Issues of Death Pt 1

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Preacher: John Wyatt

[0:00] Well, thank you very much. It's a real privilege to be here and I'm afraid we are sort! of talking about some really painful and difficult topics tonight but I hope that through it all! we can see some positive things, what it means not just death in the negative sense but what! it means for Christians to die well and to die faithfully and to die in the hope as we've heard of the resurrection and eternal life. So, these issues are all about us. If you open the newspapers, switch on the television, the chances are that you're likely to come across before long one of these tragic stories. This is an example of the story of Ann Turner. She was a doctor, a GP.

She had nursed her husband who developed a degenerative condition and all the way until he died and then to her horror she started to see similar symptoms herself. She was becoming unsteady on her feet.
She had difficulty in bathing and she decided that she wanted to kill herself and so she took some tablets, tried an overdose, it failed and then she talked to her children and persuaded her children that she wanted to kill herself and that if they really loved her they would help her to kill herself and take her to the clinic in Dignitas in Switzerland. And that's what happened eventually. It's very interesting to see the reaction of the children they wrote about it and how they felt torn apart and this is quite common in these stories. So, often loved ones, family, children, they feel on the one hand horrified at the prospect that their nearest and dearest wants to kill themselves but also a sense of loyalty to them. You know, are we just going to let her do this by herself or at least should we be there and be and be part of the experience? And so this terrible sense of conflict which often people feel in these kind of situations. Eventually they went to Dignitas, they drank a bottle of champagne, they sang some songs and then she took the lethal dose and she died. And the story was written up in a very positive way. Incidentally, it's been made, it's a DVD, the BBC filmed the process, would you believe, and they've got a reconstruction of a DVD, very well done, it's called A Short Stay in Switzerland. And I strongly recommend it to you if you want to see it. It's the sort of thing that should be a good discussion starter for a group, if you want to discuss some of these issues. This is the story of Sir Edward Downs and his wife, elderly couple. She had cancer, he was just frail. And they had a suicide pact that they would both go together and so they both went to Switzerland and they died hand in hand. And again, the general tone of the reporting was how positive, you know, what a lovely thing to do, what a noble way to die. And why did they have to go to Switzerland? Surely it would be much better to allow this to happen here in the UK. This is the tragic story of Daniel James. He was a young man, very promising rugby player, played for the England junior team, then was involved in an accident on the rugby pitch, fractured his cervical spine, paralysed from the neck downwards, became deeply depressed, felt that his life was completely over, he's a sporty type, what could he do? And then persuaded his parents that if you really love me, you'd help me to kill myself. And eventually that's what they did and their parents took him to Switzerland where he died, took the overdose. And again, most of the press coverage is very positive. What loving parents that they were prepared to sacrifice their own desires to do the best for their son.
And Baroness Warnock, very well known moral philosopher, publicly back then took courage for the parents of Daniel James to say goodbye and called for euthanasia to be legalised in the UK. More recently, this tragic case, Daniel Nicholson, sorry, Tony Nicholson, who has a rare syndrome called the locked-in syndrome. This is due to a stroke at the base of the brain, which has the effect of knocking out the pathways which allow the brain to control the rest of the body. But consciousness and awareness is completely normal. But the person is locked inside their body and is unable to move normally.

And often the only thing they can do, for instance, is just blink or have some minimal movements. And this is not a common syndrome, but it does occur. And in fact, there are thought to be several hundred people in the UK who have the locked-in syndrome as a result of a stroke. Interestingly, very few of them want to kill themselves. In fact, most of them are desperately trying to survive. [5:36] There's a wonderful film, again, I recommend the film, called The Diving Bell and the Butterfly. It's both the book and the film. And this recounts the story of a prominent man called Booby, who was a French editor of Elle magazine, I think it was. And he suddenly had a catastrophic stroke and woke up in hospital with the locked-in syndrome. And he dictated this book letter by letter, by blinking.

And that was the only way he would communicate. And the film is all done through the first-person perspective. So it's all done through his eye. And it's all happening around you. And it's a remarkable story. His family, his children, his mistress, they all come to visit him at the bedside. It's all the complicated family dynamics. And it's called The Diving Bell and the Butterfly because the Diving Bell is his body in which he's trapped. And the butterfly is his mind which is free to roam. And so on. And Booby was desperately planned to stay alive. But he eventually died of complications. Tony Nicholson wanted to kill himself. He felt his life was pointless and futile. And the problem was he couldn't kill himself by himself because he had no movement over his arms or legs. And so he went to the High Court to ask for the court to put a special jurisdiction to say that the doctor could kill him at his request without the doctor being prosecuted. And this went all the way to the Court of Appeal. And many of us in this area knew that if the Court of Appeal had backed Tony Nicholson and said yes, a doctor could do this, that would have opened the floodgates. That, just that one, the way our legal system works, that once there's a legal precedent, then the floodgates would be opened. And it hung by a knife edge, but in the end, the Highest Court in the land said no, this is a matter for Parliament, it's not a matter for the Court to change the law. And that's the way it stands at the moment. But there's still an appeal going on. That's another person with the same condition at the moment who's appealing to the High Court. So this is the kind of situation where it would be possible for the entire legal structure to change. But at the moment, doctors are under exactly the same law as everybody else.
They don't have a special OO prefix, license to kill. And therefore, intentional killing, for whatever motive is regarded as homicide, under the Homicide Act, and it carries a mandatory life sentence. This, of course, is not just people like that who have been discussed, but one of the big issues is the whole issue of dementia. And the rise in the number of people in our society with dementia, and the question about how we're going to cope with all the demands and the expense of looking after people with dementia, and so on. And this is Mary Warnock again, who was quoted in the papers as saying, if you're demented, you're wasting people's lives, your family's lives, and you're wasting the resources of the National Health Service. And absolutely fully in agreement with the argument that if pain is insufferable, then someone should be given help to die.
[9:06] But I feel there's a wider argument that if somebody absolutely desperately wants to die because they're a burden to their family or the state, then I think they too should be allowed to die.

Now, her words were greeted with horror by many people, including charities who work with people with Alzheimer's disease, as well as Christians and others. But actually, she was just verbalizing what I've heard many people say privately. They wouldn't want to say it in public, but privately. They think that actually, given the coming epidemic of elderly people with increasing needs, what some people call the demographic time bomb, which means there are more and more elderly people in our society. As I look across this room, I have to say I do see certain signs of the demographic time bomb, in terms of the number of older people, of whom I'm one. But the idea, therefore, that euthanasia might be a solution, might be a way that if we can only encourage people as they get to a certain age to do the decent thing, and stop burning up all the resources for the young people, but shuffle off this mortal coil at their own choices.
And this is an obituary which I think, again, is a harbinger of things to come. This is Nan Maitland, and at first glance, when you read this obituary, it just sounds like a completely normal obituary. The founder and president of Home Share International, Nan Maitland, died on the 1st of March. Home Share was a central concern for the last 25 years of Nan's life. Her vision, energy and inspiration were missed by all of us around her, were captured by her warm personality and compelling charm.

[10:53] But on the day after Nan Maitland died, her close friends and family received a letter through the post from her. And in the letter, this is what it said, By the time you read this, with the help of friends at the end of the good Swiss, I will have gone to sleep, never to wake. For some time my life has consisted of more pain than pleasure, and over the next months and years the pain will be more and the pleasure less. I have a great feeling of relief that I'll have no further need to struggle through each day in dread of what further horrors may lie in wait. For many years I have feared the long period of decline, sometimes called prolonged dwindling, that so many people unfortunately experience before they die. Please be happy for me that I have been able to escape from this in the unbearable future. I have had a wonderful life and the great good fortune to die at a time of my choosing. And in the good company of two faked colleagues, that sounds for friends at the end, with my death on March the 1st I feel I am fully accepting the concept of old age rational suicide. Which I have been very pleased to promote as a founder member of the Society for old age rational suicide in the past 15 months. So this idea is gaining ground that suicide is actually a rational and a reasonable, if not a noble and responsible way to die.

As we'll see a bit later on, in the past suicide, intentional self-destruction has always been seen, although in many cultures it was seen as a positive thing, it's always been seen in Christian cultures as an act of despair and hopelessness, not a noble act, not a responsible act. But we shouldn't be too surprised. In other words, suicide is actually the pagan way to die. It's the non-Christian way to die, and always was in the pre-Christian era. We shouldn't be too surprised, as in our post-Christian age, as within our society Christian influences are actually declining, we shouldn't be too surprised to see that the pagan way to die is being increasingly rehabilitated and even promoted and celebrated as the noble, the responsible, the rational way to die.

Of course, there's a terrible disconnect here because we have on the one hand people who are encouraging and promoting suicide, and yet you have whole areas of government, particularly the National Health Service, but also social services, prison services and so on, who are all totally dedicated to reducing and preventing suicide. In fact, all medics are trained in suicide prevention, recognizing the risks, ensuring treatment and so on. And as society, we are still dedicated to trying to reduce and minimize suicide. And this is just one example of many of where there's this amazing disconnect that people have that between, on the one hand, promoting and encouraging something at the same time, regarding it as an evil that has to be reduced.

And the other thing, of course, is that it's also in the context, promoting suicide among the elderly is also in the context where we know that the elderly care in the UK has many deficiencies, and there's many societies. And that attitudes towards the elderly are already issues of great concern. Ageism. It's interesting, as you get older, you realize certain things you never realized when you were younger. But I suddenly realized that ageism is very, is alive and well in our society as I've got older. And therefore, this is just one more aspect where you can see how discrimination against the elderly is wide open as it's being promoted, the idea that older people should do a decent thing and kill themselves. And of course, we have many tragic cases of poor care in the NHS.

[15:01] Yes, I speak as a doctor with great distress, but these kinds of stories are not unusual. So, before we go on, I just want to say that I'm very conscious of the fact that these issues, the death and dying and dementia and strokes and all that kind of stuff, are not issues just out there in society. They're issues in here as well. They touch all of us because of our own humanity.

The reason I'm wearing a suit is that I've just come this afternoon from a funeral from some close friends whose young daughter committed suicide. And the sort of tragedy of sudden death and all the painful issues are all very close to home for all of us. And I know that. And therefore, as I said when I was talking about abortion and issues at the beginning of life, it's very important whenever we engage with some of these issues that we don't talk about them in a judgmental and a harsh way with rhetoric about murder and all that kind of stuff. But instead, we talk about these issues with tears in our eyes because we have to empathize. What is it that drives people to want to kill themselves? What is it in our society, this terrible desire to fear of death and dying which is so current?

And how can we, as a Christian group, respond to some of these real challenges? How do we want to die? What does it mean to die well? You know, if you were to go out there and ask people how they would want to die, how would you like to die? Do you know what the commonest answer you will get? If you ask people outside, you'll get the commonest answer is, I want to die in my sleep without any warning at all. I want to just go out like a light. I don't want to have any awareness.

I don't want to have any warning. I don't want to have any, any, I just want to go out like a light. What a wonderful way to go. The interesting thing is if you talk to Christian people, many Christian people will say exactly the same thing. That's the way I want to die. I just want to die without any warning and go out like a light. It's very interesting, you know, that in the medieval period, and in fact in the entire Christian history up until about 18th century later, sudden death was always seen as the most evil way to die, the worst way to die. To be catapulted into eternity with no possibility of preparing yourself to meet your maker, of saying goodbye to your loved ones, of asking for forgiveness, of reconciliation between relationships. The idea that you just go into eternity with no warning at all was seen as the most, the worst way to die.
So isn't it interesting that in our culture, what was once seen as the worst way to die is now seen as the best way to die. You know, lucky beggar never knew what hit him. What a wonderful way to go. Bang.
[18:04] Is it really a wonderful way to go? Well, I want to suggest it isn't a wonderful way to go at all. And to the extent which we as Christians think that that's the best way to die, I suggest that we've been infected by many of the attitudes in our own society. It goes along in our society with a real interesting longing and desire for anaesthesia. You know, what modern people long for above else is just not to feel anything. I don't want to know anything, doc, just put me out. I don't want to know anything, just put me out. That idea that anaesthesia, just being completely blotto, is the best way of experiencing any kind of life event, is bizarre. And yet that is actually something very, very common on society. And I suspect it lies a lot behind the use of alcohol, drugs, and lots of other ways, which are really just different methods of getting anaesthesia. I just don't want to feel,

I don't want to experience, I don't want to be part of it. And people apply that also to the end of the life. I don't want to know anything about it, just put me to sleep, doc. I don't want to know anything about it. But is that again really the best way to die? Is that what dying is all about? I think it's a good question and we'll come back to it. There used to be an organisation called the Voluntary Euthanasia Society in the UK, which was a highly dodgy and disreputable organisation, which used to tell people how to kill themselves by hoarding tablets and putting a polythene bag over their head and things like that.
And then it underwent a complete makeover. And it changed its name to Dignity in Dying. And it has now become an extremely sophisticated, highly professional and very effective lobbying organisation for promoting euthanasia and physician assisted suicide. And it's a very well funded organisation.
I think it has more than 12 full-time staff. It has a turnover of well over a million pounds a year. And it's, and but it's operating almost entirely below the radar screen. It has lots of the great and the good as their patrons, many celebrities. It has senior doctors and lawyers and so on. And it has lots of allies, particularly in the media. And so the reason, as you might probably notice, that you seem to get this constant stream of stories about people going to Dignitas, about terrible people dying in terrible agony in the media, in the broadsheets, in the media, in television and so on.
That's not an accident. The reason that's happening is because this organisation is feeding, is finding these stories and constantly feeding them to their allies in the media, who are very keen to promote them. There are actually about 500,000 people a year who die in the UK.
[21:07] And there are something like 20 or 30 a year who go to Dignitas. And yet, if you get the impression from the media, you would get the impression every other person is going to Dignitas. It's only a handful of people every year who go. And yet, why is there such enormous publicity answer? Because this, behind the scene, there is a very effective and professional lobbying process, which is aimed at changing attitudes. And the interesting thing, it's been highly successful. Because if you look now at attitudes in the population, studies suggest that something like over 80% of the general population are in favour of a change in the law. Very interestingly, as you go to people who've actually got more and more experience of dealing with dying people. So if you go and look, for instance, at doctors as a whole, you'll find the majority are against changing the law. If you go and look at people who deal with dying people, like geriatricians and general physicians, the proportion drops again. And if you look at palliative care doctors, who actually spend their whole time caring with dying people, the proportion is the lowest of all. So, there's this paradox. The further you are away from people who are actually dying, the more it seems like a good thing, the closer you get, the less it seems like a good thing. And actually, palliative care doctors say that with proper palliative care, people asking to be killed or to kill themselves is actually very unusual. Which

again, is not the impression you get from the media. So, dignity and dying, it's well worth a visit, go on their website and read some of the accounts. This is just interesting to look at the words. Dignity and dying campaigns for greater choice, control and access to services at the end of life. We believe that people should have more control over how, where and when they die. Greater choice includes giving mentally competent terminal adults an unbearable suffering with choice of an assisted death within street, street legal safeguards. So, look at the words, choice, control, dignity. And if you look at some of the sort of words which that websites use and which other websites use, it's quite interesting just to look at all these different phrases. The right to choose at the end of life, easing the passing, assisted dying, choosing to die, easeful death, ending suffering, choice and control over how we die. Now, all those phrases are actually referring to some, to some, to some, to what lawyers call homicide. They, they're referring to intentional killing. But isn't it interesting that all those, none of those phrases actually refer directly. They're all euphemisms, they're all nice sounding phrases. And this actually reflects a very common and interesting theme in the whole history of ethics. And that is, as you trace changes in attitudes and behaviour, what you find is that nearly always changes in language precede changes in behaviour. In other words, if you want to make some practice acceptable, the first thing to do is to change the language we use about it. And this process can be seen happening in many areas. I'll just give you an example in another area. There's actually a small group of people who are promoting paedophilia, sex between adults and young children.

And do you know what they call it? Intergenerational intimacy. I mean, who could be opposed to intergenerational intimacy? What a good thing. That's just an example. So, it's very interesting why, how language is so important in moral activity. And I think it's, it's the way we are made. It's the way that God has made us. That the words we use, including the sort of conversation which goes on in our heads. You know, did I really kill my patient? No, no, no, I was just easing the passing. Oh yeah, that's right then. That sort of conversation that is going on. The words we use are very interesting.

And it's by no means surely, not related, unrelated, that in the third chapter of Genesis, in the right of the beginning, what's the very first thing that the evil one says? In your Bible, did God say, in other words, right from the beginning, the attack of the evil one is on language, is on words, is on manipulating, is on twisting. And he's still at the same game today. So I like this proverb that says, the beginning of wisdom is to call things by their proper name. The beginning of wisdom is to call things by their proper name. So what we're talking about, when we're talking about euthanasia, is intentional medical killing. It's intentional, the idea is to introduce death into a situation of a person whose life is thought not to be worth living. And a lot of confusion comes because people use language in a way which is often deliberately manipulative. I think it's very interesting and ominous that, for instance, Lord Faulkner, who is a very eminent and highly intelligent, sophisticated lawyer, has in his whole strategy for introducing physician-assisted suicide into the UK, he never uses the word suicide and he always says assisted dying. And he knows perfectly well that that phrase is highly ambiguous, what you mean by assisted dying. When that phrase was first promoted, a palliative care nurse wrote to the newspapers in outrage saying, I am appalled at the fact that this phrase is being used to talk about killing. I am a palliative care nurse, I spend every day assisting people who are dying, but I don't kill them. So how dare you take that phrase and mean it, mean bias, something completely different. Helping people to kill themselves. So intentional medical killing of a person whose life is thought not to be worth living. And incidentally, that's the, so the important emphasis is on intention, it is the intention to kill. And you can see this intention, a very important point of view, which many people don't realise, is that the drugs that are used in, by the euthanasia doctors are completely different from the drugs that are used by the palliative care doctors. So the drugs that are used by the euthanasia doctors, interestingly, gruesomely, in the history of euthanasia, nobody knew, when they started killing people, they didn't know how to do it. It wasn't something you learned at medical school. And so they experimented with all kinds of ways of killing people, sometimes with insulin or injecting air into veins or, and many of these things didn't work.

But they've honed it down now, and now they've got a pretty effective method. And the method is to give a huge dose of barbiturates, between 40 and 50 times the normal therapeutic dose. That combined with a muscle relaxant, which abolishes muscular activity, including breathing activity, and a drug which stops the heart. Why did they choose those drugs? Well, it's pretty obvious, isn't

it, what they're trying to do.
The barbiturates cause instantaneous, virtually instantaneous coma. The muscle relaxants stop the breathing activity, and the other drug stops the heart dead. And that way, you die. Pretty, pretty jolly effectively. None of those drugs are used in palliative care.
[29:09] Now, it's a constant theme from the pro-euthanasia lobby, that doctors are killing people every day in hospital. I mean, it's going on all the time, in palliative care and so on. We just want to regularise it. That's just an outright lie. And the reason that barbiturates are not used in palliative care, why not? Because they are dangerous, because they kill people. And that's precisely why doctors in palliative care don't use barbiturates. They use a group of drugs called the benzodiazepines, which are actually known to be incredibly safe drugs, that you can give massive overdoses off, and it's still very unkilled people. So the intention of what the doctors are doing is revealed by the choice of drugs that they use. So euthanasia is not the same as withdrawing medical treatment, which is futile or burdensome. That's not euthanasia. That's actually good medical care. And in my work as a pediatrician, caring for sometimes critically ill or brain damaged babies, on a number of occasions, many occasions,

I, together with colleagues, decided that carrying on life support system in a baby who is going to die anyway, and is catastrophically damaged, that carrying on and on to the bitter end is not the right or loving thing to do. And there is a time to say enough is enough, and switch off the machines. But when I switch off the life support machines and the baby dies, I am not killing the baby. It's almost as though death is already there in the room. I've been holding off death with all the machinery and the drugs and so on. And there comes a point where you take your hands away and death occurs. That's very different from where you go to the cupboard, you draw up a lethal drug with somebody who's not dying, you inject them and they die. And that's revealed for instance in the death certificate. When we write out a death certificate on the cause of death of a baby, what I write on the death certificate is not switching off life support machinery as the cause of death. That wasn't the cause of death. The cause of the death was the severe injuries that the baby had had. Severe brain damage or whatever other problem was going on with the baby. That was the cause of death. Whereas if I go to the cupboard and draw up my lethal poison, can this baby who's sitting there quite happily and inject the drug and then they die, if I'm honest, the cause of death is cardiac arrest due to lethal injection.
So that illustrates the difference. Removing life support in a way it can bring no benefit is not the same as intentional killing. And in all treatments, this simple but helpful idea is that we have to balance, every medical treatment has both benefits but it also has burdens. And a part of the art of medicine is to try to make sure that we balance the benefits and the burdens of treatment.
And if your treatment that you're giving is too burdensome and is not bringing any benefit, then to carry on giving treatment which is bringing no benefit is a bad thing. We should stop the treatment. And so, as I'm sometimes asked by Christian people, you know, if I was close to the end, should I be having every treatment possible to try and prolong my life as much as possible? Is that what a Christian person should do? Well, the answer is no, not necessarily. If that treatment is causing far more problems and burdens than the benefits it can bring, then often the right thing to do is to say, no, I don't want any more treatment. I want to be kept comfortable. But of course, actually God gives us the freedom to choose. And it's interesting in my experience how some people, at the end of their life, they want desperately to hang on and cling on to life and to have every day is precious and to have one more day of spending time with my loved ones and so on. And they want to have every possible treatment, however uncomfortable it is. Whereas other people feel, I've had my life, it's time to go home.
[33:15] And I don't want any further treatment and I want to be just kept comfortable. And it's not for me, I think, to say, well, that person was right and that person was wrong. I think that God gives us the freedom to make our own choices, but we are accountable for the choices we make and the decisions that we make. So, secondly, euthanasia is not the same as giving painkilling treatments in order to benefit the patient, which may have the unintended side effect of shortening life. This is sometimes called the principle of double effect.

It's recognizing the difference between intention and foresight. And again, this is actually a very important distinction, which is something which I think intuitively everybody gets. Well, if I was to get in my car and drive home, as I will be doing in an hour or two, and tragically, a little child runs in front of my wheels and I can't stop and I kill them, am I guilty of murder? Well, I think it's something I

foresee. I could see that it could happen. All of us can foresee it, but it's not our intention when we get into our cars to kill someone. And so I think we see that there is intuitively, there's a difference between foreseeing something as a possibility and actually intending it to happen.
And it's the same way, whenever I give a drug which I know has a side effect, when I was in cancer medicine, I used to inject into people's veins the most horrible toxic poisons. I knew about the side effects, I knew that it made their hair fall out, I knew that it made their bone marrow suppress, that it caused terrible skin conditions and so on. Yet I still went on and injected the drug. What kind of terrible, evil doctor was I? Well actually no, my intention was to treat the cancer. But I foresaw, I could see that my drug would also likely have consequences. But that's not the same thing.
So in the same way, and an example which is sometimes given, is that if somebody's is extreme pain and or breathlessness, the doctors will sometimes give very powerful painkillers, opiates like morphine or diamorphine, which are the most effective painkillers we have, but we foresee that in some patients that will actually depress respiration and may actually shorten their life. But if they're dying, we feel our intention is to cure the pain, whereas we recognize that we, that may shorten their life, but that's not our intention. And so that's sometimes again called the principle of double effect. Now in fact that example is not a terribly good example because palliative care doctors say that in fact morphine and opiates and drugs like that very rarely shorten life. And in their experience, when they use properly and safely, morphine actually often extends life in dying patients. And the reason for that is that when people are admitted at the end of life into palliative care, sometimes they're in terrible pain and distress. And because of that terrible pain and distress, they just say, Doctor, I just want to kill me, just kill me, just end my life,
Doctor, I just want to die. But once they've received morphine and proper pain relief, you know, within a few hours they're sitting up in bed saying, oh, I feel a lot better now, what's for breakfast? And so the interesting thing is that once you provide proper pain relief and symptom control, often the effect is actually not to shorten life but to extend them. Why is it that there's this whole