

community there are women facing pregnancy crisis and profound loss who need help and support. During its discussions the Task Group heard moving accounts of pain and loss, and examples of where further care and support could be provided. The Task Group therefore further recommended that a Task Group be established by the most appropriate Council of the Church to review and develop our pastoral care for women and families affected by pregnancy crisis, pregnancy loss, the diagnosis of a life-limiting condition and other related circumstances, and that this should include support for those caring for children and young people with disabilities.

42. Both recommendations were supported by the Council for Public Affairs and adopted by the General Council at their March meetings.

TREVOR MORROW, Convener

APPENDIX 1

EUTHANASIA AND ASSISTED SUICIDE

Introduction

1. Euthanasia and assisted suicide are currently illegal in both Northern Ireland and the Republic of Ireland. In recent years, a number of high-profile ‘right to die’ cases have reignited debate about end of life issues, including whether doctors should be permitted to assist a patient to commit suicide.
2. The purpose of this paper is to help the General Assembly to set out its views on euthanasia and assisted suicide.

3. Definitions

- (a) **Assisted dying** is a euphemism used by campaigners for legal change to refer to physician-assisted suicide. It is sometimes used to include also physician-administered euthanasia.
- (b) **Assisted suicide** is assistance provided by one person to another to enable the latter to end his or her life.
- (c) **Euthanasia** literally means ‘good death’ but has become almost exclusively applied to the deliberate ending of life.
- (d) **Palliative care** is the multi-disciplinary branch of health care which specialises in alleviating the pain or other suffering arising from incurable illness. It comprises specialist medicine, nursing, physiotherapy and psychological and spiritual care.
- (e) **Physician-administered euthanasia** is the administration of lethal drugs to a patient by a doctor in order to end that patient’s life. PAE may be with or without the patient’s request or consent.

- (f) **Physician-assisted suicide** is assistance with suicide provided by a physician. The doctor provides the means – the drugs, apparatus and technical knowledge – but the patient initiates the final event.
- (g) **Voluntary euthanasia** is the intentional killing of a patient at the patient's request.¹

4. **The Legal Position**

(a) **Northern Ireland**

Euthanasia and assisted suicide are illegal in Northern Ireland. Guidance by the Public Prosecution Service (PPS) for Northern Ireland issued in 2010 states:

- A person commits an offence under section 13 of the Criminal Justice Act (Northern Ireland) 1966 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide.²

The offence of encouraging or assisting suicide carries a maximum penalty of 14 years' imprisonment. However, in its policy document on assisted suicide, the PPS states that 'it has never been the rule that a prosecution will automatically follow where the evidential test of the Test for Prosecution is satisfied'.³ The PPS will look at each individual case to ascertain whether a prosecution should be brought and will consider a number of factors, including the motivation and actions of the person who has assisted a suicide.

The law has been described as having 'a stern face but an understanding heart' in that it upholds the illegality of assisting suicide as an important deterrent but has the discretion to look at the circumstances of each case.⁴

(b) **Republic of Ireland**

Euthanasia and assisted suicide are also illegal under Irish law. Section 2(2) of the Criminal Law (Suicide) Act 1993 states:

A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be

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1. This is not an exhaustive list of definitions. For further discussion see the Living and Dying Well think tank website (www.livinganddyingwell.org.uk/about/glossary) and John Wyatt, *Matters of Life and Death: Human dilemmas in the light of the Christian faith*, Inter-Varsity Press, 2009, pp.192-197.
 2. 'Policy on Prosecuting the Offence of Assisted Suicide', Public Prosecution Service for Northern Ireland, February 2010, p.1.
 3. *Ibid.*, p 5.
 4. Robert Preston, remarks at PCI's 'Living and Dying Well' conference, 22nd January 2015.

*guilty of an offence and shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.*⁵

The Director of Public Prosecutions has not issued guidelines on assisted suicide, however, in a 2013 judgement the High Court noted that “the very fact that UK guidelines on assisted suicide now exist must surely inform any exercise of discretion by the Director in this jurisdiction.”⁶ The Court went on to say that:

*... where reliable evidence of compliance with a list of factors, such as those specified in the U.K. Prosecutors guidelines, is presented to the Director ex post facto the event... She is then free to apply her discretion and make a fully informed decision about whether or not to initiate a prosecution... The Court feels sure that the Director, in this of all cases, would exercise her discretion in a humane and sensitive fashion, while it would stress that, of course, she must retain the full ambit of that discretion to decide whether to prosecute or not. The timing and sequencing involved in this approach leaves intact the legislative framework which underlines and upholds the pre-eminent right to life as enshrined in the Constitution... It also protects against the ‘slippery slope’ dangers identified in all of the cases whereby elderly or ill persons might be induced or otherwise coaxed or manipulated into seeking prematurely to terminate their own lives.*⁷

The Fleming case concerned a woman, Marie Fleming, who suffered from multiple sclerosis and applied to the High Court for a declaration that her husband could lawfully assist her to commit suicide. She was unsuccessful, and in a subsequent appeal the Supreme Court upheld the High Court’s decision, ruling that there is no explicit right to commit suicide, or to determine the time of one’s death, in the Constitution.⁸ The Court noted, however, that the Oireachtas has the option of legislating in this area and the courts could then determine whether the legislation is constitutional, based on any safeguards included.⁹

5. **Examples of international practice**

Euthanasia and/or assisted suicide are legal in a number of states.

(a) **Belgium**

Euthanasia was legalised in Belgium in 2002. The relevant Act confirmed that ‘a physician who performs euthanasia commits no criminal offence when he/she ensures that:

5. www.irishstatutebook.ie/eli/1993/act/11/enacted/en/print

6. *Fleming v Ireland and Ors* [2013] IEHC 2, para 171.

7. *Ibid.*, para 175.

8. *Fleming v Ireland and Ors* [2013] IESC 19, para 99.

9. *Ibid.*, paras 107-108.

- (i) The patient has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of making the request;
- (ii) The request is voluntary, well-considered and repeated, and is not the result of any external pressure;
- (iii) The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.¹⁰

Between 2002 and 2015, 12,726 people were euthanised in Belgium. Numbers have been steadily climbing, reaching 2,022 cases in 2015.¹¹ In 2014 and 2015, cancer was the main condition for which people asked to be euthanised (67.7%). This was followed by cases of multiple pathologies, which has been interpreted as the ‘coexistence of several serious and incurable disorders’. These are not necessarily fatal. Examples given by the Federal Commission for Euthanasia Control and Evaluation include disorders of gait and mobility due to osteoporosis, hearing impairment and the onset of dementia.¹²

(b) **The Netherlands**

Euthanasia and physician-assisted suicide were legalised in the Netherlands in 2002 by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act:

In the words of ‘the Act’, the questions that must be asked include the following. Was the physician satisfied that the patient’s request was voluntary and well-considered and that their suffering was unbearable, without prospect of improvement? Did the physician come to the conclusion, together with the patient, that there was no reasonable alternative in the patient’s situation?¹³

In 2016 the Dutch Euthanasia Review Committees received 6,091 notifications of euthanasia or assisted suicide, 4% of the total number of people who died in the Netherlands that year. 83% of cases concerned patients with cancer, neurological disorders (such as Parkinson’s disease, multiple sclerosis and motor neurone disease), cardiovascular disease or pulmonary disease. Around 2% of cases concerned patients with dementia and around 1% concerned patients with a psychiatric disorder.¹⁴

10. ‘The Belgian Act on Euthanasia of May, 28th 2002’, *Ethical Perspectives* 9 (2002), 2-3, p.182.

11. European Institute of Bioethics, *Analysis of The Seventh Report of the Federal Commission for Euthanasia Control and Evaluation to the Legislative Chambers* (for the Years 2014 and 2015), October 2016, p.1.

12. *Ibid.*, pp.3-4.

13. Regional Euthanasia Review Committees, *Annual Report 2016*, p.4.

14. *Ibid.*

(c) **Oregon, United States**

Physician-assisted suicide was legalised in Oregon in 1997. According to the Oregon Health Authority:

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications.¹⁵

The legislation states:

*An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.*¹⁶

As of January 2017, the Oregon Health Authority had received reports of 133 people who had died in 2016 from ingesting the medications prescribed under the Act. A total of 1,127 people had died in this manner from 1997.¹⁷

6. Arguments put forward for changing the law(a) **Fear of suffering and dependence**

Fear is one of the great driving forces for legal change. Some of the main reasons people seek assisted suicide or euthanasia are captured in a recent report by the Public Health Department of Washington State, where physician-assisted suicide has been legal since 2009. Among the end of life concerns of those who died in 2016 were loss of autonomy (87%), loss of dignity (66%), being a burden on family, friends and/or caregivers (51%) and inadequate pain control or concern about it (41%).¹⁸

In the 1990s, the focus of debate around changing the law was on people dying in terrible, uncontrollable pain. With advances in medical science, palliative care and pain control, the focus has shifted to neurodegenerative conditions that lead to a loss of control and dependence. In one of the most recent cases to reach the High Court of England and Wales, a leading campaigner with motor neurone disease, explained:

15. Oregon Death with Dignity Act, Data Summary 2016, Oregon Health Authority, February 2017, p.4.

16. www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ors.aspx

17. *Ibid.*, p.5.

18. 2016 Death with Dignity Act Report, Washington State Department of Health, September 2017, p.8.

*I do not wish to get to a stage where my quality of life is so limited, in the last six months of life, that I am no longer able to find any enjoyment in it. This disease is a relentless and merciless process of progressive deterioration. At some point, my breathing will stop altogether or I will become so helpless that I will be effectively entombed in my own body. I would not like to live like this. I would find it a totally undignified state for me to live in. I find the prospect of this state for me to live quite unacceptable and I wish to end my life when I feel it is the right moment to do so, in a way that is swift and dignified...*¹⁹

Cancer is the most common condition affecting people who choose euthanasia or assisted suicide where it is legal. Despite the significant advances in end of life care, fear of pain, uncertainty and loss of control remains an important factor in efforts to change the law in Ireland, the UK and elsewhere.

(b) **Personal autonomy**

“Most of all, I believe in a person’s right to determine their own life and the manner of ending it, as that is a sovereign principle. We each own our lives and no one else defines that for us.”
Chloe Smith MP

The ‘right’ to self-determination is propelling the drive for assisted suicide and euthanasia in the West. Professor John Wyatt notes:

*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... 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.*²⁰

To many people, it seems outrageous that they can control almost every aspect of their life but are not allowed to control the manner and timing of their death.

(c) **Social and economic factors**

In 2008 Baroness Mary Warnock caused controversy when she argued in favour of medical killing as a socially responsible option:

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

19. R (Conway) v The Secretary of State for Justice [2017] EWHC 2447 (Admin), www.judiciary.gov.uk/wp-content/uploads/2017/10/r-conway-v-ssj-art-8-right-to-die-20171006.pdf

20. John Wyatt, ‘Euthanasia and assisted suicide’, *Cambridge Papers*, volume 19, no. 2, June 2010, p.2.

*they're a burden to their family, or the state, then I think they too should be allowed to die.*²¹

It has also been suggested that, as people live longer with increasingly complex medical conditions, they should be allowed to end their lives to free up the time and resources of the state, family and friends.

7. Potential harms

(a) Placing vulnerable people in danger

Many people, especially older people, are already vulnerable to malicious actions by others. Research has suggested that over 23,000 older people in Northern Ireland have experienced serious physical, mental or financial abuse.²² A 2010 report by the Republic of Ireland's Health Service Executive, National Centre for the Protection of Older People and University College Dublin estimated that 10,000 people over the age of 65 had experienced mistreatment,²³ and in 2014 the HSE's Elder Abuse Service received 2,592 referrals.²⁴

In many cases abuse is perpetrated by family or carers, often motivated by financial gain. It would be naive and irresponsible to think that such people would not seek to exploit a change in the law. Moreover, many older or disabled people would feel pressurised to 'do the decent thing' to stop themselves 'being a burden' to others. It is not hard to see how 'you can take this route' could quickly become the norm that 'you should take this route'. This concern has already been expressed by many individuals who are dependent on others for care. Changing the law to allow euthanasia and/or assisted suicide would undoubtedly place increased numbers of vulnerable people in danger of harm.

(b) A mind shift from healing to killing

If we concede that people have a right to die in certain circumstances it follows that society has a duty to provide the means for their death, if they cannot arrange it for themselves. This responsibility would pass to the medical profession. Doctors would be called upon to decide when the death of a patient would be appropriate, and, if they were not directly arranging the death themselves, they may have a duty to authorise others to help with, or administer the fatal procedure. Under the guise of compassion we would be introducing a drastic change to the

21. Mary Warnock, *Daily Telegraph*, 19th September 2008.

22. 23,000 elderly people abused in Northern Ireland every year, says charity, *Belfast Telegraph*, 13th September 2017

23. *Abuse and Neglect of Older People in Ireland: Report Summary*, UCD, NCPOP and HSE, 2010, p.4.

24. *Open Your Eyes: HSE Elder Abuse Services 2014*, HSE, 2014, p.45.

values of our society – particularly a presumption in favour of life – and distorting the traditional role of medicine from its mission of healing and treating pain and discomfort. If assisted and/or euthanasia is normalised the underlying social dynamic will change. Laws are not just regulatory instruments; they communicate values and norms. The message that would be sent in this case is that if you are sick or old and a burden, ending your life is something you ought to consider.

(c) **Deciding when the unbearable is unbearable**

There is also severe risk and insurmountable difficulty in seeking to define how unbearable a person's life must be before the state agrees that assisted suicide or euthanasia is appropriate. Just as we are all different in our abilities to cope with pain and indignity, what might be an unacceptable quality of life for one person could well be accepted by someone else. Perhaps we could simply rely on the wishes of the person concerned, but would our society really be content to arrange the death of people who simply considered that they were too old or unhappy to live? How would society decide when reasons for requesting assisted suicide or euthanasia are unacceptable? The most recent report of the Netherlands' Regional Euthanasia Review Committees (RTE) states:

Opinions differ widely on whether it should in future be made possible to receive assistance with suicide if patients regard their life as 'completed', without there being a medical dimension to their suffering (which falls outside the current legal framework). In many cases where patients are suffering from multiple geriatric syndromes, they phrase their euthanasia request in terms of being 'finished with life' or state that they regard their life as 'completed'. Can a boundary be drawn between 'multiple geriatric syndromes' and 'completed life' that is practicable for both physicians and patients?...These questions are also the subject of intense discussions in the RTE... it could be beneficial to patients and their loved ones, physicians performing euthanasia, independent physicians and society at large if they could obtain greater legal certainty than the RTE can give.²⁵

It is hard to see how these questions could ever have a clear answer and it is easy to see how the scope of legalisation could continue to grow and grow, particularly if personal autonomy is used as moral justification for suicide.

8. **Our approach as Christians**

It is a bleak fact that pain, suffering, distress and death itself are inevitable parts of human life. Even if we happen to escape serious illness or injury during our lives we will always know someone who

25. Regional Euthanasia Review Committees, 2016, pp.6-7.

will have to endure the circumstances we fear the most. In contrast to the view that all suffering is merely a pointless and destructive threat to individual autonomy, Christians, while being alive to the realities of pain, disease and injury in human lives, believe that God can transform suffering for His own good ends. For example, Christian ethicist Stanley Hauerwas argues that suffering is a call to live in community:

*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.*²⁶

Compassion for our fellow human beings means that we are bound to support efforts made to reduce pain and enable healing, and have a duty to help people to die in as comfortable and peaceful ways as we can. That is the spirit behind the development of palliative care (pioneered almost entirely by Christians) which “is a striking demonstration of the belief that the process of dying need not be one of devastating loss and despair.”²⁷

As Christians, we should not be constrained by the cultural taboo but should be able and willing to consider what it means to die well. This will mean facing up to the fact that our beliefs about the sanctity of life do not mean prolongation of painful life at all costs. Christians have long accepted the propriety of medical interventions designed to relieve pain which may unintentionally shorten life. This distinction between intention and foresight must be handled very carefully but is both valid and important. There is an important difference between doing something that is intended to end the life of the person concerned and taking action which has a high probability of shortening the person's life but which is intended to deal with pain rather than cause death.

Some, of course, would argue that we should go further than simply give care and attempt to relieve pain. They believe that there are situations when we should actively take steps to end the life of the person who is suffering on the grounds that life has become too unbearable to continue. If they are right, then we have a duty to kill, or, at least, help bring about the death of people who suffer in this way and wish to end their lives.

However, in Christian thinking, our lives are not only given by God but are also a reflection of His being. We are made by God in His image and reflect His character. Our emphasis on the value of human life has nothing to do with physical or mental ‘perfection’, nor with added value in economic terms, or economic cost. A human being's value does not lie in what he or she can do but exists simply because of what and who they are. This is one crucially important reason why we value and seek to care for those with disabilities of all kinds. The dignity and worth of individual life cannot be derived simply from an analysis by

26. Stanley Hauerwas, *Suffering Presence*, T&T Clark, 1986, p.26.

27. Wyatt, 2010, p.5.

an individual of the value of his or her own life. Thus the offence of taking human life is explicitly linked to with the indwelling image of God (Genesis 9:6). Intentional killing (as in euthanasia, assisted suicide and abortion) is wrong because it violates a profound moral order that human life really does matter and has innate value.

Furthermore, the way of Jesus Christ seems to imply a firm conviction that the timing of our deaths should be left to God. The Apostle Paul earnestly believed that for him to live was Christ and to die would be gain (Philippians 1:21), that he would rather be absent from the body and present with the Lord (2 Corinthians 5:8), but he was convinced that the decision was for God to make, not himself (Philippians 1:22-26). The fact is, we do not belong to ourselves, we have been bought with a price (1 Corinthians 6:19-20). We can never really know what work God has to complete even in a person whose mind seems to be utterly confused or who is barely conscious because of sedation to relieve pain.

As human beings made for relationship with God and each other, we also have to recognise our interdependence. What we do affects others and what others do affects us. It is indeed true that “no man is an island”. This is very important to keep in mind as we consider the possible legalisation of euthanasia and assisted suicide, and the very real dangers that would be created for vulnerable people. As Christians commanded to love our neighbours, we cannot view this as a matter of a ‘sovereign principle’ at work, self-determination or economic value. Rather, we must value the systemic protection of the weak and vulnerable over the sheer maximisation of individual autonomy.

9. **Conclusion**

The current laws on assisted suicide and the guidance that has been given for their administration continue to provide a fair, balanced and compassionate approach to a difficult and complex issue. Christians should resist the legalisation of assisted suicide and euthanasia while urging government and wider society to adopt the other options that are available for the alleviation of pain and suffering. Resources must be given generously to support palliative care research and delivery because of the need and vulnerability of those affected. Facilities like the Hospice Movement must be encouraged. Above all, the Christian community should take the lead in showing the prayerful, dignified, respectful care which assures people that they are valued and loved, even in the midst of pain and helplessness.

RESOLUTIONS

1. That the General Assembly express deep concern and frustration about the prolonged absence of an Executive in Northern Ireland, the resulting stagnation in public policy and the negative effects on the most vulnerable in society, and repeat their call for all involved in the political process to find a resolution that establishes good and stable government based on good working relationships.
2. That the General Assembly note with concern the sense of disillusionment and low morale amongst governors, principals and teachers, caused by the financial situation in schools and the uncertainty for the future of education in Northern Ireland, and therefore call upon politicians if necessary to set aside their differences to enable an Executive to be formed to bring about both democratic accountability and strong leadership that will provide the clarity so urgently needed on an agreed way forward for the education system in the province.
3. That the General Assembly believe that Religious Education has a very important role to play in the spiritual, moral and intellectual development of children and young people, and therefore affirm the place of RE within school curricula and encourage time-tabling and resourcing of RE which reflect its fundamental value to school life.
4. That the General Assembly:
 - (a) strongly oppose any legislation which allows assisted suicide and/or euthanasia; and
 - (b) strongly commend palliative care, calling on the governments in Northern Ireland and the Republic of Ireland to ensure the adequate resourcing of both research and delivery in this important area.
5. That the report of the Council for Public Affairs be received.