**Briefing on Rob Marris MP’s Assisted Dying Bill September 2015**

**The proposed law**

On 11th September 2015 the House of Commons will debate the Assisted Dying Bill, a private member’s bill put forward by Rob Marris, the MP for Wolverhampton South West. The bill, as drafted by Rt Hon Mr Marris, draws on earlier bills put forward by the Lords Falconer and Joffe.

Mr Marris’s bill provides for competent adults who are terminally ill to choose to be provided with medically supervised assistance to end their own life. The remit of the bill is strictly limited:

“*1 Assisted dying*

*(1) Subject to the consent of the High Court (Family Division) pursuant to*

*subsection (2), a person who is terminally ill may request and lawfully be*

*provided with assistance to end his or her own life.*

*(2) Subsection (1) applies only if the High Court (Family Division), by order,*

*confirms that it is satisfied that the person—*

*(a) has a voluntary, clear, settled and informed wish to end his or her own*

*life;*

*(b) has made a declaration to that effect in accordance with section 3; and*

*(c) on the day the declaration is made—*

*(i) is aged 18 or over;*

*(ii) has the capacity to make the decision to end his or her own life;*

*and*

*(iii) has been ordinarily resident in England and Wales for not less*

*than one year*.”[[1]](#endnote-1)

Having set out the remit of the bill, the next section defines some of the terms used:

“*2 Terminal illness*

*(1) For the purposes of this Act, a person is terminally ill if that person—*

*(a) has been diagnosed by a registered medical practitioner as having an*

*inevitably progressive condition which cannot be reversed by*

*treatment (“a terminal illness”); and*

*(b) as a consequence of that terminal illness, is reasonably expected to die*

*within six months.*

*(2) Treatment which only relieves the symptoms of an inevitably progressive*

*condition temporarily is not to be regarded as treatment which can reverse*

*that condition.*”[[2]](#endnote-2)

Once a declaration has been made by someone to request assisted suicide, the declaration must be countersigned by the attending doctor who knows the patient and is familiar with their condition, and by an independent doctor who is unconnected with either the case or the attending physician. Both of these doctors must be satisfied that the person making the request is terminally ill, has the capacity to make the decision to end their own life, and has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress.[[3]](#endnote-3)

In addition, in deciding whether to countersign a declaration under subsection (3), the attending doctor and the independent doctor must be satisfied that the person making it has been fully informed of the palliative, hospice and other care which is available to that person. The doctors are empowered by the bill to refer the patient to a specialist, should they suspect that the patient lacks the capacity to make a competent decision.[[4]](#endnote-4)

Provision is made for the patient to revoke the declaration at any time, and this revocation must be implemented whether or not it is made in writing. Where the patient does not revoke the declaration, they will be given the lethal medication and any medical devices they might need with which to administer it, and it is then up to the patient to take the medication and end their own life. The bill does not provide for the physician to administer the lethal medication; only the patient is authorised to administer it to him/herself. The doctor is required to remain with the patient until the medication has been taken and the patient has died, or until the patient has decided not to take the medication. However, “remain with” can be interpreted as being somewhere in the vicinity, not necessarily at the patient’s bedside or even in the same room.[[5]](#endnote-5) No medical practitioner can be obliged to assist a death if their conscience precludes them from doing so.

The remainder of the bill deals with practical matters such as how the medications should be safely stored, transported and delivered, what should be inscribed as cause of death on the death certificate (“assisted death”), what codes of practice and monitoring should be associated with the proposed new law and what constitutes an offence.

It would be an offence, under this law, to make a false declaration purporting to be by someone else, or to conceal a declaration in which someone had requested an assisted suicide, or to provide a false or misleading medical opinion in respect of such a declaration.[[6]](#endnote-6)

Where a false declaration is made purporting to be by someone else with the intention of bringing about that person’s death, the offence would be punishable by life imprisonment. All other offences under this law would be subject to fines or terms of imprisonment of between six months and five years maximum.

Any reasonable person reading this might conclude that the remit of the bill is very narrow, the safeguards extensive, and the exclusion on conscience grounds fair and just. The questions remain, would there be any danger of the remit being extended, and are the safeguards adequate? The bill, as drafted, presupposes that assisted suicide is a tidy and effective solution; but is that assumption underpinned by good evidence?

To answer these questions, we can look at other places where similar laws have been enacted.

**The situation in Holland**

Euthanasia remains illegal in Holland even today. But since 2001 it has been decriminalised for the medics who practise it (and even before that the practice was to overlook it) provided certain criteria are observed. The person requesting it must be conscious, mentally competent and in unbearable pain. The request must be voluntary and made or reiterated after all other palliative options have been explained and the patient given time to consider them. More than one person must be involved in the decision, and there must be no other solution to the unbearable pain.[[7]](#endnote-7) The fact that a patient had received euthanasia must be promptly reported to the proper authorities by the physician.

These terms sound very narrow. But in the thirty-four years since they were set out by a Rotterdam court they have been interpreted in ever-broader ways. “Unbearable pain” was only ever intended to refer to physical pain, but it has now been extended to include “psychic suffering” and “the potential disfigurement of personality”.[[8]](#endnote-8)

Euthanasia was explicitly specified in the ruling to be voluntary. And yet in the ten years following this ruling, the following instances of euthanasia were recorded in Holland:

* 2,300 people died as the result of doctors killing them upon request .[[9]](#endnote-9)
* 400 people died as a result of doctors providing them with the means to kill themselves.[[10]](#endnote-10)
* 1,040 people died from involuntary euthanasia, meaning that doctors actively killed these patients without the patients’ knowledge or consent.[[11]](#endnote-11)
* 14% of these patients were fully competent.[[12]](#endnote-12)
* 72% had never given any indication that they would want their lives terminated.[[13]](#endnote-13)
* In 8% of the cases, doctors performed involuntary euthanasia despite the fact that they believed alternative options were still possible.[[14]](#endnote-14)
* In addition, 8,100 patients died as a result of doctors deliberately giving them overdoses of pain medication, not for the primary purpose of controlling pain, but to hasten the patient’s death.[[15]](#endnote-15)
* In 61% of these cases (4,941 patients), the intentional overdose was given without the patient’s consent.[[16]](#endnote-16)

(statistics and references from <http://www.patientsrightscouncil.org/site/holland-background/>)

These figures exclude thousands of other cases, also reported in the study, in which life-sustaining treatment was withheld or withdrawn without the patient’s consent and with the intention of causing the patient’s death.[[17]](#endnote-17)

A further study of the Dutch model has also confirmed what many suspected to be the case, that where euthanasia is legal and state-funded, investment in good palliative care facilities diminishes.[[18]](#endnote-18)

In addition to these known euthanasia deaths, there is evidence of Dutch doctors falsifying death certificates to indicate that deaths were natural rather than assisted, making it almost impossible to judge the true figures for deaths from euthanasia.[[19]](#endnote-19)

The current position on euthanasia in Holland is that recorded euthanasia deaths since 2006 have been rising by around 15% per year. Around 20% of requests are refused and 38% carried out. Of the remainder, some are withdrawn and some patients die while the requests are still being considered or the arrangements made.[[20]](#endnote-20)

In July 1992, the Dutch Paediatric Association issued guidelines to allow doctors to estimate what a disabled newborn’s quality of life was likely to be and, if below a certain level, to kill the infant.[[21]](#endnote-21) What is certain is that today 3% of all deaths in Holland result from euthanasia, and some estimates put unreported cases at more than 12%, since official figures do not include deaths by terminal sedation, where patients are rendered unconscious before they food and fluids are withdrawn, an act often referred to as ‘euthanasia by omission’.[[22]](#endnote-22) Initially, only 10% of requests for euthanasia were for reasons other than terminal cancer, but that figure has now increased to 25%.[[23]](#endnote-23)

Dr Theo Boer, who teaches ethics at the Protestant Theological University in Groningen and spent nine years on one of the regional euthanasia evaluation committees, believes that euthanasia, which was originally introduced to protect doctors, quickly came to be regarded as a patient’s right. “*The debate has changed. Euthanasia is no longer a last resort. It was originally seen as a law that gave doctors rights rather than patients. But we very frequently hear it discussed in terms of a patient’s right to euthanasia.*”[[24]](#endnote-24) For example, a businessman who becomes bankrupt could argue that his financial situation is causing him unbearable pain and could request euthanasia as a result.[[25]](#endnote-25) Euthanasia, originally available only to competent adults, is now available to children from aged 12 with parental consent, and from age 16 with parental involvement in the discussion, but not necessarily their consent. There are people in Holland calling for it to be extended to children under 12.

Dr Boer fears that before long euthanasia will come to be seen as the right of anyone over 70, no questions asked, and that there is a growing phenomenon of “duo-euthanasia” where the partner of a terminally ill patient asks to die with them because they cannot face the thought of life after the person has gone.[[26]](#endnote-26) There has even been one case of an eighty year old woman whose family requested assisted dying for her, but doctors refused on the grounds that she lacked the mental capacity to take the decision herself. The woman’s GP, the management of her care home, and her psychologist all supported this decision and requested an independent report into her condition. A judge sitting in emergency session overruled them all, and she was killed by a lethal injection the next day.[[27]](#endnote-27)

**The situation in Oregon**

In the US state of Oregon, physician-assisted suicide has been legally permitted since 1994. This law allows terminally ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications.[[28]](#endnote-28) Since then, the number of such prescriptions issued has risen from 24 in 1998 to 122 in 2013, and the number of those prescriptions actually used to procure deaths has increased from 16 in 1998 to 71 in 2013. Between 1997 and 2013 there were 752 such deaths in the State of Oregon.[[29]](#endnote-29) The majority of these patients had cancer, were over 65 and died at home, although some were as young as 42.[[30]](#endnote-30)

These figures show show that once assisted dying is permitted for the very few to whom it might be seen as desirable, it is only a matter of time before the numbers escalate. In addition, since the law permits these lethal drugs to be self-administered without the oversight of a doctor, there is absolutely no way of telling how many people make a free choice to end their lives in this way versus the number for whom this is an additional means of elder-abuse.

If such a possibility seems repugnant or far-fetched to most of us, it’s worth considering the experience of Baroness Finlay of Llandaff, a palliative care consultant and president of the British Medical Association, in the UK:

“*Jenny (not her real name) was a week or so short of her sixtieth birthday when she came into the hospice. She had advanced cancer and she, and her family, knew the end was close. And her family were devoted. Not a day went by without one or more of them at her bedside.*

*We stabilised Jenny’s condition; she was comfortable, more independent and able to have quality time with her family. And, as often happens with good palliative care, the prospect of her imminent death receded. Then came her birthday. It was a muted affair, but understandably so as it was clearly her last.*

*But then the family visits gradually fell away. ‘It’s a pity your family can’t come so often these days,’ one of the nurses said to Jenny. ‘Oh,’ she replied. ‘They won’t be in so much now. You see, my fixed-term life insurance expired on my birthday.’*

*This isn’t the only time I’ve been fooled. Most patients’ families are loving and caring. But sadly some are not, and they are not the rare exception.*”[[31]](#endnote-31)

Most of the assisted deaths in Oregon are of white, middle-class, retired people – precisely the ones whose heirs are likely to benefit substantially from their deaths. This immediately makes a whole class of older people extremely vulnerable, and there is little in Mr. Marris’s bill to prevent this kind of pressure being put on elderly people out of sight of the physician.

Moreover, in Oregon which does not have a UK-style National Health Service, there have been some well-publicised cases of health insurance companies offering patients euthanasia as an alternative to cancer treatment.[[32]](#endnote-32) Here in the UK, where our hospitals are increasingly under financial pressure and some are close to financial collapse, the temptation to suggest, persuade or induce patients to accept an assisted suicide as an alternative to costly treatment is immediately evident. Only the most naïve person would tell himself that this will not happen if this law is passed. Already in the UK, healthy young people with a normal life expectancy are regularly told that it is an NHS requirement that at every annual review they should be invited to have “Do Not Resuscitate” written on their medical notes simply because they have a disability.[[33]](#endnote-33) So we would be foolish to think that death would not be considered as a cost-cutting measure; clearly it already is.

One wife in Oregon describes taking her seriously ill husband to the doctor: “*I collapsed in a half-exhausted heap in a chair once I got him into the doctor’s office, relieved that we were going to get badly needed help (or so I thought).*

*“To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. ‘Think of what it will spare your wife, we need to think of her’ he said, as a clincher.*

*“Now, if the doctor had wanted to say ‘I don’t see any way I can help you, knowing what I know, and having the skills I have’ that would have been one thing. If he’d wanted to opine that certain treatments weren’t worth it as far as he could see, that would be one thing. But he was tempting my husband to commit suicide. And that is something different.*

*“I was indignant that the doctor was not only trying to decide what was best for David, but also what was supposedly best for me (without even consulting me, no less)*.” They changed doctor and her husband lived for a further five years.[[34]](#endnote-34)

You might suppose that having a legal route to assisted suicide might decrease the general suicide rate among ill and depressed people, but no such effect has been observed either in Oregon or in Holland.

In Oregon, most assisted suicides are carried out by means of the drug Pentobarbitol, the same drug that is used in the USA for executions of prisoners sentenced to death. Because European countries object to the death penalty, they have stopped supplying the drug to the USA, where it is now almost impossible to get hold of. The main assisted suicide advocacy group which drafted the original law, Compassion and Choices, is proposing to have a pharmacy in Oregon licensed to manufacture the drug, which Compassion and Choices would then distribute to doctors for prescription to patients who have requested an assisted suicide. Thus the same company which drafted and promoted the assisted suicide bill is likely to be in the position of profiting financially from the distribution of the lethal drug – surely a position inherently open to abuse where it is in a company’s financial as well as ideological interest to continue to increase the number of assisted suicides.[[35]](#endnote-35)

Although one of the criteria for eligibility is that the patient is expected to die within six months, figures from Oregon show that in 2013 eight patients died after taking lethal drugs prescribed for them in 2011 and 2012.[[36]](#endnote-36) In other words, the estimate of less than six months life expectancy was wildly inaccurate in a significant number of cases.

**The situation in Belgium**

Belgium has the world’s most liberal laws on physician-assisted suicide. One need not be terminally ill, nor an adult, to qualify. More than 1800 Belgians chose to die by this method in 2013. Many of these were experiencing the kinds of depression and psychiatric illnesses which would be regarded as amenable to treatment in the UK. After performing euthanasia, a doctor is required to file a report to a Euthanasia Commission composed of eight lawyers and eight doctors, explaining what action (s)he took and why. The Commission reviews each case to ensure that it complied with the law and if not, potentially the physician could be subject to a charge of homicide.[[37]](#endnote-37) However, all that is required is a piece of paper containing the patient’s name and signature, the date and the words, “I want euthanasia”.[[38]](#endnote-38)

Tom Mortier, whose severely depressed mother died by euthanasia, unbeknown to her family, in a Brussels hospital, is challenging Belgium’s euthanasia law in the European Court of Human Rights. He says that part of the cause of her depression was her estrangement from her son, and that had an attempt been made to contact him and put him back in touch with her, she would probably not have opted for euthanasia. His lawyer points out that she was offered death rather than treatment.[[39]](#endnote-39)

The original law passed in 2002 provides that the person requesting euthanasia must be an adult, making a voluntary, well considered and oft-repeated request which does not result from external pressure and is in “*a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident.*”[[40]](#endnote-40)

From this it can be seen that a huge leap has been taken from people whose cases are “*medically futile*” and “*incurable*” to a woman who is depressed over her family breakdown and is offered death in preference to treatment. Nor did the Belgian law stop there. In 2014 it was amended to extend the right to euthanasia to children. In the four years to 2013 the number of people dying by euthanasia increased by 89% and now represents 1.7% of all Belgian deaths.[[41]](#endnote-41)

**The situation in Switzerland**

Assisted suicide has been legally condoned in Switzerland since 1918, and does not have to be carried out by a doctor provided no self-interest is involved[[42]](#endnote-42), but records are not available for the period prior to 1998. From 1998 to 2009 the numbers rose from 43 to 297 per year, with women accounting for 55% of cases.[[43]](#endnote-43) By 2012 this figure had risen to 508[[44]](#endnote-44). (These figures only include Swiss nationals, and do not take account of foreigners, including one Briton per fortnight, coming to end their lives at the Dignitas clinic[[45]](#endnote-45)).

The law permits anyone to provide someone with the means to commit suicide but stops short of allowing a doctor to carry out euthanasia on a patient. In principle Swiss law provides for an assisted suicide only if the person has a terminal illness, but there have been reports of assisted deaths in the Dignitas clinic of people whose clinical diagnosis was depression.

**Ethical gradualism**

I have not been able to find one solitary example of a country where assisted dying has been legalised in which this has not opened a floodgate to an ever-rising tide of deaths from this cause. No matter what safeguards have been put in place, a gradual erosion of ethical standards has taken place resulting in constant widening of the eligibility criteria for an assisted death. In the majority of cases this has taken place not by enacting new laws but simply by stretching the definitions of the terms included in the existing laws.

There are other concerns regarding a gradual slide in ethical standards. The case of Compassion and Choice profiting from the sale and distribution of lethal drugs while it pushes a pro-euthanasia agenda on the public should give us pause. We already know that in the UK drug companies offer inducements to NHS personnel in the hope of increasing sales of their drugs. In fact, in 2013 an undercover investigation found that dozens of NHS officials in control of medicines budgets were being paid thousands of pounds by drug companies.[[46]](#endnote-46) The potential for a profitable and persuasive euthanasia industry to spring up as has happened with the abortion industry in this country means that many of the safeguards in Mr Marris’s bill would not be worth the paper they are written on.

Already the debate in this country has progressed beyond the right to die, to the duty to die. In 2008 Baroness Warnock, arguably our leading moral philosopher, surprised many people when she asserted that pensioners in mental decline who require a lot of care are “*wasting people's lives*” and should be allowed to opt for euthanasia even where they are not suffering pain. She saw nothing wrong with people being assisted to die for the sake of their loved ones and of society, and said that she hoped people would soon be “*licensed to put others down*” where those others were no longer able to look after themselves. Her comments related particularly to dementia sufferers, of whom she said, “*If you're demented, you're wasting people's lives – your family's lives – and you're wasting the resources of the National Health Service.... Actually I've just written an article called 'A Duty to Die?' for a Norwegian periodical. I wrote it really suggesting that there's nothing wrong with feeling you ought to do so for the sake of others as well as yourself.*”[[47]](#endnote-47) With such views informing the public debate, it is in vain to hope that we alone of all the countries who have tried it would be able to contain the effects of an assisted dying law within its original narrow confines. Parents like myself, who have disabled sons and daughters lacking the mental capacity to take their own decisions in these matters have real reason to fear for our youngsters’ safety once we are no longer here to fight for them.

It should come as no surprise, then, that it is the “worried well” who support this law, those who have not personally experienced a life-threatening condition and fear that if it happened they could not endure it. By contrast, this bill is opposed by all the UK’s major disability organisations, which represent those who have experience of pain, weakness and limitation and have found the joy of living nonetheless.

**The efficacy of assisted suicide**

According to a BBC report,[[48]](#endnote-48) attempts at assisted suicide fail to lead to an easy death in almost one in five cases. There is evidence from Holland and Oregon of supposedly fatal doses leading to nothing other than gasping, vomiting and comas from which the patient later recovered. The report quotes Dutch doctor Johanna Groenewoud: “*Patients who wish to receive help in dying face a small but nevertheless worrisome possibility that some untoward event will prevent the accomplishment of their wish*.” In 6% of cases, patients either experienced an unexpectedly lingering death or awoke from a coma that was supposed to have been fatal. 7% of cases led to technical complications or unanticipated side effects, and problems were so frequent that doctors felt compelled to intervene in 18% of cases.

Another Dutch doctor, Pieter Admiraal, concurs with this view: “*In spite of these measures, every doctor who decides to assist in suicide must be aware that something can go wrong, with the result being a failure of the suicide. For this reason, one should always be prepared to proceed to active euthanasia. In other words, the doctor should always have at hand thiopental and muscle relaxant.*"[[49]](#endnote-49) Since the proposed UK law provides only for assisted suicide and precludes active euthanasia, it is clear that a significant number of cases – possibly as high as 18% - would turn out to be failed suicides. This is quite apart from the case of patients who lack the physical capacity to end their own lives, even with assistance, as was the conclusion of a study by scientists from the Netherlands: “*...if physician-assisted suicide is legalised but euthanasia is not, some competent patients may not be able to end their own lives for purely physical reasons, as in the case of patients with neurologic illnesses who have problems with swallowing or using their hands and patients who are physically too weak to take all the oral medication themselves*.”[[50]](#endnote-50)

If problems of this magnitude were known to be associated with any normal medical procedure, I am fairly sure it would have been widely reported in the press and patients would be wary of the procedure. In one case in Oregon, after a man took the prescribed dose of lethal drugs, physical symptoms were so disturbing that his wife called 911. He was taken from his home to a hospital where he was revived.[[51]](#endnote-51) Yet I have never heard these risks mentioned by proponents of assisted suicide.

**The arguments against assisted death**

As mentioned above, it is generally the “worried well” who favour assisted suicide, armed with a scant handful of stories of extreme cases. Meanwhile, people with experience of the daily discomfort of limiting physical conditions fear any relaxation in the laws designed to protect them when they are at their most vulnerable. Debbie Purdy brought a case to Court to be allowed an assisted death before her symptoms became unbearable, something the court was unable to allow. Dr Kevin Fitzpatrick OBE puts his finger on why this was the right decision:

“I met and debated with Debbie Purdy a couple of times and I thought she

was wrong - she made what is called a ‘category mistake’ –mixing up the category of one individual saying ‘I want to die now’ with the idea that such a wish must be enshrined in law. Individual wishes are just that – individual. Laws cover every citizen of a state or jurisdiction in which they are passed - which means they are a whole different category. It was her campaigning for this category mistake to be legalised that brought us into opposition. “[[52]](#endnote-52)

In the same article, Dr Fitzpatrick makes the point that three prominent campaigners for assisted death, all of whom were terminally ill themselves, have recently died a good death, peacefully, in palliative care or hospice settings, proving that there is no need for the change in the law for which they campaigned, nor for the fear which prompted their campaigns.[[53]](#endnote-53)

One compelling argument against physician-assisted dying is that it changes the fundamental relationship of trust between doctor and patient. The one essential thing which has always distinguished the medical physician, bound by the Hippocratic Oath, from the quack and the Shaman, is the absolute undertaking to use their powers only to heal and never to do harm. Assisted dying immediately destroys this foundational principle. If we think it might have little effect in practice, we need only look, once again, to Holland, where over 10,000 people carry "anti euthanasia passports" because they are afraid of being killed without their consent.[[54]](#endnote-54)

Another supporter of these arguments is Liz Carr, the actress and comedian. She begins her article by stating, “*I’m not religious, I’m not anti-choice and yet I, along with many other disabled people who are involved in the international organisation Not Dead Yet, oppose the legalisation of assisted suicide.*”[[55]](#endnote-55) Ms Carr goes on to explain her view that Mr Marris’s bill, if passed, would lead to some people’s lives being ended, without their consent, through mistakes or abuse which could never be undone. She maintains that we should have not an assisted dying bill but an assisted living bill. And she rightly reminds us that the only effective safeguard that has ever been found against such mistakes and abuses is not to have an assisted dying bill.

Pointing out that The British Medical Association, the Royal Colleges of Physicians, General Practitioners and Surgeons, the Association for Palliative Medicine and the British Geriatric Society all oppose this bill, she asks, “*Against a backdrop of longer shifts, difficulty in obtaining appointments and the rationing of certain treatments, should we really be pushing further pressures onto our reluctant doctors?*”[[56]](#endnote-56)

Disputing that this bill would lead to greater choice, she reminds us that many people who wish for a hospice place or to die at home are denied their wish, and more people die in hospital in the UK than in most other European countries. She therefore suggests that we should do more to give people the natural death they wish for before we start ploughing our resources into ending their lives instead. Her final and most compelling point is that safety of the many must take precedence over the wishes of the few.

Those who advocate assisted dying usually see the issues as ones of autonomy and control. We ought to have the right to decide what we want to happen at the end of our life, and we ought to have the right not to be subject to circumstances beyond our control. The majority of those who speak like this are speaking hypothetically, without experience of what the end of life is actually like. Baroness Finlay, on the other hand, has spent her entire career at the side of those who are dying, and this is what she has to say:

“*Laws on ‘assisted dying’, like the one tabled by Lord Falconer and debated last year in Britain’s House of Lords, are written as if everyone is a strong-minded, no-nonsense individual and never susceptible to depression or influence or doubt. But I must tell you, most patients facing an approaching death just aren’t like that. They are struggling to come to terms with their mortality, veering between hope and despair and back again, worried about the impact of their illness on those around them and trying to make sense of what is happening to them. In a word, they become vulnerable.*”[[57]](#endnote-57) She goes on to emphasise that many people who support assisted dying lack the imagination to project themselves into a situation where they might be, for example, tempted to coerce someone for unscrupulous reasons.

Baroness Finlay has abundant experience on which to draw; she has had plenty of encounters with terminally ill patients who thought they wanted to die, who would have met the criterion of having a “settled intent” to die, but with the right care and attention recovered their zest for life.

Finally, she makes the powerful point that laws are not simply instruments of regulation: “*They send social messages.  As a society we are clear that suicide is not something to be encouraged or assisted. Legalising assisted suicide flies in the face of that.  It sends the message that, if you are terminally ill, ending your life is something that society endorses and that you might want to consider.*”[[58]](#endnote-58) And she concludes by asking if that is the kind of society we really want to live in.

**A Christian response**

It has always been a Biblical principle that all people are made in the image of God. In the Old Testament murder was seen as a more serious crime than any other not merely because of its far-reaching consequences but because the gravity of taking a life had a spiritual quality to it – in some way it polluted the land (some translations say made the land unholy).[[59]](#endnote-59) There was something sacred inherent in being human.

To the six million Roman Catholics living in the UK, the Catechism of the Catholic Church speaks unequivocally on this topic:

“*Human life is sacred because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the creator, who is its end. God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being*.”[[60]](#endnote-60)

“*Human life must be protected and respected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person – among which is the inviolable right of every innocent being to life*.”[[61]](#endnote-61)

Jean Vanier affirms that what makes us human is not our productivity or our self-sufficiency but our capacity to be loved – by other people of course, but above all by God. He applies this specifically to people with profound disabilities, the very ones whom this proposed law would endanger: “People with disabilities are so different from one another. What is absolutely certain is that their fundamental need is to be loved, and to enter into relationships…. But what is the most important is this incredible capacity for friendship and love, and the way they can throw themselves into our arms and be as they are, simple and loving.”[[62]](#endnote-62)

The Church of England’s national director on medical ethics, Rev Dr Brendan McCarthy has put out a very helpful analysis of the proposed law from a Christian point of view.[[63]](#endnote-63)

Like Baroness Finlay, he believes that this change in the law would damage both the protection for vulnerable individuals and the nature of our society. He emphasises that even when people have lost the sense of the value of their own lives, this does not diminish the intrinsic value that they have as a human person. This is a principle fundamentally embedded in our laws, and to alter it would alter the very values on which our society is built.

The fact that at times these people might need to be cared for at the cost to others of some sacrifice is simply a manifestation of the compassionate nature that characterises us as humans. Dr McCarthy recognises the impotence of the safeguards in this law to prevent all abuse. Such safeguards have not prevented the escalation of incidences of assisted suicide in every other country where they were introduced to cater for the tiny minority who wished to benefit from them. Nor have they prevented those laws from being used to despatch inconvenient elderly or incapacitated people by those who stand to benefit from the death. He concludes by calling for us to put our energy and resources into best-quality palliative and end of life care.

**What you can do**

I attended a talk last Friday given by Fiona Bruce MP. She told her audience that many MPs simply do not have a view on assisted dying, and are waiting to see what representations they receive from their constituents. So one of the most influential things you can do is email your MP[[64]](#endnote-64) and urge them to turn up for the debate on Friday and vote against the bill.

If you are of an activist bent, and you are able to get to London, Not Dead Yet are appealing for people to join their protest outside the House of Commons during the course of the debate.[[65]](#endnote-65)

Finally, and most importantly, pray. A battle is going on for the heart of our nation, and as George Müller once said, “*The greater the difficulty to be overcome, the more will it be seen to the glory of God how much can be done by prayer and faith.*”[[66]](#endnote-66)

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7. <http://www.patientsrightscouncil.org/site/holland-background/> [↑](#endnote-ref-7)
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9. Medical Decisions About the End of Life, I. Report of the Committee to Study the Medical Practice Concerning Euthanasia, The Hague, September 19, 1991 [↑](#endnote-ref-9)
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