

CAMBRIDGE



P A P E R S  
*towards a biblical mind*

*volume 19*

*number 2*

*june 2010*

ISSN 1361-7710

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# Euthanasia and assisted suicide

*by John Wyatt*

*There should be a way out for rational people who have decided they are in the negative. That should be available and it should be easy. ....There should be a booth on every corner where you could get a martini and a medal.*

Martin Amis<sup>1</sup>

## Summary

The arguments in favour of the legalisation of assisted suicide and euthanasia are no longer focussed on unbearable suffering. Instead there is a rising demand for choice and control over the time and manner of our death, coupled with fears about the social and economic consequences of increasing numbers of elderly and dependent individuals. But there are strong medical, legal, social and theological reasons to oppose this new drive for suicide and euthanasia. The potent modern myth of the autonomous individual fails to match with the inescapable reality of human dependence and relationality. The increasing public support for the legalisation of medical killing provides an urgent challenge to the medical and legal professions and to the Christian community as a whole. Are Christians capable of living out a practical and countercultural demonstration of the preciousness of human life expressed in human interdependence, personal commitment and burden-sharing?

## Introduction

Debates about euthanasia and assisted suicide are not new. In the 1990s public concern about care of the dying led to the creation of a distinguished parliamentary commission into whether legislation should be changed to allow mercy killing. At the time the major focus was on people who were dying in terrible uncontrollable pain, especially those with terminal cancer. Surely medical killing was preferable to a slow agonising extinction. After detailed investigation the House of Lords voted decisively against a change of the law, instead encouraging the development and dissemination of effective palliative care for terminally ill patients.

Fifteen years later the debate on medical killing has resurfaced, but now the issues are strikingly different. Although fear of pain is widespread, it has become apparent that with appropriate levels of medical expertise and palliative care resources, pain can be controlled. With skilled care and expertise no-one need die in agony. Now the central issue is the right to self-determination, and the diseases in focus are no longer cancer, but chronic debilitating neurodegenerative conditions such as motor neurone disease and multiple sclerosis.

With a culture of increased patient participation, the introduction of the Patient Charter and the Mental Capacity Act of 2005, modern medical care is increasingly driven and controlled by patient choice. Why, if we have such choices about the rest of our lives, do we not have choice about the timing and manner of our death? Why, if we allow a mentally competent adult to refuse life-sustaining treatment, do we not allow that same adult to choose treatment which will bring about their death, within well-defined safeguards?

## Definitions

Definitions are important because debates about medical killing have always been bedevilled by the deliberate use of ambiguous and euphemistic phrases such as 'the right to die', 'assisted dying', 'easeful death', 'death with dignity', 'choice and control over how we die', and so on.

For the purposes of this paper euthanasia is defined as the intentional medical killing of a person whose life is thought not to be worth living. Physician-assisted suicide (PAS) is the deliberate assistance by a physician in the suicide of a patient who intends to end his or her own life. It is intentional killing, but at one remove. In the case of seriously disabled patients who require help in ending their lives, computer-

<sup>1</sup> Martin Amis, *The Sunday Times*, 24 January 2010.

controlled infusion devices can be used which inject lethal mixtures at the push of a button, or even at the blink of an eyelid. The doctor provides the means, the drugs, the apparatus and the technical knowledge; explaining what to do and how to do it, but drawing back from the final act.

In both euthanasia and PAS there is intentional medical killing, a deliberate and premeditated act designed to take life, to introduce death into a situation. Although euthanasia has been legalised in Holland, Belgium and Luxembourg, in the UK and the USA PAS is seen as more acceptable to the public, perhaps because it fits with Anglo-Saxon preoccupations about individual liberty and autonomy. But there is little doubt that the legalisation of PAS is conceived by pro-euthanasia activists as a first stage in the progressive liberalisation of the law concerning medical killing.

### World-view issues

The last 50 years have seen a striking rise in radical libertarian concepts of personal autonomy. The right to self-determination has been enshrined in a succession of legal judgements and changes in primary legislation. The concept of autonomy has changed from its roots in the European Enlightenment. Kant conceived it as freedom from coercive influences in order to determine the morally correct path by rational deliberation. But this concept has morphed imperceptibly into an individualistic and narcissistic form of self-determination. To modern thinkers autonomy has become the freedom to do whatever I wish and whenever I wish, without any requirement for rational or moral justification. And it seems self-evident to many that the right to self-determination must include the right to self-destruction.

Ronald Dworkin argues that any individual's way of death should fit with how that person has lived the rest of their life. Otherwise a bad death might mar the whole story of a life, just as a bad ending can ruin a beautiful novel. 'Death has dominion because it is not only the start of nothing but the end of everything, and how we think and talk about dying – the emphasis we put on dying with "dignity" – shows how important it is that life ends *appropriately*, that death keeps faith with the way we want to have lived.'<sup>2</sup>

People who have lived their lives as an expression of self-determination and self-reliance are horrified by the prospect that their death might express a completely contrary reality in which they become dependent on others. Instead, they want to be free to die as they wish, even if that form of dying is not what others might wish. 'Freedom is the cardinal, absolute requirement of self-respect: no-one treats his life as having any intrinsic objective importance unless he insists on leading that life himself, not being ushered along it by others.'<sup>3</sup> Philosopher John Harris draws the same conclusion: 'The point of autonomy, the point of choosing and having freedom to choose between competing conceptions of how, and indeed why, to live, is simply that it is only thus that our lives become in any real sense our own. The value of our lives is the value that we give to our lives.'<sup>4</sup> Since death is conceived by secular philosophers as the cessation of all autonomous action, there is a certain irony (if not logical incoherence) in the idea that the triumph of autonomy should lead to the premature destruction of that self-same autonomy. Surely those who wish to promote autonomy as the supreme good should oppose the squandering of this ultimate value in irrational or narcissistic self-destruction.

Radical libertarianism also carries with it a profound fear of dependence, perceived as robbing the individual of the ultimate human dignity of self-determination and self-creation. We respond with disgust and contempt at the prospect of a slow deterioration, 'sans teeth, sans eyes, sans taste, sans everything',<sup>5</sup> in which we

become totally at the mercy of others.

One way modern people cope with these deep-rooted fears is to hope for a rapid and unexpected death. Whereas to many previous generations, sudden death was seen as a tragedy – to be catapulted into eternity without the chance of preparation, of repentance, of saying goodbye – instant oblivion has now become positively desirable. But if we are not fortunate enough to be wiped out by a sudden catastrophe, then we insist on the right to choose the timing and the manner of our death. In many non-Christian cultures suicide has been seen as a noble, a virtuous, a responsible way of death. The historic Greek, Hindu, Japanese and Norse cultures, amongst many others, venerated the heroic suicide, whereas it has always been opposed in all cultures influenced by the Christian faith. It is no surprise that with the decline of Christian influence in our society, suicide is being actively rehabilitated as the way of death for twenty-first-century moderns.

### Social and economic factors

If fear of dependence and the right of self-determination are the main forces driving contemporary debates, there are other more sinister aspects to be considered. As Nigel Biggar has argued, the notion that we are all rational choosers is a flattering lie told us by people who want to sell us something.<sup>6</sup> The uncomfortable truth is that much of the time we are influenced and motivated by social and psychological forces that we barely understand. The demographic time bomb of increasing life expectancy is set to unleash new social forces. There is a nightmarish vision of the future, in which large numbers of isolated and abandoned elderly people are kept alive to suffer a pointless, lonely and degrading existence, thanks to improvements in medical care. Then there are spiralling healthcare costs, particularly at the end of life, with every medical advance bringing new and more expensive treatments. How can health planners find a way to control their runaway budgets?

All this is exacerbated by the growing epidemic of Alzheimer's disease and other forms of dementia. According to current predictions, someone born now has a one-in-three chance of developing some form of dementia in their lifetime. Martin Amis argues 'There'll be a population of demented very old people, like an invasion of terrible immigrants... I can imagine a sort of civil war between the old and the young in 10 or 15 years' time.'<sup>7</sup> Moral philosopher Mary Warnock has argued in favour of medical killing as a responsible option and not only in cases where pain is insufferable: '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. ...if somebody absolutely, desperately, wants to die because they're a burden to their family, or the state, then I think they too should be allowed to die.'<sup>8</sup>

### Legal safeguards on assisted suicide

Within the current legal framework of the UK, attempting suicide is not a criminal offence; but this cannot be taken as evidence of legal neutrality about suicide. The removal of legal sanctions on those who made an unsuccessful attempt at suicide was an act of compassion towards the despairing and desperate. Suicide is only tolerated, it is not promoted as an aspect of individual freedom. The Suicide Act of 1961 enshrined the serious criminal offence of 'a person who aids, abets, counsels or procures the suicide of another'. But over time legal toleration may be increasingly perceived as a matter of individual liberty. The current debates about prosecutions under the law of assisted suicide, including recent guidance issued by the Director of Public Prosecutions that 'compassionate motivation' on behalf of the perpetrator will be

2 Ronald Dworkin, *Life's Dominion*, HarperCollins, 1995, p.199.

3 *Ibid.*, p.239.

4 J. Harris, in John Keown (ed.), *Euthanasia Examined*, CUP, 1995, p.11.

5 William Shakespeare, *As You Like It*, 1600, Act II, Sc. vii.

6 Nigel Biggar, 'The Road to Death On Demand', *Standpoint*, March 2010.

7 Martin Amis, *Sunday Times*, 24 January 2010.

8 Mary Warnock, *Daily Telegraph*, 19 September 2008.

seen as mitigating the offence of assisting suicide, may have the effect of undermining the intention of legislation. But as Professor John Keown has written in this context, 'Justice should be tempered with mercy; not undermined by it.'<sup>9</sup>

The legal prohibitions against homicide and assisting suicide provide a practical and powerful defence for relatives and for health professionals to resist the coercive power of manipulative relationships. A common feature of assisted suicide stories reported in the media has been the manipulative influence of the suffering individual. On many occasions the sufferer appears to have coerced and manipulated unwilling relatives and loved ones to assist in the final act of self-destruction. Relatives can find themselves caught between repugnance at the deliberate taking of life, a sense of failure in their duty of love and care, and a sense of personal loyalty to their loved one, however much they disagree with their wishes. Similarly, physicians can find themselves manipulated and coerced by patients. It is a common feature of euthanasia in the Netherlands that patients plead with their family doctor, often a friend for many years, not to 'abandon me in my hour of need'. In this fraught emotional context, a legal prohibition on assisting suicide serves as protection for carers and health professionals.

It is common to find elderly people who are concerned that they are becoming an unwanted burden on their relatives and carers. Desiring to act responsibly and altruistically, they may come to perceive that it would be better for everybody if their life ended. There is a deep irony that the elderly people most sensitive to the needs and concerns of others are most at risk from manipulative arguments from false responsibility. Implicit social acceptance of assisted suicide could easily result in the perception of an implicit duty to die. As Professor Nigel Biggar has said, the legalisation of assisted suicide will make society more liberal at the expense of making it less humane.<sup>10</sup> In a civilised society we frequently accept restrictions on our rights of autonomy in order to protect the interests of those who are more vulnerable than ourselves. The small number of individuals who long for a legalised way to end their lives should be prepared to forgo their demands in the interests of the many vulnerable elderly in our midst.

### Logical incoherence of euthanasia legislation

All proposed changes in primary legislation have attempted to introduce medical killing under what are described as 'strictly controlled legal safeguards'. For instance, Lord Joffe's Assisted Dying Bill of 2005 stated that the individual must meet a range of criteria. In order to qualify for PAS individuals must a) be an adult who is legally competent; b) have a medically confirmed terminal condition with a limited life expectancy of six months or less; c) be suffering unbearably, which was defined as 'suffering, whether by reason of pain, distress or otherwise, which the patient finds so severe as to be unacceptable'; and d) have expressed a 'persistent wish to die'.<sup>11</sup>

Such a proposed legal framework does not at all reflect the radical libertarian argument that self-destruction should be available on request. Instead there is a 'paternalistic' desire to restrict suicide to those in whom it may be perceived as rationally defensible, by requiring them to surmount a series of arbitrary barriers.

But it is impossible to mount a logically coherent justification as to why all of these barriers should be surmounted before legally sanctioned medical killing may be carried out. On the one hand, if personal autonomy is accepted as moral justification for suicide, then it is not logical to restrict it only to people who are both about to die *and* in severe pain. If unbearable suffering is moral justifica-

tion for suicide it is not logical to restrict killing only to those with terminal illness. Surely the moral justification is greater in those who face years of unbearable suffering rather than those who are about to die anyway? Similarly, if unbearable suffering is moral justification for killing, then it is neither logical nor compassionate to restrict killing to those who are legally competent. What if someone who is suffering terribly expresses a will to die whilst they are still competent, but then becomes confused before euthanasia can be performed? On what logically defensible grounds could we say that they should not be killed out of compassion?

The proposed legislation does not have a consistent logical basis; it cannot withstand logical analysis. This is the logical basis for the slippery slope argument. Once we breach the law's absolute and principled prohibition on intentional killing, there is no logical basis for well-meaning attempts to draw lines. And hence, given the media focus on tragic 'human interest' stories, the fashionable emphasis on radical autonomy, and the political agenda of pro-euthanasia activists, once primary legislation is enacted it is inevitable that it will be progressively challenged, extended and weakened. It is striking that many of the cases of suicides highlighted and tacitly supported by the British media would not meet the legal criteria for assisted suicide proposed by Lord Joffe. Neither Sir Edward Downes, Dr Anne Turner nor Daniel James were terminally ill with a limited life expectancy at the time they chose to die.

Once intentional killing is accepted as a moral and legal part of medical practice, it seems both logically and practically impossible to prevent the gradual extension to voluntary euthanasia of those who wish to die, even if they are not terminally ill, and the involuntary euthanasia of those whose lives seem futile and pain-filled.

To many observers of euthanasia practice in the Netherlands it seems that this process is slowly but inexorably taking place. Medical killing of adult patients who were 'suffering unbearably' was initially tolerated, then regularised and subsequently incorporated into Dutch law. Subsequently, prominent cases have included the killing of a woman who was physically healthy but suffering intractable grief from the death of her sons, euthanasia of children with terminal cancer, an elderly man who was tired of life, and newborn infants with severe congenital malformations.<sup>12</sup> A recent controversial report published by the Royal Dutch Medical Association recommended that medical killing should be made available to those who were hopeless and could be said to be 'suffering from life'.<sup>13</sup> Although this has not become official policy, the highly influential Dutch Right To Die society is currently campaigning for the extension of medical killing to people with early dementia, those with untreatable psychiatric disorders and to elderly people tired of life.<sup>14</sup>

### The Hippocratic tradition of medicine

Traditionally both euthanasia and PAS were forbidden under almost every known code of law. Until recently all accepted codes of medical ethics specifically forbade them. The Hippocratic Oath, which originated several centuries before Christ, explicitly ruled out both euthanasia and PAS. 'I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, neither will I suggest such a plan...'<sup>15</sup>

The Hippocratic tradition of medical practice drew a clear distinction between healing and harming. In most societies of the time the doctor and the sorcerer tended to be the same person. He

12 <http://InternationalTaskForce.org/fcthall.htm>;  
[www.ivpbooks.com/mattersoflifeanddeath/downloads/page195.pdf](http://www.ivpbooks.com/mattersoflifeanddeath/downloads/page195.pdf);  
[www.carenotkilling.org.uk/?show=827](http://www.carenotkilling.org.uk/?show=827)

13 Tony Sheldon, *BMJ*, 330:61, 8 January 2005.

14 [www.nvve.nl/nvve-english/pagina.asp?pagkey=105273](http://www.nvve.nl/nvve-english/pagina.asp?pagkey=105273)

15 [www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html)

9 John Keown, 'Dangerous Guidance', *New Law Journal*, 2009, Vol. 159, Issue 7397.

10 Nigel Biggar, *Aiming to Kill*, Darton Longman & Todd, 2003.

11 Assisted Dying for the Terminally Ill Bill,  
[www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.i.html](http://www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.i.html)

with the power to kill had the power to cure. But the Hippocratic physicians dedicated themselves to the protection of life under all circumstances, regardless of rank, age, or intellect – the life of a slave, the life of the Emperor, the life of the immigrant. For more than 2,000 years the medical profession has attempted to maintain the distinction between killing and curing, framing itself publicly as a profession dedicated solely to the preservation of human life ‘under all circumstances’. It is part of the special calling, the medical vocation which doctors perceive in their protection of life. Hence doctors have refused to participate in judicial execution, in killing on the battlefield, in the torture of prisoners, and the use of drugs to control political dissidents.

So there is a special irony about the proposal that only qualified doctors should be allowed to engage in mercy killing. For those with a sense of medical history it would be preferable to develop a caste of professional euthanasiasts, rather than place mercy killing within the context of traditional medical practice and therapy. Once the ‘right to die’ is established by law, doctors will have a professional and legal responsibility to discuss, offer and participate to some degree in organisation and coordination of medical killing. In the process their distinctive commitment to the protection of life is violated and, for many, personal integrity breached. It is surely better for society as a whole if the special role of doctors is preserved and protected. To do so supports professional trust, enabling us to feel safe when we are in a doctor’s hands, and enshrines a commitment to social equality by undergirding the availability and protection of medical care irrespective of who the patient is or what they have done.

### Theological perspectives

The historic biblical world-view sees all human life as uniquely valuable because all human beings are made in God’s image. In orthodox Christian thought, human beings, even when facing terminal illness, suffering from dementia or in the twilight state of the permanent vegetative state, are God-like beings.

‘Whoever sheds the blood of man, by man shall his blood be shed, for in the image of God, has God made man.’ (Genesis 9:6). As Roy Clements pointed out, this ancient text, the *lex talionis*, combines two biblical themes. First, the ancient blood taboo, a recognition of the special status of blood because it represented a spilled life, and secondly the *imago Dei*. To destroy innocent human life is uniquely scandalous because it is a desecration of God’s image. ‘A human life is not just a gift of God’s grace – it is a reflection of his person.’<sup>16</sup>

The mysterious *imago Dei* is a concept which is multifaceted, incorporating ideas of incommensurable value, relationality, interdependence and stewardship of creation. In biblical thought those made in God’s image deserve above all else protection from abuse, from manipulation, from accidental or deliberate harm. We are not at liberty to destroy innocent human life, however noble may be the motive.

This is why orthodox Christian thought has always been opposed not only to homicide, but also to suicide. Intentional self-destruction is also a desecration of God’s image. In all cultures influenced by the Judaeo-Christian revelation, suicide has been opposed. It is never glorified in the biblical narrative. Samson, that flawed and ambiguous character, is the only example of a heroic and desperate suicide whose act is in some sense approved. In the rest of the biblical narrative suicide is associated with godlessness, as in the tragic ends of Saul and Judas Iscariot. Despite this, suicidal thoughts are not uncommon in God’s people. Elijah wanted to die: ‘It is enough Lord, take my life...’, but he was sent on a sabbatical instead.<sup>17</sup> Job laments, ‘Why did I not perish at

birth, and die as I came from the womb...?’<sup>18</sup> but discovers after chapters of unrelieved agony that there is a wider picture in which his suffering is framed; ‘Surely I spoke of things I did not understand, things too wonderful for me to know...’<sup>19</sup>

In biblical thought, human beings are free to act and choose as responsible moral agents who are accountable to one another and ultimately accountable to God. But there are God-given limits to our freedom as moral agents, limits reflecting the hidden moral order of the creation, the moral warp and woof of reality. And one of those moral limits which I transgress at my peril is to choose to destroy my own life or the life of another. Even when tempted to kill out of compassion or despair I run up against the limits of my own creatureliness. ‘Within the story of my life I have the relative freedom of a creature, but it is not simply my life to do with as I please.... Suicide... expresses a desire to be free and not also finite – a desire to be more like the Creator than creature.’<sup>20</sup> In biblical thought the intentional throwing away of my own life is a harm to be avoided, not a right to be assisted.

Yet there is a paradoxical character to Christian thinking about laying down one’s life. The cross of Christ is the supreme example of a life voluntarily and intentionally laid down for others. To lay down one’s own life for the protection of others, or in the face of unavoidable persecution, is seen as the height of Christian love. So what is the difference? Sacrificing your life because there is something worth dying for is Christian martyrdom. It is an act of faith and hope. Sacrificing your life because there is nothing worth living for is suicide. It is an act of despair and hopelessness. The Christian martyr does not aim at death but aims to be faithful to God, foreseeing that death may occur as a result. ‘Forbidding suicide and honouring martyrs, the early Christians recognised life as a real but not ultimate good – a great good but not the highest good.’<sup>21</sup>

It is not only those with an explicit Christian faith who sense a profound moral repugnance at the taking of human life. The unease and distress expressed by many doctors, healthcare workers and relatives who have participated in euthanasia or assisted suicide are evidence of profound intuitions about the sacrosanct nature of human life, intuitions which Christians argue come from our creation in God’s image. When we assist in the killing of another human being, however compassionate and rational our motives might be, we damage and deface our own humanity.

### The human family

Not only does orthodox Christian thought resist the potent modern myth of self-determination, it also resists the solipsistic and narcissistic tendencies of radical individualism. For we are all part of the human family. We are created to be bound into a mutually dependent community. Indeed in some mysterious sense we reflect the being of a Trinitarian God, in whom the persons of the Trinity are mutually dependent, constituted by their relations. From a Christian perspective the myth of individual autonomy is insanely out of touch with reality. We are part of a community, bound together by duties of care, responsibility, compassion and burden-sharing. Respect for human life in all its forms, and the prohibition of suicide, is part of the glue which binds society together. It is part of the moral order, the hidden moral grain which God has placed in the creation.

This is why the active prevention of suicide is a major part of medical, social and judicial activity in our society. Indeed we risk the lives of valued citizens such as police officers to try to save the life of a man attempting suicide from a bridge. Why risk precious

18 Job 3:11.

19 Job 42:3.

20 Gilbert Meilaender, *Bioethics: A Primer for Christians*, (2nd edn.), Eerdmans, 2005, p.57.

21 Ibid. p.67.

16 Roy Clements, *Cambridge Papers*, Vol.3, No.1, 1994.

17 1 Kgs. 19:4.

lives in order to save someone who doesn't value his own life? It is because our society, though penetrated by liberal individualism, is still deeply influenced by Christian ideas of solidarity, interconnectedness and mutuality. '...any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee.'<sup>22</sup> There is a deep logical disconnect that in one part of our legal system, proceedings are taken out against prison staff who fail to prevent the 'autonomous' suicide of a prisoner in their care, whilst elsewhere lawyers make the case for a legal right to be killed.

Although born out of desperation and loneliness, suicide frequently has devastating and lifelong consequences for others. In fact it can be a profoundly selfish, manipulative and destructive act. Whether intentionally or not, the suicide strikes at all those in community with them, wounding and damaging them, often for life. When my loved one chooses to kill themselves, they irreversibly underline the failures and inadequacies of my actions. When I am forced to collude in the act of suicide, I am frequently left unjustly disabled, burdened by the irretrievable consequences of my actions. We see this in the ambiguous and troubled reactions of the families of those who travelled to Zurich to help their loved ones to die. The relatives found themselves torn between loyalty to their loved ones, and a deep sense of their own failure to express that the life of their loved one was still valuable.<sup>23</sup> To assist suicide is to strike at the heart of what it means to live in community. We are mutually dependent beings and we are all called to share the burdens of the physical life which God has given us.

### **Human suffering: a mystery of human dependence**

To many in our society, suffering seems to have no ultimate meaning. It is pointless and destructive, the ultimate threat to individual human autonomy and self-determination. It is understandable that the elimination of suffering has become, for many, the prime goal of medicine and it is an easy step to accept that, in the name of eliminating the suffering, we are forced to eliminate the sufferer.

Yet, within a biblical world-view, suffering can never be meaningless, even if it has that appearance. For Christian believers suffering is a painful reality which we are sometimes called to *accept* from the hand of a loving God. Even the word 'to suffer' implies an element of passivity. It comes from the Latin *suffere* meaning literally 'to bear under', and hence 'to permit or to allow'. The root meaning of suffering is to submit or endure some circumstance which is beyond our control.

This is why suffering is regarded by secular philosophers as an affront to modern concepts of autonomy. It is not so much that suffering impairs our ability to choose, but that suffering threatens our conviction that we are in ultimate control. It challenges the widespread fantasy that we can be autonomous individuals and emphasises our deep and inescapable creaturely dependence on others.

As ethicist Stanley Hauerwas points out, for most of us the initial reaction to witnessing suffering in another human being is to be repelled. Suffering tends to turn the other into a stranger. 'Suffering makes people's otherness stand out in strong relief.'<sup>24</sup> Yet suffering in another human being is a call to the rest of us to stand in community. It is a call to *be there*. 'It is the burden of those who care for the suffering to know how to teach the suffering that they are not thereby excluded from the human community. In this sense medicine's primary role is to bind the suffering and the non-suffering into the same community.'<sup>25</sup> The sad reality is that, so often, modern medical and healthcare systems have precisely the

opposite effect, as they isolate and marginalise the suffering.

The duty of care that doctors and other professional carers are bound by, is a moral commitment to be there for those who are ill, suffering, or dying. It is a practical demonstration of the unbreakable covenant bonds of community. It is to say to the sufferer, 'We promise to care for you whatever will happen, whatever it may cost. We will walk this road with you to the end.' We are called to struggle against death whilst recognising the ultimate futility of our struggle. Doctors, above all, must recognise the limitations of their abilities and callings. In fact it can be argued that one of the primary roles of medical professionals is to teach people the limits that come from our physical nature: '...medicine represents a way of learning to live with finitude.'<sup>26</sup>

### **Good medicine: recognising the difference between intention and foresight**

The pro-euthanasia lobby ridicules the traditional view that doctors may give a drug to relieve suffering that may incidentally shorten life, but may not deliberately give a poison to end life. This is viewed as pure hypocrisy, as a deliberate attempt by doctors to cloak their life-terminating activities in a charade of respectability. Closely related is the widely disseminated propaganda that when doctors give morphine they are intending to kill but covering their tracks, to prevent prosecution. This is both misleading and dangerous. Morphine and other opiates are highly effective painkillers. Of course they may be given with homicidal intent, but in fact when used with appropriate skill they are not dangerous lethal drugs. Many palliative care doctors argue that when used skilfully opiates often extend life, by controlling pain and improving wellbeing. When the euthanasia doctors wish to kill, they do not use morphine. They use the drugs of the anaesthetist, capable of inducing rapid-onset coma, muscle paralysis and cardiac arrest, not the drugs of palliative care.

Nevertheless, good medicine recognises the difference between intention and foresight. This is the so-called 'principle of double effect'. Whenever doctors give drugs such as chemotherapeutic agents with well-recognised and life-threatening side effects, they are operating under the principle of double effect. Their intention, the motivation behind their actions, is to cure the cancer, whilst they have the foresight that the treatment may unintentionally cause harm. When a physician gives opiates to a dying patient, the intention is to relieve pain, to bring benefit to the patient, whilst foreseeing that the treatment may unintentionally shorten life. If it had been possible to use another drug to bring the same pain-relieving benefit without the same risk of shortening life, then that drug should have been used.

### **Palliative care**

The development of palliative care, pioneered almost entirely by Christian believers, is a striking demonstration of the belief that the process of dying need not be one of devastating loss and despair. The wellspring of modern palliative care was a Christian understanding of a good death. The goal of the pioneers was not only to help people to die well but also to help them live more fully before they died. The practical daily experience of all those who care for the terminally ill is that dying well can be an opportunity for personal growth, for self-discovery, and for the restoration and reconciliation of broken relationships. It is a never-to-be repeated opportunity for forgiveness and for the re-establishment of family ties which have been severed. Some people have found that it is only when they are dying that their deepest desires can be recognised, acknowledged and, to some extent, fulfilled. Medical killing motivated so often by fear and despair, has the effect of short-

22 John Donne, *Meditation XVII, Devotions upon Emergent Occasions*, 1624.

23 See, for example, <http://news.bbc.co.uk/1/hi/health/4625538.stm>

24 Stanley Hauerwas, *Suffering Presence*, T & T Clark, 1986, p.25.

25 *Ibid.* p.26.

26 *Ibid.* p.48.

circuiting the process of dying, obliterating the opportunity for personal growth, reconciliation and fulfilment which it offers.

## The Christian hope

Mark Ashton, vicar of St Andrew the Great, Cambridge, in his moving articles on the experience of dying from cancer, expressed how this experience highlighted the profound significance of human relationships. 'People do matter more than things, and it will be leaving people that will hurt most at death.' But behind the precious human relationships, Mark gave witness to a deeper and more wonderful reality: 'It is my relationship with (Jesus) that can take me through death and which is the only hope we have of eternal life. He alone is the destroyer of death. ... It will be his voice that will call me into his presence...'.<sup>27</sup>

In the New Testament the distinctively Christian virtues of faith, hope and love are seen as eschatological virtues – they point towards the end times and the new creation. When we care for the elderly, the demented and the dying with genuine sacrificial love we are pointing towards the future. We are expressing in practical form the Christian conviction that death is not the end, the malignant and implacable destroyer of human identity and significance. Death, by God's grace, can become a gateway into a greater and more wonderful reality, a place where God himself, 'will wipe away every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away.'<sup>28</sup>

## Conclusion and practical implications

The arguments for legalising assisted suicide and euthanasia are in the process of imperceptibly changing from a duty of compassion towards the suffering, into the right of self-destruction for the hopeless. They are predicated on a potent individualistic delusion of isolated autonomous choice, a refusal to acknowledge the reality of our mutual interconnectedness and interdependence as human beings in society. The principled opposition of our current law to homicide and assisted suicide provides an essential safeguard for carers, for the medical profession and for the elderly and vulnerable who may fear that their lives have become burdensome and valueless.

The increasing public support for the legalisation of assisted suicide provides an urgent challenge to the medical and legal professions and to the Christian community as a whole. Many people have a fear of inappropriate and burdensome medical over-treatment at the end of life, and this drives the demand for assisted suicide. Although recent developments in palliative care have transformed our ability to help sufferers to die well, it remains a scandalously under-resourced and under-supported area of medicine. Tragically the quality of care which many dying people receive in

the UK and across the world falls far short of what is possible with the highest level of expertise, and many die with inadequate pain relief and symptom control. Vastly more resources are spent by Government and medical charities alike on researching treatments for life-threatening illness, than are devoted to improving the quality and availability of end-of-life care. As a community we need to insist on a reorientation of priorities so that care for the elderly, the chronically disabled and the terminally ill receives the support that is deserved.

The growing focus on personal autonomy and self-determination provides a challenge to the Christian community to demonstrate a countercultural and alternative understanding of the sanctity of human life and the nature of human interdependence and interconnectedness. In a society where millions of elderly people suffer isolation, abandonment and the silent horror of abuse, can the Christian community provide a resource of compassionate and sacrificial caring? In the history of the church, times of plague have been paradoxically associated with a spurt in church growth as a consequence of practical demonstrations of sacrificial Christian love. As the plague of euthanasia threatens to penetrate our society will the Church respond in the same spirit of sacrificial caring?

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27 Mark Ashton, *Evangelicals Now*, 2010, [www.e-n.org.uk/5014-On-my-way-to-heaven.htm](http://www.e-n.org.uk/5014-On-my-way-to-heaven.htm)  
28 Rev. 21:4

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