Assisting the suicidal and caring for the dying

David Albert Jones

In their ruling in a right-to-die case this week, UK Supreme Court judges have urged Parliament to address the issue of assisted dying. David Albert Jones reviews the bills currently being considered in Westminster and Holyrood which aim to legalise physician-assisted suicide. He explores questions of law and language that surround the issue, and asks how the Church can contribute to this sensitive debate.

Two new bills that would legalise assisted suicide


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The British people are currently facing two attempts to introduce bills which would legalise physician-assisted suicide in parts of the UK. In Scotland, Margo MacDonald MSP introduced her Assisted Suicide (Scotland) Bill in November 2013. While Mrs MacDonald did not live to see it voted on (she died in April 2014), her bill has attracted another sponsor and is moving forward. The closing date for written evidence was 6 June 2014 and oral evidence will be considered in the autumn. Meanwhile, south of the border, a similar attempt is being made in the House of Lords. On 5 June 2014, Lord Falconer reintroduced his Assisted Dying Bill. It is due to be debated on 18 July 2014.

There are some differences in details between these two bills: for example, the Assisted Dying Bill requires that the person reasonably be expected to die within six months, whereas the Assisted Suicide (Scotland) Bill does not define what it means by an illness that is 'life-shortening'. However, given the uncertainties of a prognosis of six months, this stipulation in the Assisted Dying Bill still gives considerable latitude to an amenable doctor. Both acts would facilitate suicide for people who may otherwise have had years of life ahead of them. There is also a difference of language between the bills. The Scottish Bill 'does what it says on the tin': it legalises assisted suicide. The English Bill legalises the same actions, but is coy about saying so, preferring to use the term 'assisted dying'.

A decade of concerted attempts to change the law

These are not, of course, the first attempts to change the law in this area. In fact, the modern movement to legalise such practices began in Britain in 1935 with the founding of the Voluntary Euthanasia (Legalisation) Society. However, while this movement succeeded in bringing the issue to public attention, governments and courts have repeatedly rejected attempts to change the law.

Glossing over an infamous decree promulgated in Germany in 1939, it was not until the 1980s that the euthanasia movement had its first legal breakthrough: the Netherlands effectively legalised euthanasia in a Supreme Court judgment in 1984; and in Switzerland, where the law had long tolerated well-intentioned assistance of suicide, the 1980s saw this permission extended from individuals to organisations. In 1994, the state of Oregon legalised physician-assisted suicide through a referendum, though legal wrangles prevented the Death with Dignity Act coming into force until 1997. In 2002 both the Dutch and Belgian

parliaments passed laws permitting euthanasia, and since then there have been vigorous attempts in many different countries to legalise euthanasia and/or assisted suicide. However, to date, the practices have not expanded beyond the Benelux Countries, Switzerland and a handful of states in the USA.

It was in the context of these sustained international attempts that Lord Joffe introduced a bill in the House of Lords in 2004 to legalise assisted suicide and euthanasia. This led to a House of Lords select committee examining the issue, but the report of that committee was less than favourable and a modified form of the Bill was defeated in a free vote. Subsequent to this, Lord Charles Falconer (in 2009 at Westminster) and Margo MacDonald (in 2010 at Holyrood) made further attempts which were rejected by the House of Lords and the Scottish Parliament respectively. The current bills before the two parliaments are both second attempts.

Embarrassment about euthanasia

A difference between the current bills before the parliaments on the one hand, and that of Lord Joffe and the first MacDonald Bill of 2010 on the other, is that the earlier bills had sought to legalise active euthanasia, whereby a doctor directly ends the life of a patient. In contrast, the current bills have narrowed their focus to assisted suicide, e.g. where the lethal dose is self-administered.

This shift was largely due to the evidence from the Netherlands, and increasingly from Belgium, after the extension of euthanasia to those whose competence was compromised (those with depression or dementia, or children), and even to people who were wholly incapable of requesting euthanasia (for example, young infants and unconscious adults). The deaths of hundreds (perhaps thousands) of patients by non-voluntary euthanasia are increasingly accomplished in the Benelux Countries by means of sedation and withdrawal of hydration.[1]

In recent years Belgium has also witnessed a number of extraordinary individual cases: euthanasia for anorexia nervosa, euthanasia of someone who regretted gender reassignment surgery, euthanasia of twin brothers who feared losing their sight.[2] Belgium has also pioneered the taking of organs from those who have died by euthanasia. In 2011, it was reported that these supplied 23.5% of lungs for transplant after cardiac death in Belgium.[3] Meanwhile, the Netherlands equivalent to the Voluntary Euthanasia Society has launched a national mobile euthanasia service to promote access to euthanasia in cases where local doctors may be reluctant to provide it.[4] Both countries have a system of official reporting, but the more marginal cases are less likely to be reported and those reported are scarcely ever referred for prosecution.

The Low Countries remain strongly attached to their form of euthanasia, and indeed in Belgium in February 2014 the law was extended to children, with no lower age limit.[5] However, in other countries this experience is increasingly seen as a salutary warning. For this reason, and also no doubt because of a perception that it might be easier to negotiate through sceptical parliaments, those seeking to change the law in this area have tended to confine their immediate ambitions to legalising assisted suicide. Lobby groups have felt the need to distance themselves from what they implicitly acknowledge to be the failed experiment of Benelux-style euthanasia.

The language of 'assisted dying'

In addition to honing the thin end of the wedge so that death-by-request is confined, at least for the moment, to assisted suicide, advocates of the practice have also sought more acceptable terminology for these proposals. Even the name under which the 'Voluntary Euthanasia Society' campaigned for 70 years has now become toxic: in 2005, the organisation rebranded itself 'Dignity in Dying'. The currently-preferred term, especially in England and Wales, is 'assisted dying', although its meaning has changed. In 2004, Lord Joffe used the term 'assisted dying' to refer to assisted suicide and euthanasia; however, Lord Falconer's Bill defines 'assisted dying' so that it is confined to the self-administering of a lethal drug.

To add to this confusion, Dignity in Dying deny that 'assisted dying' is assisted suicide. They claim that taking a lethal drug in an attempt to put an end to your life is not suicide if you have (or believe you have) only six months to live.[6] Hence they claim that they are not in favour of legalising assisted suicide. This is mere sophistry. If someone who has six months to live ends his or her own life, via any method, this is suicide. Plainly speaking, what is proposed in the Assisted Dying Bill is that, in some

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cases, seriously ill people who are contemplating suicide could be encouraged or assisted in that action.

The preference for the euphemism 'assisted dying' is in part to avoid the negative connotations of the word 'suicide'. Suicide is characteristically an act of despair, and the word reminds us that someone who expresses a wish to and their life must have their mental health assessed. In the early years of the practice of assisted suicide in Oregon these needs were at least sometimes addressed by referral for psychiatric evaluation. However, as assisted suicide has become more and more normal the rate of psychiatric referral among those who went on to commit suicide after expressing a wish to die has declined from 27% (in 1998) to 2.6% (in 2012).[7] If people requesting death are not even acknowledged to be 'suicidal' then their mental health needs are even less likely to be addressed.

An argument put forward by Dignity in Dying in favour of a change in the law is that there are already some terminally-ill people who commit suicide. A change in the law, they claim, would allow people to end their lives later and with more legal control and medical supervision, but would not increase the number of people deliberately ending their lives.[8] This argument is neither plausible nor borne out by the evidence. Not only does legalising a practice make it more easily accessible, it also 'normalises' the practice, making it more socially acceptable. In Oregon the rate of physician-assisted suicide has increased steadily between 1998 and 2012 by 430% overall and there is no evidence that these deaths have been compensated by a concomitant decrease in non-physician-assisted suicides.[9] Rather the suicide rate in Oregon over the same period (excluding physician-assisted suicide) has in fact increased by 32% and has now reached approximately twice the suicide rate in the United Kingdom.[10] The rise in suicides subsequent to the new law does not necessarily indicate that the law caused a shift in the acceptability of suicide, but still less does it lend credence to the claim of Dignity in Dying that if assisted suicide was legalised in Britain 'no more would die'.[11] In neighbouring Washington State the upward trend of deaths from legalised assisted suicide is steeper even than in Oregon - there was a 43% increase in numbers between 2012 and 2013 alone.

Dignity, mortality and solidarity

Law affects society and it is important, in assessing the possible impact of law, to consider the experience of countries which have passed similar laws. However, a danger with concentrating only on the possible consequences is that we may tacitly accept the idea that encouraging or assisting suicide for seriously ill people would be a good thing if only it could be controlled. We may begin to think that it is a matter of 'private liberty versus public safety'.

What is missing from this way of framing the debate is the deeper question of the meaning of inherent human dignity, especially in relation to disability or various forms of practical dependence, and the human solidarity that is expressed or undermined by our actions. If society allows suicide for certain categories of people (those who are terminally ill or those who 'suffer unbearably' with some disabling condition) but seeks to prevent suicide of other categories of people (young and/or physically-healthy people), it is implicitly saying that some lives are less worthy than others of the care or protection of society. Anyone who is suicidal feels, at that point, that life is unbearable, but it is a mark of our society how we respond to people who feel such desperation.

The opposition to assisted suicide that has been expressed eloquently by the late Alison Davis[12] and by others who live with disability, is not only about possible further consequences. It is directly about the presumption of unequal dignity or unequal worthiness of protection that is implicit in the legislation. Sometimes defenders of a change in the law argue that the debate is not about disability but is only about people who are dying. However, those advocating a change in the law most often refer not to the imminence of death but to the alleged indignity of a state of dependence, or of reduced mental capacity, or to the fear of being a practical or financial burden on others. This is the root-cause of the threat posed to disabled people by any proposed legislation.

As these proposed changes in the law threaten the equal recognition of people with disabilities, they also impinge on a fundamental principle in relation to best

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care of the dying. It is a basic principle of palliative care that such care is intended neither to hasten nor to postpone death.[13] It is hard to underestimate the importance for public trust of patients being able to have confidence that when a doctor offers pain relief, or relief from agitation, or recommends withdrawal of treatment, the doctor's aim is to alleviate symptoms and never (either overtly or covertly) to hasten the patient's death.[14]

It is these inherent threats to equality and to the rationale of end-of-life care that explain the character of the coalition that has emerged in the UK to resist the legalisation of assisted suicide and euthanasia. The umbrella organisation Care Not Killing[15] includes medical professionals (especially but not only from the field of palliative care), disability rights organisations, pro-life groups and faith communities, as well as individual activists, researchers, carers and a range of other concerned people. What unites all these is an ethic of care and a recognition of human dignity and social solidarity.

Catholic teaching on suicide and martyrdom

Where is God in all this? And what role should be played by the Church? All things relate to God, the Lord of life and death, but this issue does so in a particularly visible way because it relates to how we value the life God gives us and how we return to God through death.

In relation to suicide there is a certain paradox in the Catholic understanding, for the good news of the Gospel is that, in a sense, we can all be better off dead. If we die accepting God's mercy then we can look forward to eternal life, reunion with those who have gone before, bodily resurrection, and unimaginable bliss. At the same time this message makes the present life not less significant but more so, for good or ill. Every act of charity, every expression of care, of justice or solidarity, every good and human thing done in this life has a possible eternal significance and nothing need be lost.

In relation to the prospect of death, and in relation to care for the dying, there are therefore two things that need to be kept in mind: respecting life and accepting death.[16] Respecting life means that every person must be valued for as long as they live. One implication of this is that death should never be the aim of our action or of our inaction. We should never try to bring about or to hasten death. On the other hand, accepting death means that we should prepare properly for death. One implication of this is that we should not deny the reality of the situation or flee from the inevitable by seeking every possible treatment. To encourage or assist suicide is neither to respect life whole-heartedly nor to accept death patiently.

It might seem that Christianity alters this picture by making one or other of these elements stronger, but in fact Christianity makes *both* elements stronger: Christian faith gives more reason to cherish life, especially the lives of those who are marginalised or overlooked by society. It provides a greater reason to believe in the equal and inherent human dignity of every person, as created in the image and likeness of God, and as someone for whom Jesus died. At the same time it also gives more reason to accept death, as something in God's hands, not ours. As Chesterton remarked, 'Christianity [gets] over the difficulty of combining furious opposites, by keeping them both, and keeping them both furious'.[17]

This is why martyrdom is different from suicide. The Christian martyr does not aim at death but aims to be faithful to God to the end. In contrast someone who commits suicide is taking flight from this life and is making death into an act of self-assertion. Martyrdom accepts life and death from God. Suicide neither accepts life from God nor death.

Suicide is thus not only a rejection of life but also, in a paradoxical way, a denial of death, a denial of that good death by which God comes to us to take us home.[18] At the same time the Church is increasingly aware that the pressures that bring people to attempt suicide can disturb the balance of the mind and reduce moral culpability for the action. The Church publicly expresses hope for the salvation of those who have committed suicide. In the words of the Catechism: 'We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives.'[19]

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[1] L. Anquinet, J.A. Rietjens, C. Seale, J. Seymour, L. Deliens and A. van der Heide, 'The practice of continuous deep sedation until death in Flanders (Belgium), the Netherlands, and the U.K.: a comparative study'. *Journal of Pain and Symptom Management* 44(1), 2012: 33—43.

[2] These and other stories are listed here: http://www.patientsrightscouncil.org/site/belgium/

[3] R. Cohen-Almagor, 'First do no harm: pressing concerns regarding euthanasia in Belgium'. *International Journal of Law and Psychiatry*. 2013 Sep-Dec; 36(5-6):515-21.

[4] The World Federation of Right to Die Societies, 'Dutch Life End Clinic SLK reports on first half year of experiences'. News 6 November 2012 http://www.worldrtd.net/it/news/dutch-life-end-clinic-slk-reports-first-half-year-experiences

[5] http://www.bbc.co.uk/news/world-europe-25364745

[6] http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide

[7] Death with Dignity Act Annual Reports Year 16 – 2013 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[8] R. Tallis, 'Assisted Dying is Not the Same As Euthanasia'. *BMJ* 2014;348:21: http://www.bmj.com/content/348/bmj.g3532 and D.A. Jones 'Evidence relevant to legalising "assisted dying"' *BMJ rapid response* to R. Tallis 'Assisted Dying is Not the Same As Euthanasia'. BMJ 2014;348:21. http://www.bmj.com/content/348/bmj.g3532/rr/701150

[9] *Ibid*.

[10] Oregon Resident Deaths by Manner of Death and County of Residence, 2012 Final Data: http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/death/Documents/dman12.pdf

[11] Death with Dignity Act Annual Reports Year 16 – 2013

[12] A. Davis, 'Why euthanasia/assisted suicide would have robbed me of the best years of my life'. *Catholic Medical Quarterly* 63(2) May 2013: http://www.cmq.org.uk/CMQ/2013/May/Editorial-Euthanasia-Alison-Davis.html

[13] World Health Organisation Definition of Palliative Care http://www.who.int/cancer/palliative/definition/en/

[14] See, for example, Neuberger et al. *More Care, Less Pathway: A review of the Liverpool Care Pathway* (London: Crown copyright 2013, Produced by Williams Lea), paragraph 1.86 to 1.90 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

[15] http://www.carenotkilling.org.uk/

[16] This paragraph is taken from *A Practical Guide to the Spiritual Care of the Dying Person* paragraph 2.1 http://www.bioethics.org.uk/images/user/guide-spiritual-care-dying-person.pdf

[17] G.K. Chesterton, *Orthodoxy* (London: John Lane Company, 1909), quoted previously in this context by D.A. Jones, 'The Hippocratic Oath III: Hippocratic principles applied to the withdrawal of treatment and the mental capacity act'. *Catholic Medical Quarterly* 57(2) 2007: 15-23. http://cmq.org.uk/CMQ/2007/May/The_Hippocratic_Oath_III.html

[18] D.A. Jones, *Approaching the End: a theological exploration of death and dying* (Oxford: Oxford University Press, 2007).

[19] *Catechism of the Catholic Church*, paragraph 2283, see also *Cherishing Life* paragraph 182 http://www.bioethics.org.uk/images/user/cherishing-life-2004.pdf

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