

ASSISTED SUICIDE AND VOLUNTARY EUTHANASIA

– A Briefing Paper from the Mission and Public Affairs
Council

Introduction

1. The issues of euthanasia and assisted suicide are subject to increasing public debate, with the likelihood of legislation to permit assisted dying being introduced again to Parliament in the near future. The purpose of this debate at General Synod is to allow members to express their views and to endorse, as a basis for the Church's public advocacy, the joint statement produced by the Church of England House of Bishops and the Roman Catholics Bishops' Conference of England and Wales for the House of Lords Select Committee on *Assisted Dying for the Terminally Ill*, the Private Member's Bill introduced by Lord Joffe in 2004 (para. 5 and Appendix I).

2. This background paper consists of: definitions of euthanasia; outlines of the fundamental moral principles at stake; consideration of the 'slippery slope' argument; a definition of palliative care and some account of the hospice movement; a description of the situation in those parts of the world where some form of euthanasia has been legalised, namely the State of Oregon in the USA, the Netherlands, Switzerland and Belgium; and an account of research into UK attitudes on euthanasia. The joint Bishops' submission is at Appendix One, an article written by the Archbishop of Canterbury for the Times in January 2004 is at Appendix II and the 1998 Lambeth Conference Resolution on Euthanasia at Appendix III.

3. This paper is intended to equip Synod members with sufficient background information for the debate. It is not an in-depth study of the issues.

Background

4. In 1994 the House of Lords created a Select Committee to investigate the issue of euthanasia in the light of the Bland case (Tony Bland was a patient in a persistent vegetative state, whose artificial feeding and hydration were withdrawn after a ruling from the House of Lords: *Airedale NHS Trust v Bland*, 1993). That Select Committee concluded that there should be no change in the law on euthanasia (HL Paper 21-1, 1994¹). Ten years later, three members of the Select Committee had changed their minds. In the light of this and of a perceived change in public opinion on the matter, Lord Joffe, a lawyer with a track record of championing human rights in South Africa, agreed to sponsor a Bill through Parliament.

5. In 2004, Lord Joffe introduced his Assisted Dying for the Terminally Ill Bill in the House of Lords. In its own words, the Bill sought to:

Enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make provision for a person suffering from a terminal illness to receive pain relief medication.

6. Following a debate on the Bill, a Select Committee of the House of Lords was established to scrutinise the Bill and make recommendations. The membership of the Committee was as follows:

¹ A list of sources for these references is at the end of this paper.

The Earl of Arran
The Lord Carlile of Berriew
The Baroness Finlay of Llandaff
The Rt Hon Baroness Hayman
The Rt Hon Baroness Jay of Paddington
The Lord Joffe
The Rt Hon Lord Mackay of Clashfern
Professor Lord McColl of Dulwich
The Lord Patel
The Rt Rev Lord Bishop of St Albans
The Lord Taverne
The Baroness Thomas of Walliswood
The Lord Turnberg

7. The Church of England House of Bishops submitted evidence jointly with the Roman Catholic Conference of Bishops of England and Wales, together with a covering letter from the Archbishop of Canterbury and the Cardinal Archbishop of Westminster (see Appendix I). In January, 2005, Revd Professor Robin Gill gave oral evidence to the Select Committee on behalf of the Church of England (HL Paper 86-II, p. 492ff).

8. The Report of the Select Committee was published on 4th April, 2005. It did not conclude for or against changing the law on euthanasia. It made recommendations as to how a future bill, were it to be introduced, might be improved. It is likely that the issue will remain a live one for Parliament for the immediate and foreseeable future. Hence it is important that Synod debate the issue now.

Terminology

9. For the sake of clarity, it is proposed that the definitions adopted by the Select Committee be adhered to in this paper and in the debate. The Committee preferred to use the term *assisted suicide* rather than *assisted dying* to be understood as making available to a person the means by which s/he can end his or her own life; and *voluntary euthanasia* to be understood as deliberately ending the life of another who has requested it but who is physically unable to commit suicide. *Non-voluntary euthanasia*, in which a person's life is taken without his or her consent because s/he is not competent, and *involuntary euthanasia*, in which a person's life is taken against his or her wishes (Biggar, 2004), are not treated in this report as they did not form part of the Bill nor of the Select Committee's considerations.

Moral principles at stake

10. **The sanctity of human life:** This principle is crucial to Christians. It encapsulates their belief that life is in and of itself sacred because it is given by God. Life has an inherent value, not just a conditional one. The principle is enshrined in law in the form of an absolute prohibition on the intentional killing of innocent human beings. It is not normally taken to mean that any life ought to be preserved at all costs. But it does 'protect each one of us impartially, embodying the belief that all are equal' (quoted by the Archbishop and the Cardinal from the 1994 Select Committee's report, included in Appendix I).

11. For a Christian, this principle also encapsulates the simple belief that God owns my life, not I, and I have, therefore, no right to end it.

12. Critics of this principle dislike the word ‘sanctity’ because it suggests a religious prohibition that is inappropriate in a secular society.

13. **The common good:** The meaning of a human life is inextricably bound up with others. The strenuous requests of a small group of strong-minded individuals for assisted suicide or voluntary euthanasia are not made in isolation. They will have friends or family who will be affected; their request places demands on others, who have to accept the decision as valid and act on it; and finally their requests have wide repercussions for law and culture, as the Archbishop points out in his article to the *Times* (Appendix II). A change in the law must be based upon the common good, not on the needs or wishes of a few or of an individual.

14. To what extent would legalising euthanasia/assisted suicide hurt the vulnerable? Some disabled groups reported their concern to the Select Committee that disabled people might experience subtle pressures to avail themselves of the options of assisted suicide and voluntary euthanasia. Others, however, saw no threat in the Bill; rather it was inconsistent to support autonomy for the disabled in every other area of life than in ending it (HL 86-I, p. 50f). Many more were concerned at the effect such legislation would have on the elderly who believe themselves to be a burden already. Indeed, evidence from Oregon and the Netherlands showed that people over 80 years of age tended not to opt for assisted suicide or voluntary euthanasia (HL 86-I, p. 52).

15. **Autonomy:** This word means, literally, ‘self-rule’. The principle of respecting an individual person’s autonomy has gained headway in the last two decades, particularly in the medical profession, where it has replaced traditional

‘paternalism’. Hence doctors are now much more likely to ask their patients whether or not they wish to have treatments, and indeed to choose between treatment options, than they are to give ‘doctors’ orders’ and assume these will be obeyed by their patients. That patients should give properly informed consent to treatment goes without saying. To what extent, however, does the principle permit a patient to request treatment? The limits of the principle are not clear:

Respecting someone’s autonomy is most often a matter of not preventing them from doing something. For society to respect autonomy in matters of religion is to allow people to build churches, synagogues and mosques as they please and to allow them to practice their religion unimpeded. It does not require society or anyone else to assist them in worship or to provide them with facilities. On the other hand, providing facilities such as wheelchair access is often seen as required by respect for the autonomy of people with disabilities. (Centre of Medical Law and Ethics, HL Paper 86-II, p. 26)

16. The law as presently understood is that the patient has no right to demand treatment but that the doctor would be in breach of his or her duty to care for the patient if s/he failed to offer clinically appropriate treatment without reasonable excuse. The current case of Leslie Burke questions this legal principle, as he is requesting, through the courts, a specific treatment, namely artificial nutrition and hydration (*R(Burke) v General Medical Council*, 2005). At the time of writing this briefing paper, judgement has not been given.

17. One argument for legalising assisted suicide and voluntary euthanasia from the point of view of respect for autonomy is

that those who are capable of taking their own lives and do so are not acting illegally: this is the force of the Suicide Act 1961, by which suicide (or attempted suicide) was no longer a criminal act. However, those who cannot kill themselves, either because they do not have the material wherewithal or because they are physically incapable, would be asking others to act illegally if they helped them in some way. Some would argue that this is an anomaly, since it is normally only illegal to aid and abet an act that is inherently illegal. On the other hand, to recognise that this destructive act is not best dealt with by the criminal process is not equivalent to recognising that the act is acceptable. The fact that aiding and abetting suicide remains a criminal act signals that the law does not regard suicide as a matter of social indifference.

18. Autonomy does not have to be understood in a narrow, individualistic way. Kant's account of autonomy placed it as a means by which a person can be expected to behave reasonably. That is to say, we owe rational beings the right to exercise their autonomy so that they can determine what is the reasonable course of action, *not* so that they can demand what they want for themselves (Foster, 2001, p. 54). Onora O'Neill has more recently referred to this as 'principled autonomy', quoted by Professor Gill:

A proper understanding of autonomy, an understanding of autonomy which goes back to Kant, [is that] the rights of the individual always go hand in hand with the duty of the individual to other people (Revd Professor Robin Gill, HL 86-II, p. 493).

19. **Proportionality:** This principle recognises that a point may be reached in a patient's care when further life-prolonging treatment would be both futile and burdensome. At this point

care switches from acute to palliative and a patient is allowed to die. Allowing someone to die is distinguished from killing. Administering doses of pain-relieving drugs that have the foreseen consequence of accelerating death is not intentional killing, if the actual intention is only to relieve pain.

20. It could be argued that the distinction between killing and letting die is not clear: what is the difference between an act and omission if the consequence is the same? The *moral* difference may be found in the intention behind the act. A doctor can allow a patient to die, not because s/he wants the patient's death, but because measures to prevent death have become futile or disproportionate. By contrast a person can allow another to die, even though the person's life could be saved, because s/he hates him/her.

21. Can a consequence that is foreseen really be unintended? A fictional example may help to clarify this question. In the film *Master and Commander*, a ship finds itself in a terrible storm with its mast blown overboard. The mast remains tied to the ship by its rigging and its drag on the boat is putting everyone's life in danger. The captain is advised to cut the ship free from the wrecked mast but there is a sailor clinging to the end of the mast for dear life. To cut the ship free, therefore, would almost certainly cause the sailor to drown. The captain nevertheless orders another sailor to cut the rigging. The sailor so ordered is the best friend of the man hanging on to the mast. He obeys his captain with tears streaming from his eyes.

22. It would not be appropriate to say that the sailor intended to kill his best friend. He was performing an act that would save the ship. The fact that he foresaw his friend's death was what made him perform the act with manifest reluctance. His friend's death was *accepted* but not *intended*, and the

acceptance was *proportionate*, in that risking the death of one man was justified to save hundreds of other men, in the absence of any viable alternative.

23. Preventing avoidable suffering: Although many Christians and others can attest to the strengthening effect of going through periods of suffering themselves, no one would argue in favour of inflicting suffering on others or refusing to prevent it if possible. However, there will be different views on what is possible. What means are needed to eliminate suffering and what are their costs (in the widest sense)? The Bill included a clause requiring palliative care to be offered, but receiving information about palliative care is one thing and the actual experience of it is entirely different. Legalising assisted suicide or voluntary euthanasia may have the effect that ending a life becomes a ‘treatment option’ for the symptom of unbearable suffering.

24. Respect for dignity: This principle can be interpreted as respecting a person’s wish not to face incontinence and other forms of loss of control, or it can be understood to require absolute respect for innocent human life.

25. In its Report the Select Committee observed that the demand for assisted suicide is particularly strong among individuals whose suffering derives from the *fact* of their terminal illness, not its symptoms. Hence better palliative care would not change their minds. Moreover, such people have ‘strong personalities and a history of being in control of their lives’ (HL 86-I p. 83). A consultant in palliative care argued on the basis of his own experience that those requesting assistance to end their lives tended to be:

people who wish to be in control ... people who are not willing or prepared to engage the issues that may underlie the problems that arise (HL 86-I, p. 23)

26. Respecting their dignity would require, in his view, a range of support services to enable patients to face their fears.

‘The slippery slope’

27. There are several ways in which legalising assisted suicide and/or voluntary euthanasia could be seen as starting down a slippery slope. One is that incremental extensions may occur to the legislation: as currently worded, it applies only to the terminally ill, but the Bill accepted the *principle* that ending life is an appropriate way to deal with unbearable suffering, and there is therefore no reason *in principle* to exclude any person from its application.

28. It could be argued that such legislation sets doctors on a slippery slope away from their traditional tasks of healing and palliating disease towards active assistance in dying and ultimately taking life.

29. Another concern is that the legislation, once enacted, may be subject to elastic interpretation, in the same way as the Abortion Act has been.

30. There may be hidden pressures if terminally ill people know that assisted suicide or voluntary euthanasia are among their options; they may choose to end their lives because they believe that is what those around them want. What people want is informed and shaped by what others want, and a person may want to die because others have ceased to care for him/her.

31. The law may be abused. If it is the case that voluntary euthanasia and assisted suicide are currently being practised illegally, then this legislation may push the boundaries of practice out still further.

32. Finally, there may follow a paradigm shift in which ending a person's life comes to be seen as a therapeutic option to deal with unbearable suffering alongside other treatments.

Palliative care and the hospice movement

33. The World Health Organisation defines palliative care thus:

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (HL 86-I, p. 32f)

34. Clinicians argue that when a person is dying, treatment is not withdrawn or withheld, but rather it is changed to suit the changed circumstances. Dr Nathanson of the British Medical Association observed:

It is a very important reassurance to give, to say that we do not abandon people, that we will always look for what else we can do; and sometimes those solutions are high technology, but very often they are low technology and are about reassurance. (HL 86-I, p. 33)

35. It is widely recognised that hospices usually provide the best setting for palliative care, where the emphasis is placed

upon ensuring that the patient's journey to death is as comfortable and pain-free as possible. Most hospices have a Christian foundation and can often provide profound spiritual care as well as physical care.

36. An important conclusion of the Report is that people need not only to know about palliative care but also to have experienced it if they are to make a realistic choice about voluntary euthanasia or assisted suicide. Unfortunately, even though the UK has led the world in palliative care and the hospice movement, provision remains patchy, particularly for patients facing non-cancer deaths. Currently, at least 100 posts for consultants in palliative care medicine remain unfilled (HL 86-II, p. 135). More research – and dissemination of research results – into pain relief is urgently needed.

Legislation on voluntary euthanasia and assisted suicide in other countries

37. In countries that have legalised euthanasia, the law takes different forms.

38. **Oregon:** The Oregon Death with Dignity Act has been in force since 1997. It applies only to people who have reached the age of majority and are terminally ill. It does not make the requirement that their suffering is unbearable, and it only offers assisted suicide (ie the means by which to kill themselves) in the form of oral medication. Uptake has so far been low: in 1998 the deaths of only 16 people were due to assisted suicide under the Act. Since then the numbers have risen a little, and in 2003, out of a total of 30,000 deaths in the State, 42 died this way. In total since the Act was passed there have been 265 prescriptions of lethal drugs, of which 117 were actually taken (HL 86-II p. 54f).

39. If replicated in the UK on a pro rata calculation there could be around 650 deaths from assisted suicide (HL 86-I p. 83).

40. **The Netherlands:** The Termination of Life on Request and Assisted Suicide (Review Procedures) Act was passed in 2002, but the criminal and supreme courts have since 1973 adjudicated on a number of cases where defendants have invoked, usually successfully, the defence of necessity against a charge of murder. Hence the 2002 Act was a codification of already existing practices built up on the basis of case law.

41. The Dutch law permits voluntary euthanasia as well as assisted suicide. The law explicitly forbids the ending of a person's life without his or her consent. The law is not limited to adults and the applicant does not have to be terminally ill, but he or she must be experiencing 'hopeless and unbearable suffering'. Sixteen million people live in the Netherlands, of whom about 140,000 die each year. About 9,700 requests for euthanasia are made annually, of which 3,800 are met. Of that 3,800, only 300 are assisted suicide. (HL 86-I, p. 60f).

42. If replicated in this country the Dutch experience could lead to around 13,000 deaths a year, of which some 12,000 would result from voluntary euthanasia (HL-I p. 83).

43. **Switzerland:** Article 115 of the Swiss Penal Code prohibits incitement to and assistance with suicide if the guilty party acts from self interest but exempts those who act from entirely honourable motives, such as assisting suicide in order to bring an end to suffering. Anyone, not just doctors, may legally give assistance from such non-selfish motives. Article 114 of the Penal Code makes the killing of a human being upon their earnest request (ie voluntary euthanasia) a criminal offence punishable by imprisonment. These laws were written

in 1937 and introduced in 1942. The law does not restrict assisted suicide to persons living in Switzerland, hence the practice of ‘death tourism’.

44. Most of the people who receive assisted suicide in Switzerland are not directly supervised by doctors but are members of the growing number of ‘suicide organisations’. Up until 1993, EXIT assisted about 30 cases a year, and since then it has dealt with about 100 cases a year. DIGNITAS declared three cases in 2000, 37 or 38 cases in 2001, about 55 cases in 2002 and 91 cases in 2003 (HL 86-I p. 70f).

45. **Belgium:** The Belgian Act on Euthanasia was passed in 2002. It defines euthanasia as ‘intentionally terminating life by someone other than the person concerned at the latter’s request’. Assisted suicide is not included. The patient should have attained the age of majority, the request should be voluntary, well-considered and repeated, and the patient should be ‘in a futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated’. The Act requires the doctor to satisfy him-herself of the durable nature of the patient’s request, and must obtain a second medical opinion. At least a month’s cooling off period is required.

46. From 23 September 2002 to 31 December 2003 there were 239 recorded cases of euthanasia in Belgium, approximately 17 per month. In 2004, 347 cases were reported (HL 86-I, p. 73f).

UK attitudes to assisted suicide and voluntary euthanasia

47. (These figures are all taken from the Select Committee Report (HL 86-I, p. 76ff).

Basic public attitudes have shown a general support for some form of assisted suicide or euthanasia in incurable, unbearably painful circumstances, rising from approximately 70% to approximately 80% between 1987 and 2004. Some correlation is found between views of assisted suicide/euthanasia and certain personal characteristics:

Regular church attendance – more opponents

Race – proponents mainly white

United Kingdom nationality – more opposition in Scotland

Able-bodied – more likely to oppose

Education – proponents often more educationally qualified

Links with other moral issues – opponents are more likely to oppose abortion and to some extent capital punishment

48. In 1995, 70% of Members of Parliament were opposed to legalising euthanasia; in 2004 the opposition had risen to 79%. MPs, arguably, are more accustomed to take into account the wider social implications of changes in the law.

49. Research on the medical profession carried out by the Right to Life organisation in 2003 indicated that 22% would favour legalising euthanasia, while 61% would be opposed. Research commissioned by the Voluntary Euthanasia Society in 2003 and 2004 showed 33% of doctors might favour a change in the law, with support for euthanasia waning between the two years.

50. The Select Committee's own post bag, which was considerable, was nearly equally balanced for and against legalising euthanasia, with a slight majority in favour.

51. In 2003 surveys by the Nursing Times indicated that two-thirds of nurses would favour a change in the law.

52. However, the Select Committee quotes the conclusions of Market Research Services, that ‘research up to this point into public and health sector attitudes to the legalisation of euthanasia is limited in value and cannot be accepted as an authentic account of opinion within the United Kingdom’. (HL 86-I, p. 79).

Conclusion

53. There is clearly scope for more qualitative and quantitative work to be done on the issue of assisted suicide and voluntary euthanasia. In addition, there are resources within the Christian tradition that could be made available more widely. The resolution before Synod allows for the development of the principles and arguments contained in the joint submission and would enable further Anglican contributions to the debate and resources for all those concerned with developments in the UK, in particular for those Christians who are directly involved in the legislative process.

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Mission and Public Affairs Council

June 2005

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Additional reading

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Appendix I

Letter from the Archbishop of Canterbury and the Cardinal Archbishop of Westminster with the Joint Submission of the Church of England House of Bishops and the Catholic Bishops' Conference of England and Wales to the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill

2nd September 2004

Dear Lord Mackay,

Select Committee on the Assisted Dying for the Terminally Ill Bill

We are writing to send your Committee a joint submission from the Church of England House of Bishops and the Catholic Bishops' Conference of England and Wales.

We believe very strongly that respect for human life at all its stages is the foundation of a civilised society, and that the long term consequences of any change in the law to allow euthanasia in limited circumstances would be immensely grave. This is a view shared not just within our Churches, but very widely among those of all faiths and none who share a moral outlook founded on respect for human life and the protection of vulnerable people.

As you know, having considered the evidence and the arguments against legalising euthanasia in great depth, the House of Lords Committee on Medical Ethics in 1994 firmly rejected any change in the law to allow euthanasia. They concluded:

"The right to refuse medical treatment is far removed from the right to request assistance in dying. We spent a long time considering the very strongly held and sincerely expressed views of those witnesses who advocated voluntary euthanasia... Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions." [HMSO, London, 1994, paras 236-7].

We hope and pray that your Committee will reaffirm and endorse that conclusion, given that the strength of the arguments against euthanasia are undiminished, and the empirical evidence of the damaging effects of legalising euthanasia in the Netherlands is even stronger now.

In our submission we have sought briefly to set out what seem to us the key fundamental principles and then we make some

specific points on this particular Bill. We hope your Committee will find it helpful.

With every good wish

Yours sincerely,

Archbishop of Canterbury

Cardinal
Archbishop of
Westminster

**THE HOUSE OF LORDS SELECT
COMMITTEE ON THE ASSISTED DYING FOR
THE TERMINALLY ILL BILL**

**JOINT SUBMISSION FROM
THE CHURCH OF ENGLAND HOUSE OF BISHOPS
AND THE ROMAN CATHOLIC BISHOPS'
CONFERENCE OF ENGLAND AND WALES**

2 September 2004

Foundations¹

1. The arguments presented in this submission grow out of our belief that God himself has given to humankind the gift of life. As such, it is to be revered and cherished.
2. Christian beliefs about the special nature and value of human life lie at the root of the Western Christian humanist tradition, which remains greatly influential in shaping the values held by many in our society. These beliefs are also shared in whole or in part by many people of all faiths and none.

¹ In 1993 we made a joint submission to the House of Lords Select Committee on Medical Ethics considering the question of euthanasia. In presenting some arguments specific to this Bill, we have drawn on and restated a number of principles set out in that original submission, which we believe are just as valid today, and apply equally to the Bill being considered by this Select Committee.

3. All human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement.
4. Those who become vulnerable through illness or disability deserve special care and protection. Adherence to this principle provides a fundamental test as to what constitutes a civilised society.
5. The whole of humankind is the recipient of God's gift of life. Life is to be received with gratitude and used responsibly. Human beings each have their own distinct identities but these are formed by and take their place within complex networks of relationships. All decisions about individual lives bear upon others with whom we live in community.
6. For this reason, the law relating to euthanasia is not simply concerned either with private morality or with utilitarian approaches. This is one of the issues – relatively few in number but fundamental in importance – on which justice calls for a limit to moral or ethical pluralism. A positive choice has to be made by society in favour of protecting the interests of its vulnerable members even if this means limiting the freedom of others to determine their end.

Two arguments for legalising euthanasia

7. There are two considerations which are often appealed to in defence of euthanasia – individual autonomy (the so-called 'right' to die at a time of one's choosing) and welfare (the view that at beyond a certain point some lives are not worth living).

8. In recent years there has been an increasing emphasis on individual rights and self-determination. In the world of medicine, this has had its impact with patient autonomy being accorded an ever higher priority in medical ethics. In the Assisted Dying for the Terminally Ill Bill, the emphasis on autonomy is evident in the way that “unbearable suffering” is given a purely subjective definition: it is suffering “...which the patient finds so severe as to be unacceptable..”. The Bill requires the patient to be informed of alternative responses including palliative care, but the patient must then be helped to die if this is his or her settled wish. The Bill does however restrict its scope to those who are terminally ill, where death is likely to result “within a few months at most.”. But if the principle of autonomy is being invoked to justify the Bill it is difficult to see how this restriction could be defended. The suffering caused by a non-terminal chronic illness, whether mental or physical, may equally be “so severe as to be unacceptable” to those affected. Why should euthanasia not be made available to them too?

9. At this point the second consideration – welfare – comes in. If it is not enough simply for the patient to want euthanasia, then the justification often given is that it is in his or her best interests to die. It is argued that in some situations life has no value, especially if the patient cannot look forward to any improvement and faces a slow and lingering death. But if this is the justification, there is once again no basis for restricting the scope of euthanasia to the terminally ill, or indeed to those making a voluntary request.

10. Both autonomy and welfare considerations can lead in practice to much more widespread euthanasia than was originally envisaged. The submission to this Committee from the Linacre Centre for Healthcare Ethics contains ample evidence of this in the case of the Netherlands where, as they point out “ we see both an extension of euthanasia to those who are mentally ill or ‘tired of life’ and its extension to those who are unable to consent such as infants and young children”.

The limits of autonomy

11. Neither of our Churches insists that a dying or seriously ill person should be kept alive by all possible means for as long as possible. On the other hand we do not believe that the right to personal autonomy is absolute. Patients should not be overtreated, and may reasonably refuse particular treatments as too burdensome. Having said this, life should be respected, whether in oneself or in another; the aim of giving or refusing treatment should never be to make the patient die.
12. The exercise of personal autonomy necessarily has to be limited in order that human beings may live together in reasonable harmony. While at present people may exercise their legal right to refuse treatment (although this may be overridden in special but strictly limited circumstances), the law denies that there is a legal right to die at a time of one’s own choosing. The consequences which could flow from a change in the law on voluntary euthanasia would outweigh the benefits to be gained from more rigid adherence to the notion of personal autonomy. But in any case we

believe (para 6) that respect for the life of a vulnerable person is the overriding principle.

13. The right of personal autonomy cannot demand action on the part of another. Patients cannot and should not be able to demand that doctors collaborate in bringing about their deaths, which is intrinsically illegal and morally wrong.
14. A serious consequence of introducing euthanasia would be to undermine the relationship of trust between doctors and patients. The value attaching to human life implies that the primary duties of doctors caring for those with terminal illness are to ensure their patients are as free from pain as possible, given the information they and their carers request or require to make informed choices about their future lives, and are supported through the personal challenges which face them. But if doctors were allowed in some circumstances to kill their patients rather than care for them, this would inexorably lead to an undermining of trust. Medical treatment would come to be regarded by the vulnerable person as potentially life threatening rather than as conferring benefit.
15. A change in the law to permit assisted dying would also change the cultural air we all breathe, and affect attitudes to older people and those with chronic illness. For example, the law permitting abortion has profoundly changed society's attitude towards the status of the foetus.

Protection of the vulnerable

16. Doctors are rightly concerned to do the best they possibly can for the actual patients in front of them, and so are the families and friends of those who are ill. It is hard to stand back from the trauma of the individual suffering and look at the wider picture; to think about the long-term implications of decisions made under the pressure of individual need. This is why the law has to play its part in providing a framework within which the medical profession can operate. A foundational guiding principle of the current legal framework is that we should not deliberately kill each other.

Palliative care and burdensome treatment

17. Behind many of the arguments in favour of euthanasia lie powerful fears, and in particular the fear that the alternative to euthanasia might be a lingering and painful death, exacerbated by futile and burdensome medical treatment.
18. When death is imminent or inevitable, the withholding or withdrawing of medical treatment that is judged futile or burdensome is both moral and legal today as in the past. Doctors do not have an overriding obligation to prolong life by all available means. Treatment for a dying patient should be 'proportionate' to the therapeutic effect to be expected, and should not be disproportionately painful, intrusive, risky, or costly, in the circumstances. Treatment may therefore be withheld or withdrawn, though such decisions should be guided by the principle that a pattern of care should

never be adopted with the intention, purpose or aim of terminating the life or bringing about the death of a patient. Death, if it ensues, will have resulted from the underlying condition which required medical intervention, not as a direct consequence of the decision to withhold or withdraw treatment.

19. The hospice movement developed from a concern that people should be helped to die with dignity (that is, to live with dignity until they die). This work has enriched not only the lives of terminally ill people but also their carers, volunteers, and health professionals, who have found that caring for those who are dying can be a great source of blessing. Friendship, companionship and above all love are the key characteristics of a good death. Helping people to die well in this way is not the preserve of any particular faith. It is a profoundly compassionate and humane response to the reality of death which we all eventually face.
20. We are concerned that the lessons learned in hospices about pain control, and emotional and spiritual support should be applied throughout the health service to all dying people. This requires that medical personnel remain aware of how advice on pain control may be obtained, seek specialist help where necessary, and that adequate resources are made available for the care of sick and elderly people.
21. We believe that deliberately to kill a dying person would be to reject them. Our duty is to be with them, to offer appropriate physical, emotional and spiritual help in their anxiety and depression, and to communicate

through our presence and care that they are supported by their fellow human beings and the divine presence.

Conclusion

22. It is deeply misguided to propose a law by which it would be legal for terminally ill people to be killed or assisted in suicide by those caring for them, even if there are safeguards to ensure it is only the terminally ill who would qualify. To take this step would fundamentally undermine the basis of law and medicine and undermine the duty of the state to care for vulnerable people. It would risk a gradual erosion of values in which over time the cold calculation of costs of caring properly for the ill and the old would loom large. As a result many who are ill or dying would feel a burden to others. The right to die would become the duty to die.²

² It is noteworthy that the 1994 House of Lords Select Committee members came back from the Netherlands deeply disturbed that some doctors there were not following required procedures. The committee was finally not persuaded that "it is possible to set secure limits on voluntary euthanasia" and remained "concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death... the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support." [paras 238-9].

23. The Bill is unnecessary. When death is imminent or inevitable there is at present no legal or moral obligation to give medical treatment that is futile or burdensome. It is both moral and legal now for necessary pain relief to be given even if it is likely that death will be hastened as a result. But that is not murder or assisted suicide. What terminally ill people need is to be cared for, not to be killed. They need excellent palliative care including proper and effective regimes for pain relief. They need to be treated with the compassion and respect that this bill would put gravely at risk.

2 September 2004

Appendix II

Does a right to assisted death entail a responsibility on others to kill?

Article by the Archbishop of Canterbury, published in The Times Thursday 20 January 2005

In the passionate argument about euthanasia and the law, the thing most immediate to many – perhaps most – people’s minds is the extreme nature of the human suffering for which euthanasia is claimed as the best and most compassionate solution. It is not unfamiliar territory for those who oppose euthanasia on religious grounds. The continuing and costly investment of many religious bodies in palliative care, as well as the day to day experience of the priest or pastor alongside the dying, means that they know as well as anyone what sort of circumstances are being discussed.

Yet there are other factors at work in this argument. Ten years ago, an American court ruled that a terminally ill adult possessed a “constitutionally guaranteed right” to receive medical assistance in ending their life. Interestingly, the court cited discussion about the abortion debate in support, treating the question of assisted dying as a similar example of decisions affecting “personal dignity and autonomy” which the law should make possible.

The ruling was overturned finally. But the language was revealing. Religious opposition to the possibility of medically assisted dying is often seen simply as blind adherence to an absolute prohibition on killing, insensitive to the obvious requirements of compassion. In this connection, though, religious opposition appears also as deaf to the appeal to a

basic right, the freedom to enjoy the maximum control over your circumstances.

Thinking about the issue in relation to arguments over rights may help us to see more clearly some of the pitfalls. Do I have a right to die? Religious believers answer for themselves that they do not. For a believer to say, “The time could come when I find myself in a situation that has no meaning, and I reserve the right to end my life in such a situation,” would be to say that there is some aspect of human life where God cannot break through. It would be to say that when I as an individual can no longer give meaning to my life, it has no value, and human dignity is best served by ending it.

That would be in the eyes of most traditional believers, Christian or otherwise, an admission that faith had failed. It would imply that life at a certain level of suffering or incapacity simply could no longer be lived in relation to God.

Now it is obviously true that for someone who does not share any such belief there is bound to be a different set of values at work. Why should religious people seek to impose their views by holding back a change in the law that respects a significant right and takes wholly seriously the gravity of suffering that can't be remedied or alleviated?

Apart from the obvious answer that no one is seeking to impose anything, simply to persuade legislators in a continuing debate, there is a serious point to register here that does not concern religious believers alone. The religious attitude I have described is a much sharpened acknowledgement of something that everyone, religious or not, needs to reflect about, but which is badly obscured by the language of individual “rights”.

What anyone's life means is not exclusively their own affair. He lives in relation – to others and to a society. At the simplest level, what often most shocks and grieves people who have been close to a suicide is the feeling that someone who has killed himself did not know what he really meant to his friends or family, did not know he was loved and valued. And even when someone who contemplates suicide is confident that he has no friends or families to hurt, we can hardly say that his life is without significance just because he says so; the society he lives in has a view about the worth of human life which can not be mortgaged to how any individual feels.

This argument begins to bite in the present debate because assisted dying involves others in an act of suicide. Someone else has to accept your decision that prolonged life could have no meaning, and to act on that decision. We rightly talk a good deal about the dangers of the elderly and dying being pressurised by relatives or hospitals to take a quick way out that is convenient for others. What about the pressure a sick person who is determined to die places on those around them?

Rights create responsibilities, we often like to say. Does the recognition of a legal right to assisted dying entail a responsibility on others to kill? This is not an academic question. What legal implications could arise around the deliberate frustration of someone's legally secured rights, if relatives or physicians refused to act? And even if it were a matter of complete consent between patient, family and physicians, we should have given legal sanction to the assumption that the meaning of a life is no more than what an individual or a group of individuals decides to give it - an assumption that has wide repercussions for law and culture. The appeal to our sense of compassion in order to justify a change in our legal practice is wholly understandable; but

could it end up undermining just that broad sense of unconditional human worth and value in which compassion itself is grounded?

Euthanasia is best defined as the initiating of a process whose explicit primary aim is to end life. It is not the same as continuing a medical process whose long-term effect may be to reduce the span of life, nor is it the same as embarking on a treatment that offers short-term relief at the cost of possibly accelerating overall decline. These are the commonplaces of palliative medicine. The right to be spared avoidable pain is beyond debate - as is the right to say yes or no to certain treatments in the knowledge of factors such as these. But once that has mutated into a right to expect assistance in dying, the responsibility of others is involved, as is the whole question of what society is saying about life and its possible meanings. Legislation ignores these issues to its cost.

Appendix III

The 1998 Lambeth Conference Resolution on Euthanasia

The 1998 Lambeth Conference report from Section I *Called to Full Humanity* contains an extensive consideration of the issues around euthanasia. These are found on pages 101- 106 of *The Official Report of the Lambeth Conference 1998* (Morehouse: Harrisburg PA, 1999). They provide the background to the following resolution passed by the Conference.

‘In the light of current debate and proposals for the legalisation of euthanasia in several countries, this Conference:

- (a) affirms that life is God-given and has intrinsic sanctity, significance and worth;
- (b) defines euthanasia as the act by which one person intentionally causes or assists in causing the death of another who is terminally or seriously ill in order to end the other’s pain and suffering;
- (c) resolves that euthanasia, as precisely defined, is neither compatible with the Christian faith nor should be permitted in civil legislation;
- (d) distinguishes between euthanasia and withholding, withdrawing, declining or terminating excessive medical treatment and intervention, all of which may be consonant with Christian faith in enabling a person to die

with dignity. When a person is in a permanent vegetative state, to sustain him or her with artificial nutrition and hydration may be seen as constituting medical intervention; and

- (e) commends the Section Report on euthanasia as a suitable introduction for study of such matters in all Provinces of the Communion.'