

Euthanasia and assisted suicide – UK experience

This is one in a series of articles on the topic of euthanasia and assisted suicide available on the website johnwyatt.com

Other articles on the same topic are:

- Euthanasia and assisted suicide – historical perspectives
- Euthanasia and assisted suicide – current realities internationally
- Euthanasia and assisted suicide – UK experience
- Euthanasia and assisted suicide – underlying social forces
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- Care of the dying – palliative care and legal frameworks

Discussions about whether euthanasia should be legalised in the UK start in the 1870's. Details of the history from the late 19th century to the early 20th century are in the companion article *Euthanasia and assisted suicide – historical perspectives*.

As details of the Nazi euthanasia programme became well known in the years following the Second World War it is not surprising that discussion about legalising euthanasia in the UK died down. However the Voluntary Euthanasia Legislation Society, which had been formed in 1935, kept up the pressure. A debate in the House of Lords in 1950 met with overwhelming opposition. However the Society gained strong backing from Professor Glanville Williams, an eminent and influential lawyer who supported the medical killing of patients who were enduring a miserable life, even if natural death was not imminent.

The 1961 Suicide Act removed the legal penalties for attempted suicide, although assisting a suicide remained a serious criminal offence. There was renewed debate and discussion about euthanasia although it is interesting that much of the public debate at the time focussed on children with severe disabilities, and the “agonies” of parents caring for such children, who were sometimes “forced” to take the law into their hands by killing their children. Further attempts at legalising euthanasia failed and in 1978 the Voluntary Euthanasia Society published a self-help booklet called *Guide to Self-Deliverance* which provided advice about the most effective ways of committing suicide. Not surprisingly this caused widespread controversy and debate and the Society was increasingly seen as marginalised and extreme.

In 1994 a Select Committee of the House of Lords on Medical Ethics published a major report which concluded that although there were particular cases where euthanasia might seem appropriate, “individual cases could not reasonably establish the foundation of a policy which would have such serious and widespread repercussions.” A group from the House of Lords had visited the Netherlands and Dutch-style euthanasia legislation did not seem an attractive option in the UK. It is clear that the development of modern palliative care in the UK, pioneered by Dr Cicely Saunders at St Christopher’s Hospice in London, had a very influential role in providing an alternative to euthanasia. As Cicely Saunders argued, “You don’t have to kill the patient in order to kill the pain.”

Campaigners aim for assisted suicide not euthanasia

All recent attempts at legalisation in the UK have focussed on medically assisted suicide, rather than euthanasia. Campaigners have concluded that assisting suicide is more acceptable to the public, in line with Anglo-Saxon preoccupations with individual choice and freedom. In public debates supporters have distanced themselves from euthanasia as practised in The Netherlands and Belgium. Instead, it is argued, proposed legislation will be limited to “assisting the dying” of a small number of terminally ill individuals who wish to end their lives.

However in private, many campaigners concede that proposed legislation will not satisfy the highly publicised needs of those who are very severely disabled and unable to commit suicide, nor those who wish to die but are not terminally ill. Many, such as Mary Warnock, regard the legalisation of assisted suicide as the first step towards more wide-reaching liberalisation of the law to allow suicide and mercy killing in a range of circumstances.

In 2006 the distinguished human rights lawyer Lord Joffe introduced the Assisted Dying Bill in the House of Lords. Its aim was to legalise assisted suicide in England and Wales under strictly controlled circumstances, including a life expectancy of less than six months and “unbearable suffering”, defined as “suffering, whether by reason of pain, distress or otherwise which the patient finds so severe as to be unacceptable”. The Bill was defeated by a vote in the House of Lords.

In the same year the Voluntary Euthanasia Society changed its name to ‘Dignity in Dying’. The choice of words is, of course, highly significant and symbolic of a profound change in the presentation of the arguments for a change in the law. Since then Dignity in Dying has become a highly effective lobbying organisation with a number of distinguished and prominent supporters, including many well-known celebrity names.

In Scotland Margo MacDonald, a very popular member of the Scottish Parliament, introduced an End of Life Assistance Bill, which proposed that assisted suicide should be

available to those who had “a terminal illness or a terminal condition” and who “find their life intolerable”. As in England the legislation was modelled on Oregon-style assisted suicide. The Bill was defeated on several occasions in the Scottish Parliament and despite Margo Macdonald’s death in 2014 from natural causes (she had suffered from Parkinson’s Disease for many years), attempts at introducing similar legislation continue. In 2015 an Assisted Suicide Scotland Bill was defeated in the Scottish Parliament.

The Falconer Assisted Dying Bill

In 2014 Lord Falconer introduced another Bill for the legalisation of assisted suicide in England and Wales. The criteria were similar to Lord Joffe’s except any requirement that the individual should have “severe and unacceptable suffering” was completely removed. The wording of the Bill was based closely on the findings of a 2012 Commission supported by Dignity in Dying and chaired by Lord Falconer which stated, “We firmly believe it is only for the individual concerned to judge the extent of the suffering caused by their illness. We are also concerned that a person who has a terminal illness should not be required to be already experiencing unbearable suffering to request an assisted death; it could be the prospect of anticipated suffering that he or she does not wish to experience that gives rise to the request for assistance.”

The report of the 2012 Falconer Commission stated, “We have taken on board the strong concerns expressed by many disabled people and do not consider that it would be acceptable to society at this point in time to recommend that a non-terminally ill person with significant physical impairments should be made eligible under any future legislation to request assistance in ending his or her life. The intention of the Commission in recommending that any future legislation should permit assisted suicide exclusively for those who are terminally ill and specifically excluding disabled people (unless they are terminally ill) is to establish a clear delineation between the application of assisted suicide to people who are terminally ill and others with long-term conditions or impairments. This is something that the Director of Public Prosecution’s policy currently fails to achieve. The adoption of this distinction in any future legislation would send a clear message to the British public that disabled people’s lives are equally valued and that if the ‘opportunity’ does not exist the ‘obligation’ cannot follow in the UK.”

“However”, the report continued, “we are concerned that those who might agree to assist a non-terminally ill loved one, who has suffered such a catastrophic life-changing event, to commit suicide for wholly compassionate reasons should continue to be treated by the law with compassion and understanding.”

It is notable that the word “suicide” is carefully avoided in the wording of the proposed legislation. Instead the euphemistic and ambiguous phrase “assisted dying” is used

throughout. Yet within the body of the Bill assistance in dying is defined as the prescription of medication by a doctor to enable a terminally ill person to end their own life. In other words it represents a major change in the criminal law on killing and the protection of human life.

The wording of the bill allows an assisting health professional to:

- (a) prepare lethal medicine for self-administration by the terminally ill person;
- (b) prepare a medical device which will enable that person to self-administer the medicine;
- and
- (c) assist that person to ingest or otherwise self-administer the medicine;

However “the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed.”

In 2014 the Bill was debated in a highly publicized session of the House of Lords. The Bill failed to progress, but a very similar Bill was introduced into the House of Commons by MP Rob Marris in 2015. This was convincingly defeated, with 330 voting against compared with 118 in favour. Activists for assisted suicide vowed to fight on, claiming that the vote showed that members of Parliament were “ridiculously out of touch with the British public on the issue”.

The language of the debate

It is striking that from the very beginning, debates about euthanasia and suicide have always been bedevilled by misleading and euphemistic language, and it seems that this phenomenon is particularly common in the UK. At least the Dutch are straightforward in their discussion of euthanasia and assisting suicide. In the UK we meet euphemisms such as “an assisted death”, “ending suffering when it becomes unbearable”, “easeful death”, “choice and control at the end of life”, “easing the passing”, “merciful relief”, “stopping unnecessary suffering at the end of life”.

The change in title of the Voluntary Euthanasia Society into Dignity in Dying is itself highly significant. Without prior knowledge one would naturally assume that the organisation supported dying people to ensure that all their care needs were met and that their dignity was preserved. In reality the sole aim of the organisation is to campaign for the legalisation of medically assisted suicide. The implication of course is that dignity in dying can only be achieved by suicide.

In the literature produced by Dignity in Dying, the word suicide is assiduously avoided, presumably because of its unhelpful connotations. Instead the euphemistic and misleading phrases “assisted death” and “assisted dying” are used throughout.

What does “assisted dying” mean?

In response to the use of the phrase “assisted dying” a senior palliative care nurse wrote, “Midwives assist birth and palliative care nurses assist the dying with specialist palliative care. Assistance is not the same as killing. The use of the term assisted dying is offensive to those of us who are giving good care at the end of life. It is a deception to sanitize killing to make it more acceptable to the public.”

In normal English use “dying” implies a natural process whereas “suicide” implies the active and deliberate termination of one’s life. “Assisted dying” sounds positive and uncontroversial. Yet it is being used to describe, not the normal care and assistance of dying people which is a major part of healthcare across the country, but the intentional planning, preparation and direct assistance of a suicide, a serious criminal offence under the Suicide Act.

It is interesting to reflect on why those who wish to campaign for a change in the law, including many eminent lawyers whose careers have depended on the precise forensic use of language, are so reluctant to use straightforward unambiguous English in this case. I suggest that it indicates how important language is in the way we as human beings assess the morality of our actions. The words we use to describe our own actions and the actions of others matter. Those who are campaigning for a change in the law are well aware that many people in our society have deep intuitive concerns about legalised killing and suicide. So if I describe my actions as “assisting a dying person”, I am more likely to conclude that it is morally acceptable compared with “helping someone to kill themselves”.

In the history of ethics it often seems that the manipulation of language precedes a change in behaviour. But careful moral assessment depends on accurate and unambiguous use of language. As an ancient proverb puts it, “The beginning of wisdom is to call things by their proper names”.

Defining euthanasia and assisted suicide

A widely accepted definition of euthanasia is *“The intentional medical killing by act or omission, of an individual whose life is thought to be not worth living.”*

Note first the emphasis on *intentional killing*, a deliberate and premeditated act to take life, to introduce death into a situation. Even if a person has a terminal illness the intention is that death should occur at a specified time using lethal drugs. The intention to kill is revealed in the choice of drugs used by doctors in the Netherlands for euthanasia. They usually employ a barbiturate in extremely high dosage coupled with an intravenous muscle relaxant drug designed to stop respirations instantaneously. These drugs are totally

different from those used in palliative care. In palliative care the intention is to use drugs that control symptoms of pain and distress. The intention is not to hasten death and therefore only drugs that do not carry a risk of killing are used. But in euthanasia different drugs are used. They have one intention only - to induce death rapidly and "cleanly". The intention of the doctor is that the patient should die quickly and without complications. To refer to this process as "assisted dying" is to stretch language to breaking point.

Second, note that according to this definition euthanasia may be performed either positively by deliberate act, or negatively by omission. It is the intention to kill which is central to the definition. Hence it can be argued that to use medication to put a person into a persistent coma over many days, but deliberately omit to give any form of fluid or nutrition so that the person dies eventually of dehydration, is as much a form of intentional medical killing, as to inject a lethal quantity of a barbiturate.

In the past, the phrases 'active euthanasia' and 'passive euthanasia' have been widely used, but most ethicists now agree that they are ambiguous and should be dropped.

Third, note that euthanasia, intentional killing, is not the same as withdrawing or withholding medical treatment that can bring no benefit or that is excessively burdensome to the patient. This is universally regarded as good medical practice not intentional killing. (I will discuss this issue in more detail in Chapter 8).

Assisted suicide

Doctor assisted suicide is practically and morally very closely related to euthanasia. Again the intention of the doctor is that the patient should die rapidly and "cleanly". The doctor calculates the lethal dose, usually a massive dose of an oral barbiturate.

In the USA the commonest drug used is a barbiturate. In assisted suicide the dose given is 50-100 times greater than the therapeutic dose. The barbiturate is usually preceded by an anti-emetic medication to reduce the possibility that the patient will vomit.

The doctor ensures that the medication is available and gives detailed instructions on how the drugs should be taken to ensure that death occurs rapidly and without complications. The patient must be instructed to remain upright after swallowing the barbiturate to reduce the risk of inhaling vomit. In cases where the patient is unable to take the drug orally, the doctor may prepare a mechanism for the drugs to be administered artificially, including inserting an intravenous line and obtaining and drawing up the drugs into a syringe, although the patient must make the final decision by pressing a button.

Throughout this process the actions of the doctor are intended to end the life of the patient, to introduce death. The doctor has agreed with the patient that their life is not worth living. But the doctor hangs back from the final step – the patient must swallow the drug or press the button. Is there any real moral difference between this and the doctor taking the final lethal action? Inevitably the doctor is actively engaged and morally complicit in the destruction of the patient's life.

This material is adapted from *Right to Die? Euthanasia, assisted suicide and end of life care*, by John Wyatt, published by IVP.

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