



Physician Assisted Suicide (PAS) paper with appendices

1 Definitions of euthanasia and physician assisted suicide

Euthanasia and Physician Assisted Suicide are similar in that the goal is premature death. The mechanisms may also be similar but in euthanasia the death is brought about by the specific action of another person, usually a doctor, whereas in PAS the doctor assists in setting up the process, but the patient actually triggers the injection or swallows the lethal agent which has been provided.

PAS carries the protection that the patient is the one who initiates the final event, whereas euthanasia does not carry that safeguard. (See Appendix 1)

2 Sanctity of life

In view of the fact that the most Methodists are likely to be broadly in agreement about the theological issues, the details of the reasoning have been placed in Appendix 2. This is not to suggest that the theology is unimportant. For us as Methodists it is very important. However, our argument is more broadly based so that it does not depend solely on our theological convictions. (See Appendix 2)

3 Changing attitudes of doctors.

The medical graduates of Great Britain and Ireland in the 1950s were mostly asked to swear the Hippocratic Oath. In this they promised neither to suggest euthanasia nor assist in it. They also promised not to carry out an abortion.

Hastening death was rarely discussed in the past although it was practised discreetly, essentially as a by-product of symptom relief, but only in the terminally ill who would, in any event, be dead within hours. Euthanasia, and its close cousin PAS, are still illegal and the majority of surveys of medical opinion indicate that most doctors do not want either to be legalised. The British Medical Association and all the Medical Royal Colleges have expressed opposition to PAS. (See Appendix 3)

4 The Legal Position

a) Republic of Ireland

The current legal position in the Republic of Ireland is that in 1993 the law against suicide was rescinded (and had not been used for many years previously). Assisting someone to commit suicide remains illegal. Article 40 of the Constitution guarantees the right to life, and by extension the right to die a natural death. Currently there is little public debate on the issue of PAS but a



High Court ruling was given on January 10th refusing to allow assisted suicide in a woman terminally ill with Multiple Sclerosis. This decision has gone to Appeal in the Supreme Court and a hearing is pending.

b) United Kingdom

The Suicide Act (England and Wales) of 1961 and the Criminal Justice Act (Northern Ireland) of 1966 stated that it was no longer an offence for a person to commit suicide. This meant that in the event of an unsuccessful suicide attempt, the person in question would not be charged with a criminal offence.

Importantly however, the same Act states that “a person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence and shall be liable on conviction to imprisonment for a term not exceeding fourteen years.”

In 2010 Keir Starmer Q.C., Director of Public Prosecutions (UK) issued guidelines outlining factors that would be taken into account when deciding whether or not to prosecute a suspect for assisting a suicide. This did not constitute a change in the law. Rather it acknowledged that in some circumstances of assisted suicide, it may not be in the public interest to bring about a prosecution for the offence e.g. the victim had a clear, settled intention to commit suicide, the suspect was wholly motivated by compassion and the assistance in the suicide was only minor.

There have been numerous bills brought to the UK Parliament in the last decade, every one of which has been rejected.

UK law has made provision for Advance Directives, or Living Wills, whereby one can nominate someone with an enduring Power of Attorney who will have the legal authority to make decisions on behalf of someone who has lost mental capacity. The person with Power of Attorney should be familiar with the predetermined views of the now incompetent patient and may make such decisions as discontinuing feeding in apparently medically hopeless situations.

5 Implications of Physician assisted suicide (PAS)

a) Implications for the terminally ill

Changing the law on PAS is likely to cause major changes in attitude and behaviour and we need to consider the implications for the terminally ill.

The right to die has been present since attempted suicide ceased to be a crime in England and Wales in 1961 and Northern Ireland in 1966. What is now being requested is the right to be assisted in committing suicide, which, at present, is illegal. The recent proposals contained the supposed safeguards that the illness is terminal, that death is expected to occur within 6 months, that the present



suffering is intolerable, and that the request has been thoroughly considered and is not impulsive.

The immediate responses to these safeguards are first, that the diagnosis may not be correct. Secondly, the accuracy of the prediction of when death will occur is even worse. Thirdly, with proper terminal care, intolerable suffering should be very rare. Certainly control of pain, nausea and anxious restlessness ought to be possible in almost everyone who is terminally ill, given the resources and motivation by the carers. Finally, many people who express the desire to die, change their minds on further reflection. It is generally accepted that there is an association between malignant disease and depression and, untreated, the depression may be a contributing factor in the request.

However, as the Law stands, although there is a right to die, there is no right to be killed, or assisted in bringing about one's own death. Nonetheless, to correct a misunderstanding, it is important to remember that even the totally dependant do have the right and the option of unassisted suicide, by refusing food and fluids.

If the law were to be changed to allow PAS, the management of every patient with advanced malignancy would have to be altered to include informing the patient that PAS is one of the treatment options. Failure to do so would amount to a failure to obtain fully informed consent to treatment.

The effect on the feeling of worth in those where one of the options is PAS would be considerable. The fact that there is a right to die could easily be interpreted as a duty to die and as pointed out elsewhere, to allow choice is effectively to impose choice.

There are few, if any, more vulnerable people than the terminally ill and it is essential that those who make our laws bear in mind that what is made a right for some could well, under pressure, become a duty for others.

If PAS were to be legalised, it would be administered by a doctor so that the person whose illness is becoming demanding and time consuming may well live in the fear that the doctor will bypass the requirement that PAS must be requested. The experience in the Netherlands has shown that a considerable number of those whose lives are terminated have neither requested this nor consented to it. This would not be good for the trust which is required at the end of life. The generally accepted role of doctors is to treat illness where they can, and to deal energetically with the symptoms where they cannot, not to dispose of the lives of the sufferers.

b) Implications for the mentally ill.

Society as a whole makes fervent attempts to reduce suicides. This can be seen in the large expense in mental health services and mental health legislation which occasionally allows for people who are notably depressed and at risk of suicide, to be detained in hospital for their own safety. We can therefore say that



legislating to legalise suicides would, to some extent, go-against-the-grain of our society's ethics.

Implementing and legislating for assisted suicide is fraught with difficulties and this is pertinent in the case of mental disorder as shown in the following hypothetical example.

A middle aged man presents requesting assisted suicide after many years of suffering with a depressive disorder, living with inner despair. Turmoil has become routine for him despite the best efforts of local mental health services. Let us suppose that assisted suicide had been legalised for terminally ill individuals with physical health problems. Would we not be obliged to acknowledge that mental suffering can be at times as intense as physical suffering? Even though this man with severe depression is not terminally ill, he could reasonably argue that he faces many years of suffering and therefore his wish for assisted suicide is more pressing than the terminally ill individual who faces a somewhat shorter amount of suffering.

Thus we can see that if assisted suicide is legalised for the terminally ill, it would be difficult to refuse assisted suicide to the severely mentally unwell individual of any age who is not terminally ill.

So far there has been no attempt to pass legislation that would enable PAS on those with dementia but past experience of slippery slopes suggests that such demands would eventually be made, once the principle has been agreed.

c) Implications for people with disabilities

Society gives equal rights to people with disabilities in both the United Kingdom and the Republic of Ireland. Yet disabled people regularly report that their lives are regarded as of less value than those of their fellow citizens. This is furthered because the cost of treatment may be high in financial and emotional terms.

There is a particular fear with regard to end-of-life issues, that subtle pressure will be exerted to encourage this attitude; and in the case of serious and life-threatening illness needing costly medical care, to allow PAS.

Where a disability prevents the expression of such fears, there is a duty of society to ensure that decisions are not imposed. These can cut to the very nature of understanding the value of life, regardless of the apparent contribution, or non-contribution, of the disabled person. There is, for example, a tendency to regard people with severe learning difficulties as less than fully human and their lives less valuable than those of others. There is, further, from a Christian perspective, the requirement to support those in need, 'the widow and the orphan'.



There is, conversely, a social requirement to respect the expressed views of individuals with disabilities, who may not be able physically to carry out their wishes.

d) Implications for relatives

At the present time, if a patient feels that the suffering is intolerable, the relatives know that it is illegal for a relative to terminate their life, and most do not ask. However, legally the answer must be no. If PAS were to be made legal, this then would place a huge burden upon such a relative, especially if that relative had moral objections. In effect, providing a choice is imposing the duty to make a choice.

If the relative is asked to be part of the decision making process on PAS, there could well be indefinite mental consequences for that person, regardless of what decision is taken.

Relatives will be consulted for their opinion on whether a patient is in a state of great pain and is fully aware of what their request to end life implies, both for themselves, and for their relatives. Even where there is a Living Will, relatives may be asked to judge when this affects the process. A temporary recovery and possible change of view by the patient is a further factor, with its implications for future trust.

There is, further, not always clarity on who is next of kin and the best advocate for someone unable to make their wishes known, or confirmed. Finally, as the actual ending of life will be undertaken under medical supervision, this has implications regarding the degree of trust between the relatives and the medical staff. In brief, actions which end, or consent to the ending of the life of a fellow human being, are not autonomous decisions by the patient but have an impact on all concerned.

There have been well-publicised cases where a relative has responded to the repeated requests of a loved one and has terminated their life. These situations are usually treated reverently by society and mercifully by the judiciary.

Changes in law may make a substantial impact upon relatives. There is a fine line between allowing choice and imposing it.

e) Implications for palliative and terminal care.

When one hears of intolerable suffering the symptom which springs immediately to mind is pain. However, nausea, sometimes associated with vomiting, coughing or hiccoughing, anxiety, restlessness and extreme lethargy can singly, or in combination, cause intolerable suffering. Happily it is rare that any of these symptoms cannot be controlled, provided there are sufficient resources and



motivation. In the light of the general costs of medical care, the expense need not be great. In addition provided that sufficient support is available, many can be treated at home. Where this is not possible, most of the remainder can be treated in hospices, which are much less expensive to run than hospitals, as the costly infrastructure of hospitals is not required.

If PAS were available, the motivation to provide good terminal care could be undermined. It is generally reported that this has not happened in the Netherlands but there are many who disagree with this view.

The corollary applies. If better palliative care were readily available, there would be less demand for PAS.

6 What is happening in other countries

Euthanasia, or more commonly PAS, is legal in several countries, namely the Netherlands, Belgium, Luxembourg, Switzerland and Oregon State in the USA. The Northern Territory in Australia legalised PAS but was over ruled by the Commonwealth Government. In recent years it also has been rejected in Canada, France, Israel, some US states, Scotland and the UK. The people of Massachusetts voted narrowly against PAS at the beginning of November 2012.

It is difficult to establish the consequences in those countries where it has become legal because of the emotional issues surrounding it. Sensational anecdotes abound from both those in favour and those against. However, there are documented accounts of the safeguards being flouted and the rules being broken without any investigation or prosecution. In other words, the safeguards are not working. (See appendix 4 for a detailed study from the Netherlands.)

7 Conclusions.

Although not everyone believes in the sanctity of human life, the overwhelming view in society is that human life is special, and quite distinct from all other forms of animal life. This is clearly seen in all the efforts to preserve human life, the risks people are prepared to accept to rescue those in danger and even the lengths to which Governments have gone in legislating to reduce the risks of suicide. Police in both jurisdictions have the initial power to intervene when anyone is suspected of being about to commit suicide

It is acknowledged that there can be considerable suffering at the end of life but we believe that the answer to this is to improve terminal care, not to assist in suicide. It is our belief that we do not need a change in the law to permit Physician Assisted Suicide but we do need a major improvement in both nations, in the care of the terminally ill. At the present time the care offered to people in these situations is very much hit or miss, depending on where they live, the availability of resources and the energy and care of their GPs. It seems



unfortunate that so much terminal care is dependant on charities which, in turn, are dependant on the generosity of the public, to fund their work.

We are pleased that the attitude of the courts has largely been merciful in dealing with those who have broken the law in assisting those in distress to end their lives, but we also are conscious of the need to protect the vulnerable, many of whom would feel insecure if the law were changed. It is an old legal maxim that hard cases make bad law and the vulnerable must be protected from the pressures which would almost certainly occur if the law were changed.

A final important point is the change in the doctor/patient relationship which would occur if doctors were to be given the responsibility of working under a system where they would be responsible, not only for the maintenance of health in good times but also, in other circumstances, for recommending, and then facilitating, suicide.

Appendix 1 Definitions

Euthanasia, literally a good or easy death, and physician assisted suicide (PAS) are similar in that the goal is premature death. The mechanisms may also be similar but in euthanasia, the death is brought about by the specific action of another person, usually a doctor, whereas in PAS the doctor assists in setting up the process, but the patient actually triggers the injection or swallows the lethal agent.

PAS carries the safeguard that the patient is the one who initiates the final event. Euthanasia does not carry that safeguard and, in those countries where it is legal, there is said often to be a fear among patients, that the final injection, or whatever, may be given without their consent.

There is a variety of forms of euthanasia. In active euthanasia, a specific action by the doctor results in the death of the patient. In passive euthanasia, withholding or withdrawing treatment results in death, for example withholding drugs or turning off a life support system. It is acknowledged that decisions about withdrawing non-palliative medical treatment at the end of life can be ethically and emotionally very difficult e.g. a decision on treating or leaving untreated an infection in someone who is already at the end of life or on whether to withdraw life support in someone in an Intensive Care Unit with 'brain death' and no chance of recovery.



Voluntary euthanasia is where a patient, with full mental competence has requested an end to life, and non-voluntary is where the patient isn't competent to decide, and the decision is taken on his or her behalf.

Involuntary euthanasia occurs where the patient is mentally competent but is not consulted for one of many possible reasons, including medical paternalism, which is sometimes a fear among patients in those countries where euthanasia or PAS are legal.

Suicide is the deliberate taking of one's own life. In assisted suicide, one is assisted in taking one's life and in PAS the assistance is provided by a doctor. Suicide attempts may fail, for a variety of reasons, even with PAS, and there have been reports from the Netherlands of failure of the initial PAS, having to be 'completed' by the doctor by the use of an unplanned lethal injection.

The topic of this paper is PAS.

Appendix 2. Sanctity of life. Some theological reflections

Doctors come from all faiths and none. The main thrust of this paper has been to raise questions about PAS which broadly impact on everyone regardless of their faith perspective. However, this paper is produced by the CSR for the Methodist people in Ireland and is therefore also informed by reason, experience, tradition and scripture – with scripture as the final authority. So here are some brief reflections on two important theological issues.

(a) Sanctity of human life.

Presumably everyone in the medical profession, along with the overwhelming majority of the population regard human life as special, though they may not use the term 'sanctity'. As Methodists we draw our understanding of this not just from some kind of innate instinct but from the teaching of Scripture. Only two areas will be briefly cited.

Creation.

Most religions have a concept of God as creator and that God's creation gives value to human life. The Judeo/Christian scriptures have a particular insight, namely that God created humanity in His image. Genesis 1: 26-27

Being created in the image of God brings with it a number of very important implications:

- Humanity has a unique place in creation. We may share many biochemical processes with the rest of creation but we are made in the image of God, and are thus in a different category. Adam was made from the dust, but God breathed life into his nostrils and he became a living soul. Gen 2:7

- God's image implies dependence. Human beings are not self-explanatory. We derive our meaning from outside ourselves, from God, in whose image we are made.

- God's image implies communion. 'Let **US** make humanity in **OUR** image.'



Our understanding of God as Trinity has important and relevant things to say about our relationships.

- God's image implies the dignity of each human life
- God's image implies the equality of human beings

As we recognise the image of God in everyone around us, it will surely cause us to think deeply about how we treat others, especially when the other is sick and most vulnerable.

You shall not kill.

Again, this is a concept common to many religions. Interestingly, in Genesis the seriousness of murder (even to the point of capital punishment) is linked to the image of God. Gen 9:6 This commandment seems quite straightforward and there will be few, if any, who doubt the iniquity of 'cold-blooded murder', but when considering the extremes at the beginning and the end of life there are some who see a variety of shades of grey. Nevertheless, this commandment given to Moses and reinforced by Jesus must speak clearly to the question of PAS. The role of the doctor is to cure, if possible, to relieve suffering but not to kill.

(b) Love your neighbour as yourself.

The whole of the law is well summed up in the two great commandments; to love God with your whole heart, and to love your neighbour as yourself.

There is no doubt that in this debate the command to love your neighbour will be quickly cited. Here is my neighbour who is suffering terribly, perhaps even intolerably, so surely the loving thing for the doctor to do is to administer an injection that will bring the suffering (and life itself) quickly to an end. This emotive argument seems to be a very powerful one.

However, there is another question that should be asked, one that has famously been asked before. And who is my neighbour? The fact is that I have very many neighbours. In considering the question of PAS I must think about the impact on all my neighbours. This we have attempted to do in this paper as we have considered the implications of PAS for other groups such as the disabled, those suffering from mental illness, family and friends of those with terminal illness and the medical profession. All of these are our neighbours and we must love them. Thus in the face of human suffering the theological issues are not as simple as in the case of asking the vet to put our very sick dog 'to sleep'.

Appendix 3 Changing attitudes of doctors.



The medical graduates in the British Isles in the 1950s were mostly asked to swear the Hippocratic Oath. In this they promised neither to suggest euthanasia nor assist in it. (They also promised not to carry out an abortion.)

Hastening death was rarely discussed although it was practised discreetly, but usually only in the terminally ill who would, in any event, be dead within hours, as happened to King George V. Abortion of an unwanted pregnancy is now generally seen as a right for all pregnant women.

Doctors no longer work in isolation. This is especially the case with hospital doctors. Hospitals are expensive and if the bills are not paid the hospital will close down. Doctors may waive their own fees but cannot overrule the hospital management and waive the fees for accommodation, nursing care and investigation, and euthanasia is less expensive than these. A recent article in the British Medical Journal pointed out that if the government really wants to reduce health care costs, euthanasia should be considered, as it would be very effective.

The treatment of advanced malignancy can be expensive and there have been some disturbing cases reported from Oregon, USA, where Physician Assisted Suicide (PAS) is legal. In some cases where expensive surgical treatment has been recommended, the patients' Medical Insurance Company has informed the patients with such conditions that their insurance policy doesn't cover the proposed treatment but that it does cover PAS. How terrible to get a letter effectively saying, 'we can't pay to keep you alive but we are prepared to pay to have you killed!'

Appendix 4 The Netherlands

It is almost impossible to find the truth about the outworking of the law in those countries where it is legal. There are innumerable anecdotes, usually heavily biased one way or the other. One of the most serious was by the American Republican Presidential candidate Rick Santorum who was reported to have said that euthanasia makes up 'ten percent of all deaths, and half of those people are euthanized involuntarily, because they are old or sick. And so elderly people in the Netherlands don't go into a hospital.' This is far from the truth.

Euthanasia became legal in The Netherlands only in 2002, but between 1984 and 2002 there had been an agreement that doctors would not be prosecuted if they carried out either euthanasia or PAS, so long as they observed certain safeguards, including a spontaneous request for this by the patient, the involvement of a second doctor and the routine reporting of every case.

The publication in July 2012, in the online section of the highly esteemed British medical journal, The Lancet, on the trends in The Netherlands, seemed an opportunity to settle for us, the issues of what is happening in at least one country. This detailed paper is freely available on line on The Lancet website. However, although it is an excellent piece of research, it not only left many



questions unanswered but it also suffered from the biased reporting in the media, which has become the norm in this emotive area.

The authors, two respected medical academics and a statistician from The Netherlands, did a stratified sampling of all the deaths in that country in 2010. They contacted by post the attending physicians in 8496 sampled deaths, asking for details of the final illness, and analysed the findings. The sampling was carried out in an acceptable statistical way. The findings were compared with similar surveys in 1990, 1995, 2001 and 2005.

The study showed a small increase in the numbers having either euthanasia or PAS, going from approximately 3800 in 2001 (2.8% of all deaths) to approximately 4050 in 2010 (2.8% of all deaths). Understandably the contribution to these figures of PAS is quite small, being in the region of 0.1 to 0.2% of all deaths.

On the face of it this increase in these deaths is so small as to be ignored. However, what has not been included in these figures is a category which was included in the 2001 and 2005 surveys but not in the earlier reviews. This is an ill defined category called Continuous Deep Sedation. This is a grey area and included in it are what have also been termed Intensified Alleviation of Symptoms, and Palliative Sedation. There are other terms such as Early Terminal Sedation. Effectively what is happening with many, if not all, of these patients is that they are made comatose by medication and then left unfed and dehydrated so that early death is inevitable. This grey area merges into other fields of medicine where, for example, without surgical intervention death would be inevitable in someone who had previously been diagnosed with an inoperable malignancy elsewhere in the body, but where surgical management of, for example, severe bleeding is deemed meddlesome. They may be unconscious and bound to die in the very near future so that there is no point in keeping them alive by feeding and hydrating them, and general medical practice dictates that nutrition be withheld but that they be kept sedated while awaiting death.

The disturbing thing about this group is its size. In 2001 this figure was 5.6% of all deaths. In 2005, it was 8.2% and in 2010 it had reached 11.6% of all deaths. Many of these people would have been dead in a matter of hours but the problem is that there are no breakdown figures and, very significantly, they have not been included as euthanasia cases. Consequently we have no idea of how many of them were really cases of slow euthanasia. This is important as by 2010, this group had become four times the size of the euthanasia group.

The presence of this large group of sedated patients in this study means that we cannot be sure of the true euthanasia figures and this must lead us to question the conclusion that the euthanasia numbers had not increased.

Three other matters of concern emerge from this paper. First, 20% of the euthanasia group were not reported in the manner prescribed by the law. Secondly, about 50% of the sedated group in the grey area, were so managed without consent from the patient or discussion with the families. Thirdly, the



reporting by the media generally ignored the huge grey area group and simply stated that euthanasia had not increased significantly over 10 years, whereas it almost certainly had.

So the truth of the matter is that we don't really know the trends in the Netherlands, despite this recent comprehensive report. Probably there has been an increase in euthanasia of one hundred percent or more in the last 10 years but this is hidden in this grey area where doctors appear to be free to end the lives of their patients, often without consent from the patients or their families, without the safeguard of the agreement of a second doctor and without being required to register the death as euthanasia.

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