My Brother's Story

From: Lesley Close

Even though he was 9 years older than me, my brother was my best friend. I was his little sister. When he grew up he became a singer songwriter, not a famous one, you understand, but he enjoyed what he did and did some work with the Open University. He was also very sporty and particularly enjoyed running marathons. So he was a regular sort of guy. And then in the late 1990's, in his early 50's, he started to have problems, firstly with running, then walking and then he started to get a limp and acute cramps. In 2001 he was diagnosed with motor neurone disease (MND)

We learnt pretty quickly that this was a disease that was progressive and incurable and which can weaken the diaphragm and produce breathing difficulties. My brother was given between 6 months and five years to live. We also learnt of something called existential suffering - the spiritual distress that can occur as one confronts issues of existence such as living with the prospect of death, progressive disease, and greatly reduced independence. In my brother's case he had started to experience a problem with clearing his throat and choking to death was a real possibility of which he was very afraid. He faced the prospect of reaching the point where he was unable to communicate at all and all his bodily functions would have to be dealt with by carers. He would become what has been described as 'a living head on a dead body'.

My brother and I are not religious people, neither is my sister who is 12 years older than me, but my parents were very much Church of England. That's how we were brought up, though we all stopped going to Church in our teens; so when John got his diagnosis we had some real thinking to do. His

view on his own mortality was very matter of fact; he didn't believe in the afterlife, but he was not scared of dying. The first thing he did on diagnosis was to ensure all his songs were digitised so they would be kept for posterity.

As his illness progressed, he lost the ability to walk, confining him to a wheelchair. His approach to all these restrictions was very positive, even to the point starting to use his mechanical aids earlier than necessary. He wanted to be ahead of the game!

As John deteriorated, he moved into a disabled person's flat and, because there was a spare bedroom, my partner and I were fortunate to be able to stay with him every Saturday night. These were precious times, but eventually he needed 24 hour care which meant live in help, so we had to stop our Saturday night sleepovers. Fortunately, John managed to get a marvellous carer, who couldn't have been better; unfortunately, she only had a 3 month's work permit, so time was precious.

Then in January of 2003, John read a news article about Reg Crewe and how he had gone to Dignitas to die. At this point, nobody in the UK had really heard of Dignitas. John's comment was "That's how I want to go, when the time comes" and so began my brother's quest to determine the manner and timing of his own passing. He joined Dignitas and then awaited permission (a 'green light') from a Swiss doctor to put his plans into action.

His quality of life was now beginning to deteriorate rapidly. For some time he had no longer been able to speak or sing, and could only communicate through a computer using his non-dominant left hand. He had already lost the use of his right arm and hand and was petrified of losing the other which would leave him unable to communicate at all. By this time his excellent carer had left to be replaced by a succession of less-than-perfect ones. I had given up work so my partner and I effectively became his full time carers for the last few days of his life.

Then, on 12 May, I received a phone call from Ludwig Minelli at Dignitas to say that John had been accepted and a date had been fixed for May 26 – Bank Holiday Monday. This felt very surreal. To be given a very specific time to die felt very strange indeed; for John…. and for me.

Our last two weeks together were spent going for walks around Milton Keynes, where John lived, enjoying the spring blossom. I was reminded of Dennis Potter's comment in his last interview with Melvyn Bragg having been diagnosed with terminal cancer – "Instead of saying 'Oh that's nice blossom' ... last week looking at it through the window when I'm writing, I see it is the whitest, frothiest, blossomest blossom that there ever could be, and I can see it."; there was a very real heightening of the senses. We discussed having a 'leaving party'. John was against it because one of the symptoms of his illness was crying, not for any emotional reason – it was just one of the things that happened with his MND. But then John changed his mind and we did have the party. Everybody had a really good time and John cried……..and everybody else cried. It was beautiful.

So, we flew to Zurich, John, my partner and myself, my sister and John's girlfriend. We didn't think too much about the legal implications because, quite frankly, at the time there was no appreciation of what the implications might be. John was only the 7th British person to go to Dignitas. On the night before he died we sat down to watch John's favourite film, 'The Life of Brian', and we laughed and we cried.

Then the following afternoon, I helped connect John's feeding tube to the drug and he was able to turn the tap to release the drug… and that was it. After a couple of days in Zurich we returned home, but without John.

Sometime later, I applied to Thames Valley Police, under the Freedom of Information Act, to see my police record. The DPP had decided it was not in the public interest to prosecute. I felt strangely annoyed because they hadn't really investigated the circumstances and I could have done it maliciously for all they knew, but I'm glad I didn't have to go through problems of confiscated computers and fingerprinting etc.

John was not scared to die, even though he had no expectation of anything to follow. Curiously, both my parents, devout Christians, fought death all the way. On reflection, I was so grateful to be

allowed to be with John as he died: it was exactly the sort of death John wanted, given the circumstances. The last gift my brother gave me was the chance to hold his hand as he died, which gave me the comfort of knowing that he died with great dignity.

Post Script

I have just heard a programme on Radio 4 about Dame Cicely Saunders, the founder of the Hospice movement. There are two quotes that sum up her attitude, but hide the fact that, as a Christian, she was vehemently opposed to assisted dying

"You matter because you are you, and you matter to the last moment of your life."

"I realized that we need not only better pain control, but better overall care, people need the space to be themselves. I coined the term total pain from the understanding that dying people have physical, spiritual, psychological and social pain that must be treated. I've been working on that ever since."

I agree with those sentiments, but I disagree with her view that the timing of one's last moment can only be decided by a supernatural being. In the face of the many life -prolonging treatment options facing patients with cancer whose lives are sometimes 'artificially' extended by medical care, surely that is the case? Perhaps I am being overly cynical and such 'enhancements ' are simply God's gift to the dying, given via the doctor... But surely God would not want anyone to suffer intolerably, even in imitation of his son's suffering on the cross?

I believe that giving those mentally competent, terminally ill adults who wanted it the right to decide the timing of that last moment for themselves would not so seriously undermine the beneficence of God that he cast hell-fire and damnation on the rest of his people who chose *not* to end their intolerable suffering that way. And that's what is comes down to, personal choice.

The points about changes in the perception and treatment of the dying and our reaction to the prospect of death (both our own and of those we love) were well made. What was lacking, as with most practitioners of palliative medicine, was an expressed understanding of the suffering which is caused by a loss of dignity, the existential suffering I mentioned. No amount of love or caring treatment could have alleviated that for John, being naked on a shower chair while he struggled to empty his bowels in front of strangers...

I suspect existential suffering is seldom mentioned because, unlike the physical pain of cancer which can be treated with drugs (up to and including the point of terminal sedation), little can be done to alleviate it (and doctors don't like failing).

Excerpt from The Parliamentary Debate on DPP guidelines - 27 March 2012

Paul Blomfeld – MP for Sheffield Central, Labour

This is not an easy contribution for me to make, and I have thought long and hard about it. My father took his life last July and my emotions are still a bit raw. I was deeply shocked at the time, although I should not have been surprised, as he had always said that he would rather end it than face a distressing and lingering death. He was 87 and he had lived his life to the full, right to the end, but he had watched many of his friends go. He regularly talked about one who had been confined to bed, doubly incontinent and, having become both deaf and blind, unable to communicate with anybody. My father saw no point to that kind of life.

My father was a strong man who had had a tough east-end childhood. He was an RAF pilot in the Second World War. He had his share of health problems and faced them all positively. He was not afraid of pain but he could not face the indignity of that lingering degrading death. I am sure that he made up his mind soon after receiving a terminal diagnosis of lung cancer but he still died prematurely. I am sure that what drove him to end his life when he did was the fear that, if he did

not act while he could, he would lose the opportunity to act at all. If the law had made it possible, he could, and I am sure he would, have shared his plans. He would have been able to say goodbye and to die with his family around him and not alone in a carbon monoxide-filled garage. He and many more like him deserved better.

I was in two minds about whether to share this experience, and what made up my mind was the attitude of my father's friends, who had clearly thought about their own future and had nothing but respect for his decision. One contacted me only yesterday and asked me to share his experience of his daughter's death. She was a young woman with everything to look forward to who was diagnosed with an aggressive cancer in her mid-20s. She fought it in every way she could, with everything to look forward to and undergoing all the treatments available, but ultimately they all failed. He said that even when there was no hope left for her and the hospital had withdrawn her food, they had to watch her die the most horrendous, slow death over several weeks from graft-versus-host disease, a consequence of a failed bone marrow transplant. They were deeply scarred by that experience, and still when they think of her that memory overshadows all the happy times. They thought it would have been so much kinder to have brought her life to an end as she would have wanted at an earlier point when everybody recognised that all treatments had failed and there was no hope.

I welcome the DPP's guidance but I think that ultimately we will need to go further. Of course there must be safeguards and constructing them robustly will be difficult, but the challenge of the task should not put us off the need to do it. This issue will not go away. As medical technology advances, more and more people will face these decisions and more will be pressing at the boundaries of the law. I think this is a question not of whether we should go further and legalise assisted dying but of when. The longer it takes us to act the more needless suffering we will have consented to.

Edward Leigh – MP for Gainsborough, Conservative (in immediate response)

Paul Blomfield spoke with great emotion. Like his father, my mother died at the age of 87; it is very difficult for us to speak about these very personal matters. I know that my mother, like many elderly people, wrongly felt that she was a burden. Of course she was never a burden, but I think that many people feel like that; there might be absolutely no pressure on them, but they feel that they would make it easier for everybody if they were to ease their path out of life. We must never allow old people in this country to feel that they are a burden. That is where I come from.

My views have progressed on this matter over the time I have been in Parliament. I freely confess that when I first came here I believed that the state had the right to take life and I voted, like many of my colleagues, in 1983 to restore capital punishment. I now think I was wrong and I have come to the conclusion that the only logical and right course of action is always to proclaim life. As it happens, at the moment I am reading a history of Stalin's Russia, and one cannot understand the attitude of a society in which life is held so cheaply. I know that we are a million miles from that but in my view the end never justifies the means. That is why I personally voted against all the recent wars—or certainly did not vote for them. I believe that life must come first and that we must proclaim life.

That does not come from my religious views; it is a matter of absolute certainty and belief and is incredibly important for society if we are to create a society of light and hope and not one in which people ultimately feel they are a burden. That is why I have consistently voted, opposed, spoken against and moved amendments on abortion and I would vote against capital punishment. I am totally opposed to euthanasia in any shape or form. Some people will say, "That's all very well for you. At the moment you are reasonably healthy. What if you are faced with the appalling difficulties and problems that we have been talking about today?", and my answer is that I do not know. All I know is that we must proclaim this truth, and the House of Commons should proclaim it—that anybody, however young, unborn, crippled, hopeless, diseased or idiotic, has as much right to life as anybody else, and all life is precious because the external human body is simply a mirror of the soul. If we renege on that moral certainty and if we start on a journey, it is a very dangerous journey indeed.

Spiritual Reflection

The gift of life and the gift of death

From: Rev David Shaw

We talk a lot about God's gift of life, perhaps we might reflect upon God's gift of Death

Rev David Shaw is the Minister at Upper Chapel, Sheffield

Is life a loan or a gift?

From: Rev. Andrew McKean Hill

Assisted suicide is a highly divisive moral issue – whether or not in desperate circumstances one has the right to take one's own life, or to request the assistance of another in doing so. Since it is strongly opposed by the so-called 'Christian right' it behoves, those of us with less extremist and more liberal views - rather than arguing from general philosophical axioms - to investigate instead whether there is not a more sympathetic Christian case; and the Christian case I would make centres around this simple question "Is life a loan or a gift?"

Definition of Christianity

A case might begin by defining Christianity as the religion of Jesus rather than the religion about Jesus, and by bearing in mind his two great commandments expressed in the Christian gospels thus:

> *You shall love the Lord your God with all your heart and with all your soul, and with all your strength and with all your mind; and your neighbour as yourself. [Luke 10:27/Mk 12:29-31]*

The case would recognise that these two commandments are in effect three - a commandment to love God, a commandment to love our neighbours and a commandment to love ourselves.

In order to give these three commandments a more specifically Christian flavour we may note that in John's Gospel at the Last Supper, Jesus tells his friends:

> *A new commandment I give unto you that you love one another as I have loved you.*

Christian Ethic

The case might then go on to state that the Christian ethic – within which 'dying with dignity' is a topic - is the working out of this three dimensional, inter-dependent, love of God, love of neighbours and love of self both in individual human lives and in the life of human communities; and since the Christian ethic is :

- neither an ethic of human autonomy;
- nor an ethic of human dependence;
- but an ethic of inter-dependence and of self in community;

it asks 'What is the most loving thing to do in a particular situation?' It notes that since the life of the world is incomplete, unfinished, imperfect – creation continues. Likewise the Christian ethic is incomplete, unfinished and imperfect – and the search for answers is ongoing. Christian ethics are not an exact art. It, therefore, makes sense to understand Christian ethics according to a polarity of better and worse, and not as mutually exclusive right and wrong alternatives. From a Christian perspective the question should be 'What is the better thing to do in these circumstances?'

From a christian perspective what makes death better or worse?

A case would then ask – from the Christian perspective 'What makes death better or worse?'

- Dying in isolation is worse; dying in community better because we are 'members one of another'. 'It's my body' is only half a truth because my body has extensions which relate me to others known and unknown. Wrote John Donne in a famous passage:

> *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.*

- Dying uncared for is worse; dying cared for is better and that includes care for our hopes and dreams and personalities as well as care for our physical bodies.

- Dying among people we don't know and have not learned to trust is worse; dying among people we know and have learned to trust is better. For Christians, dying is a condition of trust in which the individual has entrusted his or her life, personality, fears and hopes to others.

Assisted Dying

So if there is a Christian case for assistance in dying for the terminally ill it would need to conform with these three criteria:

- dying in the care of others;
- dying among people we trust; and
- knowing that when *anyone* dies a little bit of us dies as well.

Common Concerns of Christians

The public debate on these issues often obscures two concerns common to both Christian sides of the assistance in dying debate:

- The first concern is that hi-tech medicine has seriously drawn out the dying process and made our understanding of death far more complicated than it used to be. One used to be simply dead or alive. Now one can be suspended indefinitely between the two.

- A second concern is that there should be better care of the dying, more palliative and hospice care anyway. It is an injustice to both sides of the debate when journalists and programme makers place campaigners for active assistance in dying and campaigners for more hospice care on opposite sides of the table as in the worst of election debates. Both groups of people desperately want better care of the dying.

Differences Among Christians

Nevertheless there are some differences to be recognised.

- Regarding sanctity of life issues Christians can be very selective and overlook that at some times some Christians have made exceptions. Killing in self defence, in a just war, as capital punishment, when desperate for food - at various times these have all been regarded as justified exceptions to the sanctity of life rule. So any case against assisted dying needs to be aware of such lurking Christian exceptions.

- Also there are differences regarding the intentional use of drugs with a common effect – death. Proponents of assisted dying regard bringing life to an end (at the patient's request) so as to relieve suffering, as having exactly the same effect as relief from suffering which results in death. Supporters of assisted dying regard this difference of intent as a moral quibble. Opponents say it isn't.

But , it certainly isn't a moral quibble if life is a loan, because loans have strings and for Christians the strings are held by God; and the loan may only be handed back when God wills it back. But an alternative Christian view is that life is a gift, and gifts are given outright without strings. Gifted life is entrusted into human hands; and human hands are responsible for their own decisions and actions, and those decisions and actions may include the decision about when our lives shall end.

So is life a gift or a loan? No doubt you will tell me afterwards.

Rev Andrew Hill is a retired Uniatarian minister

Choice

From: Rev Jane Barraclough

What does personal choice mean in the context of assisted dying?

Well, pretty much the same as it means in any other context. A comparable situation, although it may seem an odd comparison, is the context of abortion, a situation in which we permit people, usually women, sometimes couples, to make a choice based on their own reasons. As a society, we neither advocate a termination nor do we prohibit it. Neither do we insist on probing too deeply into personal motives. In other words, we treat people like grown-ups.

For example, a single woman might decide that she is content to raise a child on her own; another single woman in a very similar situation might decide that she is not prepared to go ahead under those circumstances.

This is comparable to the assisted dying situation as follows: an individual might be prepared to live with a high level of pain, another individual in similar circumstances might decide that they are not prepared to go on living with such a level of pain. One individual might be content to continue living completely dependent on state, family and friends, another might not.

The point is: it is not for us to decide, it is a personal choice. I would hope the NHS is still up to providing counselling in such a situation, should the individual want it.

It shows humane concern that we would not want people to feel under pressure to decide **one way or the other**. The example that is often used is that we would not want people to give up on life because they feel a "burden," but at the end of the day we cannot control how people feel. They have a right to their feelings.

Humane concern in these circumstances can very easily tip into a situation in which other people think they know best. Think they know what is best for another person. And that, at best, is deeply patronizing, at worst downright paternalistic (and women can be paternalistic too, by the way).

Freedom of choice in any situation means that we permit people the right to their own motives. Just because their decision might not be the same as our own, or might not suit us, or might make us deeply uncomfortable, does not negate their right to freedom of choice.

All of this involves difficulty and the emotional pain of loss of so many kinds. These choices are best made when we are relatively well but people also have the freedom to choose when they are very ill, perhaps the only time when we really know what is at stake.

If we take human freedom and responsibility seriously, then it cannot be a right and privilege we withhold in difficult times, perhaps one of the most important times in a human life, when we come to our time to die.

Rev Jane Barraclough is the Minister at Cross St Chapel, Manchester

Milk to keep babies alive and the right to die with dignity.

From: Rev Peter Hewis

Many years ago BBC 2 TV had Saturday night debates and one on euthanasia featured two Unitarians; speaking in favour of the right to a dignified death was the then chairman of the Euthanasia Society the Reverend Ben Downing and speaking against euthanasia was another Unitarian, Dr. Katherina Dalton.

The same debate has continued ever since the then Voluntary Euthanasia Society was founded in 1935 when a Unitarian was the prime mover. If you visit the Great Meeting in Leicester you see many memorials to eminent Unitarians including those of several Mayors that the Chapel had provided for the city. One tiny memorial is rarely seen but on a table in the chancel you can see a tiny plaque about 8 inches by four inches and it reads, *"Given in memory of C. Killick Millard, Medical*

Officer of Health for Leicester." Dr. Killick Millard was the founder of the Voluntary Euthanasia Society. Rev Dr R. F. Rattray, his minister who was also the Principal of University College, Leicester, supported him as did Canon F. R. C. Payne of Leicester Cathedral; Rev A. S. Hurn the retired minister of Great Meeting Leicester and Frederick Attenborough who I think was the father of David and Richard Attenborough. H. T. Cooper, the Honorary Solicitor of the Committee was also a member of the chapel.

During his working life some accused Killick Millard of being evil and wanting to get rid of the weak but nothing could be further from the truth. His critics forgot to mention that in 1900 around 15% of infants in Leicester failed to reach their first birthday but after conducting trials with milk powder provided to poor families he began to reduce infant mortality. *(The powder came from the West Surrey Central Dairy, later to become Cow & Gate.)* In 1904 Dr. Millard had read reports from America that the health and survival rates of poorer children in New York were greatly improved when powdered milk was added to their diets. Milk to keep babies alive and the right to die with dignity, both ideas from an enlightened Unitarian in Leicester.

The last time I looked at the memorial to such a remarkable man was some years ago but in that very week the right to die had become a major issue in Britain.

A man from Liverpool, Reg Crewe had gone to Switzerland for what many called a mercy killing, but what I call voluntary euthanasia or the right to die. Reg was paralysed from the neck down and had been ill for years. The family had discussed his situation and Reg made his wishes known many times. In Switzerland with his wife of 51 years and his daughter by his side he whispered, "Let's hope this will open the doors for euthanasia" and then added, "Don't let me down". His final words were, "I'm leaving you both, God bless, I can't fight any more." At three in the afternoon Reg died peacefully and his wife Win commented, "I did dread it but the end was for him." Daughter Jan said, "They should be able to do this in their own country, dad didn't waver for a moment and he died with dignity."

Now thankfully most people can die in dignity but the law in Britain still insists that no one can aid or abet death, even if it is for a merciful release and at the person's request.

Where do we stand? Like Ben Downing and Kitty Dalton only you can decide as an individual but I stand alongside Killick Millard and support the right to die with dignity. As part of the Ministerial Training course in Oxford I would have two sessions, one led by me on euthanasia and one led by Professor Dr Bee Wee on palliative care. Most of us agree with Albert Schweitzer that all creatures have a will to live and during more than forty seven years as a minister I have found that 99.9% of people have the will to live right to the very end but I have also found that for about .1% life is so miserable and the quality of life is so poor that they wish for a dignified end. During my ministry only three people have expressed a wish for an assisted end to life and in my view each request was well thought out and justified. In two cases they were terminally ill and in the third a lady of 103 said to me, "I have had a long and happy life but now in this nursing home I have nothing in common with anyone, my eyesight, most of my hearing and my taste buds have gone, I have no relatives left and it is just time to go peacefully."

My hope for you and me is to live to a ripe old age with decent health but I also believe that people should have the right to choose either palliative care or to die with dignity.

Peter Hewis is a retired Unitarian Minister, a former President of the General Assembly and Emeritus Chaplain and Fellow of Harris Manchester College, Oxford.

The Right to Die?

From: Paul Cannon

Does a mentally capable individual have a right to die?

Whether you answered yes, no, or don't know, the follow up question is:

Are there any circumstances where you might make an exception to your previous answer?

For example, one might agree that there is a right to die but feel that there are circumstances where an otherwise mentally capable individual's wishes should be over ruled. Equally, one might believe that there is no right to die, but that in certain circumstances, the prospect of an intolerable existence in the face of an incurable disease for example, where an individual should be granted an exception.

The first question is philosophical and is unlikely to be definitively answered in anything other than a geological time frame. But in the here and now we are confronted with the problem of what may be referred to as assisted suicide, seen by the law as murder, and living wills, or Advanced Decisions to Refuse Treatment, which specifically rules out the legal right to actively be assisted to die (Mental Capacity Act, 2005).

At this point it is necessary to draw make it explicit that this debate has no bearing on the treatment of dying patients in pain. The law is really clear on this, provided the primary intent is to alleviate pain and suffering a patient may be given as much pain killer as needed - even if a side effect of this is death. This is not euthanasia or assisted dying, it is just good medical practice. Just to be clear, so there is no confusion, it is completely legal to give a fatal dose of pain killer provided the intent is to treat pain rather than to cause death. Nobody needs to fear a painful death because of a lack of pain medication for legal reasons, through poor medical practice maybe, but not because a change in the law is required.

What this debate is about is administering medication where the primary intent is the death of the patient. What is being requested by the advocates of a change in the law is the possibility to administer a lethal dose of medication, with the intention of causing death, without fear of prosecution.

So should those who wish to die be legally allowed to seek assistance to help them to die?

Should a doctor be allowed to prescribe a medication with the primary intent of ending life?

At the moment it is legal to end life by withdrawing a treatment, but it is illegal to end life by administering one.

Should this be changed?

If so, under what circumstances?

No one is calling for 'death on demand' for anyone over 18 who is mentally capable (although if one believes in a right to die it would not be an illogical extension of the argument to do so).

Equally, the debate tends to be focused on those who are unable to take their own lives. It is worth noting that until 1961 suicide was illegal in England and Wales, and there seems to be an assumption that those who are physically capable of ending their own lives, and wish to do so, ought to do it themselves rather than 'outsource'.

Then there is the thorny issue of mental capability. We are fortunate in the UK to have the Mental Capacity Act, 2005, which in many ways is a very good Act and a great improvement on its predecessors. This Act lays down 5 principles of which 1 and 3 are most relevant:

(1)A person must be assumed to have capacity unless it is established that he lacks capacity.

(3)A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(Included within this Act is the law concerning Advanced Decisions to Refuse Treatment)

It is easy to argue that someone in a psychotic state lacks the required insight to be regarded as mentally competent, but can the same be said of someone who has been living with chronic depression for years who decides that this is an intolerable existence and wishes to end their life. Should such a person be condemned to live merely because they lack the physical capacity to end their own life?

Some people may argue that wishing to end one's life is proof in and of its self that an individual is not mentally capable. Others may take a different tack, that living in a manner where it is not possible to take one's own life is itself intolerable, and a reason to request an assisted suicide.

As with much moral reasoning we seem to be driven far more by our innate comfort level than with any logical reasoned argument. Just as people confronted with the moral problem of what they would do in the hypothetical event of a runaway train which is going to run into a carriage containing 10 people causing their certain deaths, whereas if they activate the points and switch the train to a different track it will hit a carriage containing only 2 people thereby saving 8 lives, tend to choose not to activate the points, but are unable to defend their position beyond merely stating that it would be wrong of them to do so, we to are in a position of choosing whether we ought to enable those who would rather be hit by the train, metaphorically speaking, than continue to live the lives they are enduring.

Some would argue that the right should only be extended to those with a terminal diagnosis; others prefer limiting it to those who are expected to die within a certain time frame, sometimes quite short.

Once these questions have been addressed it is time to start adding in safeguards to prevent the abuse of any such legalization of the right to die. Some may feel that the risk of these abuses alone may be sufficient reason to limit the circumstances in which an individual has a right to die, or even to deny that right entirely.

The more cynical amongst us would have little difficulty imagining a world where services are reduces to a point that makes life intolerable in the knowledge that it won't be long before no service, beyond a physician assisted suicide, need be provided at all.

Those involved with campaigning for the rights of the elderly will be no strangers to families reluctant to seeing inheritances disappearing in care home fees.

Our mission, should we choose to accept it, is to come up with a motion that can be put to a vote at the 2013 General Assembly. We should not be afraid to be to be overt in our uncertainty on our collective view on the fundamental rights issue; such an honest admission would be far preferable to a dishonest fudge.

What is important is that we reach agreement on wording that we as Unitarians can collectively support and campaign for

It does not need to be our final word in this topic, it is probably best that it isn't, but it does need to reflect our collective compassion, our willingness to challenge the status quo, and our relevance to 21st century life, and death, within our wider community .

So here are the three questions for you to collectively think through:

1. Is there a right to die?
2. When should this right apply?
3. Should it be restricted to those who are unable to end their own lives?

To avoid getting bogged down in arguments over safeguards, we will call for them to be adequate with a view to addressing this specific issue in a future motion to be put before the General Assembly.

Paul Cannon RGN RSCN is a registered nurse and a member of the New Unity congregation

'Dilemmas of Life and Death'

From Rev Cliff Reed

The idea that life is a gift and therefore something to be treasured, protected, and used well, is established in most, if not all, religious traditions, including our own. We celebrate new life when a child is born and we celebrate the various stages of growth and development that follow. We also

place a high value on healing the sick and injured, on saving lives that are in danger, and, ideally, on giving a good quality of life to everyone. So we have no problem with celebrating life – something we do in worship on a regular basis. Even at funerals these days we are at pains to say that we are celebrating the life of the deceased. But does this sometimes mask a reluctance to come to terms with death? Do we not regard death in wholly negative terms these days; something to be prevented by all possible means, regardless of the cost – however that be calculated? In the days when, as we suppose, belief in the afterlife was pretty well universal, religion provided a system of language, ritual, and behaviour for coping with it. This has largely gone. We see a 'fetishisation' of life – even in some religious bodies – that portrays death as always and necessarily bad. I think this is very wrong, and helps to explain why death has become a taboo subject, even at funerals! Death is as much a gift as life, when it comes at the right time. Life on this earth may be for living, and is not to be cast away carelessly, but it is not and should not be for ever. When the body is broken irretrievably; when it is wracked with pain without hope of relief; when the mind has decayed to the point where the personality, the reasoning self and its capability for joy, is already gone, then death is a gift – a divine gift to be welcomed with gratitude. Whether or not we believe in life after death (in whatever form) doesn't really affect this – unless you see life after death in the negative terms of hell and damnation (which I don't)! Dying should not be prevented when it is clearly both desirable and close anyway. The palliative care provided by the hospice movement shows that indignity and suffering can be greatly reduced in order to give a good death. Officious medical intervention to stop someone dying who is close to it anyway – and who welcomes it and has said so – should be (and largely is) regarded as bad practice. And giving a last helping hand across death's imminent and welcoming threshold has always been the compassionate act of any doctor worth his/her salt, without anything being said. But if death is not imminent, even if it is desired by the person concerned, should any doctor be required, or even asked, to bring it about? That seems a step too far because it imposes on that doctor's conscience. And I don't think any of us would be comfortable with doctors who were happy to kill their patients. Even at clinics abroad where people go to die, what happens is suicide, not homicide. They are given the means to end their own lives – and every chance not to - but the action is theirs. I may have my reservations when people choose that path, but I certainly do not condemn them. Do I have a glib, morally-impregnable position on this? I hope not, and I rather distrust those who do, but our guide must be compassion, reverence for life, and reverence for death too.

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On the subject of choosing the time of one's own death, I have always been struck by a passage in Appendix A of J.R.R. Tolkien's, 'The Lord of the Rings'. It is all the more remarkable when we bear in mind that Tolkien was a devout Roman Catholic. The words are those of an aged king to his queen, a king who has it in his power to determine the time of his own death. He says to her:

"Take counsel with yourself, beloved, and ask whether you would indeed have me wait until I wither and fall from my high seat unmanned and witless. Nay, lady,...to me has been given not only a span thrice that of Men of Middle Earth, but also the grace to go at my will, and give back the gift. Now, therefore, I will sleep."

Rev Cliff Reed is a retired Unitarian minister and former President of the General Assembly

My Life and My Death

From Rev David Usher

Most of us will have a personal experience which will have affected what we think about Assisted Dying. Perhaps someone we have loved has had a protracted and difficult death, during which they have pleaded in vain to be allowed a merciful release. At the very least, we will have known about cases which have come to court, in which someone has been prosecuted for having assisted someone to die. Whatever our emotive or instinctive responses to such situations have been, it behoves us as religious people to have a more considered view which is consistent with our theology and which rises above easy sloganising. What is the theological basis on which a Unitarian might base their support for, or opposition to, Assisted Dying? One's view of death is largely determined by

one's view of life. I do not dismiss out of hand the possibility of some form of consciousness after death, but the expectation of it is not the basis of my daily faith. I believe that the life I have, granted through whatever miraculous processes were responsible for my being, is mine to make the most of for its own sake, and my appreciation of it is measured by two primary factors - how much I am enjoying it personally and how much it is of value and usefulness to others. The balance between those two factors can vary, and there might well be times when my personal enjoyment is outweighed by the value that others still derive from my living, and vice versa. But neither factor should be completely ignored.

The tragedy of suicide is often the disregard shown to others who are directly affected by a person taking their own life unilaterally and unexpectedly, and the lasting damage that causes to those others. Assisted dying is not suicide, because it is done in consultation with others, and with all due process. It is done when the individual has decided that they are no longer enjoying life and do not expect to in the future, and others directly affected by that life have recognised that that life has come to the end of its savour, value and usefulness. That is not a statement of functional utilitarianism or callous calculation. It is a statement of loving respect and reverence for life in its finitude. We know that death is the end which awaits us all as the necessary condition of living. Death is as much God-given as is life. The question is not whether or not to die, per se, but whether or not to accept death.

As someone who believes that religious faith, and how to live by it, is a matter for personal discernment and not ecclesiastical diktat, an integral part of being free to live well according to faith is the liberty to die well in that same faith. I would want the manner of my death to be at one with the manner of my living. I would want my dying to be the natural final act of my living, one in which, if circumstances allow or require, I am the active participant and not the helpless victim. If others of different faith persuasion feel differently about how they wish to die, so be it. But I want to live according to my faith, not according to the faith of others.

Rev. Dr. David Usher is the District Minister for Unitarians in London & the South East

Reflections on Death

From: Rev. Margaret Kirk

Much of my life has made me aware of the delicacy and denial that surrounds the subject of death. If it enters a conversation there is often embarrassment and evasion followed by a speedy attempt to change the subject. There have been times when I have spoken of death and been repulsed gently by words that have accused me of being unduly morbid when I have sought to open up a conversation which I have thought was needed.

I have learnt to tread carefully and not make assumptions about the readiness of even close friends to speak about dying. And it was a great sadness to me that one of my dearest friends in her advanced years was never able to speak freely to me about her funeral wishes. I think this was, possibly, a generational thing and I ask myself, is it easier now? The answer seems to me to be both `yes` and `no`.

I am grateful that my experience of meditation with Unitarians has allowed the subject of death to enter in as a reality – gently and in a wholesome way. Although it is an awareness that is difficult to integrate deeply, I have found that meditation allows me to understand better the flow of life; to come to terms with impermanence, and to accept that unless I can recognise it as a reality, my life is somehow less meaningful. I find helpful the Sufi idea of `dying before you die` and find myself smiling at the Tibetan Buddhist wisdom: ` Death comes to everyone – me too, maybe.` Weeks and months of meditation with a small group has helped me to be a little less entangled, a little less anxious, a little more able to let go of needing to be in control and, I like to think, more able to face the mystery of death. I believe this is true for many of those who meditate.

But our culture doesn`t prepare us too well for letting go and the cult of Eternal Youthfulness created by advertising is designed to intensify our anxiety. The ageing process is one we try to hold back like Canute the tide, as we are prevailed upon to use all kinds of cosmetic interventions. Few of

us are immune from this even though we may scorn it. And maybe it wouldn`t matter if it weren`t for the fact that it prevents us from accepting the process of ageing as a natural one. We are seduced into believing that getting old naturally, without intervention, is actually an *unnatural* thing to do. How difficult then to meet the reality of ageing and dying and see it as anything other than an unwholesome and negative experience. How easy to regard any mention of dying as insensitive and inappropriate.

In his book Eternal Echoes, John O`Donoghue, makes the point that we avoid talking and thinking about death because it makes us afraid. He has a lot to say about this which is worth reading but even more valuable, I think, is his view that being fully present with someone who has accepted they are dying is one of the greatest gifts we can give them and ourselves: “One of the most beautiful gifts you could ever give is the gift of helping someone to die with dignity, graciousness and serenity.”

A few people have spoken to me about this experience and, notwithstanding the anxieties and the grief that attend caring for a dying person that we love, the overwhelming testimony is one of privileged richness.

I was struck by something the novelist Ian McEwan said recently having sat at the death bed of his friend Christopher Hitchins: ` No man was ever as easy to visit in hospital; he didn`t want flowers and grapes, he wanted conversation and presence. All silences were useful. He liked to find you still there when he woke from his morphine- induced dozes.`

A friend wrote to me about her experience of being at the death bed of her father-in-law. This was only seven months after she had coped with the death of both parents. As she put it, she felt she was only able to catch her breath to face the next hurdle and helping him to prepare to die just felt like another hurdle but it was different from all the other deaths because she writes: “I had the privilege to have the time and circumstances to savour with him the fearless, wordless, wonderful spiritual process of dying” and in conclusion: “My feeling about death at the moment is that when the time feels right, welcome it like birth, letting go of all preconceived beliefs.”

She adds “I honestly don`t mind dying tomorrow while I`m still loving today.”

Rev Margaret Kirk is a retired Unitarian minister

Pastoral care and symbols at end of life services.

From: Wies Houweling

Ministers and pastoral workers are trained not to let anyone down, but not trained in pastoral assistance when people have to make decisions on ending their lives. I wasn’t trained when it happened. It had occurred to me that it could happen because people who are in a lot of pain and who are not going to be healthy again will have to answer that question in today’s world where medical care is so good that it can keep you alive even when there are no prospects.

In the congregation were I was a minister we had group conversations about this subject. 10 years ago there were a few cases in newspapers and on TV to which everybody reacted and most of the time had an opinion. The discussion in church didn’t lead to a verdict. There were people in favor and people against. Everybody agreed that it is very difficult to be in a position where you have to make a decision on your own life and to communicate with your loved ones about it.

There are churches very much against people making the decision to end their lives and they also deny pastoral care in this phase of life that has a lot of pain and grief. Just when they need someone to be in a position to talk about life and what it means to end it, there is no one willing to take that role other than the medical staff. The medical staff is certainly not trained to help families in this position. It is hard enough on doctors to assist in these matters.

The role of the minister

The role of the doctor and the whole procedure in the Netherlands is legally very strict. In most cases the doctor will be very pleased to have the assistance of a pastor or minister. In two cases I had a very good conversation with the doctor. We both knew our roles and positions and were glad to assist each other. Patients in stressful situations aren't very patient to legal procedures that take at least ten days and ministers don't know a lot about medical procedures so the doctor and the minister can help the patient together.

What is helpful? There are many different people in different situations. In both cases I knew the men. They were long life members of the congregation and had both asked for my help because they knew I didn't object and was used to talking about life and death issues.

The pastoral care involved the conversations with family and partner. It was not a decision they took on their own. The decision in one case was taken with his children and in the other case with the partner. It is very important that loved ones agree. Loved ones have a hard time making the decision too. They are torn between seeing their loved one suffer and missing him/her forever.

Symbol: the gift of life

To help in this difficult situation it was good to talk about life as a gift. When a child is born we cherish this new life as a beautiful gift. We live our lives and maybe some of us come to a point where we say for ourselves, I cannot bear this gift any longer. I cannot stand the pain: I want to end it. It is due to individualism and to medical development that we are in the position that we are thinking about these things whether they are legal or not. The decision is never final as long as the patient is still a life. At any moment the patient can decide not to go along the track he and his loved ones have decided upon earlier. Sometimes it takes two weeks, sometimes six weeks. I have never experienced a longer period. It is mostly shortening a painful life by three or six months. When you are in the position where you talk about the gift of life you are in an excellent position for a minister. That is what ministers are trained for but not in this situation. But the symbol 'Gift of Life' works because you can start with all the good things people have experienced and shared with each other. You can have individual conversations if people are very upset. It takes time but it is best for the patient. In one case I experienced, the patient decided not to do it because the partner didn't agree. The pastor doesn't have to have an opinion - he or she facilitates the conversation on the gift of life. Once they asked me can you do that, give it back? There are two things. 1. Apparently we live in a world where this happens 2. If there is a God of Love and life who wants best for people what do you think?

Rituals

There can be many kinds of rituals, but they must be simple because it will take place at the hospital in a private room or at the house and the patient is very ill. I took the Easter Candle from the church. Symbol of life and presence of the community. It is the patient who decides who is present and who is not present. I lit the candle on one occasion, in another occasion a teenager present lit it. The rest of the family brought along small candles and pictures.

In presence of the loved ones we gave thanks for the gift of life and all the good things experienced. We asked for forgiveness for the things that went wrong (they were mentioned in the pastoral conversation before and were agreed to be mentioned by me) I blessed the children and said to the patient 'It is ok you can go' now the family had eye contact and hugged. I blessed the patient.

The doctor came with the first injection we prayed the Lord's Prayer together and the patient slept, after a few minutes the second injection.

I stayed for a short moment and left the family in their privacy and agreed to come back the next day for funeral arrangements.

What happens to the pastor?

For a minister this is not an easy task. Being present when someone dies never leaves you untouched. I still remember every detail. I was alright in my roll but I was exhausted. I always took

the rest of the day off and tried to take good care of myself. It is a role/task a minister can do very well, but it is not easy. Liberal ministers should be prepared to talk with people on this subject and assist the family. Who else?

Wies Houweling is General Secretary of Vrijzinnige Geloofgemeenschap NPB (The Liberal Faith Community of the Dutch Protestants Bond.)

Philosophic reflections on ending one's life

From: Rev Feargus O'Connor

My personal view of voluntary euthanasia has been formed in the light both of my strong sense of compassion for all suffering beings (and a consequent wish to help them end that suffering when, according to the dictates of an informed conscience, it is seems morally right to do so) and my respect for the personal autonomy of every individual. Such a sense of compassion and respect for personal autonomy certainly lead not a few enlightened individuals to embrace a dignified voluntary death in order to escape unbearable physical pain and unendurable mental anguish. It would therefore be appropriate to consider the moral and religious arguments in favour of what we might fittingly call rational and altruistic suicide and reflect upon the personal testimony and moral example of two great philosophers, Socrates and David Hume.

In 399 BCE the Greek philosopher Socrates knowingly embraced a voluntary death with dignity, resignation and philosophic calm. In so doing he inspired numerous admirers, not only philosophers in the ancient world but many thinkers and creative artists ever since. They were inspired with the conviction that suicide, far from being cowardly, ignoble and undignified, can on the contrary be noble, dignified, brave and wholly rational. Socrates' example has convinced many thoughtful and caring people that, in particular circumstances, voluntary death can make an ideal and fitting end, imbued with a religious spirit of fortitude and hope, to a life well lived.

In Plato's dialogue *Phaedo* we read the moving account of the last day of Socrates' life in prison as he calmly awaits his imminent death and talks about what he considers the compelling arguments in favour of the immortality of the soul. It is clear that what Socrates is intending is suicide but, as he sees it, suicide with a moral and religious sanction.

Later the Roman writer Cicero and others reflected the attitudes to voluntary death prevalent not only in Stoic, Epicurean and other philosophical circles but among a large part of the educated classes in the Classical Greek and Roman world. Cicero himself and other notable philosophers not only defended what they considered rational suicide but practised it when they deemed it morally justified.

Several eminent modern philosophers have boldly defended altruistic suicide in the light of what they consider the common good. Among these philosophic defences the most cogent and eloquent is arguably that of David Hume.

In his essay *Of Suicide* (1779) he convincingly demolishes the essential planks of specious orthodox religious arguments against voluntary death. Hume's is a humane voice, like that of Voltaire, and in his incisive arguments he is seen to be a true beacon of the Enlightenment: helping dissipate the fog of superstition, cruelty and dogmatic religious obscurantism.

Hume effectively answers these dogmatic objections to altruistic suicide with characteristic lucidity and elegance. His intention is to use sound philosophic argument as a 'sovereign antidote…to superstition and false religion' and 'restore men to their native liberty by examining all the common arguments against suicide, and shewing that action may be free of every imputation of guilt or blame'.

Firstly, he considers the question of whether suicide is a sin against God. Hume argues that people are 'entrusted to their own judgment and discretion… and may employ every faculty with which they are endowed, in order to provide for their ease or preservation' and consequently everyone has 'the free disposal of his own life'.

It therefore arguable that 'a man who, tired of life, and haunted by pain and misery, bravely overcomes all the natural terrors of death and makes his escape from the cruel scene' is doing nothing morally wrong. To those who argue that it is encroaching on 'the peculiar province of the Almighty' for us to dispose of our own lives Hume replies, tellingly, that 'it would be equally criminal to act for the preservation of life [in using sophisticated modern treatments keeping people artificially alive] as for its destruction…'

'The government of the world is placed far beyond [humankind's] reach and violence', he argues, and nothing happens without the consent of the Supreme Being, who, it is assumed, devised and continues to govern it by scientific laws. It is difficult not to agree with Hume's own conclusion that voluntary death, rationally determined, is no more a violation of the laws of Nature than inoculation for smallpox or any other interference with the course of natural events to save human life through other important medical advances.

Hume quotes the Roman Stoic philosopher Seneca's words 'And let us thank God that no man can be [forced] in life'. In one moving passage Hume answers the Roman Catholic Thomas Aquinas's objection that ending one's life is ingratitude for a gift graciously given. For is not a gift, once given, then in the ownership of the recipient, who has unfettered ownership and disposal of it?

'Do you imagine that I repine at Providence or curse my creation because I go out of life, and put a period to a being, which, were it to continue, would render me miserable?… I thank Providence, both for the good which I have already enjoyed, and for the power with which I am endowed of escaping the ill that threatens me.'

The sentiments expressed in the last sentence effectively refute Thomas Aquinas's argument that voluntary death is an ungrateful rejection of life: Hume argues that a timely and dignified exit is fully compatible with an enlightened liberal religious outlook. Voluntary death, he tells us, is the merciful means to 'remove us from the regions of sorrow and pain' and whenever these 'so far overcome my patience, as to make me tired of life, I may conclude that I am recalled from my station in the clearest and most express terms….'

Hume equally effectively refutes two other orthodox religious arguments advanced against suicide: namely that it is a serious offence against the self and the community. His arguments are essentially those of utility and personal autonomy.

He shows that, though there is a network of reciprocal obligations between individuals and society at large, there are clearly defined limits to these social duties. If we withdraw from society and no longer accept its benefits we no longer have those reciprocal obligations.

'I am not obliged to do a small good for society at the expense of a great harm to myself; why should I prolong a miserable existence because of some frivolous advantage which the public perhaps may receive from me? Why may I not cut short these at once by an action which is no more prejudicial to society?'

He considers some hypothetical cases when continued living and a miserable and disease-ridden existence may actually seriously harm others. Voluntary death in such cases 'must not only be innocent but laudable'. He makes another telling point: that it is generally those who enjoy the blessings of life, such as good health and wealth, who have most reason to feel content with their lot. What right have such fortunate individuals to deny a dignified death to others in pain, misery or unbearable personal anguish and mental torment?

On the duty which Aquinas claims we have to show to ourselves Hume is equally persuasive in refuting that Dominican's blinkered dogmatism. Hume's strongest argument is that of personal autonomy. When 'age, sickness or misfortune may render life a burthen, and make it worse than annihilation', why should we be prevented from dying with dignity when we ourselves decide that the time has come? Who else has the right to decide for us?

Hume concludes: 'If it be no crime, both prudence and courage should engage us to rid ourselves at once of existence, when it becomes a burthen. 'Tis the only way we can be useful to society, by

setting an example, which, if imitated, would preserve to every one his chance for happiness in life and would effectually free him from all danger or misery'.

The right to die with dignity and so to avoid undignified, dehumanizing suffering should surely be an inalienable one? The moral case for the right of voluntary death is one bound up with that of personal autonomy and the dignity of personal choice. Is this not wholly compatible with the good of society as a whole?

Socrates and many other great moral exemplars have claimed that right and so, if the forces of state power and dogmatic religion are not to deny us what is ours by right, should we not be allowed to follow our individual consciences and exercise that inalienable right in the noble and enlightened spirit of Socrates and David Hume?

Rev Feargus O'Connor is Minister at Golders Green Unitarians

In response to the motion at the GA 1012

From: Rev Celia Midgley -

Compassion and protection are keywords in Robert's presentation; these are also important to me and I take a very different view I have seen and been moved by real life situations and I have seen and been moved by that fine play 'Whose life is it anyway?' but

I am very concerned about the old and the sick and the disabled, who are vulnerable and may feel open to pressure and abuse and feel that they are in the way. There's a worrying slippery slope here and I am not persuaded about safeguards

I am also concerned more fundamentally about the insidious flavor of eugenics here and the slide into a Brave New World. We are all, as Richard Gilbert puts it 'more human than otherwise and we are our brothers and sisters keepers.

So, lastly, what we should be calling for is better funded and more compassionate treatment of the old, the sick and the dying and those who are severely incapacitated. We slipped up here in not having a motion about the urgent need for proper, public funding of the Health Service

Rev Celia Midgley is a retired Unitarian minister and former President of the General Assembly

From: Rev Phil Silk

I think it is very appropriate for our democratic organisation to vote YES to the proposed motion on the right to die. Whatever our individual or congregational views, we always proclaim our belief in the right- even responsibility - to act according to our consciences; one of our few historic agreements is that we will promote civil and religious freedom. Few such issues affect so many today in our society. How can we not encourage Parliament to provide a careful system to allow everyone the right to choose how to end our lives (as we already do on how to live our lives). We are not trying to force anyone, but to empower them. This includes the right of conscience for those in the medical professions, as well.

At first I was disappointed that this year's motion was referred back to the membership. But collectively we had not prepared well for this motion, so it will be much more useful having another year for serious consideration. It is up to each of us to see that our congregations do explore both the issue of freedom of conscience and the specific issue of how to promote dignity in dying for all.

I will leave it to others to develop the case for the right to die, but I certainly hate seeing what is to me unnecessary suffering. Yes, hospitals need to improve. Yes, we need more hospices. Yes, we want to avoid pressure on people. But we already put pressure on people. We already interfere with God/Nature/ Fate to keep people alive. We have humane systems to protect animals, too. Aren't we animals? Do we lose our consciences when we face death? Would we rather people

committed suicide rather than wait for a time when we are no longer capable of doing it?

It is interesting that both in Oregon and in Switzerland, once people have been accepted for assisted dying a majority of them never need to resort to it. But they had the comfort of knowing they could do, if necessary.

I certainly want this potential escape route for myself. But I do not want to require you to avail yourself of the system, nor to help carry it out against your conscience. Why should others refuse to allow me and others like me to exercise our consciences?

I urge you to support the motion on both grounds, but at least on the first.

Rev Phil Silk is a retired Unitarian minister

From: Paul Wheeler

I support the campaign group Dignity in Dying, who call for terminally ill mentally competent adults to have the legal right to seek assistance to bring their life to an end if they so choose. And I want to see Unitarian churches publicly backing that call. However, the GA motion from Fulwood Old Chapel, Sheffield which is the basis of this discussion, goes far beyond what Dignity in Dying is asking for.

As it stands, it calls for legislation respecting the right of anyone with a debilitating and/or incurable condition to have compassionate assistance to enable their life to be terminated in a painless and dignified way without fear of prosecution. The inclusion of anyone with a debilitating and/or incurable condition extends considerably the number of people to whom the right would apply. It also takes us into a "grey" area on a subject in which most people much prefer clear black and white lines to provide protection against potential abuse of people who are vulnerable because of their condition.

I have a sight impairment which, with the current state of medical knowledge, is incurable. But, I do not consider that my impairment justifies me having the right to assistance to end my life. In saying this, I recognise that the extent to which my disability limits my life is relatively minor and that many people have disabilities that seriously limit their life. However, in my view, to allow having a "debilitating and/or incurable" condition to qualify a person for assistance to end their life would undermine significantly the value placed by society on the lives of people with disabilities. Consequently, I believe we should follow the path of Dignity in Dying and focus our call for change on those who are terminally ill.

I believe that we, as a church, should declare our support for the recommendations of the Commission on Assisted Dying" chaired by Lord Falconer, with two important provisos:

1. That the requirement that a terminally ill person should have to be diagnosed as having less than a year to live be removed, so that anyone diagnosed with a terminal illness should have the right to an assisted death irrespective of how long they are expected to live otherwise.
2. That the requirement that a terminally ill person seeking assistance to end their life should be able to self-administer the drug without any help be removed, since this requirement would render the right to assistance ineffective for many of those suffering most.

In summary, what we would be saying is: "Anyone who is terminally ill, as diagnosed by two doctors with expert knowledge of their condition, and who is not under the influence of a mental illness, and who is aware of all alternative options of treatment and counselling, and has not been subjected to any duress, should have the legal right to seek assistance to end their life without anyone providing that assistance being prosecuted."

Paul Wheeler is a member of Unitarian Meeting Bristol

Ministers' declaration of support for Fulwood Old Chapel motion

In the 2010 British Social Attitudes survey 82% of the general public believed that a doctor 'should probably or definitely be allowed to end the life of a patient with a painful incurable disease **at the patient's request'.** Closer analysis showed that 71% of religious people and 92% of non-religious people supported this statement. This is not an isolated opinion poll finding: in fact repeated surveys in this country consistently show that a decisive majority of people believe in the civil right of terminally ill people to be allowed to die with dignity at a time and in a manner of their own choosing.

Dignity in Dying, originally the Voluntary Euthanasia Legalisation Society, was founded by a Unitarian doctor, Dr. Charles Killick Millard, and its founding executive committee included Rev. Dr. R.F. Rattray, a former President of our General Assembly. A later chair of the society was Rev. Ben Downing, a respected Unitarian minister. Among its present patrons are prominent Anglican clergy and Progressive rabbis as well as eminent doctors and figures in the arts. The right to voluntary euthanasia is certainly a humane and progressive cause supported by very many past and contemporary Unitarians.

We therefore express our full support for the GA motion put forward by Fulwood Old Chapel, Sheffield… We commend Fulwood Old Chapel's clear and informative background paper explaining the persuasive ethical arguments in favour of voluntary euthanasia, the recommendations of the Bill on Assisted Dying of Lord Joffe and the recent published report of the Commission on Assisted Dying, chaired by Lord Falconer, the former Lord Chancellor, and on which a former Commissioner of the Metropolitan Police and several eminent doctors and other medical experts served, and call on fellow Unitarians to show their full support for the Fulwood Old Chapel motion, now referred back, which we hope will be reintroduced and passed at the GA Annual Meetings in 2013.

Signed in a personal capacity by:

Rev. Brian Anderson , Rev. Jane Barraclough, Rev. Dr. Richard Boeke, Rev. Celia Cartwright, Rev. Dr. Peter Godfrey, Rev. Peter Hewis, Rev. Margaret Kirk, Rev. Tony McNeile, Rev. Feargus O'Connor, Rev. Gillian Peel, Rev. Lynne Readett, Rev. Phil Silk, Rev. Dr. David Usher, Rev. Geoffrey R. Usher, Rev. Charles VanDenBroeder, Rev. Martin Whitell, Rev. Sue Woolley

(17 signatories)

Living Wills

Taken from a book 'About Death: Living wills and Advanced Decisions in the UK' by Dr Hilary Page (Mospeate Publishing ISBN 978-0-9564949-1-7) *– by kind permission. Dr Page's own Advance Decision appears in the book as an example.*

A living will can be a spoken intention, but is usually a document or letter you write when you are of sound mind, giving guidance and directions about your medical care, should you in future loose the mental capacity to take part in discussions with the doctors and nurses looking after you.

The term *living will* was previously used to cover three options: a *Statement of Values*, an *Advance Directive*, and an *Advance Decision to Refuse Treatment*. The Advance Directive and the Advance Decision are now taken to be synonymous.

Statement of Values

This is a written or verbal statement in which you may describe:

- **Aspects of your life which you value**
- **Preferences about your personal care**
- **Your attitude to life and death**
- **What you would like to happen to your body after death**

The statement of values is not about medical treatment, but guides to your family and health professionals in making decisions about your personal care should you become unable to contribute to discussions and decision making. When a patient lacks mental capacity, doctors and nurses must consider what they and the rest of the health care team know about the patient's wishes, feelings, beliefs and values. A statement of values can be very personal and specific.

The Advance Decision to Refuse Treatment

The Advance Decision (otherwise known as an Advance Directive) is made when you have mental capacity and comes into effect in future if you have lost mental capacity to give or refuse consent to medical treatment. It can be used to avoid having your life prolonged by medical treatment in circumstances when you would prefer to be allowed to die. It directs that in clinical circumstances which you describe, treatment which is purely aimed at sustaining your life should be withheld or withdrawn, even though your life is at risk.

The Advance Decision has legal standing as an expression of your best interests. You can nominate a representative, usually a member of your family or a friend, to discuss your treatment with doctors.

When you have lost mental capacity and are terminally ill it allows your family to open discussion with doctors and nurses about what the aims of your treatment should be and whether it would be more appropriate, bearing in mind what you have expressed, to provide palliative care rather than trying to prolong life.

At the end of life doctors have a duty to refrain from treatment which is unduly invasive or burdensome to the extent that the patient's suffering outweighs any possible benefit. They must provide treatment which is in the patient's 'best interests', and follow any Advance Decision which the patient has made.

Although it has always had legal standing in this way, an Advance Decision can now be legally enforceable.

The Mental Capacity Act (2005) Code of Practice includes the words: 'health care professionals must follow an Advance Decision if it is valid and applies to the particular circumstances. If they do not, they could face criminal or civil liability.'

However the criteria for validity and applicability must be met, including the statement 'I refuse treatment even though my life may be at risk as a result.'

There are safeguards to ensure doctors do not hastily decide to withhold treatment, or allow a patient to deteriorate or die in circumstances the patient did not anticipate when they made their Advance Decision. Treatment must be provided to prevent the patient's clinical condition from deteriorating while an apparent Advance Decision is assessed.

An Advance Decision will not prevent emergency resuscitation. The Mental capacity Act states 'A person does not incur liability for carrying out or continuing the treatment, unless at the time, he is satisfied that an Advance Decision exists that is valid and applicable. Guidance states that when death is imminent, unless there is a Do Not Attempt to Resuscitate (DNAR) agreement, treatment must be aimed at keeping the patient's options open, as far as possible. ' Time is needed for assessment of mental capacity, and for evaluation of the validity and applicability of an Advance Decision. Diagnosis and expected response to treatment must be considered. Life sustaining treatment can be withdrawn later, or withheld in accordance with an Advance Decision, after discussion with the patient's family or representative.

An Advance Decision can lead on to a DNAR agreement but only if, that agreement is made with doctors and nurses who know the patient, and who agree that it is appropriate to refrain from any attempt at resuscitation, should cardiac or respiratory arrest or other immediately life threatening event occur.

How to write an advanced decision to refuse life sustaining treatment

The NHS produce a form, which you can download from the NHS website www.endoflifecareforadults.nhs.uk Click on publications, then click on all national End of Life Care Programme publications then go to support sheet 4, Advance Decision to Refuse Treatment, then click on Download Advance Decision to refuse Treatment: proforma. Local hospices, palliative care nursing services or dementia services, or your GP, may be able to provide the form. Some patient's organisations provide a form adapted to a particular illness.

There are four elements to the Advance Decision form – making sure it is *valid*, describing the circumstances in which the decision is *applicable*, the *decision* that you refuse life sustaining treatment and the optional *' detailed instructions'* appropriate to your diagnosis. If you have no illness to which you want to refer, leave out the detailed instructions. In this way you can write an advance decision while you are in good health.

You do not need to confer with your doctor or a lawyer, unless you want to give specific detailed instructions. This more generally worded Advance Decision contains no detailed instructions but in the event that a person is dying and has permanently lost mental capacity it will empower their family to talk to doctors about the possibility of allowing them to die.

REFERENCES

The Original Motion
(2012 General Assembly Meetings)

The Motion

That this General Assembly of Unitarian and Free Christian Churches believes that :

any individual who faces an intolerable existence because of a debilitating and/or incurable condition should have the right to seek support for the termination of their life in a painless and dignified manner, and

Legislation should respect their choice and allow them compassionate assistance in achieving such a death without fear of prosecution.

Background Paper

Background

The 1961 Suicide Act decriminalised suicide. This means whilst it is illegal, those attempting suicide will not be prosecuted; but assisting or encouraging another person to die is still a crime that carries a term of imprisonment of fourteen years.

This law was challenged by Debbie Purdy and she won her case in the House of Lords in 2009. She suffers from progressive multiple sclerosis and wanted an assurance that her husband would not be prosecuted for assisting her to take her own life when she wished to do so.

As a result, guidance for prosecutors was made public. It made a distinction between compassionate assisted suicide and malicious acts, but made no absolute statement for those involved in such situations.

A Bill on Assisted Suicide was put before the House of Lords in 2005 by Lord Joffe. Their Lordships chose to delay the Bill, so it was never sent to the Commons for discussion by MPs and has never been represented.

In the last few months, Lord Falconer, the former Lord Chancellor, published a report, for consultation, along similar lines to Lord Joffe. It proposes:

- Assisted suicide should be available for terminally ill patients with less than a year to live
- Two doctors would have to confirm the diagnosis
- The person must be aware of all alternative options of treatment and counselling
- The person should not be acting under the influence of mental illness
- There should be no duress
- The person should be able to self-administer the drug without any help

It should be noted that anyone with incurable diseases – like Terry Pratchett with Alzheimer's or even Debbie Purdy with multiple sclerosis would not qualify under these proposals.

Why we should have a debate now?

Pressure is mounting upon Parliament to change the law to allow for some compassionate acts of assistance to those wishing to end their lives when their illness has made their future life seem unbearable.

Currently, Unitarians have no agreed position on this subject, although there was a workshop at the GA in 2007. We believe that Unitarians need to debate this issue and hold a view, as a Movement, that can be presented when there is a public consultation on the subject.

The Issues

The issues around this subject can be summarised as follows:

- The rights of the individual
- Dignity and compassion for the dying.
- Religious, moral and ethical positions, including the Hippocratic oath
- Protection of the individual from malicious acts and undue outside pressure
- The mental capacity of patients to make appropriate decisions
- How close to death a person should be before such actions are acceptable
- The degree of assistance provided by others
- Alternative routes and palliative care

The Proposition

The proposers of this motion believe that Lord Falconer's proposals are inadequate insofar as they do not fully meet the needs of people with debilitating and/or incurable conditions. They are, however, a step in the right direction.

We are also concerned that the law is more interested in prevention than in enabling people to fulfil their wishes and provides insufficient protection to those compassionately assisting.

Clearly, we recognise the need for an appropriate balance between rights and safeguards which meet the needs of those who have determined that assisted suicide is their only course of action.

To be clear…… This motion is not about

- the legitimacy of suicide in general,
- making a general benchmark about the value of a life
- compelling the unwilling to assist in a compassionate suicide.

Please note: We recognise that the subject of this motion might evoke strong feelings and, for some, uncomfortable memories. It is our intention to ensure that support is available after the session for those who may be find the discussion upsetting.

Definitions

The terms “Assisted Suicide”, “Assisted Dying” and “Euthanasia” are often used interchangeably in normal conversation with many people not recognizing any difference in meaning. It is sometimes important to acknowledge distinctions between these terms in order to debate the issue accurately and fairly.

Throughout this discussion document, and only for the sake of clarity and consistency, we have used the term **Assisted Dying** to encompass the whole subject that proposes a change from the present legal situation in the UK.

However, there are some definitions that might help the discussion where differentiation is needed, though it should be recognized that there are no universally acknowledged definitions.

Assisted Dying (permitted in the US states of Oregon and Washington), sometimes referred to as physician assisted dying, applies only to terminally ill, mentally competent adults

Assisted Suicide (permitted in Switzerland) allows assistance to die for chronically ill and disabled people along with terminally ill people

Euthanasia is a term often used to refer to the administration of life ending medication by a third party

Voluntary Euthanasia (permitted in the Netherlands and Belgium) allows a doctor to administer the medication directly to a requesting patient

Non-voluntary Euthanasia describes a situation where a third party (usually a doctor) administers life ending medication without the consent of the patient.

Note: Both Voluntary Euthanasia and Non-voluntary Euthanasia are illegal in the UK although evidence shows that both do occur.

And just in case the subject comes up!

Eugenics is the study of or belief in the possibility of improving the qualities of the human species or a human population, especially by such means as discouraging reproduction by persons having genetic defects or presumed to have inheritable undesirable traits (negative eugenics) or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics).

The Law

Suicide Act 1961

An Act to amend the law of England and Wales relating to suicide, and for purposes connected therewith. [3rd August 1961]

1 Suicide to cease to be a crime.

2. Criminal liability for complicity in another’s suicide.

(1)A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.

(2)If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.

(3)The enactments mentioned in the first column of the First Schedule to this Act shall have effect subject to the amendments provided for in the second column (which preserve in relation to offences under this section the previous operation of those enactments in relation to murder or manslaughter).

(4)No proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.

Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide

Issued by the Director of Public Prosecutions ***February 2010***

Introduction

1. A person commits an offence under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide. This offence is referred to in this policy as "encouraging or assisting suicide". The consent of the Director of Public Prosecutions (DPP) is required before an individual may be prosecuted.
2. The offence of encouraging or assisting suicide carries a maximum penalty of 14 years' imprisonment. This reflects the seriousness of the offence.
3. Committing or attempting to commit suicide is not, however, of itself, a criminal offence.
4. This policy is issued as a result of the decision of the Appellate Committee of the House of Lords in R *(on the application of Purdy) v Director of Public Prosecutions* reported at [2009] UKHL45, which required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" (paragraph 55) in cases of encouraging and assisting suicide.
5. The case of *Purdy* did not change the law: only Parliament can change the law on encouraging or assisting suicide.
6. This policy does not in any way "decriminalise" the offence of encouraging or assisting suicide. 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.
7. For the purposes of this policy, the term "victim" is used to describe the person who commits or attempts to commit suicide. Not everyone may agree that this is an appropriate description but, in the context of the criminal law, it is the most suitable term to use.
8. This policy applies when the act that constitutes the encouragement or assistance is committed in England and Wales; any suicide or attempted suicide as a result of that encouragement or assistance may take place anywhere in the world, including in England and Wales.

The investigation

9. The police are responsible for investigating all cases of encouraging or assisting suicide. The Association of Chief Police Officers (ACPO) intends to provide all Police Forces with guidance on dealing with cases of encouraging or assisting suicide soon after the publication of this policy. Prosecutors who are involved in such cases should ensure that they familiarise themselves fully with the ACPO guidance when it is available.

10. The ACPO guidance will specifically recommend that police officers liaise with the reviewing prosecutor to seek his or her advice at an early stage and throughout their enquiries so that all appropriate lines of investigation, in the context of the individual case, are discussed and agreed by the Prosecution Team. This is to ensure that all relevant evidence and information is obtained to allow a fully informed decision on prosecution to be taken.
11. The reviewing prosecutor must ensure that he or she has sufficient evidence and information in order to reach a fully informed decision about the evidential and public interest stages of the Full Code Test (see paragraph 13 below). The reviewing prosecutor will need detailed information about the mental capacity of the person who committed or attempted to commit suicide and about any relevant public interest factor.
12. The reviewing prosecutor should only make a decision when he or she has all the relevant material that is reasonably capable of being obtained after a full and thorough investigation. The reviewing prosecutor should tell the police if any further evidence or information is required before a decision can be taken.

The decision-making process

13. Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide. The Full Code Test has two stages: (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.
14. The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met.

The evidential stage

15. Section 2 of the Suicide Act 1961 was amended with effect from 1 February 2010. It is therefore essential that prosecutors identify the timing of any act of encouragement or assistance that it is alleged supports the bringing of a criminal charge relating to the suicide or attempted suicide of the victim.
16. Where the act of encouragement or assistance occurred on or after 1 February 2010, section 2 of the Suicide Act 1961 as amended by section 59 and Schedule 12 of the Coroners and Justice Act 2009 applies.
17. In these cases, for the evidential stage of the Full Code Test to be satisfied, the prosecution must prove that:
    - the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and
    - the suspect's act was intended to encourage or assist suicide or an attempt at suicide.
18. "Another person" referred to in section 2 need not be a specific person and the suspect does not have to know or even be able to identify that other person. The offence of encouraging or assisting suicide can be committed even where a suicide or an attempt at suicide does not take place.
19. It is no longer possible to bring a charge under the Criminal Attempts Act 1981 in respect of a section 2 Suicide Act 1961 offence by virtue of paragraph 58 of Schedule 21 of the Coroners and Justice Act 2009. Attempts to encourage or assist suicide are now captured by the language of section 2, as amended.

20. In the context of websites which promote suicide, the suspect may commit the offence of encouraging or assisting suicide if he or she intends that one or more of his or her readers will commit or attempt to commit suicide.
21. Section 59(4) of the Coroners and Justice Act 2009 adds section 2A into the Suicide Act 1961.
22. Section 2A provides that a person who arranges for someone else to do an act capable of encouraging or assisting the suicide or attempted suicide of another person will also be liable alongside that second person for the encouragement or assistance.
23. Section 2A also makes it clear that a person may encourage or assist another person even where it is impossible for the actual act undertaken by the suspect to provide encouragement or assistance – for example, where the suspect believes he or she is supplying the victim with a lethal drug which proves to be harmless.
24. Finally, section 2A also makes it clear that a suspect who threatens or puts pressure on the victim comes within the scope of the offence under section 2.
25. The amendments to section 2 of the Suicide Act 1961 are designed to bring the language of the section up-to-date and to make it clear that section 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.
26. Prosecutors should consult the Ministry of Justice Circular 2010/03 which provides further detail about the changes made to section 2 of the Suicide Act.
27. Where the act in question occurred on or before 31 January 2010, the former offence of aiding, abetting, counselling or procuring the suicide of another, or an attempt by another to commit suicide, contrary to the then section 2 of the Suicide Act 1961, applies.
28. In these cases, for the evidential stage to be satisfied, the prosecution must prove that:
    - the victim committed or attempted to commit suicide; and
    - the suspect aided, abetted, counselled or procured the suicide or the attempt.
29. The prosecution also has to prove that the suspect intended to assist the victim to commit or attempt to commit suicide and that the suspect knew that those acts were capable of assisting the victim to commit suicide.
30. In relation to an act done prior to 1 February 2010, it is possible in law to attempt to assist a suicide. Such an offence should be charged under the Criminal Attempts Act 1981.
31. This enables an individual to be prosecuted even where the victim does not go on to commit or attempt to commit suicide. Whether there is sufficient evidence of an attempt to assist suicide will depend on the factual circumstances of the case.

Encouraging or assisting suicide and murder or manslaughter distinguished

32. The act of suicide requires the victim to take his or her own life.
33. It is murder or manslaughter for a person to do an act that ends the life of another, even if he or she does so on the basis that he or she is simply complying with the wishes of the other person concerned.
34. So, for example, if a victim attempts to commit suicide but succeeds only in making him or herself unconscious, a person commits murder or manslaughter if he or she then does an act that causes the death of the victim, even if he or she believes that he or she is simply carrying out the victim's express wish.

Explaining the law

35. For the avoidance of doubt, a person who does not do anything other than provide information to another which sets out or explains the legal position in respect of the offence

of encouraging or assisting suicide under section 2 of the Suicide Act 1961 does not commit an offence under that section.

The public interest stage

36. It has never been the rule that a prosecution will automatically follow where the evidential stage of the Full Code Test is satisfied. This was recognised by the House of Lords in the *Purdy* case where Lord Hope stated that: "[i]t has long been recognised that a prosecution does not follow automatically whenever an offence is believed to have been committed" (paragraph 44). He went on to endorse the approach adopted by Sir Hartley Shawcross, the Attorney General in 1951, when he stated in the House of Commons that: "[i]t has never been the rule... that criminal offences must automatically be the subject of prosecution".
37. Accordingly, where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.
38. In cases of encouraging or assisting suicide, prosecutors must apply the public interest factors set out in the Code for Crown Prosecutors and the factors set out in this policy in making their decisions. A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which outweigh those tending in favour.
39. Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether nonetheless a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.
40. The absence of a factor does not necessarily mean that it should be taken as a factor tending in the opposite direction. For example, just because the victim was not "under 18 years of age" does not transform the "factor tending in favour of prosecution" into a "factor tending against prosecution".
41. It may sometimes be the case that the only source of information about the circumstances of the suicide and the state of mind of the victim is the suspect. Prosecutors and investigators should make sure that they pursue all reasonable lines of further enquiry in order to obtain, wherever possible, independent verification of the suspect's account.
42. Once all reasonable enquiries are completed, if the reviewing prosecutor is doubtful about the suspect's account of the circumstances of the suicide or the state of mind of the victim which may be relevant to any factor set out below, he or she should conclude that there is insufficient information to support that factor.

Public interest factors tending in favour of prosecution

- 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.

43. On the question of whether a person stood to gain, (paragraph 43(6) see above), the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the

suspect may gain some benefit – financial or otherwise – from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

44. A prosecution is more likely to be required if:
    1. the victim was under 18 years of age;
    2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
    3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
    4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
    5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
    6. 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;
    7. the suspect pressured the victim to commit suicide;
    8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
    9. the suspect had a history of violence or abuse against the victim;
    10. the victim was physically able to undertake the act that constituted the assistance him or herself;
    11. 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;
    12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;
    13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
    14. 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

Public interest factors tending against prosecution

45. A prosecution is less likely to be required if:
    0. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
    1. the suspect was wholly motivated by compassion;
    2. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
    3. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
    4. 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;

5. 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.

46. The evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.
47. These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.
48. If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim, the public interest factors tending in favour of or against prosecution may have to be evaluated differently in the light of the overall criminal conduct.

Handling arrangements

49. Cases of encouraging or assisting suicide are dealt with in Special Crime Division in CPS Headquarters. The Head of that Division reports directly to the DPP.
50. Any prosecutor outside Special Crime Division of Headquarters who receives any enquiry or case involving an allegation of encouraging or assisting suicide should ensure that the Head of Special Crime Division is notified.
51. This policy comes into effect on 25 February 2010 and supersedes the Interim Policy issued on 23 September 2009.

Further References

General
http://en.wikipedia.org/wiki/Assisted_suicide
UK Law
http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60
http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html
Scottish proposals
http://www.palliativecarescotland.org.uk/files/blogattachments/Key%20Features%20of%20the%20Proposed%20Assisted%20Suicide%20%28Scotland%29%20Bill.pdf
Dutch Law
www.nvve.nl
Swiss Law
http://www.ejpd.admin.ch/ejpd/en/home/themen/gesellschaft/ref_gesetzgebung/ref_sterbehilfe.html
Washington State Law
http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245
Oregon State Law
http://www.finalexit.org/oregon_death_with_dignity_act.html
Northern Territories, Australia
http://corrigan.austlii.edu.au/au/legis/nt/consol_act/rottia294

Medicine

British Medical Association

BMA response to invitation to give evidence to the Commission on Assisted Dying

In January 2011, the BMA was invited to give written and oral evidence to the Commission on Assisted Dying. The Association declined the invitation on the basis that the stated purpose of the Commission, 'to investigate the circumstances under which it should be possible for people to be assisted to die in the UK', was inconsistent with the BMA's own policy position opposing all forms of assisted dying.

Policy passed at the 2011 Annual Representatives Meeting approved this response.

From BMA Ethics – End of life decisions

End-of-life decisions

The current policy is that the BMA:

i. believes that the ongoing improvement in palliative care allows patients to die with dignity
ii. insists that physician-assisted suicide should not be made legal in the UK
iii. insists that voluntary euthanasia should not be made legal in the UK
iv. insists that non-voluntary euthanasia should not be made legal in the UK; and
v. insists that if euthanasia were legalised, there should be a clear demarcation between those doctors who would be involved in it and those who would not.

This was reiterated in 2009 when the BMA's ARM rejected a proposal to change the law and allow competent, terminally ill patients to choose assisted dying. It also voted against legal immunity for people who accompany patients to an assisted death abroad.

Assisted dying

'Assisted dying' covers euthanasia (where someone other than the patient administers a fatal dose) and assisted suicide (where patients are assisted to end their own lives). Traditionally, the BMA opposed any form of assisted dying, but in 2005 its ARM (its policy-making body) recognised that there were diverse opinions within society and the profession. It agreed that Parliament and society at large should decide the issue of possible legalisation. This meant that the BMA took a neutral stance on assisted dying. In 2006, however, BMA members voting at the ARM made clear that the majority opposed such legislation. Therefore the BMA dropped its neutral stance and again opposes all forms of assisted dying.

Euthanasia

Euthanasia which is the active and intentional termination of a person's life remains illegal in the UK. It is morally and legally different to the withholding or withdrawal of treatment. Arguments for legalisation of euthanasia are generally based on arguments about competent individuals' rights to choose the manner of their demise or about cases where medicine is unable to control distressing terminal symptoms. Although the BMA respects the concept of individual autonomy, it argues that there are limits to what patients can choose if their choice will impact on other people.

Arguments against legalisation often focus on practical points. If euthanasia were an option, there might be pressure for all seriously ill people to consider it even if they would not otherwise entertain such an idea. Health professionals explaining options for the management of terminal illness would have to include an explanation of assisted dying. Patients might feel obliged to choose it for the wrong reasons, if they were worried about being a burden, or concerned about the financial

implications of a long terminal illness. Legalisation could generate anxiety for vulnerable, elderly, disabled or very ill patients.

Physician-assisted suicide

Aiding or abetting suicide is also illegal and carries a potential 14-year sentence. The arguments for and against assisted suicide and physician-assisted suicide are similar to those made in relation to euthanasia. Assisted suicide differs from euthanasia in that the individual retains control of the process, rather than the doctor or anyone else assisting. In its early policies, however, the BMA did not distinguish between euthanasia and physician-assisted suicide. In 1997, BMA policy mentioned both for the first time and while recognising that a diversity of opinion existed about them, opposed any changes in law to permit either.

In 1998 the BMA Medical Ethics Department published a discussion paper debating whether the moral arguments about physician-assisted suicide and euthanasia differ significantly. The BMA's ARM also called for a conference 'to promote the development of a consensus on physician-assisted suicide'. This took place in March 2000, resulting in a consensus statement opposing physician-assisted suicide.

The Royal College of Physicians

Statement – 09 May 2006

The results of a survey of Fellows and Collegiate Members of the Royal College of Physicians shows that the College cannot support legal change on assisted dying.

Respondents were asked whether they agreed or disagreed with the following statement:

(We) *believe that with improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed*.

Free text comment was also invited.

5,111 responses were received. In answer to the question, 1,327 (26.0%) stated that they believe a change in the law is needed and 3,741 (73.2%) that a change in the law is not needed. 43 (0.8%) gave no answer but provided comment. Responses against change were highest in the specialty of palliative medicine (95.4% of 281 responses) but no specialty group submitting more than 50 returns fell below 65% in opposing a change in the law. Specialty representation appeared broadly representative of practising physicians.

There were no significant differences between Fellows and Members; between physicians of different positions/grades; between on line and paper returns; or between early (up to 48 hours) and final returns. In all cases, the proportion opposing legal change exceeded 70%.

Early, albeit incomplete, analysis of the free text section of the consultation identified a small (under 5%) proportion of respondents alleging bias in the first question against legal change. All involved in organising the consultation were genuinely concerned to discover the views of Fellows & Members; and to demonstrate the integrity of the process. A validation questionnaire was therefore sent by email. The question was proposed by the sponsor of the Assisted Dying for the Terminally Ill Bill, Lord Joffe, who suggested that this would produce a 'very different' response. The question asked was:

Do you believe that a change in legislation is necessary for the small number of terminally ill patients for whom palliative care does not meet their needs?

The validation to the main consultation was open for 48 hours.

2,144 responses were received, with the analysis based on 2,059 responses where the RCP Code or GMC number was given. 578 (28.1%) believed that a change in legislation is necessary and 1,469 (71.3%) that a change in legislation is not necessary. There was no answer in 12 (0.6%).

The figure of 71.3% against legal change in the validation exercise is close to the 73.2% found in the first question of the main consultation.

Council of the College notes that the preliminary analysis of the free text comment supports the responses to the first question; and that the validation questionnaire has produced an almost

identical proportion of respondents (71.3% compared to 73.2%) opposed to legal change. In view of the strong majority view in response to part 1, Council believes that a reasonable conclusion of the overall opinion of its Fellowship and Collegiate Membership may be drawn.

In the light of the views expressed, Council of the Royal College of Physicians concurs with the Royal College of General Practitioners that the College cannot support legal change at the present time.

Nevertheless, the College acknowledges:

- that a significant minority of its Fellowship and Collegiate Membership support a change in the law;
- that there remain many shortcomings in the provision of palliative care;
- that the ethical and juridical issues are complex and strongly felt;
- and that physicians of all shades of opinion in the current debate share a commitment to the improvement of care at the end of life.

As previously stated, irrespective of whether the present Bill is enacted or not, it should be seen as a further signal to campaign for better care for dying patients. This should include an extension of palliative care services and more discussion of end of life issues in the face of changing values, ethnic diversity and technological advance. The Royal College of Physicians remains committed to making its contribution as a professional body and by encouraging its Fellows and Members in their diversity of views to play an informed role in continuing debate.

The Royal College of Surgeons

Public call for evidence from the Commission on Assisted Dying

Response from the Royal College of Surgeons of England

The Royal College of Surgeons welcomes the opportunity to submit a response to the Commission on Assisted Dying. We are pleased that the Commission on Assisted Dying has been convened, as we recognise that there is a need for greater clarity around the issue.

Key messages

• The law is it currently stands should not be changed and no system should be introduced to allow people to be assisted to die. • The College does not recognise any circumstances under which it should be possible for people to be assisted to die. Assisted dying facilitated by a medical professional should not be allowed under UK law for the following reasons: • It would fundamentally alter the role of the doctor and their relationship with their patient. Medical attendants should be present to preserve and improve life – if they are also involved in the taking of life this creates a conflict that is potentially very damaging.

• Whilst we recognise that patients with 'difficult to manage' symptoms can create situations that are distressing for the patient, their family and those caring for the patient, a compassionate response to these situations should involve empathy and working hard to control symptoms and not simply to hasten death. It is unusual to encounter a patient whose symptoms are truly unmanageable and greater availability of palliative care expertise would help this further.

• There is a danger that a "right to die" may become a "responsibility to die" making already vulnerable people even more vulnerable. We hope that the Commission will be able to make recommendations that respond compassionately to this difficult issue but still protect the doctor-patient relationship and the rights of those approaching the end of their life.

April 2011

The Royal College of General Practitioners

We are not aware of any stated position from the Royal College of General Practitioners

The Royal College of Nursing

RCN moves to neutral position on assisted suicide

Published: 24 July 2009

The Royal College of Nursing moved to a neutral position on assisted suicide following a discussion at its Council meeting today (24 July).

RCN Council's UK position, which followed an extensive and detailed consultation process, means that the RCN moves from opposing assisted suicide to a position where the College neither supports nor opposes a change in the law to allow assisted suicide.

Council also decided that nurses need detailed guidance on the issue which will now be commissioned. The guidance will consider the complicated legal, regulatory, ethical and clinical frameworks around assisted suicide.

Dr Peter Carter, RCN Chief Executive & General Secretary, said: "Assisted suicide is a complicated issue and this was reflected in the range and variety of responses that we received to our consultation. The split in responses shows that there is no overwhelming support among nurses for either opposing or supporting a change in the law on assisted suicide. We fully support the common themes that came through the consultation, namely maintaining the nurse-patient relationship, protecting vulnerable patients and making sure there is adequate investment in end of life care.

"We will continue to play an active role in any discussion around assisted suicide to ensure that the nurse voice is heard. It is vital that we now commission further work to make sure that nurses receive much needed guidance around the legal, ethical, regulatory and clinical issues of assisted suicide."

The decision, voted on by Council members, follows a three month consultation with RCN members which drew over 1,200 individual responses.

RCN members voiced a range of opinions on the issue. The majority of individuals supported assisted suicide (49%), however there was also substantial opposition (40%). The remaining submissions were either neutral on the issue (9%) or failed to record a position (1%).

Chair of Council, Sandra James, said: "Assisted suicide is a high-profile and emotive issue and it is right that we consulted thoroughly with members before coming to our decision. Council had a long and careful deliberation of the range of options available. In reaching our decision we considered individual members' opinions as well as the views from RCN branches and forums, and non-RCN affiliated bodies."

Today's decision comes in the wake of defeated amendments to the Coroners and Justice Bill which sought to legalise aspects of assisting suicide including travelling with those who wish to commit suicide abroad.

Views of the Medical profession

Further References

http://www.bma.org.uk/images/endlifedecisionsaug2009_tcm41-190116.pdf

http://www.bma.org.uk/ethics/end_life_issues/index.jsp

http://www.palliativecarescotland.org.uk/content/publications/FINAL-SPPC-submission-to-the-consultation-on-the-proposal-for-an-Assisted-Suicide-Scotland-Bill.pdf

Living wills

About Death: Living Wills and Advance Decisions in the UK *by Dr. Hilary Page*
- Mospeate Publishing 2010

Medical Ethics References

Beauchamp T.L & Childress J.C. (1994)	**Principles of Biomedical Ethics**	OUP
Glover J (1990)	**Causing Death and Saving Lives**	Penguin
Harris J (1991)	**The Value of Life**	Routledge
Singer P Edt (1993)	**A Companion to Ethics**	Blackwell
Warnock M & Macdonald E (2009)	**Easeful Death**	Oxford

Further Reading

Arditti M (2010)	**The Enemy of the Good**	Arcadia

The British Social Attitudes (BSA) survey

In the 26th report (2009-10) the question was asked:

Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life, if the patient requests it?

About the Survey

The *British Social Attitudes* (BSA) survey series began in 1983, and has been conducted every year since, except in 1988 and 1992 when the core-funding from the Sainsbury Family Charitable Trusts was devoted to conducting post-election studies of political attitudes and voting behaviour in the *British Election Study* (BES) series held at the UK Data Archive under GN 33066. However, for reasons of continuity, in 1997 a scaled-down BSA was also fielded in addition to the BES. Core-funding for BSA is supplemented by financial support from a number of sources (including government departments, the ESRC and other research foundations), but final responsibility for the coverage and wording of the annual questionnaires rests with the National Centre for Social Research (NatCen – formerly Social and Community Planning Research).

In 1994, 1998 and 2003, the BSA survey was accompanied by the *Young People's Social Attitudes Survey* (YPSA) (held at the Archive under GN 33338), which was designed to explore the attitudes and values of children and young people, and where possible to make comparisons with those held by adults. The sample for YPSA was drawn from young people aged 12-19 years living in the households of adults interviewed for the BSA survey.

Main Topics:

The questionnaire normally has two parts, one administered and one left for self-completion and later return. Each year the interview questionnaire contains a number of 'core' questions. These cover major topic areas such as defence, the economy, labour market participation and the welfare state. The majority of these questions are repeated in most years, if not every year. In addition, a wide range of background and classificatory questions is always included. The remainder of the questionnaire is devoted to a series of questions (modules) on a range of social, economic, political and moral issues – some asked regularly, others less often. Cross-indexes of those questions asked more than once appear in the reports. Between 1984 and 1986 the ESRC funded the introduction of a panel element into the series, enabling about half (about 700) of the first year's respondents to be

re-interviewed with a slightly adapted questionnaire.

Since 1985, an international initiative funded by the Nuffield Foundation, known as the International Social Survey Programme (ISSP) has been running. The BSA series contributes data each year for the ISSP, and so some questionnaire modules now allow cross-national comparisons. The ISSP modules are always contained in the self-completion part of the questionnaire.

A Christian Case for Assisted Dying

The Reverend Professor Paul Badham (full text of a paper presented at a conference on assisted dying held St. Michael's Hospice in Harrogate on April 24th. 2012)

Why I would welcome a change in the law

I would like to start by expressing my gratitude to St. Michael's Hospice for organizing this symposium and inviting me to participate. Assisted dying and palliatives care are often seen as alternative approaches to terminal illness. I believe they need each other. When Baroness Finlay introduced her Palliative Care Bill she claimed that '95% of the pain in terminal illness can be and should be controlled' [13] That would be a welcome improvement on the present situation, but it would still mean that one person in every 20 will suffer uncontrollable pain during their final days on earth. If I found myself in that position, 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 including 84% of monthly Anglican Churchgoers [14] and 71% of people who describe themselves as 'religious.'

The relevance of the teaching of Jesus

For any Christian what we want for ourselves is an important consideration in making moral judgments. This is because Jesus taught that the whole of religious law and prophetic teaching could be summed up by saying that we should love God and love our neighbour as ourselves. His golden rule was that we always treat others as we wish to be treated ourselves. According to R.M. Hare, a former Professor of Moral Philosophy at Oxford, 'there is no moral question on which these teachings have a more direct bearing than on euthanasia. '[15] It was this consideration that led the Church of England Working Party *On Dying Well* to the conclusion that euthanasia was not always wrong. They said that 'there are bound to be cases where any of us who is honest with himself…would wish to have our deaths hastened so that the manner of them might be less unbearable. Thus a direct application of the teaching of Jesus to these cases would legitimize at least some instances of euthanasia.' [16]

However the working party did not go on to recommend the legalization of euthanasia because they believed that the law should not be changed for a few 'hard cases' but must rather consider the wellbeing of the large majority whom they believed would be at risk. Writing in 1975 they thought that if euthanasia were allowed it would put health care at risk, weaken trust in doctors, and hold back the development of palliative care. I shall explore later in my paper whether or not these fears are justified by looking at what has actually happened in jurisdictions which have changed their laws. But first let me examine some specifically religious arguments against changing the law.

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 appears not to see human life as a gift from God to be treasured. In

[13] Speaking in the House of Lords 23rd. February 2007
[14] Robin Gill.*Euthanasia & the Churches* Cassell 1998 p.21
[15] R.M. Hare, *Essays in Bioethics* Oxford, Clarendon 1993,p.72
[16] Archbishop's Council, *On Dying Well* Church House Publishing 1975 & 2000 p. 23

response to such claims I would point out that from a New Testament perspective 'The Gift of God is Eternal Life'[17] and the gift of eternal life is not taken away by death. Christianity has always seen 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. 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. Under the present guidelines such help cannot be given by a British health professional but can only be given by a relative or friend unless the dying person is able to go to Switzerland for professional help.

The commandment 'Thou Shalt Not Kill'

For many 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 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 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 trivial offences For example consulting a medium, for reviling one's parents, for homosexuality, adultery or incest, or having sex while the woman is menstruating. Parents had the right to complain to the elders of the city that their son has become a disobedient glutton and a drunkard and could have him stoned to death. People could even be killed for picking up sticks on the Sabbath day. A priest's daughter who had pre-marital sex was to be burnt alive. [18] 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 in any way. 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.'[19] 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

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 but is good that in many areas of medical practice a close bond now exists between doctors and clergy.

Is it good for us to suffer?

However some tensions remain. According to Pope John Paul 2, 'suffering especially in the final stages of life has a special place in God's plan of salvation'.[20] This view challenges both palliative care and assisted dying and is of course very similar to what all Christians used to think about the

[17] Romans 6.23
[18] Leviticus 20.6,10,13,17,18, Exodus 21.17, Deuteronomy 21.18 Leviticus 21.9
[19] 2 Maccabees 14.41-42
[20] *The Declaration on Euthanasia of the Sacred Congregation for the Faith* Rome 1980

pains of giving birth. According to the Bible women shall bring forth children in pain.[21] That suffering too was seen as part of God's plan of salvation. But no Christian thinks like that today and all women should be grateful that Queen Victoria insisted on her right to anaesthesia in childbirth and thereby changed the climate for every other woman.

The parallel between birth and death

There is another parallel too. At the beginning of the twentieth century all Christian 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 right to plan one's family. Birth statistics in Italy Spain and Poland show that most Catholic couples also believe this. 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)* and that it is as catastrophically wrong in both cases.[22] 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 Christian opposition to euthanasia is based on the grounds that we should always seek to ensure that the legal system 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 exposed to 'intolerable suffering at the very point when their helplessness is at its greatest'. It is precisely the most vulnerable who should be allowed the means to ensure that their lives are not 'dragged out endlessly'.[23] 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. [24]

Does allowing Assisted Dying weaken health care provision?

The most common argument against changing the law is that it would put us on a slippery slope towards declining health care. A right to die would become a duty to die. If these 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 it seems from the OECD tables that the Swiss have 18.3 hospital beds per 1000 inhabitants which is the highest ratio in the world and compares with 4.1 in Britain.[25] It means the Swiss have four and a half times as many hospital beds available as we do. Consequently sick people in Switzerland have longer hospital stays than in any other country.[26] That requires more doctors. The Swiss have 3.85 doctors per 1000 people. We in Britain have only 2.71[27] A Swiss level of health care is expensive, and Switzerland spends more per capita on health than any country other than the USA. However unlike the USA the Swiss provide health cover for all their people. In 2007 per capita expenditure on health in Switzerland was 4011 US dollars compared with 2560 US dollars in Britain. [28] In other words the Swiss spend 57% more on health care than we do.

One consequence of this is that the Swiss live almost two and a half years longer. In 2009 Swiss life expectancy was 81.8 years while British life expectancy was 79.2 years .[29] This level of life

[21] Genesis 3:16
[22] Hans Kung and Walter Jens, *A Dignified Dying* SCM 1995 p.119
[23] Hans Kung and Walter Jens, *A Dignified Dying*, London, SCM 1995,p.34 & 119.
[24] Douglas .Davies , *A Brief History of Death* Oxford , Blackwell 2005 p.205
[25] O.E.C.D. statistics from http;//www.nationmaster.com/graph/hea_bed-health-hospitals-beds
[26] O.E.C.D. statistics from http;//www.nationmaster.com/graph/hea_dur_of ho-health-duration-of-hospitalisation
[27] OECD Healthdata_frequently asked questions 2010
[28] http://www.infoplease.com/ipa/AO934556.html
[29] http://apps.who.int/whosis/database/life_tables/life_table

expectancy shows that vulnerable and frail Swiss people do not feel under pressure to ask for assistance to die merely because their laws allow this. Their cancer survival rates also demonstrate this. 53.6 % Swiss men survive cancer for more than five years, but only 44.3% of British men do. [30] What this comparison between Britain and Switzerland shows is 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. Certainly the hundred and eighty Britons who have travelled to the Dignitas Clinic in Zurich for an assisted death are far outnumbered by those who travel to Swiss hospitals and sanitoria for the latest and best medical treatments.

Does allowing voluntary euthanasia weaken trust in doctors?

The Dutch have had voluntary euthanasia for forty years. The situation there is controversial. Both sides in the voluntary euthanasia debate make claims based on what they believe the situation to be. In this position I think the best approach for us is to focus on what the Dutch themselves now think about their own laws. When voluntary euthanasia was first proposed in the Netherlands in 1966 it was deeply unpopular, and opposed by 49% of the population. No political party dared legislate for it and 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' [31] Gradually however the Dutch came to see that such fears were unjustified and after 30 year's experience of voluntary euthanasia the number of Dutch people opposed to it dropped from 49% in 1966 to 10% by 1996.[32] In 2002 voluntary euthanasia was finally legalized. 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. [33] The case for seeing 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.

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 assisted dying has been legalized.[34] 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 were glad they had lost 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 had risen from 22% to 51% during those eight years. [35] 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

[30] Regina Herzlinger, 'Switzerland has the medical bills covered, *Times* February 27th. 2009
[31] Margaret Otlowski, *Voluntary Euthanasia and the Common Law* Oxford Clarendon 1997 p. 437
[32] Ruurd Veldhuis,'Tired of living and Afraid of Dying' *Studies in Christian Ethics* 11.1 1998, pp. 63-76, 70
[33] Z. Kmietovicz, Respect-Why doctors are stll getting enough of it' *British Medical Journal* 2002 ; 324 (7328)
[34]Lord Falconer *Report of the Commission of Assisted Dying* Demos 2011 p. 158
[35] Ann Jackson, 'The Reality of Assisted Dying in Oregon: Draft notes of Compassion in Dying: All Parliamentary Group Meeting 19th. April 2006 p.11

courts in Montana have made clear that they will no longer prosecute people who act in accord with such legislation. More recently it seems that Hawaii intends to introduce similar laws and the people of Massachusetts are seeking a referendum on the issue.

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. According to the Journal of Medical Ethics the evidence is that legalizing assisted suicide *decreases* the prevalence of involuntary euthanasia.[36] The British Medical Journal 29th. Sept. 2007 found that people are more likely to be killed without their consent in European countries that forbid 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.[37] 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 [38] . 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.' [39] 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 countries which have embarked on this process. Although some of the evidence I cite is drawn from specialist journals the main data on relative standards of health care and life expectancy derives from the websites of the World Health organization and the OECD which are readily accessible to all of us. I hope that for the future Christian compassion will lead to us joining the countries in which assisted dying is permitted.

Paul Badham is Emeritus Professor of Theology at Trinity Saint David University (Lampeter Campus). He is a Patron of Dignity in Dying and author of *Is there a Christian Case for Assisted Dying?* SPCK 2009

Further Reading

Views of other religions

The Church of England
http://www.churchofengland.org/media/57990/assisteddyingpdfmar09.pdf
The Roman Catholic Church
http://www.cbcew.org.uk/document.doc?id=33
The Case for - Is There A Christian Case for Assisted Dying? *by Prof Paul Badham*
The Case against – A time to live *by George Pilcher*
http://www.eden.co.uk/pdfs/9781854249876.pdf (introduction only)
British Humanist Association
http://www.humanism.org.uk/campaigns/ethical-issues/assisted-dying

Research

Improvements to palliative care
http://ukpmc.ac.uk/abstract/MED/7537908/reload=0;jsessionid=hsQvvTnzPTgTNopmukik.4

[36] C.J. Ryan, 'The effect of new evidence on Euthanasia's slippery slope' Journal of Medical Ethics 24/5 pp.341-4 October 98
[37] 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
[38] C.Seale 2009 'End of life decisions of UK doctors *Palliative Medicine* 23/3 : 198-204
[39] C.Seale 2009 'Hastening death in end of life care' *Social Science & Medicine* 69:1659-1666.

http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf
http://medtextfree.wordpress.com/2012/02/09/34-palliative-medicine/
Pain Management
http://pain-management-info.com/
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2801%2906142-6/fulltext
Depression and death
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1291326/
http://www.annals.org/content/132/3/209.abstract
http://pmj.bmj.com/content/76/899/555.full
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

The slippery Slope

http://www.maranathacommunity.org.uk/pdf/maranatha-dec09-slippery-slope-to-euthanasia.pdf

Organisations

Care not Killing
www.carenotkilling.org.uk
Dignity in Dying
http://www.dignityindying.org.uk
Exit International
http://www.exitinternational.net/
Fast Access
http://www.euthanasia.cc/
Dying matters (the National Council for Palliative Care)
http://www.dyingmatters.org