

DIGNITAS

To live with dignity

To die with dignity

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Call for Evidence by the Commission on Assisted Dying

**Submission by “DIGNITAS – to live with dignity – to die with dignity”,
Forch, Switzerland**

Contents of this submission	page
1) Introduction.....	1
2) Article 8 § 1 of the European Convention on Human Rights (ECHR) and the right to a voluntary death.....	3
3) The protection of life and the general problem of suicide.....	6
4) Suicide prevention – experience of DIGNITAS.....	8
5) Questions raised by the Commission on Assisted Dying in its Call for Evidence.....	9
6) Conclusion.....	26

1) Introduction

In recent years, questions dealing with the subject of assisted suicide and euthanasia have arisen more and more frequently. Of the many reasons for this development, one is the progress in medical science which leads to a significant prolonging of life expectancy. In fact, even during the last congress of the Swiss

GPs¹ this was an issue when it was emphasised that a sudden death, for example due to a “simple” heart attack or a stroke is nearly unthinkable today, due to possibilities of modern intensive care. Obviously, this progress is a blessing for the majority of people. However, this progress can also lead to a situation in which death as a natural result of an illness can be postponed to a point much further in the future than some patients would want to bear such illness. Consequently, people who have decided not to carry on living but rather to self-determinedly put an end to their suffering started looking for ways to do so. This development went hand in hand with tighter controls on the supply of barbiturates and progress in the composition of pharmaceuticals which led to the situation that those wishing to put an end to their life could not use this particular option anymore for their purpose and started to choose more violent methods. A further, parallel, development was the rise of associations focusing on patient’s rights, the right to a self-determined end of life and the prevention of the negative effects resulting from the narrowing of options.

In Switzerland, over 25 years ago, EXIT (German part of Switzerland) was the first association to offer the option of an accompanied suicide to its members. Later, associations like the EXIT-A.D.M.D. (French part of Switzerland), EX-INTERNATIONAL and DIGNITAS followed, the only difference being mainly the acceptance of members residing in countries other than Switzerland. Due to the above-indicated aspects and other developments in modern society, the focus of all associations has also widened to include directly or indirectly working on suicide preventive issues, especially suicide attempt prophylaxis.

Today, EXIT has some 53,000 members, EXIT-A.D.M.D. 15,000 and EX INTERNATIONAL approximately 700 members. DIGNITAS, together with its independent German partner association DIGNITAS-Germany, counts 5,600 members worldwide of whom over 700 reside in the U.K.

In the past almost 13 years of DIGNITAS’ existence, 164 members of DIGNITAS residing in the U.K. have made use of the option of an accompanied suicide in Switzerland². For all members, being assisted and accompanied through the final stage of their life towards their self-determined end was and is an issue of major importance. DIGNITAS always encourages members to have their next-of-kin and/or friends at their side during this stage, as well as on their journey and at the accompaniment itself. However, the present legal situation in the U.K. has the appalling effect that this very important support towards the end of life must take place shadowed by the fear of prosecution, sometimes even leading patients to decide to travel only with very few loved ones or even alone. This effect, deriving from the current legal situation can only be seen as a disrespect of

¹ Congress of Swiss General Practitioners in Arosa, March 31st – April 2nd, 2001, see online: <http://www.arosakongress.ch>

² For a detailed statistics: <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2010.pdf>

human dignity. The publication by the Crown Prosecution Service (CPS) of the “Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide”, issued by the Director of Public Prosecution (DPP) in February 2010³, sparked by the court case of Debbie Purdy, did not change this; in fact, it could not change the legal status quo as the DPP simply does not have the competence to change the law – only Parliament can do so.

The fact that suicide as such is not a crime (anymore) in the U.K., yet aiding, abetting, counselling or procuring the suicide of another or an attempt by another to commit suicide (Suicide Act 1961) *is* a crime, finds a different approach in Swiss law: whilst in Switzerland, too, suicide as such is not a crime, article 115 of the Swiss Criminal Code states:

“Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be imprisoned for up to five years or pay a fine, provided that the suicide has either been completed or attempted.”

The obvious difference is the “selfish motives”: whilst the U.K. law categorically threatens to punish assistance in suicide whatever the motives, Swiss law makes a clear distinction of motives, excluding assistance out of non-selfish motives, and thus gives a basis for assisted (accompanied) suicide – made possible by associations like EXIT, EXIT-A.D.M.D., EX-INTERNATIONAL and DIGNITAS.

DIGNITAS very much welcomes the investigation work of the Commission on Assisted Dying as it brings the issue of end-of-life-questions to the level where it should be addressed: the legislation.

The categorical approach in the U.K. law of criminalising assistance in suicide raises the question whether this is in line with the European Convention on Human Rights which the U.K. ratified on March 8th, 1951 and implemented in its law.

2) Article 8 § 1 of the European Convention on Human Rights (ECHR) and the right to a voluntary death

In the judgment of the European Court of Human Rights in the case of DIANE PRETTY v. the United Kingdom dated April 29th, 2002, at the end of paragraph 61, the Court expressed the following:

“Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.”

³ To be found online: http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

Furthermore, in paragraph 65 of the mentioned judgment *DIANE PRETTY*, the Court expressed:

“The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.”

On November 3rd, 2006, the Swiss Federal Court recognized that someone’s decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the Convention stating:

“The right of self-determination in the sense of article 8 § 1 ECHR includes the right to decide on the way and the point in time of ending ones own life; providing the affected person is able to form his/her will freely and act thereafter.”⁴

In that decision, the Swiss Federal Court had to deal with the case of a man suffering not from a physical but a mental ailment. It further recognized:

“It cannot be denied that an incurable, long-lasting, severe mental impairment similar to a somatic one can create a suffering out of which a patient would find his/her life in the long run not worth living anymore. Based on more recent ethical, juridical and medical statements, a possible prescription of Sodium Pentobarbital is not necessarily contra-indicated and thus no longer generally a violation of medical duty of care . . . However, utmost restraint needs to be exercised: it has to be distinguished between the wish to die that is expression of a curable psychic distortion and which calls for treatment, and the wish to die that bases on a self-determined, carefully considered and lasting decision of a lucid person (‘balance suicide’) which possibly needs to be respected. If the wish to die bases on an autonomous, the general situation comprising decision, under certain circumstances even mentally ill may be prescribed Sodium Pentobarbital and thus be granted help to commit suicide.”

And furthermore:

“Whether the prerequisites for this are given, cannot be judged on separated from medical – especially psychiatric – special knowledge and proves to be

⁴ BGE 133 I 58, page 67, consideration 6.1. To be found on-line:
<http://www.bger.ch/index/jurisdiction/jurisdiction-inherit-template/jurisdiction-recht/jurisdiction-recht-leitentscheide1954.htm>

difficult in practice; therefore, the appropriate assessment requires the presentation of a special in-depth psychiatric opinion...”

Based on this decision, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the European Court of Human Rights.

On January 20th, 2011, the European Court of Human Rights rendered a judgment⁵ and stated in paragraph 51:

”in the light of this jurisdiction, the Court finds that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention”

Even though the European Court of Human Rights thus confirmed the statement of the Swiss Federal Court and also recognized that someone’s decision to determine the way his or her life will end is part of the right to self-determination protected by article 8 § 1 of the Convention, it failed to postulate a positive obligation for the contracting states of the Convention to give those individuals, who would like to make use of this right, an entitlement against the state to make access possible to the necessary means for safely making use of such right.

The case has now been requested to be referred to the Grand Chamber of the European Court of Human Rights. In addition, there are two further cases pending at the said Court which rest upon this very issue. In light of the fact that the Court confirmed the judgment of the Swiss Federal Court and because of respect for human personal autonomy, which the Court acknowledges as an important principle in order to interpret the guarantees of the Convention, further legal developments are to be expected.

Dignity and freedom of humans mainly consists of acknowledging the right of someone with full capacity of discernment to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising said dignity and freedom. In the judgment *DIANE PRETTY v. the United Kingdom*, the Court correctly recognized that this problem will present itself increasingly within the Convention’s jurisdiction, due to demographic developments.

We would like to emphasize that in this context, since the case of *ARTICO v. Italy* (judgment of May 13th, 1980, series A no. 37, no. 6694/74⁶), the developed

⁵ Application no. 31322/07; Judgment of a Chamber of the First Section (in French), available online: <http://cmiskp.echr.coe.int/tkp197/view.asp?item=1&portal=hbkm&action=html&highlight=31322/07%20%2031322/07&sessionId=70300354&skin=hudoc-en>

practice (so-called ARTICO-jurisdiction) is of major importance. In paragraph 33 of said judgment the Court explained:

“The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; . . .”

As the Convention, in the frame of the guarantee of article 8 § 1, comprises the right or the freedom to suicide, then everyone who wishes to make use of this right or freedom has a claim that he or she shall be enabled to do it in a dignified and humane way. Such individuals should not be left to rely on methods which are painful, which comprise a considerable risk of failure and/or endanger third parties. The available method will enable the individual to pass away in a risk-free, painless manner and within a relatively short time. Such a method must also consider aesthetic aspects in order to enable relatives and friends to attend the process without being traumatized.

3) The protection of life and the general problem of suicide

In the judgment *DIANE PRETTY v. the United Kingdom*, the Court rightly paid great attention to the question of the influence of article 2 of the ECHR – the right to life, especially the aspects of protection for the weak and vulnerable. In the meantime, the experience of the US-American state of Oregon due to its “Death With Dignity Act” shows that the question of the weak and vulnerable does not pose a problem in reality: neither the weak nor the vulnerable nor those with insufficient (or even without) health insurance would choose the option of physician assisted suicide – but in fact the self-conscious, the above-average educated, the strong ones.⁷

Yet, the principle of protection of life cannot be seen only in the light of the individual life of a single person who wishes a self-determined end to their life; it must also be applied in questions regarding public health.

Until now, national and international debates on assisted suicide and euthanasia never realized that, apart from the small number of individuals who wish to end their life due to severe suffering with one of the few available methods (palliative care, assisted suicide, etc.), there is a problem on a much larger scale which questions the sanctity of life: the general problem of suicide and suicide attempts.

On average, a person dies every two hours in England as a result of suicide. It is the commonest cause of death in men under 35. It is the main cause of prema-

⁶ To be found online: <http://cmiskp.echr.coe.int/tkp197/view.asp?item=1&portal=hbkm&action=html&highli ght=6694/74&sessionid=70300408&skin=hudoc-en>

⁷ See the death with dignity act annual reports of the Department of Human Services of the state of Oregon, to be found online: [http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/ Deathwith DignityAct/Pages/ar-index.aspx](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/Deathwith DignityAct/Pages/ar-index.aspx)

ture death in people with mental illness.⁸ Many other states, like Switzerland, show a very high number of suicide attempts and even higher counts of failed suicide attempts. In response to the request regarding information on suicide and suicide attempts in Switzerland from Mr. Andreas Gross, a member of the Swiss National Council, the Swiss government rendered its comments to the parliament on January 9th 2002. The government explained that, based on scientific research (National Institute of Mental Health in Washington), Switzerland might have up to 67,000 suicide attempts annually – that is 50 times the annual number of 1,350 of fulfilled (and registered) suicides. Thus, the risk of failure of an individual suicide attempt is up to 49:1!

In the year 2009, the U.K. counted 5,675 registered suicides;⁹ in England and Wales, in the year 2008, this number was 4,570.¹⁰ Given the results of the scientific research mentioned before, the suicide attempts in England and Wales must be estimated to be up to 228,500 per year.

Referring to the previously mentioned ARTICO-jurisdiction: even if this risk was ‘only’ 19:1 or even ‘only’ 9:1, it would indicate that an individual can only make use of the right to end his or her life self-determinedly by accepting such a high risk of failure and therefore an unbearable (further) deterioration of his or her state of health. This signifies however, that the right to end ones life self-determinedly under the conditions currently found in the U.K. and other contracting states of the ECHR is neither practical nor efficient.

The negative and tragic result of “clandestine” suicides is diverse:

- high risk of severe physical and mental injuries for the person who attempts suicide;
- psychological problems for next-of-kin and friends of a suicidal person after their death;
- personal risks and psychological problems for rescue teams, the police, etc., who have to attend to the situation at or after a suicide attempt;
- enormous costs for the public health care system, especially costs arising from caring for the invalid, and for a country’s economy (for example due to delay of trains) and the public sector (rescue teams, police, coroner, etc.)¹¹

⁸ National Suicide Prevention Strategy for England, p. 3, to be found online: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019548.pdf

⁹ <http://www.statistics.gov.uk/cci/nugget.asp?id=1092>

¹⁰ <http://www.samaritans.org/PDF/SamaritansSuicideStatistics1999-2008.pdf> referring to the Office for National Statistics.

¹¹ See the study of Peter Holenstein: <http://www.dignitas.ch/WeitereTexte/Studie%20Suizidkosten.pdf> . In Switzerland, in the year 1999, there were 1’269 registered suicides leading to estimated costs of 65,2 Million Swiss Francs; given that the estimated number of suicide attempts is considerably higher (based on information provided by forensic psychiatrists, coroners, etc., the study calculates with a suicide attempt rate

Despite the enormous number of fulfilled and failed suicide attempts and their negative effects, governmental measures towards an improved suicide and suicide attempt prevention appear to be lacking almost entirely. Yet, it must be the aim of all efforts to reduce the number of suicides, especially the number of unaccompanied “clandestine” suicides, and, of course, the much higher number of suicide attempts.

4) Suicide prevention – experience of DIGNITAS

Everyone should be able to discuss the issue of suicide openly with their GPs, psychiatrists, carers, etc. The taboo which covers the topic must be lifted. The possibility of – anonymously as well as openly – using a help-line is a very important service provided by some institutions.¹² However, for many people “talking about it” does not suffice: they seek the concrete option of a painless, risk-free, dignified and self-determined death, to put an end to their suffering.

DIGNITAS’ experience with people who do not suffer from an illness or other impairment but who wish to end their life due to a personal crisis shows that giving them the possibility to talk to us openly and without fear of being put in a psychiatric clinic has a very positive effect: they are being taken seriously (often for the first time in their life!). Through this, they are offered the possibility of discussing solutions for the problem(s) which led them to feeling suicidal in the first place. They are not left to themselves and rejected like other suicidal individuals who cannot discuss their suicidal ideas with others through fear of being deprived of freedom for at least some time, in a mental institution.

Furthermore, through their contact with DIGNITAS, their suicidal ideas are not only taken seriously but they also know that they are talking to an institution which could in fact – under certain conditions – arrange for a ‘real way out’. This aspect of authenticity cannot be underestimated.

The experience of our association, drawn from almost 13 years of working in the field of suicide prevention, shows that – paradoxically – the option of an assisted suicide without having to face the heavy risks inherent in commonly-known suicide attempts is one of the best methods of preventing suicide attempts and suicide.

Knowing about such an option will deter many from committing suicide through insufficient, undignified means. Furthermore, next-of-kin and friends are involved in the preparation process and encouraged to be present at the last hours: this gives them a chance to mentally prepare for the departure of a loved

that is 10 to 50 times higher than the registered suicides), these costs could well be around 2'431,2 Million Swiss Francs.

¹² In the U.K. provided for example by The Samaritans, see http://www.samaritans.org/our_services.aspx

one and thus give their support and affection to the suicidal person until the very end of life.

The issue is not whether someone would take advantage of an assisted suicide: in fact, the majority of members of DIGNITAS who have requested the preparation of an accompanied suicide and who have been granted the “provisional green light” do not make use of the option after all. Based on a study on our work, we know that from a sample group of people who – through the given procedure in our association – received approval from a Swiss physician that he or she would issue the necessary prescription for an assisted suicide, 70 % did not contact us again after such notification. Only 13 % – some after quite a long time – made use of the option of an assisted suicide¹³. For many, the prospect of such a prescription signifies a return to personal choice in a time when their fate is very much governed by their suffering. It enables many to calmly wait for the future development of their illness and not to prematurely make use of an assisted suicide.

This shows that a liberal solution, which entirely respects the suicidal human being, offers more sophisticated results than solutions which in such situations deprive individuals of their dignity, personal freedom and responsibility for themselves.

5) Questions raised by the Commission on Assisted Dying in its Call for Evidence¹⁴

1. Do you think that it is right that in certain circumstances, the DPP can decide not to prosecute a person who assists another person to commit suicide?

DIGNITAS feels that this question could be misleading as it appears to suggest that since the publication of the “Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide” in February 2010 there is currently more (or less) room for weighing whether a prosecution takes place or not. However, as stated before, the Policy did not change anything in the law. Even before the publication of the Policy U.K. members of DIGNITAS travelled to Switzerland for an accompanied suicide, most of them being accompanied by relatives and/or friends, and found themselves facing the uncertainty of their loved ones possibly being prosecuted upon their return home. Yet, even at that time, to our knowledge, none of such relatives and friends has ever been prosecuted.

Of course the Policy, which gives a margin of appreciation for the DPP in allowing for decisions not to prosecute, is at least some comfort for relatives and friends of patients deciding to travel to DIGNITAS. To DIGNITAS’ knowledge, so

¹³ Extract of the study (available in German) online: <http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf>

¹⁴ See online: <http://www.commissiononassisteddying.co.uk/submission-of-evidence>

far all cases of investigation in connection with assisted (accompanied) suicides of U.K.-DIGNITAS members have been closed under the notion of there “not being any public interest to prosecute”.

As already pointed out before, the overall legal situation in the U.K. in this issue appears to be in conflict with the European Convention on Human Rights. It is only a matter of time until a U.K. resident – just like Diane Pretty and Debbie Purdy before – will bring a legal challenge to the law and the Policy. Depending on the proceedings, this could lead to a judgment by the European Court of Human Rights – and those judgments are binding for contracting states.

2. Is it right that it is currently illegal for a healthcare professional to assist somebody to commit suicide and that a healthcare professional is more likely to be prosecuted for providing assistance than a friend or family member?

In DIGNITAS view, this situation constitutes an unlawful discrimination. As already stated, attendance of relatives and friends with a loved one at the end of life is very important and has the effect of preventing suicide. A family member who is at the same time a healthcare professional could face the situation of risking prosecution if he or she helped a loved one. In addition, this exclusion precludes help from precisely those people who, by profession, know best how to look after a suffering patient: they would be forced to disrespect the possible wish of such an individual to bring an end to his or her suffering.

3. Does the DPP policy currently provide sufficient safeguards to protect vulnerable people?

Up front, it is necessary to define what a vulnerable individual is. The general understanding may be that individuals under the age of 18, individuals who are dependent on medical care and individuals who suffer from loss of capacity to consent (for example due to dementia) would be classified as vulnerable. However, this aspect needs to be further explored, separately, as not every individual who may be seen by third parties as vulnerable would personally share this view. There is a fine line where protection turns into undesired paternalism.

At first glance, one could assume that the DPP policy would indeed provide sufficient safeguards, for example by stating that a prosecution would be more likely if the victim did not have the capacity to reach an informed decision to commit suicide. However, the Policy does not (and cannot) tackle the issue at its root. It is DIGNITAS’ experience that one cannot protect the possibly vulnerable by simply threatening to prosecute certain individuals who might provide assistance in suicide. In fact, those intending to put an end to their life are put at even more at risk by doing so and are prone to fail in their attempt – with all the

heavy consequences – if they do not receive help and attention from third parties.

The notion of “vulnerable” people who should be protected must also be seen in connection with the “slippery-slope” argument which is used again and again by opponents of any sort of legalisation on end-of-life assistance: it is known by now – especially through the very instructive annual reports of the Ministry of Health of the US-American State of Oregon¹⁵ – that assisted suicide has absolutely nothing to do with “vulnerable” individuals. Furthermore, “vulnerable” is a pretext argument which distracts from the real problem: Those who become suicidal yet are left alone with their problems – because there is still a taboo hovering over this issue, because the individuals’ fear of being put in a psychiatric clinic or fear of having his or her suicidal thoughts denounced, belittled, ignored or dismissed. These individuals are the really vulnerable ones. There are all sorts of suicide prevention measures and strategies¹⁶, but such strategies should be renamed and focused on suicide *attempt* prevention – not only suicide prevention. We also refer in this context to our comment with question 8 and 9a.

The Journal of Medical Ethics carried an article with the title “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups”¹⁷. The problem-related relevant part of the abstract of this article has the following wording:

“Background: Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a “slippery slope”, predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.

Methods: The data from Oregon (where PAS, now called death under the Oregon ‘Death with Dignity Act’, is legal) comprised all annual and cumulative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.

¹⁵ Death with dignity act annual reports of the Department of Human Services of the state of Oregon, to be found online: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

¹⁶ See for example “The National Suicide Prevention Strategy for England”, to be found online: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019548.pdf

¹⁷ Journal of Medical Ethics 2007;33:591-597; doi:10.1136/jme.2007.022335, to be found online: <http://jme.bmj.com/content/33/10/591.abstract>

Results: Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.

Conclusions: Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.”

4. Do you think that any further clarification of the DPP policy is needed? Or has the DPP policy already gone a step too far?

Once again, it must be stated that the DPP has no power to change the law and thus contribute towards a sensible legal solution, one by which U.K. residents would no longer have to leave their home country and become a “suicide tourist” because they want to make use of their right to a self-determined end in life, for example with EX-INTERNATIONAL or DIGNITAS in Switzerland. In the light of this, the DPP could not go “a step too far” when it only put into a written Policy what had been practice before.

5. Do you think there should be change in the law to create a legal framework that would allow some people to be assisted to die in certain circumstances?

Absolutely. No one should be forced to leave his or her home in order to make use of the basic human right of deciding on the time and manner of the end of his or her life. In this context it should be pointed out that only individuals with at least a minimum of financial resources – a right denied to many in the U.K. – can afford to travel abroad as a “suicide tourist” in order to make use of the option of a self-determined end in life, a further unacceptable discrimination. The present legal situation in the U.K. (and other countries) is a disgrace. It shows the disrespect law-makers have towards public opinion which is in favour of freedom of choice in these “last issues”.¹⁸ DIGNITAS strongly supports the

¹⁸ See for example the First Report of the Select Committee on Assisted Dying for the Terminally Ill Bill, to be found online: <http://www.parliament.the-stationery-office.co.uk/pa/1d200405/1dselect/ldasdy/86/8609.htm> or press coverage: http://www.timesonline.co.uk/tol/life_and_style/health/article5337761.ece

notion that the U.K. and other countries should adopt a legal scheme similar to Switzerland which, and this in fact is the long term aim of DIGNITAS, would make DIGNITAS obsolete.

6. If some form of assisted dying were to be legalised, who do you think should be eligible for assistance?

It is generally and widely accepted that individuals suffering from a physical terminal illness such as most forms of cancer, amyotrophic lateral sclerosis (motor neurone disease), multiple sclerosis, etc. should be eligible for assistance with a self-determined end in life or even euthanasia. However, there are further “categories” of suffering individuals who should be eligible for assistance yet who are not affected by a terminal illness per se, such as, for example, paraplegics and quadriplegics¹⁹ or patients suffering from Parkinson’s, Multisystem-atrophy and Chorea Huntington. Furthermore, individuals suffering from a mental illness also have a right to a self-determined end in life as long as they have capacity to consent: the Swiss Federal Court, in its decision of November 3rd 2006²⁰ acknowledged this, as mentioned before.

Overall, limiting access to assistance in dying to certain individuals automatically leads to a discrimination against those excluded. What is even worse, those excluded are exposed to the high risks connected with suicide attempts via inadequate means with all the dire consequences. From a humanitarian perspective, restricting an individual’s access to a risk-free, dignified and accompanied (assisted) suicide cannot be justified.

Furthermore, from a legal, human rights perspective, setting up categories which would include and exclude certain individuals from having access to a self-determined end in life could constitute an unlawful discrimination. Article 14 of the ECHR states:

“Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

Furthermore, the Court has a well-established standing on the practicability and efficiency of its guaranteed rights and freedoms through its ARTICO-jurisdiction:

¹⁹ Such as for example the rugby-player Daniel James who was left paralysed with no function of his limbs, pain in his fingers, spasms, incontinence and needing 24 hour care after a sports accident.

²⁰ BGE 133 I 58, to be found on-line: <http://www.bger.ch/index/jurisdiction/jurisdiction-inherit-template/jurisdiction-recht/jurisdiction-recht-leitentscheide1954.htm>

“The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective;...”²¹

Given that, as mentioned before, the European Court on Human Rights basically acknowledged the right of an individual to decide how and when to end his or her life, a narrowing of access to this right could constitute a conflict with the Convention.

Generally, the European Court on Human Rights has stated on several occasions that the ECHR has to be read as a whole. The Convention revolves around the idea of ‘man’ as a mature individual, fully responsible for his or her actions. This is the form of the enlightened individual in the sense of the philosopher Immanuel Kant, that is as an individual who has freed him- or herself from self-inflicted immaturity and thus from governmental, religious and other social paternalism.

7. If some form of assisted dying were to be legalised, what safeguards would be required to protect vulnerable people?

We refer to our comment on question 3.

8. What do you think are the main risks (both to individuals and to society) that would be associated with legalising any form of assisted dying?

One of the main arguments of opponents to legalisation of any form of assisted dying is the so-called “slippery-slope”. Opponents argue that any form of legalisation could pressure individuals to end their life, for example because they would not want to be a burden to their loved ones anymore. We refer to our comment on question 3 above and the statement of the full professor (“Ordinarius”) for law ethics at the University of Hamburg, Germany, Dr. iur. REINHARD MERKEL, who looked into this argument in his report “Das Dambruch-Argument in der Sterbehilfe-Debatte” (“The slippery-slope argument in the euthanasia debate”)²². In this report he emphasized that arguments of this nature have always been the most misused instruments of persuasion in public debates on controversial subjects. They have always been the probate residuum of ideologists and demagogues.

Based on the experience of the Zürich City Council, we now know that allowing physician assisted suicide (PAS) even in nursing homes for the elderly does not lead to any rise of such assisted (accompanied) suicides: of the 16,000 residents in the Zürich homes for the elderly, only zero to two assisted suicides per year

²¹ Case of ARTICO v. Italy (judgment of May 13th, 1980, series A no. 37, no. 6694/74), paragraph 33, to be found online: To be found online: <http://cmiskp.echr.coe.int/tkp197/view.asp?item=1&portal=hbkm&action=html&highlight=6694/74&sessionId=70300408&skin=hudoc-en>

²² in: Frank Th. Petermann, (ed.), Sicherheitsfragen der Sterbehilfe, St. Gallen 2008, p. 125-146

took place since the authorities allowed associations like EXIT, DIGNITAS and others to access such homes in 2002.

9a. If some form of assisted dying were to be legalised, who do you think should make the decision on whether somebody who requests an assisted death should be eligible for assistance?

There can be only one person making the final decision on whether to continue with life or put an end to it: the individual him- or herself. DIGNITAS favours the possibility of assisted (accompanied) suicide which implies that a) the individual has the capacity to consent and thus rationally express his or her will to end his or her life and b) the individual is able to carry out the final act which puts an end to his or her life (for example drinking the lethal barbiturate) by him- or herself.

Basically, any intervention by third parties with requests by individuals who wish to end their life stands in conflict with the individual’s right to self-determination and thus implies paternalism. However, we must not ignore that some form of “gate keeping” would make sense: the request of a patient stricken with terminal cancer must not be lumped together with the request of a young man suffering after the breakdown of the relationship with his girlfriend. Whilst both requests are to be taken seriously and should be respected up-front – this being the base of an authentic suicide-attempt prevention approach – the patient suffering from cancer certainly needs a different kind of attention to his or her request than the young man. In the first case, counselling on alternative options such as palliative care and the preparation of at least an option to an assisted suicide (what we at DIGNITAS know as the “provisional green light”) are the means of choice, whilst the in the latter case counselling making it clear that “other parents have beautiful daughters too” should take place. However, as already stated, in both cases the principle of respecting person’s request to end their life and certainly not denouncing, belittling, ignoring or dismissing that request should be the rule. Individuals who express a wish to end their suffering have valid personal reasons to do so – they want to be acknowledged and heard and not simply be dismissed as “being in a crisis” or even committed to a psychiatric clinic.

In this context, one should not overlook the fact that several completely different types of suicidal individuals may be found who are rarely comparable one to another. Quite a number of commonly heard phrases – like “a suicide attempt is normally just a cry for help”, “80 % of people who have survived a suicide attempt would not like to repeat it”, “someone who talks about suicide will not do it” – are simply “thought savers” (an expression created by the American

journalist Lincoln Steffens, a friend of President Theodore Roosevelt²³). “Thought savers” are a way to stop thinking about a particular problem without solving it. It is quite significant that such “thought savers” are very common in relation to the suicide problem. With a “thought saver”, one may get rid of the problem, belittling it so that it appears no longer worth thinking about. Nobody asks, for instance when speaking of a “cry for help”: why does this person feel the need to undertake the risk of a suicide attempt in order to find help, instead of talking to other people and saying that they need help? In the special case of a suicidal situation, the reason for the “cry for help” without words is the risk of losing one’s liberty (due to being put in a psychiatric clinic) or the risk of not being taken seriously or being rejected (deprived of affection) if one talks to someone else about suicidal ideas. At DIGNITAS, we hear again and again how individuals felt quite a major relief after having had the opportunity of speaking to us openly about their idea to commit suicide: these individuals acknowledge that being taken seriously and receiving honest information on the possibilities at the end of life and the risks involved with a self-attempted suicide helped them to ease the urgency of the feeling of wanting to die as soon as possible.

In Switzerland, the “gate keepers” are basically medical doctors. Only a medical doctor can prescribe the lethal drug Pentobarbital of Sodium which is the one drug of choice for a dignified, risk-free and painless accompanied suicide. Furthermore, associations like EXIT and DIGNITAS are the ones with many years of experience and trained staff to take care of the requests by individuals wishing to end their life and arrange for accompanied suicides in the framework of the Swiss law. It is generally known that many medical doctors help their patients in one way or another to end their suffering upon explicit request of the patient. However, this is taking place in a rather clandestine manner. Furthermore, many medical doctors understandably argue that they should not be burdened with the responsibility of being the one and only gate-keepers of access to a self-determined end in life.

This last aspect even takes on more weight when it comes down to asking psychiatrists to serve as a part of the “gate-keeping”. As mentioned before, the Swiss Federal Court set the prerequisite of a “special in-depth psychiatric opinion”. Yet, it ignored the fact that psychiatrists regularly face an important conflict of interest in such cases: psychiatrists earn their income through the existence of mental disorders in other individuals. Therefore, if psychiatrists are asked to carry out appraisals (which would mean that such a patient could end his or her life), then these psychiatrists, from an economic point of view, are compelled to accept a reduction of their income. Amongst medical doctors, psychiatrists (more or less like paediatricians) are the category of medical

²³ In: The Autobiography of Lincoln Steffens

doctors with the smallest income and the economic conflict of interest is obvious.

In addition, there is a psychological conflict of interest: from the statistics on causes of deaths it can clearly be seen that the occupational group of medical doctors has the highest rate of suicide amongst all occupational groups. Amongst the medical doctors, psychiatrists have an even higher rate of suicide than their colleagues not specialising in psychiatry. Therefore, and for this very reason, a psychological conflict of interest arises for medical doctors and above all psychiatrists: if he or she helps a patient to realise his or her wish for a self-determined end to life by establishing an in-depth appraisal, then he or she further reduces the already low barrier against his or her personal suicidal tendencies by which he or she sees his or her existence endangered. This is known in analytic psychology as transference and countertransference.

The Swiss scientist Frank Th. Petermann showed in his publication “Capacity to Consent (Urteilsfähigkeit)”²⁴, the numerous problems which derive from intending to make medical doctors and psychiatrists the “gate-keepers” of assisted suicide.

Through giving third parties the responsibility for deciding whether somebody who requests an assisted death should be eligible for assistance, paternalism over individuals is enforced instead of strengthening the self-determination of individuals; a result which is in direct contradiction with the meaning and content of the ECHR.

9b. Should this decision be made by doctors, by an independent judicial body such as a tribunal, or by another type of organisation?

We refer to our comment with question 9a

10. If some form of assisted dying were to be legalised, should doctors be able to take a role in assisting those who request assistance to die? A. If yes, what actions should doctors be able to take? B. If no, please explain your reasoning.

Not only medical doctors, but any individual should basically be able to take a role in assisting those who request assistance to die. To give all the human care possible to an individual wishing to end his or her life due to any sort of suffering is the minimum human approach that could be asked from any individual – not only medical doctors. In any case, it would first be necessary to define what “assistance” comprises. However, it is understood that the expert medical knowledge provided by medical doctors would and should play a role in

²⁴ Frank Th. Petermann, capacity to consent (Urteilsfähigkeit), pages 81 – 85, cipher 228-234

the requests of individuals who wish to end their life due to severe suffering. It is certainly undisputed that the assessment of a medical file is a helpful basis upon which to look into the request of an individual for an assisted (accompanied) suicide. As stated before, in Switzerland medical doctors are very much the “gate-keepers” to an assisted suicide. However, for reasons outlined in our comment with questions 9a, this “putting the decision-making burden” more or less exclusively on the shoulders of medical doctors is not a sensible approach.

11. If some form of assisted dying were to be legalised, what provisions would be required to protect doctors and other healthcare professionals who are ethically opposed to assisted dying?

If medical doctors and healthcare professionals were to be in any way the “gate-keepers”, they should not and must not be forced to get involved in assisted dying if they do not want to do so. Freedom of choice on the side of the individual who wishes to put an end to his or her life also has to respect freedom of choice for individual medical doctors and healthcare professionals to participate or not in assisted suicide.

However, the fact that some medical doctors and healthcare professionals try to withhold medical documents or even issue “varnished” medical reports once they become aware that these documents could be needed for a request for the preparation of an assisted (accompanied) suicide, needs to be attended to. We know from ‘DIGNITAS-friendly’ medical doctors in the U.K. that the Medical Defence Union (MDU) unofficially advises its members not to hand out any medical reports in such cases. However, normally patients certainly do have a personal right to access their medical file without delay. Paternalism and discrimination of patients because of some ethical personal opinion of medical doctors and healthcare professionals cannot be accepted.

12. Could assisted dying have a complementary relationship to end of life care or are these two practices in conflict?

Most certainly, these two practices are not in conflict but in fact have a complementary relationship. Almost every day DIGNITAS receives calls for help from patients stricken by the final stage of terminal cancer and their relatives and friends. As the administrative proceedings involved with the preparation of an accompanied (assisted) suicide generally take up at least two to three months, often even longer, terminally ill patients are always recommended to pursue, for example, palliative treatment possibly leading to terminal sedation. Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and

impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual²⁵. Palliative care is widely accepted and practiced. It is the means of choice if the suffering of the individual is intolerable (in the view of the patient, of course) and the life expectancy is only a matter of a few days, maybe a few weeks. It is certainly humanitarian and good practice in the sense of “the good Samaritan” to give a suffering, dying patient all the end of life care necessary and requested by the patient in order to soothe his or her ordeal.

However, voices claiming that palliative care “can solve anything” and “soothes any suffering” lack reality and try to mislead the public. As already mentioned, there are uncountable illnesses which are not terminal as such, at least not in the short run. Patients suffering from neurological illnesses such as multiple sclerosis, etc., or even more so quadriplegics (as for example in the before mentioned case of Daniel James²⁶) or patients suffering from ailments related to old age (as for example the well-known British conductor Sir Edward Downes) are generally not per se eligible for palliative care and terminal sedation because they are not suffering from a life-threatening illness. Certainly, they receive medical treatment for pain relief, but that cannot be compared with the dosages usually applied in end-of-life palliative care. Without doubt, such patients are experiencing severe suffering which can lead them to wish to end their life. In such cases, the wish for an accompanied (assisted) suicide is a personal choice which must be respected.

Generally, and especially in end-of-life issues, one must avoid lumping together that which needs to be distinguished. There is no such thing as “the one typical terminally ill patient” and there is no “typical suffering which would make the individual eligible for a certain end-of-life care”. Human beings are individuals. Every suffering individual experiences his or her situation differently. Physical and mental pain is subjective; it can be judged by third parties only to a minor degree. A humanitarian approach demands that the individual is seen as such – and not just as “one patient amongst many others”.

13. If the law was to be changed to permit some form of assisted dying, what forms of assistance should be permitted? Should assisted suicide be permitted? Should voluntary euthanasia be permitted? (Please see the definitions above).

As already stated before, DIGNITAS favours the option of assisted (accompanied) suicide such as Swiss law allows them to practice and which the Swiss associations have been offering to their members for some 25 years now. Assisted (accompanied) suicide implies the following:

²⁵ Definition by the World Health Organisation, see online: <http://www.who.int/cancer/palliative/definition/en>

²⁶ See foot note no. 18

- The individual is respected in his or her request to have an end to his or her suffering.
- This request is explicitly expressed by the individual, not only once but several times during the process of preparation and re-confirmed even in the final minute prior to the assistance. (In the case of accompanied suicide in Switzerland, this is the moment prior to handing over the lethal drug to the individual).
- The individual expresses his or her desire to end his or her life not only verbally but undertakes the last act in his or her life him- or herself (In the case of accompanied suicide in Switzerland, this is the action of the individual actually drinking the lethal drug or absorbing it in another form such as feeding it him- or herself through a PEG-tube).
- All actions are based exclusively on the explicit will of the individual.
- With assisted (accompanied) suicide the taboo of ending someone’s life actively (on request by the patient, which would be voluntary euthanasia or even without such request which would be non-voluntary, active euthanasia) does not have to be broken. Without the final act of the individual, there will be no ending of life.
- Access to the option of an assisted suicide has a very important, yet all too often overlooked suicide attempt preventative effect. A suffering individual often finds him- or herself between a rock and a hard place: on the one hand there is the option of enduring the suffering and on the other hand there is the option of an attempt with inadequate means, lonely, risky and with the outlook of possibly severe consequences for the individual and third parties. In this situation, the option of an assisted (accompanied) suicide offers the individual the freedom of choice in a setting that would certainly be considered more dignified than jumping from a bridge or a shot in the head! Besides, as already mentioned, it is proven that only a minority – 13 % – of those who receive access to the option of an accompanied suicide at DIGNITAS actually make use of this option.

However, these aspects of assisted (accompanied) suicide cannot hide the fact that with assisted suicide “only”, some individuals would be excluded from assistance in dying: an individual in a coma or suffering from advanced dementia would not be able to express his or her will, would not have sufficient capacity to consent and/or simply would not be able to do the last act which brings about the end of life him- or herself. For these situations, separate approaches will be necessary: the strengthening and implementation of the already wide-spread and widely accepted Patient’s Advance Decisions (also called Patient’s Advance Directives or Patient’s Living Will) and possibly even regulations on how to implement (voluntary and non-voluntary) euthanasia –

such as in The Netherlands, Belgium and Luxembourg. Still, based on DIGNITAS’ experience, the large majority of requests for an individual’s dignified end in life can be covered by assisted (accompanied) suicide.

14. Should those who wish to be assisted to die, but are physically unable to end their own lives, receive assistance to die? If yes, what assistance should be provided?

We refer to our comment on question 13.

15. Please include here any further comments, evidence or personal experience that you would like the Commission to consider:

Hereafter, we add an extract²⁷ of the philosophical and political principles guiding the activities of DIGNITAS which we feel may well serve as a basis for any considering of end-of-life-issues:

The fundamental values of DIGNITAS are based on values that the Swiss state has upheld since the founding, in 1848, of the modern federation, and the further development of these values on a national and international level since then.

The starting point is the liberal position that in a free state any freedom is available to a private individual provided that the availing of that freedom in no way harms public interests or the legitimate interests of a third party. Just like John Stuart Mill stated:

“Over himself, over his own body and mind, the individual is a sovereign.”²⁸

These values are:

- Respect for the freedom and autonomy of the individual as an enlightened citizen
- Defending this freedom and autonomy against third parties who try to restrict those rights for some reason, whether ideological, religious or political
- Humanity which seeks to prevent or alleviate inhumane suffering when possible: probably the most shining example of this in our history, on a national and international level, led to the founding of the Red Cross
- Solidarity with weaker individuals, in particular in the struggle against conflicting material interests of third parties
- Defending pluralism as a guarantee for the continuous development of society, based on the free competition of ideas

²⁷ From the booklet/brochure „How Dignitas works“, available online: <http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf>

²⁸ John Stuart Mill, Essay on Liberty, Library of Liberal Arts edition, p. 13.

- Upholding the principle of democracy, in conjunction with the guarantee of the constant development of fundamental rights

Respect for the freedom of individuals:

Respect for the freedom of individuals in the form of an enlightened citizen who takes on personal responsibility (a “citoyen” in the sense of the political philosopher from Basel, ARNOLD KÜNZLI, who died in 2008²⁹); he also reveals, among other things, that – in contrast to earlier law – constructive law valid today no longer punishes a suicide attempt.

Freedom from the expectations of a third party:

It is also clear that every person on Swiss soil is entitled to the freedom to live his or her life independent from the individual ideological, religious or other types of ideas of a third party.

No one has the right to impose or even attempt to impose his or her individual ideological, religious or political beliefs on another. Muslims should not do it to Christians, Jews or Buddhists. Christians should not do it to Jews or those of other beliefs and a believer should not do it to an unbeliever – not even using the indirect method of a governmental regulation.

In this case, the state should be the guarantor for a pluralistic society and must forbid anything that would restrict this pluralism or lead it in a certain direction in the interest of a specific ideological viewpoint.

Humanity:

When addressing the question of whether a person who wishes to die should be offered help, humanity needs to be the central focus.

The term “humanity” is admittedly vague in and of itself; however, it plays an important role for example in the “Declaration of Geneva”, which was adopted by the General Assembly of the World Medical Association in 1948 and last amended in 2006.

Although this declaration does not make any reference to medically assisted suicide, it does begin with the formulation:

“I solemnly pledge to consecrate my life to the service of humanity”

The declaration also contains the following as its final sentences:

“I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat”.

²⁹ As described in his essay „Bourgeois und Citoyen: Das Doppelgesicht unserer Gesellschaft“, in: Michael Haller, Max Jäggi, Roger Müller (Ed.), Eine deformierte Gesellschaft, Die Schweizer und ihre Massenmedien, Basel 1981, p. 299 ff.)

Since experience shows, however, that it is difficult to interpret the undefined terms of humanity, respect or even dignity as such, in the end the only help comes from the decision to stop and consider what is the true objective of medicine instead of relying on interpretation.

The German medical ethicist EDGAR DAHL from the Giessen Clinic formulates it this way³⁰:

“Medicine consists first and foremost of prevention, diagnosis and therapy. This means that it strives to avoid disease, identify disease and treat disease. One could conclude from this that the objective of medicine is to maintain the health of the individual. In fact, the Declaration of Geneva states that “The health of my patient will be my first consideration”. As enlightening as this declaration appears to be, it is however incomplete. A look at palliative medicine is sufficient to show that a doctor’s duty is not at all limited to simply maintaining health. For example, palliative doctors spend their days and nights caring for patients whose health cannot be restored.

Based on this, it would seem more suitable to consider the objective of medicine to be the alleviation of human suffering. Looking at it this way, we would also be encouraged by asking ourselves why medicine is committed to avoiding, identifying, and treating disease. The fight against disease is not an objective in itself. Rather, this fight is taken up to protect us from physical and emotional suffering, which tends to accompany illnesses.

By fulfilling its objective to alleviate human suffering, medicine is however continually bound to respecting the self-determination of human beings. No one is allowed to treat a patient against his or her will. That doctors are only permitted to introduce or terminate medical procedures with the express permission of the patient is now a generally accepted fact. For example, whether or not a life-prolonging procedure is introduced or terminated is always and exclusively dependent on the agreement of the patient involved.

When medical ethics, as described above, are based on the alleviation of suffering and the respect of self-determination, it should be obvious that these ethics are completely compatible with assisted suicide, since a doctor who fulfils the request of a terminally-ill patient to stop all further therapy and prescribe a lethal medication is alleviating suffering and respecting self-determination.”

A policy that is aimed at doing everything possible to prevent every suicide without taking into account the will of the person concerned violates humanity. Whoever acts in this way to force people to attempt to bring about their own

³⁰ in his essay „Im Schatten des Hippokrates / Assistierter Suizid und ärztliches Ethos müssen sich nicht widersprechen“, published in „Humanes Leben – Humanes Sterben“, 4/2008, p. 66-67, Augsburg, Germany.

death in a violent manner, and thus accept the possibility of inhumane risks, is acting inhumanely.

Is it somehow humane to allow a person to achieve his or her own will by attempting something, such as that reported by an interested person from England who e-mailed DIGNITAS in 2008, and to accept the consequences thereof?

“Dear Dignitas. My name is J.(xx) H.(xx). I am 19 years old, and live in Scotland, UK.

About 2 months ago I attempted to commit suicide by jumping off a multi storey car park. My attempt failed, and instead of dying, I write this e-mail to you from my hospital bed.

I crushed both of my feet, broke my leg, broke my knee, broke my sacrum (part of my pelvis) and most devastatingly, broke my spine, in 3 places, which has resulted in a degree of paralysis in my legs. I spent 6 weeks in hospital in my home town of Edinburgh, and was then transferred to a special spinal rehabilitation hospital in Glasgow.

I am told that I will need to spend 6 months at this hospital, and that I will be in a wheelchair for the rest of my life. I now have a loss of sexual function, which seems unlikely to return, as well as huge problems managing my bowels and bladder (I cannot feel them moving).

I was already suicidal, and now that I will be disabled for the rest of my life, at such a young age, I truly cannot bear the prospect of life. I am only 19, and I now have the grim reality of 60 years in a wheelchair. The physical pain I am in alternates between bearable and completely unbearable. Perhaps the pain will ease off with time, but this is not a certainty. There are times every day where I scream with pain, due to being moved in bed, hoisted into the wheelchair etc.

I would like to ask if I could be considered for an assisted suicide, as I am completely certain I would like to end my life, and believe I should have the right to do so.

I would be too afraid to try and kill myself again, given the devastating effects of my first failed attempt. It would also be much more difficult to attempt suicide from a wheelchair. I only wish that my country was humane enough to let a person die.

Please consider my letter, I hope to hear a response,
J(xx) H.(xx)”

In this message, which must horrify every person who has any feelings whatsoever, the author has not yet shared what the problem was that motivated him to attempt suicide in the first place.

However, one thing is certain: If, after becoming suicidal, he had had the opportunity to talk with other people about his problem without having to fear that he would be immediately admitted to a psychiatric ward, his fate would have most certainly been different. People would have tried to show him that there were also solutions other than suicide for his problem in order to give him a real chance to solve the underlying problem without resorting to violence against himself. This way, he would not have had to accept the risks that have now marred him in such a devastating way. Under humane conditions of this kind, he would have certainly had a real chance to overcome his suicidal tendencies.

In this context, it is especially important to ask why it is ethically commendable to put a severely suffering animal to death, but it is impossible to allow a severely suffering human to end his or her own life, without having to accept the inconceivable risks of failure and additional self-mutilation. What abstruse ideas could lead someone to declare that what is humane for a person to do to a suffering animal is unethical if done to a suffering human, especially since an animal *cannot* express itself in human speech, yet a human can clearly state his or her will?

Solidarity for the interests of those who are weaker:

Solidarity with, and protecting the interests of, people who are considered weaker, especially in the struggle against the conflicting – and often financially motivated – interests of third parties, is one of the fundamental qualities of the Swiss public spirit.

The principle “One for all and all for one” is not fully realised in the narrow limitations of that which the state directly encourages as solidarity based on the laws it creates, but rather it is only fully realised in the broader field of social solidarity in civil society, that is, turning a certain group of people towards another group that is in need of special help.

Plurality:

The defence of a pluralistic system is equally important because it alone guarantees that the free competition of ideas, and thereby the further development of society, remains possible.

Democracy and basic rights:

Further significant fundamentals of our shared existence include the principles of democracy within that sphere which is not left up to the individual’s own discretion as a consequence of his or her basic rights.

In this context, it must be said that a representative survey on the topic of assisted suicide found that 75 % of the evangelical population and 72 % of the

Roman-Catholic population would claim the possibility of assisted suicide for themselves and thus endorsed it³¹.

Citizens are not the property of the state:

Finally it must also be said that people who inhabit a country should never be degraded by being considered the property of the state. They are the bearers of human dignity, and this is characterised most strongly when a person decides his or her own fate. It is therefore unacceptable for a state or its individual authorities or courts to choose the fate of its citizens.

6) Conclusion

“No one shall set upon a long journey without having thoroughly said goodbye to loved ones and no one shall set upon such journey without careful preparation”.

At a time in which lonely, unassisted suicides among older people, in particular, are increasing sharply – as a result of the significant increase in life expectancy and the associated health and social problems of many men and women who have become old, sick and lonely – careful and considered advice in matters concerning the voluntary ending of one’s own life is gaining relevance. Furthermore, developments in modern medical science have also led to a significant prolonging of life. Yet, there are individuals who explicitly would like to add life to their years – not years to their life.

It is about time that the law makers in the U.K. (and other countries) respected the will of the people and implemented sensible solutions that allow individuals, who choose so, to have a dignified, self-determined end to life at their own home, surrounded by those close to their hearts.

DIGNITAS very much welcomes and supports the work of the Commission on Assisted Dying and hopes that the final report of the Commission will find some open ears in Parliament, given that a delegation of the Select Committee on Assisted Dying for the Terminally Ill Bill of the House of Lords visited DIGNITAS in February 2005.

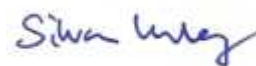
Yours sincerely

DIGNITAS

To live with dignity - To die with dignity
Secretary General



Ludwig A. Minelli



Silvan Luley

³¹ in “Reformiert”, August 29th, 2008; GALLUP TELEOMNIBUS survey from 3-12 July 2008 through ISOPUBLIC, Schwerzenbach, online (in German): http://www.reformiert.info/files_reformiert/1492_0.pdf