

# Submission against legalisation of physician-assisted suicide and euthanasia.

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Written by Dr Alison Hawthorn

What makes human life worth living?

Is just being human of innate value in itself?

How should these value judgements be made? On what basis?

The following collection of thoughts will hopefully shed some light on this important subject.

The euthanasia debate is the surface manifestation of an underlying clash between two opposed philosophies, namely the ethic of the intrinsic value and worth of the human being versus the concept of individualism and absolute autonomy in which one's capacity to control one's body and assert one's rights defines one's value and dignity.

## DEFINITIONS

**Euthanasia** is the active, intentional termination of a patient's life by a doctor who thinks that death is of benefit to the patient.

**Voluntary euthanasia** is the ending of a person's life at the request (at least with the consent) of that person.

**Non-voluntary euthanasia** is a similar act but carried out in circumstances in which the patient is unable to request euthanasia him or herself (for example, unconscious, demented or intellectually disabled adults; an infant or child). They are incompetent to consent or refuse euthanasia.

**Involuntary euthanasia** is the ending of the life of a patient who is perceived to be suffering carried out against the wishes of a competent person.

**Compassionate discontinuation of burdensome or futile treatment** knowing that the person will then die of their disease is not euthanasia.

**Physician-assisted suicide (PAS)** – is where a doctor helps the patient to commit suicide. In the Netherlands, no distinct moral difference is being made between PAS and euthanasia. The practical difference may not be significant – there is little difference between a patient taking a lethal medication into his mouth and swallowing it and the doctor placing the lethal medication into the patient's mouth and the patient swallowing it.

**Treatment refusal** is the right of the competent individual to refuse treatment. Such a right is legitimate and previously existed under common law but became enshrined in various forms of legislation throughout the Western world such as the Victorian Medical Treatment Act 1988 (<http://health.vic.gov.au/mta>). Refusing treatment is very different to actively seeking death prior to the time that a person would otherwise die. Providing basic needs like fluids, nutrition, shelter, warmth and cleanliness are not treatments but constitute basic human rights.

## INTRINSIC VALUE OF ALL HUMAN LIFE

At the centre of Christian ethics is that God created man in His own Image. The fact that the first man and woman were the epitome of God's creation is stated in Genesis 1. God breathed into them the breath of life: he gave and it is His prerogative to take life. Throughout the Old Testament, the Scriptures emphasise God's sovereignty over life and death. "It is I who put to death and give life" (Deuteronomy 32:39). The sixth of the 10 Commandments God gave to the Israelites states "though shall not murder" (Exodus 20:13). It does not say sometimes it is ok. God commands us not to take another person's life. Period.

Christianity espouses the equality and inestimable value of every human being. Christians are also exhorted by Jesus' example in the writings of the New Testament to show sincere and practical love, compassion and

concern for the sick and to attempt to alleviate their suffering. Christianity brought about a duty to care. This includes restoring and enhancing health where possible, but where impossible, caring for the suffering is paramount until the day on which God takes that life.

From such admonitions to be charitable to all people regardless of race, social status and religion grew hospitals, orphanages and houses for the aged and poverty-stricken all over the world.

The Hippocratic Oath (see appendix 1) is most famous for its command "to help or at least do no harm" and to respect all human life. It states, "Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course".<sup>1</sup>

To Hippocratic physicians, the circumstances of a person's life were irrelevant. Whether the patient was a slave, a foreigner, a disabled infant or the Emperor, all were viewed as equals in the physician's dedication to healing and sustaining life.

Traditional medical ethics grew out of the marriage of Christian and Hippocratic values. This tradition rests on the assumption that a human life is invaluable and inherently dignified from the time of conception until the time of their natural death.

In this framework everyone has the same rights whether they are able to express their rights or not.

## **RIGHTS AND VALUES DEPENDANT ON AN INDIVIDUAL'S CAPACITY**

The supremacy of autonomy and freedom of self-determination in conferring rights (rather than the intrinsic humanity of a person conferring rights) has been heavily relied upon to break down barriers to physician-assisted suicide and euthanasia. However, this notion means that one must have the capacity to be autonomous in order to have rights, and therefore value and worth. The extent to which one can choose and direct one's destiny determines one's supposed quality of life. The intellectually disabled, disabled newborns, the demented and the comatose have little or no autonomy and therefore, have few rights, and are deemed, by this way of thinking, to have little worth or quality of life

People feel that dependence on others is just a burden and feel they have no worth because of their lack of autonomy. Individual autonomy and its incumbent "rights" can be elevated to the point at which they override social responsibility and ignore the fact that we are essentially social and interdependent beings.

In 1993, the British House of Lords Select Committee on Medical Ethics stated "Society's prohibition of intentional killing is the cornerstone of law and social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia." This was upheld again in 2004 see Appendix 2.

Liberal use of tragic stories and hard cases in which a lethal injection is portrayed as the only compassionate and humane option have been used to undermine the basic principles of life sought to be protected by the above statement .

To assert that someone is better off dead because the personal assistance he or she requires is shameful. It sends a negative message to society and the disabled.

Loss of dignity is described by many as – loss of personal self-care, ability to drive, shop, walk, stand, and assisted transfers and toileting. Human dignity is inherent. It is not lost by incapacity for self-care. It does

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<sup>1</sup> Vernon D Plueckhahn & Stephen M. Cordner, *Ethics, Legal Medicine and Forensic Pathology*, Melbourne, 1991, p.2-3.

not rely upon the degree to which one is independent or capable. The intellectually or physically disabled, the demented, ill or comatose have not lost their human dignity. To assert that they have is to deny respect for their personhood and make them vulnerable to "compassionate" dismissal from life.

## **END OF LIFE CARE**

The issue of "dying with dignity" is a reason for the provision of good quality holistic palliative care which is responsive and respectful of patients and their family's needs and desires. It is not a reason to legalise euthanasia or physician-assisted suicide.<sup>2</sup>

Dr. Cicely Saunders, who founded the first modern hospice, demonstrates a basic tenet of palliative care in saying: "You matter because you are you. You matter to the last moment of your life, and we will do all we can not only to help you die peacefully, but also to live until you die."

Inadequately treated pain, depression and feelings of hopelessness are some of the most common factors that lead patients to think about suicide. Given good palliative care all these conditions are treatable.

## **RISKS OF LEGALISING EUTHANASIA**

Legalising physician assisted suicide and euthanasia would open the flood gates for wide-reaching harms such as:

1. Impossible to have safeguards in place to protect the vulnerable
2. Those who feel a burden on their family will feel they have to request euthanasia
3. Pecuniary interests of relatives to suggest their grandparents don't need to suffer any more so they can gain their inheritance
4. May be cry for help rather than request to end their life
5. Demanding, difficult patients might not be able to be seen by their doctor objectively, so much easier to arrange their disposal than care for them
6. Economic pressures on health care and personal assistance of disabled people, so much cheaper to just end their lives
7. Reduce incentive for research and provision of palliative care
8. Reduce incentive for research into currently incurable conditions
9. Loss of trust in medical and nursing professions to always care and do their best for their patients no matter what their circumstances

## **IN SUMMARY**

In summary, the risks are too great, as stated in 1994 by The New York State Task Force on Life and Law "...laws barring assisted suicide assistance and euthanasia serve valuable societal goals: they protect vulnerable individuals who might otherwise seek suicide assistance or euthanasia in response to treatable depression, coercion or pain; they encourage the active care and treatment of the terminally ill; and they guard against the killing of patients who are incapable of giving knowing consent."<sup>3</sup>

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<sup>2</sup>Bob Thomas (Ed.), *A life worth Living: The Euthanasia Debate*, Presbyterian Church of Victoria, 1995, p.15.

<sup>3</sup>As quoted in Frank Brennan, *Legislating Liberty: A Bill of Rights for Australia?*, Queensland, University of Queensland Press, 1998, p.108.

The quest for humane care of the dying must continue, but without violating the ancient proscriptions against killing which are so fundamental to the protection of the vulnerable.

Parliaments and courts must protect the weak and vulnerable in society by the upholding of laws which prohibit the taking of another's life. Physicians must resist the pressure to become merchants of death and rather retain and maintain their singular role of caring and healing within a doctor-patient relationship characterised by integrity and trust. It is the duty of society to protect doctors from having such a lethal tool, Just as exists now in Australia where it remain illegal to kill anyone, health care providers must remain in the business of caring for people not killing.

## APPENDIX 1

### **The Hippocratic Oath**

I swear by Apollo Physician and Asclepius and Hygieia and Panaceaia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

## APPENDIX 2

<http://www.linacre.org/AssistedDyingBillSub.htm>

## Submission to the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill

The Linacre Centre for Healthcare Ethics, September 2004

### Resume

*Euthanasia is standardly defended by reference to one or both of two considerations: autonomy and welfare. Either consideration can lead to much more widespread euthanasia than defenders of its legalisation had originally envisaged. If euthanasia is about patient choice, why should the patient need to be terminally - or physically - ill to receive it? If euthanasia is about benefiting the patient, why should patients who cannot request it be deprived of this benefit? Thus we see in the Netherlands an extension of euthanasia to those who are mentally ill or 'tired of life', and also to significant numbers of patients who have not consented to it – including patients who could have consented but in fact have not. In this submission, we argue that respect for the patient's life is part of respect for the patient's human dignity, and that palliative care, not euthanasia, is the morally appropriate response to terminal suffering. The law should continue to uphold human dignity and equality by prohibiting homicide/assisted suicide for disabled and able-bodied alike. Suicidal people should not be confirmed in their own estimate of their lives' value; instead, they should be supported and protected, whatever their physical condition.*

## 1. Introduction

The Linacre Centre for Healthcare Ethics<sup>[1]</sup> is a research institute under the trusteeship of the Catholic Trust for England and Wales. We publish material, run conferences and provide speakers on a range of bioethical issues, and also offer advice and information to individual health professionals and patients. We welcome the opportunity to contribute evidence to the Committee on the Assisted Dying for the Terminally Ill Bill, and would be pleased to respond to any questions the Committee may wish to raise on this evidence, or on related issues.

## 2. Respect for life

The Catholic Church holds - in common with other faiths - that human life is a gift from God, to be cherished and protected. In the Jewish and Christian understanding, human beings are created in the image and likeness of God, and God's loving care extends not only to the strong and well but to those who are suffering in body and mind. We do not have absolute dominion over our lives, but hold them in stewardship from God. The appropriate response to human suffering is solidarity with, and care for, the sufferer; it is not deliberate killing of that person, with or without request. Respect for a human being cannot be divorced from a valuing of, and respect for, that person's presence in the world.

The Church teaches that the fundamental moral principles of Christianity are accessible to human reason, without reliance on revelation. Thus the secular belief in human equality, enshrined in the Universal Declaration of Human Rights of December 1948 (since recognized by the European Convention on the Protection of Human Rights and Fundamental Freedoms) squares well with the teaching of the Church on the basic equality of human beings. Human beings are 'equal' at a deeper level than their varying mental or physical condition might suggest: they are equal in their nature and basic dignity as human beings. An essential part of respect for human dignity is respect for the value of human existence: human bodily life. A valuing of each person's life, and a refusal to attack that life as 'worthless' or 'unwanted' by that person or others, is integral to a society in which all are valued and protected.

### 2.1 Suicide Act 1961

Thus the Suicide Act 1961 protects all members of society equally from assistance in suicide. The Act does not discriminate between disabled and non-disabled suicidal people: there is no suggestion that disabled people, unlike other suicidal people, have lives of doubtful worth which may therefore be curtailed. Many disabled people welcome the protection the Act provides from pressures to ask for

'help in dying' which they themselves might feel at times of pain or despair. While decriminalizing suicide itself, out of concern for the survivor of a failed suicide attempt, the Act nonetheless treats suicide as contrary to the wider public policy of upholding human dignity and equality by excluding participation in intentional killing. [2] In its prohibition of assisting suicide, the Act is a central component in the network of laws protecting the vulnerable.

### 3. Defences of euthanasia

What are the ways in which voluntary euthanasia (and assisted suicide, which is not significantly different) are standardly defended? Euthanasia is normally defended by reference to one or both of two considerations: autonomy and welfare - the latter assumed to include the timely ending of a life thought 'worthless' or 'undignified.' These two considerations pull in different directions, and each in its own way can encourage a widespread practice of euthanasia, not limited to the cases permitted by the Assisted Dying for the Terminally Ill Bill. In the Bill itself, this tension between autonomy and welfare, and logical pressure to expand the grounds for euthanasia, are very much in evidence.

#### 3.1 Autonomy

The stress on the patient's autonomy, and subjective assessment of the value of his or her life, can be seen in the way 'unbearable suffering' is given a purely subjective definition in the Bill: suffering, whether mental or physical, which the patient him or herself finds unacceptable. While the Bill requires the patient to be informed on alternative responses to his or her suffering, such as palliative care, a patient who rejects such alternatives, and states that the suffering is unbearable, may then be 'helped to die'. Although doctors conscientiously opposed to euthanasia will not be required to perform it, they will be required by the Bill to refer the patient to a more compliant colleague. Thus doctors will not be permitted to respect what they reasonably regard as the patient's best interests, but will be required to transfer the patient to someone they think will act in a way directly contrary to those interests. There is a negation here of the doctor's right to protect (or at least, not to threaten) the patient's interest in life, in favour of the patient's presumed right to secure an end to his or her existence. Even a patient who is suffering 'unbearably' can, the Act assumes, make a free choice to die which is not unduly influenced by depression or lack of knowledge of alternatives.

However, this emphasis on the patient's wish to die (rather than receive, for example, palliative care) is combined in the Bill with a requirement that the patient be terminally ill for euthanasia to be performed. It is difficult to see why this should be required: if the patient's suffering, whether mental or physical, is unacceptable to the patient, why is it relevant what the source of the suffering is? Why introduce this one 'objective' criterion of the patient's closeness to death, given that the suffering caused by a non-terminal illness, mental or physical, may be no more acceptable to a patient than that caused by a terminal illness?

#### 3.2 Welfare

There is, in short, a wish to set some limits on patient autonomy and the presumed right to die. [3] Most supporters of euthanasia would not defend it in cases where the patient was suffering from some purely temporary condition. This is because they see euthanasia as defensible not simply as something wished for by the patient, but as something which is in the patient's interests, objectively defined. Life, they think, has no value in some situations, though not in every case in which death might be sought; in particular, life has no value if the patient cannot look forward to any improvement in a serious and distressing illness.

However, once a 'welfare' view of euthanasia is adopted, there is once again a 'slippery slope' to other forms of euthanasia than those involving terminal illness, or indeed a voluntary request. The very existence of some human beings is seen as a bad or worthless thing, so that death is in such people's interests. But if this is true, why should euthanasia not be given to the chronically ill? And why should it not be given to children and the mentally incapacitated, who will also 'benefit' from it, but are unable to request it?

### 4. The Netherlands

The position of euthanasia advocates who stress both 'autonomy' and 'welfare' considerations is inherently unstable. There is not just a 'logical' but a 'practical' instability: either consideration can

lead in practice to much more widespread euthanasia than was originally envisaged in official guidelines. Thus in the Netherlands we see both an extension of euthanasia to those who are mentally ill or 'tired of life' [4] and its extension to those who are unable to consent, such as infants and young children. [5] Indeed, there is now official toleration of non-voluntary euthanasia, in that (for example) euthanasia of children is required to be reported. In 2001, 100 out of 1088 deaths of babies under one year of age involved the giving of drugs with the explicit purpose of ending life. [6]

Three major Government-ordered studies of euthanasia and other end-of-life decisions have been carried out in the Netherlands, where euthanasia was accommodated for many years by court decisions before being legalized by statute. These studies show a far from reassuring picture with regard to observance of guidelines, including the requirement that the patient give consent. [7] In the studies, the term 'euthanasia' is used in the official Dutch sense of 'active voluntary euthanasia'; moreover, not all deliberate life-terminating acts - let alone deliberate life-terminating omissions - are classed as 'euthanasia', 'assisted suicide' or 'life terminating acts without request'. To arrive at a more realistic, though still conservative, figure for euthanasia in the Netherlands, it is necessary to count all acts - and if possible, omissions [8] - on the part of doctors which are chosen with the 'explicit intention' (or 'explicit purpose') of ending life. These figures are available for 1990 and 1995; however, the data for 2001 make it impossible to determine the exact level of (for example) non-voluntary active killing, since doctors who gave intentional overdoses of painkillers with the intention of hastening death were not asked, as in previous years, if the patient had consented.

## 4.1 Compliance with guidelines

When we read that 900 patients were deliberately killed without their request in 1995 (a figure which rose to 980 in 2001) we should remember that this figure, alarming as it is, does not include 1,537 cases where palliative drugs were given with the explicit, unrequested aim of hastening death. [9] If we include this group of cases, it becomes clear that more than a third of those actively killed were killed non-voluntarily. Even excluding this group of cases of active non-voluntary euthanasia, one in five of those actively killed were killed without their request. [10] If we turn to euthanasia by omission, there were as many as 18,000 such cases in 1995, [11] of which 14,200 - a substantial majority - were without the patient's request. It is worth noting that by no means all the patients killed without request, whether by act or by omission, were incompetent at the time. [12]

### 4.1.1 Reporting

It is often said that euthanasia will be better controlled where it can be freely reported. [13] In fact the Dutch experience shows widespread underreporting, in addition to widespread disregard of other guidelines. About half the cases of 'euthanasia' and 'assisted suicide' revealed by the 2001 survey went unreported, as did 99% of cases of termination of life without the patient's request, 100% of cases of intentional lethal overdose of painkillers (whether requested or unrequested), and a huge majority of cases where the patient killed was a child. [14]

This is in line with earlier research, which found that between 15% and 20% of doctors said they would not report their euthanasia cases under any circumstances, and that 20% of doctors' most recent unreported cases involved ending life without consent. [15] Such cases, both the 1990 and 1995 studies revealed, were virtually never reported. [16] Even where euthanasia takes place 'with consent', there is a real possibility of pressure being brought to bear by doctors and/or relatives. It is startling to note that more than 50% of doctors surveyed thought it appropriate to suggest euthanasia to patients. [17]

As one researcher comments, 'When, as the 1990 and 1995 studies document, 59% of Dutch physicians do not report their cases of assisted suicide and euthanasia, when more than 50% feel free to suggest euthanasia to their patients, and when 25% admit to ending patients' lives without the patient's consent, it is clear that terminally ill patients are not adequately protected.' [18] Most striking of all, in both the 1995 study [19] and the 2001 study, [20] the authors suggest that it is the *patient* who is responsible for avoiding termination of his life: if he does not wish euthanasia, he should say so clearly, orally and in writing, well in advance.

## 5. Palliative care



What then, should the terminally ill patient be offered in place of euthanasia, which the Dutch experience over many years has shown to be impossible to contain? Euthanasia in the Netherlands has been linked to poor palliative care, though such care is improving. Thankfully, the hospice movement in the U.K. is particularly strong; however, efforts must certainly continue to extend high quality care to all who need it.[\[21\]](#)

We warmly endorse the holistic care provided, in particular, in the hospice setting: care responding to the patient's physical, social, psychological and spiritual needs. It is worth remembering that drugs are not the sole response to the emotional distress a terminally ill person may experience. For this reason, we would question the wording of Clause 15 in the Assisted Dying for the Terminally Ill Bill, which gives the patient a right to 'request and receive' drugs which 'may be necessary to keep him free as far as possible from pain and distress'. Without denying that drugs are sometimes needed to treat mental, as well as physical, suffering, it is the experience of those working in palliative care that patients can often be otherwise assisted to a point where they are fully reconciled with their situation, and able to use their last days to the full. Drugs are often not the best response to mental distress, and it wrong to require that such distress be removed 'as far as possible' by such drastic measures as making the patient unconscious throughout the dying period. It should be for the palliative care team to determine when there is no better response than sedation to mental suffering, though this option must be kept in mind.[\[22\]](#)

We would emphasise the moral importance of intention in regard to palliative care (and indeed, human action generally). It is often permissible to accept a foreseen but unintended side-effect such as the shortening of life, or the patient's inability, due to sedation, to engage in social or spiritual activities. While it is normally the case that palliative drugs are more likely to extend than to shorten the patient's life, where the reverse is true, their use can still be justified, if the life-shortening side-effect is balanced by the intended effect of treating pain. The same can be said of the side-effect of shortening life as a result of stopping treatment which is burdensome to the patient. There is a significant difference between continuing to value the patient's life, while foreseeing that it will be shortened by giving or omitting treatment, and seeing life as having no value, and thus to be deliberately curtailed.

## 6. Conclusion

To conclude: a doctor's willingness to kill some patients – whether because this is their 'choice' and/or because the doctor thinks their lives have no value - undermines a commitment to the patient's true welfare which is basic to medicine. Voluntary euthanasia is not a 'private' choice: it very much affects (among other things) the character of doctors, and their treatment of other patients. Once legalized, euthanasia would become a 'quick fix' for disposing of 'difficult' patients in response to the demands they make on care. Medicine would be robbed of the incentive to find genuinely compassionate solutions to the difficulties presented by such patients. The kind of humane impulses which have sustained the development of hospice medicine and care would be undermined, because too many would think euthanasia a cheaper and less personally demanding solution.[\[23\]](#) Doctors would be mistrusted by patients, who would die in an atmosphere of suspicion. Many patients would be killed without request, even if this remained illegal. The suicidal would be confirmed in their estimate of their lives' value, while the non-suicidal would be, at least, disheartened by the public view of lives such as theirs. For all these reasons, it is vitally important that society continue to value the lives of all its members, including those who, in pain or distress, do not see their own lives as worthwhile. Euthanasia betrays the suicidal by accepting their own view of their lives: suicidal people, whatever their physical condition, need protection and support.

## APPENDIX 3

The following is written by Dr Rick Thomas is also well worth consideration and can be found at:  
<http://www.cmf.org.uk/publications/content.asp?context=article&id=26327>

Experience in other jurisdictions, such as Belgium, the Netherlands and the American states of Oregon and Washington, shows clearly that any change in the law to allow assisted suicide, or any other form of euthanasia, leads to 'incremental extension' and 'mission creep' – a steady annual increase in numbers and a broadening of categories of those to be included (from mentally competent to incompetent, from terminal to chronic illness, from adults to children, from assisted suicide to euthanasia). This process will be almost impossible to police.

This bill also gives huge power to doctors without proper accountability and its so-called safeguards are paper thin. Furthermore, as we have seen already with the Abortion Act, a small number of doctors will push its boundaries and will be very difficult to regulate.

God calls us to give our whole selves to the love and service of others by expending our time, money and energy in finding compassionate solutions and offering hope to those who suffer (Matthew 22:37-40; Mark 8:34; Philippians 2:4-11; Galatians 6:2, 10). This has found practical shape historically in the hospice movement and in good palliative care – pioneered in large part by Christian doctors and nurses.

In one multi-site study in the US, half of those with terminal illness who had initially considered seeking assisted suicide changed their minds over the subsequent few months. (6) In another study, in Oregon, 26% of those seeking assisted suicide met the criteria for depression. Less than 3% of such patients were referred for formal psychiatric assessments. In the same study, researchers found that 2–17% of those in Oregon and the Netherlands, who died by assisted suicide, had been suffering from clinical depression at the time. (7) Over time, there has been a dramatic fall in the number of individuals receiving assisted suicide in Oregon who are first referred to a mental health professional on the grounds that a suspected mental disorder may be impairing judgment. In 1999, the figure was 37%; the number in 2010 was 1.5%. (8)

A frequently heard argument is that assisted suicide gives patients the chance of dying a 'good death'. However, the reality can be very different. Dutch research shows that distressing complications can occur. For example, in 18% of cases the patient failed in the attempt and doctors had to intervene and kill the patient – assisted suicide became, in effect, euthanasia. (9)

There is clear evidence from the Netherlands that at least one thousand patients, including the elderly, incapacitated, those suffering emotional distress, the disabled and even children and newborn babies, are being killed every year without their expressed consent. (11) (12) (13) As Dr Karel Gunning, a Dutch General Practitioner, states: 'Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.' (14) (the Pandora box)

In practice, once any so-called 'right' is established in law, experience in other jurisdictions shows that incremental extension takes place over time. There is both a steady increase in absolute numbers of cases and also inclusion of those who are outside the stated boundaries of the law. There is also pressure to extend the law as activists bring new cases to the courts using the same general arguments of autonomy and compassion.

Doctors study and work to preserve lives, not to end them; to be purveyors of health, not death.

Trust is crucial to the doctor–patient relationship. The patient's confidence that the doctor will always act in such a way as to do no harm is foundational to that relationship. Giving doctors the power deliberately to end the lives of their patients will inevitably redefine the nature of the relationship and risks undermining that essential trust and confidence. Doctors could eventually become hardened to causing death, and begin to

see their most vulnerable patients as 'disposable'. (15) Such patients could decide not to ask for medical help, for fear that they be encouraged to consider assisted suicide by doctors who they feel they can no longer fully trust.

Of the four commonly quoted principles advanced as guides to bioethical debate and practice (namely respect for autonomy, beneficence, non-maleficence and justice (18)), autonomy has taken centre stage. But if understood as 'the right to do what I like', autonomy is a mirage – it fails to recognise that my choices affect yours and vice versa.

We live in a highly individualistic culture where there is much emphasis on an individual's rights, but much less about responsibilities and less still about restrictions. The truth is that we are not just individuals but individuals living in community, whether that community is a family, neighbourhood, workplace or society. A right exercise of autonomy will recognise the implications our decisions will have for others. It will balance rights with responsibilities and forgo some freedoms out of respect for others' rights and the common good (as with the observance of speed limits and smoking restrictions). We all accept that in a democratic society there are limits to personal freedom – that is why we have laws.

Assisted suicide, by definition, is not a private act – it requires the involvement of another person, often a doctor. The patient's autonomous decision therefore impinges on the autonomy of the physician – the patient's 'right to die' would impose on the doctor a duty to assist. The doctor (or more than one) would be obliged to make a value judgment about whether a patient's *quality* of life was such as to preserve or terminate it; any notion of the *sanctity* of human life would be undermined.

The following medical aphorism is attributed to Dr Edward Trudeau (1848–1915): 'To cure sometimes, to relieve often, to comfort always.'

Doctors can be tempted to feel a sense of failure when faced with relentless, incurable disease in their patients. But the truth is, doctors are not called to cure all – they are called to care for all. Compassion does not mean that they should intervene to end the lives of those they cannot cure.

Christians believe that human life has intrinsic value because it is the gift of God, created in his image (Genesis 1:27). The inviolability of human life is based on this intrinsic dignity and sanctity, and is independent of capacity or productivity.

Also worth reading

<http://www.carenokilling.org.uk/statements/euthanasia-and-assisted-suicide-a-joint-statement-by-doctors-and-lawye/>.