

## **ASSISTED DYING/SUICIDE AND VOLUNTARY EUTHANASIA**

While acknowledging the complexity of the issues involved in assisted dying/suicide and voluntary euthanasia, the Church of England is opposed to any change in the law or in medical practice that would make assisted dying/suicide or voluntary euthanasia permissible in law or acceptable in practice. The Church also acknowledges that those who seek a change in the law are often motivated by compassion and by a desire to see individuals treated with dignity and respect; motives that the Church also upholds. Equally, the Church shares the desire to alleviate physical and psychological suffering, but believes that assisted dying/suicide and voluntary euthanasia are not acceptable means of achieving these laudable goals.

**Principles:** at the heart of this debate is the relationship between two important principles: personal autonomy and the protection of life. Often these principles are complementary but, at times, they compete for priority. The Church believes that personal autonomy has an invaluable role to play in a civilized society but autonomy ought not to be understood or exercised without regard to others. Autonomy ought to be ‘principled autonomy’. Our actions affect others both directly and indirectly and this reality ought to place boundaries on unbridled autonomy.

In truly extreme cases, protection of life is sometimes impossible to achieve. This does not, however, undermine the importance of this principle or necessitate a change in the law. For Christians, the innate dignity and value of human beings comes from the belief that we are made in the Image of God. It is not, of course, necessary to share this religious conviction to agree that every human being is uniquely and equally valuable. Without such a belief, society would degenerate into moral disorder with a social misapplication of ‘survival of the fittest’ replacing allegiance to our common humanity. Human Rights are built on the foundation of the ‘right to life’ as is much of the criminal code. Compassionate reactions to natural disasters and to the victims of war stem from a belief in the value of life. There ought always to be a ‘presumption in favour of life’ and where personal autonomy and protection of life conflict, protection of life ought to be given priority. Society and its agents ought to act to protect life and only where this is truly not tenable, such as in a situation of extreme violence or danger, ought this principle to be breached.

In assisted dying/suicide and voluntary euthanasia, individuals seek the right to dictate how they may die, requiring doctors and nurses, as the agents of society, either to take life or to assist in the taking of life. Where a right is given, a corresponding obligation to respect, protect and to promote that right must also be acknowledged. A right for one must be a right for all and a right for all can only be upheld by society ensuring that every person has access to that right. An obligation on society and its agents to take life or to assist in the taking of life, by ensuring a universal right to assisted dying/suicide or to voluntary euthanasia, would create a new and unwelcome, role for society.

**Practice:** There are problems ensuring that any law permitting assisted dying/suicide or voluntary euthanasia could be sufficiently safe-guarded against abuse. Evidence from jurisdictions that allow assisted dying/suicide or voluntary euthanasia suggests that there have, indeed, been problems of ensuring that due process is always carried out and that adequate support services are always in place.

**Elastic interpretations of the law:** as well as there being concerns that one change in the law will lead to further, greater, changes there is an inevitability that any law, however, tightly formulated will be interpreted variously by different people. A reference to ‘severe suffering’ for example, can only be interpreted subjectively while an estimate of how long a terminally ill person may have to live can only be precisely that: an estimate. Inevitably, doctors will vary in their approach and consistency will be impossible to achieve with ‘wider’ interpretations of the law becoming acceptable.

**Hidden pressures on patients and staff:** even with safeguards of mandatory counselling and ‘cooling off periods’ it is impossible to ensure that vulnerable, terminally ill patients, especially elderly patients without close family support, will not feel under moral, economic or social pressure to accept assisted dying/suicide or voluntary euthanasia. What may appear as greater freedom of choice for some can easily become a greater source of pressure for others. One such person is one too many and would represent an affront to them, to health professionals and to society.

**A redefinition of healthcare:** it has been a source of comfort and assurance to millions of people that the NHS has provided care and protection as well as life-enhancing and life-saving interventions since its inception over sixty years ago. Trust in the health service is crucial to the health and well-being of individuals and of the population. To introduce assisted dying/suicide or voluntary euthanasia into the NHS (for only in this way could the ‘right’ be made universally accessible) would be to change fundamentally the nature of the NHS. The effects of this are likely to be far-reaching, particularly if assisted dying/suicide or voluntary euthanasia were to be perceived as being a ‘cost-effective’ way of dealing with terminal illness.

**The doctor and nurse/patient relationship:** the nature of this relationship would change fundamentally and irrevocably if assisted dying/suicide or voluntary euthanasia were to become part of the ‘treatment’ that health professionals were to be able to offer their patients. Trust between doctor/nurse and patient is not always easily achieved; any change in medical or nursing practice in the area of care of the terminally ill is likely to have an adverse effect on such relationships. A ‘conscience clause’ allowing doctors and nurses to ‘opt out’ of assisted dying/suicide or voluntary euthanasia would often mean that patients would be introduced to new staff, unknown to them, at a most vulnerable stage in their lives, undermining patient care

**The Effects on Palliative Care:** making assisted dying/suicide or voluntary euthanasia ‘workable’ would require large resources, employing medical, nursing, counselling, legal and social-work staff with accompanying additional training and resources. With all of this, there is still no guarantee that assisted dying/suicide or voluntary euthanasia would be safely and fairly administered. In the mean-time, medical palliative care, which has been shown to be highly effective is still not uniformly available throughout the country. The additional psychological, social, family and (where requested) spiritual support services needed to address all of the needs of terminally ill people in a full palliative ‘care-package,’ are equally under-resourced. What is required is a commitment to making effective support a reality for all terminally ill patients. Suffering may be met with compassion, commitment to high-quality services and effective medication; meeting it by assisted dying/suicide or through voluntary euthanasia, however well intentioned, is merely removing it in the crudest way possible. **March 2009**