Introduction

Would it ever be possible to create legislation to allow assisted suicide which carried a guarantee that it would never be abused, and, even if that were the case, should such a law be enacted? These were the questions debated by philosophers and experts in end-of-life care in a ‘mock trial’ held by the Royal Society of Edinburgh and supported by the Faculty of Advocates. Speaking for the motion were Professor A C Grayling and Professor Raymond Tallis. Professor John Haldane and Baroness Finlay spoke against.

Motion

If it could be demonstrated that it would never be open to abuse, would you support, in principle, the idea of assisted dying/suicide?

The event was chaired by Mr Richard Keen, Dean of Faculty, Faculty of Advocates.

Speakers – For the Motion

Professor Anthony Grayling, Professor of Philosophy at Birbeck, University of London

The debate about assisted dying is a deeply moral one, and turns on our relationships with other people. It should be premised on our concern for others, primarily on our compassion for people who are suffering and our respect for the autonomy of the individual; this includes people’s right to make decisions about how they live and how they die.

Human rights laws give us a right to live, but Professor Grayling thinks that this should go further, giving us a right to a quality of life. If people feel that life is not worth living, then we should respect that.

Professor Grayling made it clear that he was talking about extreme circumstances, about the person who is terminally ill and who is suffering, physically or emotionally. Although palliative care is very good in Britain, pain cannot always be completely controlled and there can be other affronts to people’s personal dignity and well-being, such as incontinence, choking or gasping for breath. In these circumstances, people should have the right to be helped to what he called “an easeful passing for someone who has suffered too long”.

There would have to be safeguards, he said. There could be no question of someone else taking the decision on a person’s behalf, or for hospitals to do so in order to free up beds. It must be the rational, clear-minded and settled will of the person in question.

Real autonomy does not involve patronising ‘does he take sugar?’ attitudes and behaviour, and it comes with responsibility too. The individual must be aware of what he or she is asking others to do. This is why England’s Director of Public Prosecutions has been asked to clarify whether a family member, or other person, who helps a loved one to die, will be punished. At the moment, such an action can carry a 14-year prison sentence. This is severe punishment, said Professor Graying, for an act of love.
It is very sad, he said, that more than 100 people have gone to Switzerland for assisted suicide, some dying earlier than they would have chosen so that they could get there while still able to do so; others have killed themselves while they still could, again, cutting short lives.

To refuse a request to help someone to die is to let them down – the honourable thing is to respond. Passing legislation to make this possible would not be a slippery slope. Evidence from elsewhere suggests that such a law does not lead to great numbers of assisted suicides. Nor do people feel that just because something is legal, they should do it to stop themselves being a burden on their families.

“It’s not beyond the wit of man”, he said, “to come up with legislation which is careful, responsible and tender, and in the interests of the human being as he or she reaches the end of life”.

**Professor Raymond Tallis, philosopher, poet, author and cultural critic**

In response to questions from Professor Grayling, Professor Tallis expanded on the evidence from other jurisdictions which have introduced laws to legalise assisted dying or assisted suicide.

He also explained that his own view on the issue had changed when, as Chair of the Royal College of Physicians (London) Ethics Committee, he realised that palliative care did not solve all problems. As a clinician for many years, specialising in old age care, he also drew on his on-the-ground experience to say that he believes there are times when helping someone to die is the right thing to do.

He does not believe that legislation – such as that in place in Oregon, US, The Netherlands and Belgium – has an adverse effect on the doctor–patient relationship. He added that indeed trust between patients and doctors is highest in The Netherlands. “This is understandable”, he said, “because the patients know that their doctor will be there for them in their hour of need”.

He does not believe that such legislation would lead to exploitation of vulnerable people. It tends to be the feisty, middle-class and outspoken people, accustomed to self-determination, who take up the right to assisted dying.

And far from it being a slippery slope, he said that such legislation could bring about the opposite effect. Public opinion is strongly opposed to assisted suicide in cases such as that of the young paralysed rugby player who persuaded his family to take him to Switzerland because he felt his life wasn’t worth living, whereas public opinion is favourable to allowing the terminally ill to do so.

If anything, a mature debate about such issues encourages respect for life, rather than a descent to genocidal tragedies.
Speakers – Against the Motion

Professor John Haldane FRSE, Professor of Philosophy and Director, Centre of Ethics, Philosophy and Public Affairs, University of St Andrews

“It could not, in principle, ever be demonstrated that assisted dying/suicide would never be open to abuse”, said Professor Haldane; “in any case, though sometimes well-intended, it runs counter to the deepest moral values and virtues”.

He agreed with Professor Grayling that compassion and respect for autonomy are important, but said that the value of human life must be considered too.

In his view, an ethic of humanity, solidarity and assistance means that we must support – in a compassionate way – those who are dying. That ethic would, however, be incompatible with public policies which license assisted suicide, and would not allow the killing of human beings, even with their consent or at their request.

In general, the fundamental ethical stance towards human life is to protect it and this should mean that we do our utmost not to do harm. Assisting someone to commit suicide would be against this ethic.

He outlined some of the legislative activity around this issue in the UK. There have been a number of attempts, via Private Members’ Bills in the UK and Scottish Parliaments, to legalise assisted suicide, as well as House of Lords Select Committee investigations. All have been defeated, or have failed to support assisted suicide. “The issue has”, he said, “had more attention in the UK than in any other part of the world”.

Professor Haldane discussed whether it is possible to have an ethical framework for assisted suicide and concluded that it is not. Specifically, he looked at issues around autonomy, compassion and respect for life.

“There are several problems with autonomy, not least finding a suitable definition, and determining its scope”, he said. This definitely does not mean rejecting the importance of autonomy – just indicates that it can go too far and work against the common good. He cited cases where it might be argued that a person misuses his or her right to autonomy – such as someone who had voluntarily become an amputee, and others who were prepared to be murdered and eaten. “Exercising autonomy isn’t necessarily good”, he said.

There is a core ethical case against assisted suicide. If autonomy is the issue, why restrict it to cases of diminished quality of life and, in any case, who decides what the standard of life should be? And where do we draw the line – if assisted suicide is permitted, should other ‘welfare’ killing be sanctioned, whether by physicians or others?

Surely compassion does not necessarily lead to the conclusion that it is best to bring about someone’s death – there is virtue, rather, in affirming life in circumstances of suffering.

And assisted suicide does not take into account the common good: it draws others in, as agents (such as clinicians, family members), and also creates a framework where people might feel they have to take the assisted suicide option, because they don’t want to be a ‘burden’.

“Ethics is not just about making good”, he concluded. “It involves coping with the bad, and ethics of solidarity, humanity and assistance point to assisted dying – i.e., supporting someone at the end of life – rather than assisted killing”.

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Baroness (Llora) Finlay of Llandaff, Professor of Palliative Medicine, Cardiff University School of Medicine, and immediate Past President of the Royal Society of Medicine

“The motion”, said Baroness Finlay, “does not represent the real world. Rather, it is some ‘airy fairy’ version of reality which does not exist. If you believe the world is perfect, then support the motion; if not, then abstain”.

“It’s not about morality, or religion”, she said “– it’s about public safety under the law. Yes, there could be safeguards, but how safe is safe? Could they ever be safe enough? Hanging was abolished, because of the risk of hanging the wrong person. Similarly, with assisted suicide, the stakes are simply too high – you get it wrong, and in the real world, chances are you would, then there’s no going back”.

There are no certainties, even in modern medicine, and it is very difficult to define terminal illness. Very little, in reality, is cured; it’s difficult, if not impossible, to predict when someone is going to die.

She drew on examples from her own experience as a doctor to show how a man given less than three months to live in 1999 had gone on to live a very full life for more than 20 years. She also cited the case of Lockerbie bomber al Megrahi. Doctors expected him to be dead within three months when his release from prison on compassionate grounds was recommended [in August 2009]. He is still alive.

There is also an issue of mental capacity. Even psychiatric evaluation (of people who want to die) might not pick up evidence that the person’s cognitive or decision-making processes may be affected, but many things, including steroids and opioids, might distort this. Shouldn’t we be protecting people with impaired cognitive abilities rather than aiding them to die?

Issues around assisted suicide or voluntary euthanasia are rarely black and white, and most people do not have strong views either way. In other words, most of us fall into the silent majority and need to be protected.

She said that there are two roads which clinicians – doctors and nurses – could take when a patient tells them that he or she wants to die. Depending on how the doctor steers the conversation, the outcome for the patient is determined. If the doctor – where permitted in law – sets in motion the process of assisted suicide, then that is how the situation is likely to develop. But the alternative response is to ask what is making the situation so bad for the patient at that moment, and asking what can be done to ameliorate these particular circumstances.

In the real world, medicine is about making lots of decisions, often very quickly. But the bigger the decision – the higher the stakes – the more careful the clinician has to be. A situation whereby the doctor enables the patient to die early colours the whole doctor–patient relationship, especially as the clinician should be there to guide the patient in difficult times. Patients are not always rational and cool-headed – and doctors aren’t always good communicators. Improvements can and should be made, but this does not mean that such a radical step as legalising assisted suicide is necessary or even desirable.

In the real world, families aren’t always loving and selfless. She mentioned a case where a woman’s very attentive family kept asking for her to get more pain control, although the patient herself said she didn’t need it. After the woman’s birthday, her family visited far less frequently – it turned out that a life insurance policy had expired on the birthday and her family were £11,000 worse off as a result.

“Human nature finds loopholes”, she said, “and no safeguards would be watertight”.
**Summing up**
Both sides were allowed to sum up and to respond to points made by the other speakers and answer questions from the Chair. There was some debate over the effect of legislation in other jurisdictions on numbers of people requesting – and following through with – assisted suicide. Professor Tallis said that only a very small proportion of the people in Oregon who discussed the possibility with their doctor went on to receive or fill a prescription for fatal drugs; Professor Finlay said there weren’t sufficient safeguards to know what happened to the drugs which were obtained.

**Outcome**
The audience was invited to vote on the motion twice: at the start of the event and at the end. The results were as follows:

First vote: 77 yes; 3 no

Second vote: 68 yes; 11 no.

The Chair summed this up by saying ‘both panels achieved a victory’.

**Questions**
Following the vote, there was a short opportunity for audience questions. One teacher who had brought members of her Higher class said that she’d been convinced to change her vote from yes to no, but asked whether Professor Haldane and Baroness Finlay felt that it was wrong to support assisted dying even if it could not be abused. Both said it was, with Baroness Finlay adding that it was a principle of justice at stake.