MISSION CATALYST

Intelligent comment on faith and culture

THE VALLEY OF THE SHADOW

The future of the end of life

TONY NICKLINSON
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WHY END OF LIFE ISSUES MATTER

QUESTIONS OF ASSISTED DYING ARE NOT GOING TO GO AWAY. CHRISTIANS CAN’T AFFORD TO IGNORE THEM

In February 2010 a House of Commons ‘Note’ was produced for Members of Parliament. It stated that, “population ageing is seen as one of the greatest challenges facing contemporary society, because of its many social, economic and political implications.”

This phenomenon is not limited to so-called Western nations, but is discernible throughout the world as the benefits of health care, aid and development programmes, greater economic empowerment and universal access to education impact societies.

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The speed of change in the UK is breathtaking. According to that same parliamentary note, there were four million people over the age of 65 in 1951, 10.3 million people in 2010, and a projected 16.9 million or 23 per cent of the population by 2035. Locally, in areas like Devon, West Somerset and Berwick upon Tweed the over 65s will rise from 31 per cent to 42 per cent in that time scale.

These factors have huge implications for society generally, but also for the mission of the church.

Some of the implications are economic, relating to such as pensions. There are social implications, such as how we will care for an ageing community.

And there are certainly ethical issues too, the most sensitive of which surrounds those for whom prolonged life means a severely reduced quality of life. An ageing population means increased incidents of dementia, Parkinson’s disease and other chronic debilitating illnesses. For some the quality of life is, or will become, so reduced that they want the law to give them the right to end their life.

Alongside them are those who have suffered traumatic accidents, or acute illnesses which leave them with what is known as ‘locked-in syndrome’, effectively unable to do anything for themselves but rely wholly on others for mere survival.

For these reasons some are calling for the legalisation of assisted suicide, amongst them Lord Falconer who published a Bill to this effect in May 2013.

It is a carefully crafted Bill, one that seeks to be compassionate for sure, grounded in the rights of the individual to decide about their own life. It is only a Bill to legalise euthanasia in the case of those who are terminally ill and who have less then six months left to live. As such, it does not affect the cases of those who suffer from other conditions, though it is clear that proponents would like to see legislation that includes those with degenerative illnesses such as Motor Neurone Disease, Alzheimer’s, Dementia or Locked-in syndrome.¹

I have three particular concerns about the Bill. The first is that the Bill, if made into law, will have limited application initially but the principle will have been established and it will be widened in the years to come. Everyone knows that. The 1967 Abortion Act has set the precedence for this as Prof Michael Marsh’s contribution on p14 demonstrates clearly.

The second concern is that this debate becomes primarily a debate amongst medics, centred on the degree to which we can manage pain, define the meaning of ‘terminally ill’ and how well we can find two independent doctors to vouch that someone is dying. Death and dying do have medical dimensions of course but they also have social, pastoral and theological dimensions.

My third concern therefore is theological. Christians have long spoken of the sanctity of life, but as that life begins to ebb there is a huge danger in our ethics changing thereby sending a message that, in certain circumstances, life is of less worth, less ‘sanctified’ than when we were younger or fitter. This is something I pick up on p9.

But, a word of warning. If Christians are true to our calling, then pastoral compassion must feature in this debate too. Indeed, it should be as central as the medical, ethical and theological voices. The stories on p4 from Rob Ellis and p6, an extract from Tony Nicklinson’s evidence given to the Falconer Commission, begin to take us close to the painful decisions that some face.

Weigh in your heart, as best you can, whether your stance in this debate would be different if it was someone you love who was suffering, maybe even if it was your end of life we were talking about.

David Kerrigan
General Director

¹ See www.parliament.uk/briefing-papers/sn03228
murder’ (Exodus 20: 13; Deuteronomy 5: 17). The Hebrew word for ‘murder’ is ratsach (Greek phoneuo) and its meaning is further defined in four main passages in the Pentateuch (Exodus 21: 12-14; Leviticus 24: 17-21; Numbers 35: 16-31; Deuteronomy 19: 4-13).

These passages resolve any ambiguity for us and give a precise definition of what is prohibited, namely the ‘intentional killing of an innocent human being’ (Exodus 23: 7; 2 Kings 21: 16; Psalm 106: 37-38; Jeremiah 19: 4). Euthanasia clearly falls within this biblical definition.

It is often argued that we have only two equally undesirable alternatives to choose from – either ‘living hell’ or the euthanasia needle – both of which are imperfect and unloving solutions.

But there is a third way – the way of the cross. It 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 to human suffering (Matthew 22: 37-40; Mark 8: 34; Philippians 2: 4-11; Galatians 6: 2, 10).

Euthanasia is wrong because God says it is wrong. Instead he points us to a better way, offering hope, love and compassionate care.

By Dr Peter Saunders
Chief Executive, Christian Medical Fellowship

**DOES THE BIBLE CONDONE EUTHANASIA?**

**TWO BIBLICAL EXAMPLES OF EUTHANASIA ARE ASSESSED AGAINST THE REST OF SCRIPTURE**

There are two instances of euthanasia in the Bible. In the first, Abimelech, believing himself to be fatally wounded (with a fractured skull after being hit on the head by a millstone), asks his armour-bearer to kill him to spare him the ‘indignity’ of being killed by a woman (Judges 9: 52-55). In the second, an Amalekite despatches the mortally injured Saul, still alive after a failed attempt at suicide (2 Samuel 1: 6-9).

These two cases demonstrate the two main arguments for euthanasia, autonomy (‘death with dignity’) and compassion (‘release from suffering’).

The Bible tells us that human beings are unique amongst God’s creatures in being made in the image of God (Genesis 1: 26) and it is on this basis, after the flood, that God introduces to all humankind the death penalty for murder (Genesis 9: 6-7).

The prohibition against killing *legally innocent* people is later formalised in the sixth commandment, ‘You shall not murder’ (Exodus 20: 13; Deuteronomy 5: 17). The Hebrew word for ‘murder’ is ratsach (Greek phoneuo) and its meaning is further defined in four main passages in the Pentateuch (Exodus 21: 12-14; Leviticus 24: 17-21; Numbers 35: 16-31; Deuteronomy 19: 4-13).

These passages resolve any ambiguity for us and give a precise definition of what is prohibited, namely the ‘intentional killing of an innocent human being’ (Exodus 23: 7; 2 Kings 21: 16; Psalm 106: 37-38; Jeremiah 19: 4). Euthanasia clearly falls within this biblical definition. There is no provision for compassionate killing, even at the person’s request and there is no recognition of a ‘right to die’ as all human life belongs to God (Psalm 24: 1). Our lives are not actually our own. Suicide (and therefore assisted suicide) is thus equally wrong.

Jesus taught in the Sermon on the Mount that we should go beyond the mere letter of the sixth commandment to fulfil the very spirit of love on which it is based (Matthew 5: 21, 22). We are called to walk in Jesus’ footsteps, to be imitators of God, to love as he himself loved (1 John 2: 6; Ephesians 5: 1; 2; John 13: 34, 35).

Sadly, however, many Christians today are confused about euthanasia and fall prey to emotive hard cases and false dichotomies.

Euthanasia is wrong because God says it is wrong. Instead he points us to a better way, offering hope, love and compassionate care.
The phone call that we had waited for – expected, dreaded and yet also longed for – came in the middle of the night. My mother had been taken ill at her care home and taken into A&E. The line was poor, and the doctor spoke in impeccable but accented English. Before it cut out I gathered that they had taken the clinical decision not to treat her but to make her comfortable “because of her medical history.” The following day, as we joined my father and my brother and his wife at her bedside, the decision not to treat was explained slightly differently: mum was now on the Liverpool Care Pathway.

Five and a half years earlier my mother had suffered a catastrophic stroke. There had been no significant impairment to movement, but her speech function had been wrecked. Apart from the odd (often wrong) word, she spoke in tongues for the last five and a half years of her life. It became clear fairly soon that the inability to process output was matched by a similar difficulty in processing input. She could not communicate in speech, but neither was she understanding what she was told. Some speech therapy was provided but proved futile because of this, and attempts to help her communicate through writing also came to nothing. Mum became angry and frustrated because she could not communicate: she appeared to think that her speech was normal and could not grasp that we heard only gobbledygook. My dad was the main lightning rod for her anger, adding extra distress for him. She became clingy and unpredictable, sometimes even violent. Our mother was disappearing before our eyes. It was no surprise when, well over a year after the stroke, we finally saw “dementia” appearing on various pieces of official paperwork.

A brief experiment with her returning home failed miserably. Emotionally volatile, failing to understand what was going on, taking it all out on dad – it was clear that long term care was required. The same patterns of behaviour continued there but gradually mum tried less and less to communicate, this strong-willed person we had known was finally giving up and withdrawing into a private space of confusion and isolation.

For a gregarious person who liked to be in control, whose idea of relaxing was to talk with those she liked and loved, it must have been a living hell. Often unco-operative in the home, she would still occasionally light up when we visited – though increasing deafness and sight problems (goodness only knows what happened to the glasses which she refused to wear, the carers couldn’t tell us) made this difficult too. Other illnesses of varying severity came and went. On one occasion, a year or so before the final illness, she haemorrhaged but refused to allow doctors to examine her. The strong will was still there after all.

Her quality of life seemed wretched, almost non-existent. The care home was excellent with her, dad and others of us visited regularly, but the light in her eyes had long gone. She had become one of those “poor old things” of whom she had often said in healthier days: “I don’t want to end up like that.” I reflected in my more sombre moments that it would have been kinder if that stroke in 2007 had taken her, and that attempting to medicate her to prevent a further stroke seemed an odd course of action in some respects. I say “attempting to medicate” because mum had become increasingly unco-operative with her medication too. Sometimes we wondered whether she was trying to tell us something, but that’s just speculation.

The phrase “Liverpool Care Pathway” (LCP) was used as if we should know what it meant. We didn’t, not really. It is probably fortunate that we were unaware of the controversy which surrounded it in some quarters, a controversy which has since led to it being discontinued. The pathway prioritises palliative care for the patient but goes a step further by offering neither food nor water. The controversy suggested that hospitals had financial incentives to meet targets involving the LCP, and the potential for abuse here is obvious. I can only report that on the first day, and on subsequent occasions...
the consultant in charge of mum’s care asked us whether we continued to be comfortable with her treatment. Their recommendation was that she remained on the pathway unless there were signs of recovery, but that after 48 hours this was increasingly unlikely. We were advised that food and water, which would have to have been given through a drip, would almost certainly not lead to recovery but just more discomfort for mum as she would have been disturbed more often for her toilet needs. And the recognition by the staff that we were now in a situation where the Pathway was appropriate meant that we were given extra privacy and gentle but constant support.

We told them that we were comfortable with this mode of treatment, and we were, but it was – truth be told – an uncomfortable kind of comfort. Despite all that I have said about her quality of life and how it might have been kinder if she had died on the occasion of the original catastrophic stroke, now that it came to this it seemed a little as though the decision about whether she would live or die was being put into our hands. Put like that, it felt painful and unwelcome. And yet, whatever the awful tug of love that wanted somehow to hold on to her we also knew that her condition and quality of life could only be worse still should she rally, and that she herself had many times spoken with fearful pity about those whose plight was actually less horrible than hers now seemed.

So we sat by the bed and waited. Taken ill in the small hours of Wednesday morning, we watched and waited with her as her physical systems closed down over the next few days. There was a moment when she seemed to recognise two grandchildren, but we weren’t really sure. As we sat with her and together, we remembered her as she had been, how we would enjoy her company, and how she enjoyed life. On the Friday our vigil marked her 90th birthday, but as the weekend began there seemed little change. On the Sunday morning the consultant said it could go on for days, but when we slipped out for lunch mum finally slipped away from us: she had travelled the pathway. As Dad took her hand an hour later he said “at last she is at peace.”

Mum’s illness posed a number of theological questions for me. The first relates not to her end but the five and a half years after the stroke. Mum’s illness was not unique but as the dementia worsened it raised serious questions about identity; and the years of misery brought back all those old questions about bad things happening to good people. This, it turned out, was a terrible thing to happen to anyone. The ending of her life was also more painful and problematic than I had imagined it would be, given the years that led up to it. But despite my “uncomfortable comfort” with the LCP, I cannot say that, given the same choice tomorrow, I would choose any different. It is extraordinarily difficult to sift one’s own motives at the best of times, but here? Would a decision to keep mum “alive” have been about a refusal to take my own grieving to the next inevitable stage, or about my own unwillingness to face a difficult decision? One searches one’s heart also for darker motives: convenience, cost, or, perhaps most alluring, a sparing of one’s own pain in watching her suffer. In the end it was about a “letting go” rather than a “clinging on”. The chaplain prayed with us, read a Psalm, held her hand, but also somehow normalised what we were experiencing. “In the midst of life we are in death” the old Prayer Book says. In mum’s life we had been in the midst of death for such a long time it was time to trust the Lord she had put her faith in all her days and let her go.

I miss her still, of course. Much more, strangely, than when she was in the care home and unable to talk to us there. There is a finality now: but it also seems easier to see her life in the round rather than have it defined by those last years. Her illness and death did, I think, in ways that would have pleased her, bring her family even closer together and in new ways. She “gave” this to us even in her torment. I like to think that our letting her go was the last gift of love we could give to her.

“THE PATHWAY PRIORITISES PALLIATIVE CARE, BUT OFFERS NEITHER FOOD NOR WATER”

Joyce Ellis

“WHETHER SHE WOULD LIVE OR DIE FELT LIKE IT WAS BEING PUT INTO OUR HANDS”
A locked-in-syndrome sufferer has his case put forward at the Commission on Assisted Dying. This is an edited excerpt of that evidence.
Lord Falconer: Jane what would be really helpful is if you could just tell us what happened to Tony and what effect it had on him over a period of time. You used to live in Dubai... you went on a...

Jane Nicklinson: He was on a business trip and he had a massive stroke and he is now left with locked in syndrome, which basically means he can't move and he can't speak, the only movement he has is a slight head movement and eyes, so he has to blink if he wants to converse with you. He blinks it out with the aid of a board, or he has a specially adapted eye-blink computer.

“WE HAVE A LAW WHICH: CONDEMNNS ME AND OTHERS LIKE ME TO A LIFE OF MISERY”

Lord Falconer: What effect has it had on his ability to understand and think about things?

Jane Nicklinson: None whatsoever, I have actually got a statement which he wants me to read out, and you will see by the way he words it and everything that his mind is completely on the ball.

Baroness Elaine Murphy: It’s that lack of communication that you feel is the most difficult thing for him to bear rather than the psychical dependence?

Jane Nicklinson: I think that’s the worst. It is everything really but I think if he could speak then maybe things might be different. He just gets... sorry... I can’t describe how frustrated he gets when he is trying to tell someone something, even if it is one of the carers to move a leg or move a foot or something and he can’t make them understand. He just, he looks like he is going to explode at any moment. I’ll go and slam a door or throw something or scream or swear you know; he can’t do any of these things. He just gets so frustrated with people and the more frustrated he gets the worse it is because then you can’t understand even more what he wants because he cries and his eyes go all funny and everything so you can’t see what he is looking at.

Excerpt from statement by Tony Nicklinson, read to the Commission by Jane Nicklinson:

“To end, on a personal note I decided in 2007, some two years after my stroke, that I didn’t want to go into old age like this. I engaged a lawyer to draw up a living will and stopped taking all drugs that were meant to prolong my life. I also wished for a life-threatening condition like cancer so that my life may end sooner rather than later because the law is not helpful to me. I also considered starvation but concluded that I didn’t possess the courage to go through with it nor did I have the courage to put my family and friends through that amount of distress.

So, we have a law which: condemns me and others like me to a life of misery; makes my wife (or anybody else) a murderer for simply carrying out my wishes; puts people in jail for up to 14 years for helping someone to commit suicide; makes me wish for a fatal condition; makes me consider starvation as a way out and sends society’s cripples abroad to die. Tell me, just what is compassionate about that? Who will defend such a law? What sort of person might he be? Who can defend the indefensible? Perhaps your Commission will tell us.”

Mission Catalyst

Full interviews and more evidence can be read at commissiononassisteddying.co.uk

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LEARNING ABOUT LIVING
FROM THE DEBATE ON
ASSISTED DYING

THE
SANCTITY
OF
DEATH
IS THERE SOMETHING CHRISTIANS CAN LEARN FROM THE DEBATE SURROUNDING EUTHANASIA THAT GOES BEYOND ENTRENCHED POSITIONS?

On 30 April 2013, the Guardian ran a headline saying “Assisted suicide poll shows support amongst majority of religious people.” There was a shock wave across the religious society – could that really be true?

A lobby group, Catholic Voices, responded, “It shows how little exposed even practising religious people are to the teachings of their Church,” perhaps missing the fact that increasingly Christians are reaching judgments without asking to be guided by religious leaders. In fact, only amongst Muslims and Baptists was there a majority against assisted suicide!

In a telling quote from Professor Linda Woodhead of Lancaster University, the organiser of the survey, “neither age nor gender nor church attendance significantly predicted opposition to assisted suicide. The only thing that did was a claim that God or the teachings of Scripture supplied moral authority. These attitudes are held by a distinct minority of believers.” (italics added)

Cherishing the hope that “these attitudes” are still held by some Baptists, Scripture seems a good place to start.

The sanctity of life

The Bible makes clear that we worship a living God, not a god of stone or wood, but one who is intimately involved with those he has created. He is the God in whom “we live and move and have our being” (Acts 17: 28), the God who breathed life into us (Gen 2: 7). In that beautiful phrase, we are told we are fearfully and wonderfully made, knit together in our mother’s womb (Ps 139: 13-14).

These verses lay a vital foundation for knowing what life is worth. God is the author, the giver and the sustainer of life. Human life is priceless because it is a gift of God, a reflection of the divine nature. Life is not ‘ours’ even if the life in question is ‘mine’.

It is from this foundation that Christians have long been committed to upholding the sanctity of life.

For example, some parts of the Christian church are against any artificial form of contraception as they argue this interferes with the normal procreative purpose of sex. Most Christians would be against abortion, some without any exception, though others would be more sympathetic in the case of rape, or where the life of the mother is endangered. Similarly, the source of embryonic stem cells raises acute ethical issues as it requires the destruction of a human embryo.

These ethical constraints surrounding the beginning of life can be matched by ethics concerning the end of life. Suicides are almost always a pastoral tragedy and the taking of life is not supported by Christian theology. Capital punishment raises profound concerns for many, as does the waging of war.

One thing is clear however. Though our belief in the sanctity of life is deep-seated in our theological understanding of God and humankind, nonetheless the absoluteness of any position has long been undermined by social changes.

Most couples, irrespective of their faith or lack of it, use contraception. The right to choose an abortion is enshrined in the laws of many countries. Embryonic stem cell research is permitted in law, with certain safeguards, though some scientists are now focusing on bone marrow stem cells as an ethical alternative. The United States, avowedly Christian in many ways, supports capital punishment in many of its States.

The sanctity of death?

And so to the matter in hand. The law in the UK refuses to recognise the right to assisted dying. Nonetheless the pressure is growing to allow people, in carefully controlled circumstances, to exercise their choice to die.

Labour peer Lord Falconer introduced a Bill to the House of Lords in May 2013 with the hope that it will attract sufficient support to persuade some or all of the main political parties to include it in their manifesto at the next election. The Bill is only designed to enable those who are terminally ill, with six months or less to live, to be able to choose to die.

Though the scope of this Bill is limited therefore, there can be little doubt that once the line is crossed, the pressure to allow similar choice will eventually extend to those who are elderly and whose quality of life is severely impaired, those who wish to leave ‘a living will’ to direct what should happen should they become incapacitated, or those who are wholly dependent on others for their physical needs.

Theologically, Christians have a very counter cultural view of death. It is seen as the fruit of a fallen world (Romans 5: 12).
The valley of the shadow

actions, some passive, others active. The rights and wrongs are still with us. I have the right to die', to extinguish the life I have lived, to be relieved of pain.'

Christians will not easily concede that 'we cannot live longer than they wish violations of their human rights.

The arguments against any form of euthanasia include the fact that life is sacred and is not ours to end, that indirectly any decision to end someone’s life actually devalues life for everyone. As such the slippery slope argument is a genuine concern.

Lord Walton, Chair of the Lords’ Select Committee looking into euthanasia in 1993 reported: “We concluded that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death.”

On the contrary, the philosopher A C Grayling stated in 2003 “Many are needlessly condemned to suffering by the chief anti-euthanasia argument: that murder might lurk under the cloak of kindness.”

Finding an alternative

The argument about assisted dying will be played out along the ethical lines outlined above. Scant regard will be given to theological considerations per se though these will, and must, inform those who seek to ensure that this is a well-informed debate. The question is, can we find a mechanism whereby theological insights can translate into ideas that can be shared by all, irrespective of faith?

My own starting point on this is somewhat personal. A few months ago I contracted a serious infection following a visit overseas. After a few days I was admitted to hospital and stayed for six days. The details are irrelevant, save to say that for the first time in my adult life I was very ill and largely helpless without the attentiveness of those who were my carers. They were simply wonderful. They treated me with kindness, understanding and dignity at a time when that was all I had to cling to, and thankfully I was on the road to recovery after a few weeks.

It was a curiously powerful life experience. At first I kept apologising for being a burden, though I had no choice but to accept the care on offer. I came to terms with my needfulness and accepted it as a grace being extended to me. I felt it reminded me that my worth was not being assessed by my past undertakings or future potential, but simply the fact that I was a human being in need. It was strangely significant, and deeply humbling, to find in my weakness the grace of compassion.

Of course I am not comparing my circumstance to that of someone terminally ill, or locked-in. All I am saying is that I glimpsed something we can easily lose – the value of caring for those in need, and being cared for.

Dame Cicely Saunders, who founded the Hospice movement, knew the importance of every life. “You matter because you are you”, she said. “You matter to the last moment of your life and we will do all we can to help you die peacefully, but also to live until you die.”

The last word goes to M Scott Peck, the American author of “The Road Less Travelled.” He dares to suggest at the end of life, with pain controlled, a person might learn “how to negotiate a middle path between control and total passivity, about how to welcome the responsible care of strangers, about how to be dependent once again ... about how to trust and maybe even, out of existential suffering, at least a little bit about how to pray or talk with God.”

rather than as something quite ‘natural’ and so death is not something we welcome as intrinsically good. It may bring an end to suffering but it is not good in itself.

However, from the perspective of faith, death is the transition from this life into an experience of eternity with Christ. On that basis, one could argue that death couldn’t come quick enough. But even though the Apostle Paul writes, “for me to live is Christ, to die is gain” (Phil 1: 21), the context does not allow us to hold that Paul was saying that life and death are of equal worth.

Our prior belief in the sanctity of life, therefore, must govern our approach to ageing, the depletion of quality of life, the reality of suffering and the experiences of death and dying.

In practical terms this means that we reaffirm that all those who are elderly, sick, infirm, terminally ill and dying nonetheless bear the image of God. Their life is precious, even if its utilitarian value to society is less than it was, or might have been. In today’s rights orientated world, Christians will not easily concede that ‘we have the right to die’, to extinguish the life gifted to us.

The rights and wrongs of euthanasia

Euthanasia covers a multitude of different actions, some passive, others active. Passive euthanasia can be the withdrawal of treatment, for example, switching off a life-support machine or the withholding of treatment such as surgery that will not cure but will only prolong life for a period of time. Active euthanasia is what is in view here – such as the provision of drugs that will end someone’s life.

The arguments in favour of euthanasia (literally ‘easy death’) include the right to die in dignity, without pain, with the assistance of others if necessary if they cannot do so alone. It is argued that our bodies are our own, and to make people live longer than they wish violates their human rights.

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Dame Cicely Saunders, who founded the Hospice movement, knew the importance of every life. “You matter because you are you”, she said. “You matter to the last moment of your life and we will do all we can to help you die peacefully, but also to live until you die.”

Former Canon Chancellor of St Pauls Cathedral, Giles Fraser would concur. Writing in the Guardian in May this year he said “my problem with euthanasia is not that it is an immoral way to die but that it has its roots in a fearful way to live.”

He went on “I do want to be a burden on my loved ones just as I want them to be a burden on me – it’s called looking after each other.”

This has to be argued for. Human life is priceless and once we decide it is dispensable, no matter how compelling the reason, we will have crossed a Rubicon.

A severely disabled person or someone with early signs of dementia who doesn’t want the right to die but knows that society ‘understands’ they have that right, will also hear that their life is seen differently from others for whom life is inviolable. And that is the slippery slope that people fear.

The last word goes to M Scott Peck, the American author of “The Road Less Travelled.” He dares to suggest at the end of life, with pain controlled, a person might learn “how to negotiate a middle path between control and total passivity, about how to welcome the responsible care of strangers, about how to be dependent once again ... about how to trust and maybe even, out of existential suffering, at least a little bit about how to pray or talk with God.”
Muslim beliefs and culture give people here a framework in which to bear their suffering. Life is given and taken away by God. The time and manner of dying, be it a sudden accident or a life limiting illness such as cancer, is determined by God. It is he who decides all things. Illness is not seen as a punishment but as a trial to be borne uncomplainingly, with courage and dignity. Only last week a woman suffering from lung cancer commented to us, “This is my test, my examination from God.”

Families want their loved ones to be treated until the end of life, even when treatment is no longer effective. There is a strong belief that everything must be done to continue saving life. Treatment must remain active until the end. So we often see patients having inappropriate treatment long after it can help. So understandable, but in palliative care we want to weigh up the burden of enduring a difficult treatment that may no longer be effective against the benefit, often very little, it may give. These are the some of the difficult palliative care decisions we try to help professionals and people reflect on when caring for these very vulnerable patients and families.

Muslim culture is strongly relational as witnessed by large extended families, particularly in more traditional and rural areas, but this is changing as couples marry later and have fewer children. Families want to care for their own and want them to spend their final days at home. There is a strong commitment to caring which is private and does not want too much intrusion by professionals. Filial responsibilities are taken seriously. At and after death, prescribed rituals allow the community to grieve collectively, to remember and pay their last respects, and give practical support to the grieving family. These rituals continue at intervals throughout the first year acknowledging the time it takes to grieve.

Western culture places a high emphasis on individualism and independent decision making, particularly where there are many treatment options. In more paternalistic societies, where treatment options are more limited, decisions about revealing a serious diagnosis remain the responsibility of close family and are seen as sheltering individuals from further trauma. However, many younger people are aware of their diagnosis, having surfed the internet for more information. The challenge is to check the quality of the information, and to help people in a compassionate and realistic way make sense of it in the light of their own situation, in order to make more informed decisions.

In a country with limited resources, palliative care does not have a high priority but does feature in the government’s cancer plan, although there is no budget for it. At the time of diagnosis between a quarter and half of patients are already beyond the stage of a cure. In advanced stages of illness, these people often present with multiple problems which are way beyond the scope of many family doctors’ training, who feel out of their depth. Unless the family has health insurance the burden of healthcare falls on them directly.

We are attempting to set up community services offering supportive care to families and patients, offering training in holistic care to family doctors, nurses and non-medical volunteers, and raising awareness of palliative care in the community. We are privileged to work with some highly motivated Muslim colleagues who share a similar world view and with whom we are able to share the extra dimension of grace.
... To befriend death, we must claim that we are children of God, sisters and brothers of all people, and parents of generations yet to come. In so doing, we liberate our death from its absurdity and make it the gateway to a new life.

In our society, in which childhood is something to grow away from, in which wars and ethnic conflicts constantly mock brotherhood and sisterhood among people, and in which the greatest emphasis is on succeeding in the few years we have, it hardly seems possible that death could be a gateway to anything.

Still, Jesus has opened this way for us. When we choose his way to live and die, we can face our death with the mocking question of the Apostle Paul: “Death, where is your victory? Death, where is your sting?” (1 Corinthians 15: 55). This is a choice, but a hard choice. The powers of darkness that surround us are strong and easily tempt us to let our fear of death rule our thoughts, words, and actions.

But we can choose to befriend our death as Jesus did. We can choose to live as God’s beloved children in solidarity with all people, we can also become people who care for others. As men and women who have faced our mortality, we can help our brothers and sisters to dispel the darkness of death and guide them toward the light of God’s grace...

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... Dying is always suffering, because dying always puts us in the place where others do to us whatever they decide to do, good or bad.

It is not easy to trust that our lives will bear fruit through this sort of dependence because, for the most part, we ourselves experience dependence as uselessness and as burdensome. We often feel discomfort, fatigue, confusion, disorientation, and pain, and it is hard to see any fruit coming from such vulnerability. We see only a body and a mind broken to pieces by the plow that others hold in their hands.

Believing that our lives come to fulfillment in dependence requires a tremendous leap of faith. Everything that we see or feel and everything that our society suggests to us through the values and ideas it holds up to us point in the opposite direction. Success counts, not fruitfulness – and certainly not fruitfulness that comes through positivity. But passion is God’s way, shown to us through the cross of Jesus. It’s the way we try to avoid at all cost, but it is the way to salvation. This explains why it is so important to care for the dying. To care for the dying is to help the dying make the hard move from action to passion, from success to fruitfulness, from wondering how much they can still accomplish to making their very lives a gift for others. Caring for the dying means helping the dying discover that, in their increasing weakness, God’s strength becomes visible.
The well-known words of the Apostle Paul, “God chose those who by human standards are weak to shame the strong” (1 Corinthians 1:27), take on new meaning here because the weak are not only the poor, the disabled, and the mentally ill, but also the dying – and all of us will be dying one day. We must trust that it is also in this weakness that God shames the strong and reveals true human fruitfulness. That’s the mystery of the cross. When Jesus was on the cross, his life became infinitely fruitful. There, the greatest weakness and the greatest strength met. We can participate in this mystery through our death. To help each other die well is to help each other claim the fruitfulness in our weakness. Thus our dying enables us to embrace our cross with the trust that new life will emerge. Much of this becomes concrete when we are with people who must come to terms with their approaching death…

... Although the Resurrection of Jesus is the cornerstone of my faith, it is not something to use as an argument, nor is it something to use to reassure people.

It somehow doesn’t take death seriously enough to say to a dying person, “Don’t be afraid. After your death you will be resurrected as Jesus was, meet all your friends again, and be forever happy in the presence of God.”

This suggests that after death everything will be basically the same, except that our troubles will be gone. Nor does it take seriously Jesus himself, who did not live through his own death as if it were little else than a necessary passage to a better life. Finally, it doesn’t take seriously the dying, who, like us, know nothing about what is beyond this time- and place-bound existence.

The Resurrection does not solve our problems about dying and death. It is not the happy ending to our life’s struggle, nor is it the big surprise that God has kept in store for us. No, the Resurrection is the expression of God’s faithfulness to Jesus and to all God’s children. Through the Resurrection, God has said to Jesus, “You are indeed my beloved Son, and my love is everlasting.” The Resurrection is God’s way of revealing to us that nothing that belongs to God will ever go to waste. What belongs to God will never get lost – not even our mortal bodies. The resurrection doesn’t answer any of our curious questions about life after death, such as, How will it be? How will it look? But it does reveal to us that, indeed, love is stronger than death. After that revelation, we must remain silent, leave the whys, wheres, hows, and whens behind, and simply trust…

“We can choose to befriend our death as Jesus did.”

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“WE CAN CHOOSE TO BEFRIEND OUR DEATH AS JESUS DID”
ASSISTED DYING
A LEGAL FRAMEWORK?

LORD FALCONER’S ASSISTED DYING PROPOSALS SHOULD BE ASSESSED IN THE LIGHT OF PREVIOUS MEDICAL LAW

It is possible that assisted suicide (AS) may be legalised.

The AS literature is extremely daunting, extensive, and lacks uniform answers, while Christian opinion is divided. Effective challenge is therefore difficult. Yet Christians should be conversant with the arguments advanced for legal change.

Here, I offer new initiatives from a biomedical perspective, a viewpoint not always foremost, perhaps, in the thoughts of those either proposing, or worried by, disturbing legal changes.

Christians, in facing uncertainties of AS law change, should be wary of Lord Falconer (Demos, 2012) and cognate proposals. My argument, derived from analysing the use of the Abortion Act (1967) over its 45-year lifespan, asserts that the Suicide Act (1961) should remain as deterrence against deviant practice certain to ensue, over time, with legalised AS. More robust safeguards can be devised for monitoring assisted suicides, thereby tempering theological or other difficulties facing Christians on this issue.

Background on Lord Falconer

Lord Falconer represents the major legal thrust for AS, his initial push for legal change being rejected by the House of Lords. Note that despite continuing prohibition, the Director for Public Prosecutions has not prosecuted over 200 assisting ‘offenders’. Undaunted, Lord Falconer’s recent guidelines are based on law deemed ‘inadequate and incoherent’, adrift of ‘public opinion’ (which allegedly supports AS), and requiring ‘updating’. Victims, in Falconer’s proposal, must be declared of sound mind and ‘terminally ill’ by ‘two independent doctors’. Much thereby hangs on those declarations.

Could we proceed without legal change? Much useful wisdom can be derived from the Abortion Act, especially if we (i) examine the performances of the two certifying doctors, (ii) realise how any legal provision is susceptible to manipulation – or frankly ignored – if need arises, and, most importantly (iii) recognise the effacement of legal statute through changed societal fashions and medical advances arising through time. These issues bear critically on AS, if legalised.

David Steele’s 1967 Bill

This Bill required abortions to be undertaken in registered hospitals in clean conditions. Despite achieving those aims, another completely unforeseen outcome whereby the Act would now be understood and acted upon, arose. That outcome, with all restraints now abolished, resulted in a ‘slippery slope’ maximising within three years to 200,000 abortions per annum – a rate consistently maintained and causing, to date, eight million abortions.

The Act stipulates five certification bands, but excluding foetal abnormalities (“E”) most certifications now employ “C” – that continuing pregnancy would be the greater harm to physical or mental well-being. But peak rates for “C” cases (50%) actually involve young, unmarried women aged 15-24 of which one-half (50% in UK: 60% in Scotland) are terminated medically, before nine weeks.

The Abortion Act warns us:

First, that its original stipulations have become modified through changed social mores, and newer therapeutic options.

Second, greater worries regarding the widespread use of “C” raise

“SLIPPAGE AND THE KIND OF DISREGARD TAINTING ABORTION”


Weaknesses in the Act

As time progresses (50 years with abortion), it is clear that any legal provision - like a photograph - becomes historically ossified. Once law is enacted, modification is extremely difficult making erasure from the Statute Book virtually impossible.

The Act's provisions remain unyielding (i) when forces within society are rapidly changing, (ii) whose demands are considerably different from circa-1960 cultural norms and (iii) in light of continuing (apart from additional future) medical and pharmaceutical advances. These changes, entirely unforeseen in 1967, should alert us to longer-term deviations should AS now be legalised. The loopholes in the Abortion Act clearly demand strict oversight by the

annexed to local (hospital/university) ethics committees. These already exist, are accepted by the public, and function well. A retired judge or other senior legal figure could be chairperson, directly accessing the DPP with whom all applications are lodged.

Others (senior social workers/religious ministers) with appropriate expertise should contribute. Those with experience of ethics committees know that good decisions are always possible, when deciding individual lives. One difficulty would be the undesirability of all members favouring AS. Disagreements occurring over time from properly-affected assessments would benefit patients' interests.

Powers to co-opt other cognate expertise - anaesthetists capable of judging the competence of therapeutic

pain relief, or cancer specialists' input - are critically essential to realistic outcomes: all the more reason why every medical assessment, and views and opinions deriving, should be fully declared.

Falconer's criteria – ‘terminally ill and death within 6 months’ – are completely indefinable, and, unattainable.

‘Terminal’ – while vaguely understood - cannot guarantee doctors' ability to implement either criterion. If you think otherwise, recall Al Megrahi, and exercise your skills in deciding the future date of Nelson Mandela's decease.

Informed and careful assessment of mental capacity are vital, since subjects' moods are notoriously changeable. In doubt, experienced psychiatric evaluation is crucial, and impossible on a single visit. Thus, very informed decisions, made over time, are vital before forms are signed. Frighteningly, Lord Falconer fails to recognise this. Depression must be critically distinguished from (a) demoralisation, and (b) states of

hopelessness which engender suicidal ideation in patients with end-stage cancer.

Each AS should be properly recorded (ONS), available for public review, interim parliamentary scrutiny, and later research into AS practice. The police should be informed, thereby overcoming the distress of conducting lengthy interviews post-mortem, as happened with Daniel James’ parents on their return from Switzerland.

All lethal drug prescriptions dispensed and recorded by a registered pharmacist would be notified to the Assessment Board.

Finally, why should doctors (contra the Hippocratic Oath) be coerced into killing patients?

These multiple weaknesses encompassing Lord Falconer's badly thought-out proposals reveal their flawed status. Don't be fooled.
**Dilemmas of Life: Deciding What’s Right and What’s Wrong**
David Cook  
IVP, 1990  
Price: £5.99 from ivpbooks.com

In this book, acclaimed Christian ethicist David Cook explores a variety of models for determining morality. Whilst Eastenders may provide a moral framework of choice for some, Cook argues that even moral mash-ups are inadequate. Rather, a comprehensive morality has its basis in right relationships between God and man and between human beings. We live out and test our morality in reference to Christ. For professionals dealing with moral complexities in the workplace, this book offers insightful examples and presents a framework for thinking, rather than providing answers to ethical dilemmas. The brevity of this book belies its depth and whilst not at all contemporary, it maintains an enduring relevance.

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**Matters of Life and Death**
John Wyatt  
IVP, 2nd Edition 2009  
Price: £16.99 from ivpbooks.com

This book is based on a series of lectures hosted by the London Institute of Contemporary Christianity and covers some of the modern issues surrounding human life. It argues against a divide between science and faith, but rather for a thoughtful and biblical engagement around issues that are at the forefront of news and thinking today. The book looks at issues such as human reproduction, genetics, abortion and euthanasia, and challenges Christians not to simply bury their heads in the sand, but instead to enter into the debate and make a positive contribution. Wyatt helps Christians to engage in some of the big dilemmas surrounding both the beginning and the end of life.

Peter Dunn is Director for Mission at BMS World Mission.

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**Our Greatest Gift: A Meditation on Dying and Caring**
Henri Nouwen  
Harper One, 1994  
Price: £8.99 from amazon.co.uk

Littered with personal anecdotes and poetic meditations, Henri Nouwen’s wonderful work on facing death and relating to those who must face it soon provides no simple formulae for counselling, nor does it lay out legal or ethical arguments. It is, instead, a true meditation on the spiritual and psychological issues that surround what must come to us all. Full of gentle warnings against populist attitudes (within the church and outside it) to death, this book mines a deep, contemplative spirituality. Sensitive and beautifully written, this book may frustrate those looking for hard answers, but will help anyone wishing to engage more profoundly with the process of letting go that is essential to death.

Jonathan Langley is Editor of Mission Catalyst

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**Walking with God through Pain and Suffering**
Timothy Keller  
Hodder, 2013  
Price: £14.99 from hodder.co.uk

When was the last time you read a Christian book about suffering? C.S Lewis perhaps, or Joni Eareckson? This is a much-awaited book for a 21st century culture that rarely encourages us to avoid thinking too much about death or pain. Keller tackles complex questions in a philosophical, cultural and biblical manner, with a pastoral heart throughout. He has researched everyone on the subject from Calvin to Camus. The apologetics of this book are likely to be appreciated by atheists and theologians alike. But make no mistake, Keller concludes that suffering is at the heart of the Christian story. He says: “The best people often have terrible lives. Job is one example, and Jesus — the ultimate ‘Job’, the only truly, fully innocent sufferer — is another.”

Gareth Wilde is pastor of Broadmead Baptist Church, Woodford Green