

Right or duty to die?

The former Lord Chancellor, Lord Falconer, will introduce a bill in the House of Lords next week that would legalise assisted dying. Support for the measure is growing, according to a new YouGov poll, with Christians among those who believe it should be available to the terminally ill



MORE THAN three-quarters of the adult population of Great Britain would like to see a change in the law on assisted dying – and fifty-six per cent of those who identify as Catholic agree, writes *Linda Woodhead*.

One of the reasons for this shift is that the experience of dying has changed. Over the last 150 years or so, death from infection and infectious diseases has largely been replaced by death due to chronic illnesses – and even these are becoming more treatable.

People also have much higher expectations of longevity, good health and control of disease. When suffering occurs, perhaps over a protracted period, we are therefore more likely to find it intolerable than did previous generations.

There is also a growing conviction that individuals have the right to choose when and how to end their lives. Our survey finds that 82 per cent of those in favour of allowing euthanasia give this as their reason, as do 75

per cent of Catholics who support change. Few now think that suffering is natural, God-given or serves a good purpose – thus the second most popular reason for allowing euthanasia is that it is “preferable to drawn-out suffering”.

But 16 per cent of the population think the law should not be changed and 14 per cent don’t know. Among self-identified Catholics the proportion of opponents is 30 per cent and among churchgoing Catholics 42 per cent, with 44 per cent supporting a change. Unlike the issues of sexuality and family, also addressed in the Westminster Faith Debates, our poll finds religion is the only factor that really counts – age and gender make no difference.

Only Muslims say their belief in the sanctity of human life is key to their opposition to change.

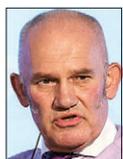
For the general population, including Catholics, it is the possibility that vulnerable people could be harmed which counts most.

The answer that carries most weight – prob-

ably with legislators as well – is that you cannot build in adequate safeguards. People who support euthanasia say they do so for people “with incurable diseases”. But the difficulties of defining what constitutes a disease “worthy of death” are enormous.

In practice, as in Switzerland, allowing assisted suicide is likely to mean allowing it for anyone, including those with depression. But vulnerable people may not be in a good state of mind to know whether they really want to die, and this decision is irrevocable.

■ **Linda Woodhead** is professor of the sociology of religion at Lancaster University. She organised the Westminster Faith Debates with the Rt Hon. Charles Clarke; the debates were funded by Lancaster University, the Arts and Humanities Research Council and the Economic and Social Research Council. The debate on 2 May was the last in the 2013 series. Videos and podcasts can be viewed at www.religionandsociety.org.uk



This debate is not about compassion, autonomy, personal morality or religious conviction, writes *Rob George*.

It is about whether the law should change to protect doctors who supply lethal drugs to terminally ill patients for the purposes of suicide from being convicted. It is not to promote a person’s freedom; they are already free to kill themselves.

Campaigning organisations tell us that people who are terminally ill are dying anyway and helping them on their way is not assisted suicide but “assisted dying”.

This is disingenuous. The fundamental plank of health care for people who are dying from incurable disease is to care for them while they die.

It led to palliative care and the hospice movement and underlies our disturbance at any sign that care of the vulnerable and dying might be wanting. It is a world away from doctors and other clinicians acting in order that they die and being protected by law to take lethal action.

Good law-making rests on what

‘An “assisted dying” law undermines the universal protection of lives’

words mean, not what we might like them to mean. If you die by your own hand, that is suicide; and, if a doctor gives you the means to do that, it is physician-assisted suicide (PAS). Furthermore, having agreed that you are better off dead, the doctor has a duty to succeed. Whether that stops with a prescription, administering a liquid or an injection is merely practical and the false distinctions between modes of ending a life collapse.

We are led to believe that legalised PAS will be accessed by only a tiny number of people; the experience in Oregon and Holland exposes this as fallacy. We are told not to worry as there will be “safeguards” to protect the vulnerable; but this assumes a perfect world in which every seriously ill person is clear about whether they want to die or not, in which doctors respect that, in which all families are loving and caring, and in which society is happy to bear the cost of the care during a natural death. The real

world just isn’t like that.

It also assumes that people who seek PAS will be examined by a reassuring “family doctor” who knows them well. Not so. Most doctors are opposed to PAS and will not touch it.

In Oregon, patients who want assisted suicide often end up being assessed by doctors whom they have only just met. The “safeguards” safeguard nothing other than our sensibilities as they have no defensible foundation once we agree that some people are better off dead.

So why is “assisted dying” being foisted onto a profession that does not want it and considers it both unethical and unsafe? Simple: embedding the practice in health-care bubble-wrap gives an aura of caring compassion, safety and legitimacy.

Are there discriminatory risks? The most obvious is that giving terminally ill people the option of PAS may be seen by campaigners as a reasonable entitlement, but

there’s another perspective. An “assisted dying” law undermines the universal protection of lives. “Assisted dying” confers a “right to die” to some at the expense of a “right of protection” to many.

Take the physician out of assisted suicide and you see it for what it is – giving the means to suicide at best, but at worst protection for anyone with darker motives. Would we not do better to learn from those who have discovered how to transcend suffering and find dignity in the worst of circumstances so that we can all learn how to parry the “slings and arrows of outrageous fortune”? What is worse: not to kill someone who wants to die, or to kill someone who may have more and better living to do?

■ **Rob George** is professor of palliative care at King’s College London and a consultant physician in palliative care to the communities around Guy’s and St Thomas’ Hospitals.



If you wish to research assisted suicide, asking participants about their experience is not an option, write *Sheila Payne (left) and Claudia Gamondi*. In a new research study in Switzerland, we therefore approached family members of those involved; eleven agreed to talk to us.

Assisted suicide is not "legalised" in Switzerland, but it is tolerated if certain conditions are met. One is that the act must be unselfish – no third party must gain. The police are notified of all deaths and appear to carry out a "light touch" investigation. Research suggests that there are approximately 400 deaths by assisted suicide in Switzerland per year, though actual numbers may be higher.

Physicians are not present at the death and their role is limited to prescribing drugs and issuing death certificates. Four main organisations provide assistance in the different cantons. Of these, the only one that provides help to non-Swiss residents is Dignitas. These right-to-die associations have thousands of members, they undertake political lobbying and disseminate information, and they advise people.

Assisted suicide consists in the voluntary ingestion of a lethal dose of a drug, taken with the intention to die. The act must be pursued by the person who wishes to die. Not all assisted suicides are of people with terminal illnesses, though most cases involve people with cancer or progressive neurological diseases. A small

'Relatives we interviewed said that those who sought death did so on the basis of long-standing personal beliefs'

proportion suffer from depression. Family members may be involved in decision-making, helping during the ingestion of the drug, and dealing with the aftermath. There are thought to be about 1,200 such family members per year in Switzerland. Those we interviewed said that those who sought death did so on the basis of long-standing personal beliefs. As one put it: "He had always said, since I was a child, that if he fell ill from a serious illness, he would kill himself." Some reported that, long before diagnosis, the person had told them that they were contemplating suicide in the case of a serious illness.

Many relatives had moral concerns and questioned both whether assisted suicide was right in general, and whether it was right for the person in question. They also debated whether or not to be involved. Some described feelings of social isolation during the decision-making phase and the later bereavement.

But in general our small study suggests that the relatives tended to share the deceased person's values. As one told us: "It is a bad thing,

but I thought: it is better like this ... it is a painless thing, safe, without the worst consequences." Another said: "I'm absolutely happy with what I have done, but at the beginning you have plenty of doubts. In the night, you ask yourself: 'Did I do right? Should I have gone and asked someone's advice? I should have waited a little more ...'"

Contemporary debates around assisted suicide and euthanasia in the UK tend to emphasise the lack of adequate pain management or referral to palliative care as precipitators for hastening the end of life. We found no evidence of this. All the patients in our study were enrolled in a palliative care service and chose assisted suicide despite having access to good symptom control and psychosocial support.

This is similar to research data from the US state of Oregon, which found that 78 per cent of patients who died with assisted suicide were enrolled in a hospice programme. Rather, our study found that those who chose assisted suicide did so not as a result of a lack of alternatives, but from a long-standing commitment to the "cause" of assisted suicide, and out of a fear of dependency and loss of control.

■ **Professor Sheila Payne is director of the International Observatory on End of Life Care at Lancaster University and Dr Claudia Gamondi is consultant in palliative medicine, Oncology Institute of Southern Switzerland, Ticino.**

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