

Bearable and unbearable suffering in later life.

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Introduction

Research indicates that both thoughts about and the actual risk of committing suicide increase with increasing age (Huertas et al., 2020; Ladwig et al., 2008; WHO, 2014: 22). At the least, then, one can say that suffering is aligned with age. For some, this means that old age provides ‘a suicide enabling script’ whereby voluntary death—or self-murder—is deemed more rational, permissible, and wiser than when it is enacted at other, earlier stages of life (Winterrowd, Canetto and Benoit, 2017: 174). But while increasing agedness may furnish such a script, for many older people the likelihood of turning such thoughts into action is constrained. For many older people, whatever the intensity of their desire to end their life, the means of ending life are not readily to hand, the perceived outcome of such attempts is itself uncertain and the strength and determination to complete the suicidal act limited. In consequence, the act is often never undertaken or if undertaken is uncompleted (Crandall et al., 2007; Wiebe et al., 2019: 5). This raises the question of the appropriateness of assisting older people faced with the sufferings of age to end their life more securely and at their request.

Whether framed as voluntary death or self-murder, suicide has been de-criminalised in so many countries that it may almost be said to reflect a near universal right for adults to end their life, whenever and however they choose, with or without suffering, providing only that, in the process, no harm is done to others (Mishara and Weinstubb, 2017). Assisted suicide is a different matter. It remains a criminal offence in all but a few jurisdictions and even where such assistance is made available it is provided under a tight set of conditions, designed to ensure a clear distinction between legitimate medical practice and activities that constitute not medical assistance but aiding and abetting self-murder.

Where such laws have been enacted, there has been a slow but steady increase in the numbers of people seeking medical assistance to end their life. Here, age plays an important if often unmarked role. Although studies indicate that the modal age of those seeking assisted dying or euthanasia lies between 60 and 85 years old (Steck, Egger, Maessen, Reisch and Zwahlen, 2013: 942), most research on patients and relatives who have considered or sought assistance with dying rarely emphasize their agedness. Instead, they focus upon the presence of intolerable physical pain, physical loss of control, a deteriorating quality of life and the

importance of controlling the form and timing of death (Hendry et al., 2013). Except for the latter, these are not so very dissimilar from the reasons revealed in the suicide notes of older people (Cheung, Merry and Sundram, 2015). It seems it is not age per se that motivates the desire to end one's life, so much as its painfulness and suffering, even if age itself might serve as both a source of suffering and a mediator of its bearability and tractability.

Beyond deeming people seeking medically assisted death legally capable of reaching and holding to such a decision, a key requirement in most legislation is the presence of an *unbearable* degree of suffering. With assisted suicide and the explicit involvement of other persons, serious sanctions are invoked if such assistance is seen to involve unlawfully assisting in (and thereby causing) suicide. By legalizing medically assisted dying and voluntary euthanasia, while still criminalizing aid or assistance to someone committing suicide, assistance with *voluntary dying* is thereby delineated from aiding and abetting what becomes, in effect, *self-murder*. Although not all countries have specific legislation criminalizing assisted suicide, most have sections in their criminal law that serve a similar purpose, that is to bring charges against anyone involved with colluding with a suicide (Lewis, 2006). Hence the nature of suffering provides the fulcrum upon which such decisions most often hang. The focus of this paper is the nature of such suffering, its judged intractability and unbearability, and its consequent relevance to debates about medically assisted dying and the place of age in this wider debate.

As several authors have noted, the delineation of unbearable suffering constitutes “the most difficult requirement to form a judgment on” (Pasman et al., 2009: 1235). While there are several other contexts where assessing or judging the presence, degree and nature of suffering are relevant, this paper will focus primarily on assessments made in relation to applications for medically assisted death, voluntary euthanasia, and the related procedure of palliative or terminal sedation (Jackson, 2002; Papavasiliou et al., 2013). These three related procedures have in common the relief of present and prevention of future suffering by medical means. As regards the first two, though often used inter-changeably, voluntary euthanasia refers to the intentional ending of life by a physician administering drugs while medically assisted death involves the physician prescribing the drugs which the person him or her self then takes (Materstvedt et al., 2003). In contrast, terminal sedation is intended primarily to relieve suffering not by inducing death but by rendering the patient permanently unconscious until they die from their underlying condition (Riisfeldt, 2019).

The first section of the paper considers the issue of assessing suffering as a matter of ‘degree’ and the reliability and validity of such assessments. Here the emphasis is not upon

age or specific conditions per se, but on the rationale for distinguishing between degrees of suffering, in implicit contrast to the assessment of pain. The second section turns from focusing on differences in degree to the nature of suffering itself. How much does the cause of suffering matter? Does suffering induced by physical conditions that cause distress and pain differ qualitatively or quantitatively from suffering induced by mental anguish and psychic pain? Are there, over and above somatic and psychic sources of suffering, other sources of suffering where life is felt equally unbearable – for example in cases of what has been termed ‘existential’ suffering? This leads to a further consideration that is addressed in the third section of the paper, whether or not enduring later life (old age) may constitute ‘an enabling script’ for rendering assistance to end one’s own life not only understandable, but permissible.

In the light of the above and given the context of the conference from which these papers derive, in the fourth and final section of the paper I discuss whether assisted dying in later life may be compatible with sustainable religious faith. Whether, in short, divisions of opinion on this matter are not simply between secular and sacred views of life, but constitute sources of division within faith communities themselves, an issue touching not just upon suffering, but upon how life itself is regarded.

Degrees of suffering

Though pain measurement has been the subject of considerable research in medicine, pharmacology and psychology, less attention has been paid to assessing suffering. The relief of suffering underlies almost all aspects of medicine and surgery and unlike pain, it does not form the basis for any specialty. Still, it is surprising that so few attempts have been made to measure the suffering that patients experience. This is especially pertinent to debates about assisted dying, since judgements of insufficient suffering are among the most frequently cited reasons for denying applicants their request for assisted dying (Evenblij et al. 2019: 7). No “agreed-upon definition of unbearable suffering in end-of-life situations [has] materialized” (Dees et al., 2010: 349).

In 2004, Aminoff and colleagues noted that “there have been no reports in the medical literature on methods of examining the level of suffering” because, they felt, of the difficulty involved even in conceptualizing suffering (Aminoff, Purits, Noy and Adunsky, 2004: 123). Subsequently Schulz and colleagues sought to develop measures of suffering based on their framing it as “a holistic construct with multiple dimensions... includ[ing] psychological

distress ...physical symptoms and ...an existential or spiritual dimension, which includes loss or impairment of inner harmony and meaning and purpose” (Schulz et al. 2010: 775). These authors developed several scales designed to assess each of these different aspects of suffering. In a later review of these and other related scales assessing suffering, most were found to have been designed for medical and nursing staff “to assess suffering in advanced or terminally ill patients”, based upon a semi-structured interview between clinician and patient (Krikorian, Limonero and Coley 2013: 131).

None of these scales has had widespread application and tests of their psychometric adequacy (judged by their reliability and validity) have been largely confined to the field of palliative care. While this may be appropriate, where a combination of physical pain and psychic distress may well lead to quantitative change in the course of treatment and care, in the context of physician assisted dying where judging whether suffering meets the criterion of ‘bearability’ the issues underlying the assessment are rather different. Here subjective consideration of someone’s suffering as being ‘unbearable’ is paramount, while also requiring a necessary consensus between the patient’s own judgement and the clinician’s judgement of the validity of the patient’s claim. Here the focus shifts from evaluating the objective conditions of someone’s illness to the characteristics of the person suffering. Who should determine what is or is not bearable to the person faced with any number of ills of different forms and qualities? How under these very different circumstances should suffering and sufferer be viewed where making the judgement of suffering is a matter of life and death?

The experience of suffering

Central to this issue is the contrast between what might be called the object and subject position of suffering and the extent to which the law, unlike medical practice, requires not a psychometrically sensitive and sophisticated measure of degrees of suffering but a consensually derived view of suffering—in effect an agreement between the suffering expressed from the subject position of the applicant and the suffering witnessed from the object position of the clinician. Here, one can distinguish between two different clinical approaches toward the assessment of suffering. The “subjective account” such as that proposed by Eric Cassell (1991; 1999) gives precedence to the subject pole while the “objective account” such as outlined by Stan van Hooft (1998) gives precedence to the object pole. For Cassell “suffering is an affliction of the person, not the body” which forms “a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted” (Cassell, 1999: 531). Within the framework established by Cassell, it

is the totality of suffering – its capacity to threaten the integrity of the person—that matters, not the source[s] or form[s] that suffering takes.

In contrast, van Hooft rejects this subject-centred position in favour of an externality whereby suffering can be as well judged by those witnessing as by those enduring it (van Hooft, 1998). He argues that suffering can be observed from a number of domains, which may or may not be inter-related, but which are not made determinate upon a subjective account. These domains he refers to as aspects of the Aristotelian person with its four types of ‘soul’ namely “the vegetative, the appetitive, the deliberative, and the contemplative [which] in modern parlance ...could be thought of as a person’s biological functioning, their emotional and desiring functions, their practical and rational lives, and their sense of the meaning of their existence” (van Hooft, 1998: 126). Within each of these domains, van Hooft asserts, the degree and extent of suffering can be observed, without accessing the suffering experience itself, or even acknowledging the existence of any subjectivity in the (human or non-human) being observed. While Cassell considers that medical practice can and should be concerned with the totality of a person’s suffering, van Hooft would limit medicine’s role to intervening only in those aspects of suffering affecting a person’s biological and emotional functioning, where an objective assessment can be made of the severity of disease and the intensity of pain associated with it (van Hooft, 1998: 128).

Clearly the assessment of suffering is more problematic than the assessment of pain. Depending upon how it is conceptualized, assessment methods will either privilege the observed signs of disease and distress or the subject’s sense of their incipient or actual disintegration as a person. The former position enables the concept of suffering to be applied both to human and non-human beings as well as to those human beings who may be unaware of their suffering. This would include, for example, determining acceptable and unacceptable levels of suffering inflicted upon laboratory animals (Olsson et al., 2020). There are sufficient objective signs to indicate, not simply the presence, but the degree of suffering, the argument goes, that protocols can be instituted to place a cap on the degree of suffering of such animals (Beauchamp and Morton, 2015).

Beauchamp and Morton give the example of the 2010 EU Directive on the Protection of Animals Used for Scientific Purposes, which states that: “severe pain, suffering or distress, which is likely to be long-lasting and cannot be ameliorated” should not be inflicted upon laboratory animals (Beauchamp and Morton, 2015: 433). The elision between pain, suffering and distress enables the authors of the Directive to equate the intensity of an animal’s suffering to the intensity of pain inflicted, mediated by its long-lasting nature and irreversible

impact. Beauchamp and Morton go on to instance Danish legislation that goes further, delineating a level of pain and suffering beyond ‘severe’ and of such intensity as to warrant euthanasia to put an end to the animal’s suffering (Beauchamp and Morton, 2015: 437). The authors note however that even this legislation leaves “unstated how to interpret or even to find the differences between categories such as “severe,” “very severe,” and “intense” (Beauchamp and Morton, 2015: 438). Even when human subjectivity is removed, the delineation of the observed severity of suffering as a continuum remains at most imprecisely defined, leaving it to the judgement of those witnessing the animals in the experiment, much as the doctors are left to judge whether a patient’s suffering is or is not legitimate grounds for their agreeing to terminate his or her life. The further one moves from van Hooft’s first domain of biological functioning, the greater the scope there seems for disagreement over what is or is not ‘intense’, ‘severe’ or ‘unbearable’ suffering (Rietjens et al., 2009; van Tol et al., 2010).

Forms and sources of suffering

Cassell proposed that threats to the integrity of the person formed the essence of human suffering but his formulation has not gone unchallenged. While the Cartesian division between ‘*res cogitans*’ and ‘*res extensa*’ might suggest that suffering can only be a subject state of the former, even Descartes realized that the person, as human being, embodies both (Descartes, 1998: 41). This would imply, at least, that threats to the integrity of the person can arise from at least two sources—the body and the mind. Any condition that threatens the integrity of the one would seem to do so equally for the other.

Recognising that similar degrees of suffering can arise from conditions affecting the body and the mind has been acknowledged in recent judgements in Belgium and the Netherlands. This concerns the eligibility of persons suffering from psychiatric conditions to be considered for physician assisted suicide, providing they are judged to have capacity to make such reasoned judgements and that the source of their suffering is not susceptible to amelioration (Kim, De Vries and Peteet, 2017). Most of the objections to extending eligibility for physician assisted dying to persons with psychiatric disorders lies not with the ‘severity’ of degree argument, but with the question of the ‘tractability’ and ‘terminality’ of the conditions serving as cause of that suffering (Kious and Battin, 2019).

Though related, the two are distinct. Some conditions are untreatable, although they are not necessarily terminal, in the sense of leading to immanent death. Others may be

terminal, but the possibility of intervention – including effective amelioration of mental and/or physical suffering—may be high. The reluctance, for example, to extend physician assisted dying to persons whose suffering arises from psychiatric conditions is not because of the lack of *terminality* associated with the condition, but because of the potential *tractability* of the condition. Years of intense psychic pain, associated with chronic depression, may be every bit as unbearable as months or weeks of intense physical suffering associated with an inoperable cancer. While the latter may be inoperable and incapable of significant amelioration, ruling out any recovery from depression may feel to many clinicians a decision too difficult to make. Still, the question remains of the effect of successive treatment failures and the prospect of hopes of recovery dashed within weeks or months by a further relapse renders life under these conditions just as unbearable or even more so, than if there were never any relief.

If the bearability of suffering entails not just the experienced (or observed) intensity of psychic or somatic pain, but its perceived intractability, then it could be argued that the older a person is, the shorter their expectancy of life and hence the greater the tolerability of any suffering, knowing that their days are numbered. In fact, requests for medically assisted deaths are expressed increasingly more often in later life—after the age of sixty— with the notable exception of requests occasioned by psychiatric illnesses (Blanke et al., 2017; Smets et al, 2011; Steck, Egger, Maessen, Reisch and Zwahlen, 2013). Does this mean that suffering is harder to bear in later life or that the conditions causing most suffering increase with age or is it that the sheer weight of years itself bears down upon persons—adding a further element to their suffering? In addressing this question, a third form of suffering has been proposed, what some writers have called ‘existential suffering’, induced by the weight of a long, purposeless life now, or in future (Boston, Bruce and Schreiber, 2011; Lacour and Hvidit, 2010; Murata and Morita, 2006; Schuman-Olivier et al., 2008; Strang et al., 2004).

While potentially akin to psychic pain and suffering, in the sense employed by Cassel, existential suffering is used to describe not so much the presence of psychic or somatic pain but the absence of meaning or purpose, of feeling without hope, or use, or value (Schuman-Olivier et al., 2008). These authors distinguish between what they term chronic existential suffering and acute existential distress. The former they liken to a constellation of personality traits with ongoing doubts about meaning in life, beset by questions about why they were chosen to suffer, and lacking any sense of purpose in life while the latter is more a reaction, occasioned by facing one’s imminent mortality. It is, they argued, only the latter—which they frame as the acute existential distress in the face of terminal disease—that legitimates

medical intervention to reduce such suffering, whether that be continuous sedation or assisted dying, unlike the former which lacks any ‘medical’ context.

While such a definition is presaged upon an already existing terminal illness, absent the illness and the imminent prospect of dying, existential suffering seems to lack any medical or psychiatric delineation. So, many clinicians would argue, pure existential suffering scarcely justifies physician assisted dying or voluntary euthanasia, let alone terminal sedation, since the evaluation of such existentially determined suffering lies outside the competencies of physicians and psychiatrists (Young, 2014). This latter, generic existential suffering, however, seems to come closer to the state of persons considering ending their own life because of its increasing emptiness and purposelessness: why go on when one is not living at all, but just existing. So why, can it be asked, if physicians and psychiatrists are able to assess the intensity of suffering in one case can they not be considered capable of assessing it in other cases (Varelius, 2014). The suicide of the Austrian writer and Auschwitz survivor, Jean Améry, in 1978 provides a particular example of such existential suffering.

His translator, John Barlow, has described how Améry saw suicide (what he called ‘voluntary death’) as his ‘preferring annihilation to the continuation of an existence lived in ignominy, desperate pain or utter helplessness” (Barlow, 1999: xviii). Written two years before he killed himself, Améry’s book, *On Suicide*, provides what can in many ways be described as an account ‘from the inside’ of what existential suffering is like, in someone who looked forward to his old age as little more than the further substantiation of the painfulness of life, when the moments of living grow shorter, shallower until they shrink to nothing (Améry, 1994; 1999).

Tedium vitae: the unbearable weight of the years.

In contrast to seeking a voluntary death arising in the context of acute or intense existential suffering, the possibility has been raised that the sheer length of life may also serve as a cause of unbearable suffering. This issue is highlighted in another, more recent suicide of a literary figure, the American writer and scholar, Carolyn Heilbrun. Like Améry, Heilbrun had announced her intention of ending her life some years ahead of her actual suicide. For her, life had not felt meaningless or dogged by misfortune. She had been a well-regarded professor of literature, a crime writer of some repute and had maintained a long and seemingly contented partnership with her husband for many decades. But when writing about women’s lives after sixty, she stated quite clearly that she had no wish to live beyond

seventy. In fact, she was 76 years old when, after completing her regular walk with a friend, returning home to finish off some correspondence, she swallowed a number of pills, put a bag over her head, wrote a brief note and died. Her death was not occasioned by any terminal illness, nor any serious psychiatric illness, nor *strictu sensu*, by any Améry-like chronic existential distress. Rather she simply felt that she had had enough and that whatever remained was no longer worth keeping. Her suicide note merely read: “End of the journey: Love to all”.

This notion of having lived long enough—of a completed life—has since seen a social movement termed (in English) *Of Free Will* that was set up in the Netherlands by Yvonne van Baarle. Its goal is to assist older people “who consider their life complete” to end it (Beekman, 2011: 12). The group seeks to offer support to older people who consider they have reached or are reaching a point when more life is a worse prospect than death, to act upon their beliefs and embrace death. *Of Free Will* specifically defines later life and older people as those who are 70 years of age or older, following the traditional notion that ‘three score years and ten’ represents the normal extent of a human life, as outlined in Psalms 90: 10, which goes on to note that “though men’s lives be so strong that they come to four score years, yet is their strength then but labour and sorrow” (Psalms 90: 10, cited in Badham, 2009: ix). In short, even when it is achieved, life extending beyond seventy can be considered and has long been considered, a period of ‘labour and sorrow’ and as such itself a source of suffering from which people might legitimately seek release.

According to Beekman, around 500 elderly people have requested assistance to end their lives on such grounds, though only a very small minority (he reckons about 1%) of such requests have ever been granted (Beekman, 2011: 19). The movement taps into an increasingly popular view and opinion polls indicate that substantial numbers of the Dutch population consider that elderly people should be eligible for help in terminating their life, whether or not they have a painful or terminal illness (Beekman, 2011; Buiting et al., 2013; Raijmakers, van der Heide, Kouwenhoven, van Thiel, van Delden, and Rietjensal, 2015). Although support for the right to an assisted death for those who judge their life ‘complete’ remains less than that for those who are terminally ill, it is growing, and old age now serves for many people as a permissive script to enable voluntary dying—whether as a rational suicide or as assisted dying (Holzman, 2021).

Describing her intention to end her life once she reached seventy, Carolyn Heilbrun wrote: “Is it not better to leave at the height of well-being rather than contemplate the inevitable decline and the burden one becomes upon others?” (Heilbrun, 1997: 7). For her,

still alive and still writing in her mid-seventies, “there are no cures for aging despair” (Heilbrun, 2004: 213) and shortly after, before this her last publication was in press, she ended her life. For Heilbrun it was not so much the *taedium vitae* that oppressed her, but the sense of her age and retirement left her with little prospect of contributing to the world, and looking ahead she saw years of uselessness, not merely limited pleasures and limited desires. This sense of suffering from the weight of the years, that underpins the ‘Of Free Will’ movement, carries with it two related issues, each I suggest embedded in the life and death of Améry and Heilbrun, that with the coming of age, there is both an ending of opportunity to make something (new/more) of life and the sheer intractability of this position. To still feel worthy, to still be human, is to do the right thing, to recognize that one is free to do that right thing and to as Améry put it to take “the road to the open” (Améry, 1999: 142). Even though life might still be bearable, it can be intolerable to still bear it.

Conclusion: What role for faith?

A number of writers, both religious and non-religious, have considered that suffering can play a meaningful part in constituting human life and stress the importance of bearing suffering as a virtue. Unbearable suffering becomes from such a perspective a sign of bad faith, of failing to meet the moral requirement of being fully human in the face of adversity. Deciding on self-murder, whether or not it is assisted, on the grounds of unbearable suffering attests to that bad faith. While it is recognized, for example, in Pope John Paul II’s encyclical, *Evangelium Vitae*, that “the life of the body in its earthly state is not an absolute good”, and thus need not be sustained at any price and under any conditions, ending it can only be justified when it takes the form of self-sacrifice rather than on the more specious grounds of seeking an escape from suffering. The encyclical is critical of what it sees as “a certain Promethean attitude which leads people to think that they can control life and death by taking the decisions about them into their own hands”. What scope is there, then, for finding a place for assisted dying, at any stage of life, within the context of a sustainable religious faith in a higher power?

Some have argued that the encyclical embodies an anti (or post) -Cartesian philosophy, seeing the body as necessarily embodying the person. Disposing of the body is thus a violation of personhood, not the person merely disposing of one of his or her (albeit much cherished) earthly possessions. On this view “all living members of the human species are persons, i.e., beings of incomparable worth, the bearers of rights that must be recognized by others and protected by society... [and] although human persons are more than their

bodies, they are nonetheless bodily beings, and their bodies and bodily life are not merely goods for the person but goods of the person, and as long as there is in our midst a living, human body there is in our midst a living human person” (May, 2003: 322). This position has not changed greatly although a few theologians have acknowledged the potential value of legalizing assisted dying while staying within the Christian faith. This is however a minority position and as Jones has put it: “there remains a significant ecclesial consensus across Anglican, Catholic, Orthodox and Non-conformist churches in opposition to legalizing assisted suicide or euthanasia” (Jones, 2016: 332).

While such arguments hinge upon the ontological status of persons, they fail to target what arguably is the key issue in assisted dying—namely the question of whether there are limits to human suffering. While a strong case has been made for the necessity of human suffering in framing human subjectivity, does this mean that every possible degree of suffering is equally as necessary or are there limits to what suffering a person can reasonably be expected to tolerate? This can be considered the issue of the normativity of suffering. While relevant to both secular and spiritual judgements, I want in this final section to focus upon the latter, since it seems clear that, within the framework of secular law, there is a normative understanding of limits that can be framed as ‘unbearable’ suffering. Roughly speaking, secular judgements requires that both the sufferer and those approached to aid the sufferer to end his or her life establish a sufficient consensus that the suffering that is experienced by the former and witnessed by the latter is understood and agreed to be ‘unbearable’. Can any such consensus ever be reached when the witness is a religious? And if not must there remain an unbridgeable divide between two types of witness—between the physician and the priest?

This is perhaps an increasingly blurred divide: just as there are physicians opposed to either voluntary euthanasia or medically assisted dying, so too are their priests for whom the relief of unbearable suffering through assisted dying can constitute a permissible, even religious act. In bringing this paper to a conclusion, I should like to draw upon the writings of Paul Badham, Emeritus Professor of Theology and Religious Studies at the University of Wales, the so-called ‘Apostle of Suicide’ (Jones, 2016). Badham challenges the necessity of such a divide. While Jones raises the problem of the company one keeps, as a Christian, in advocating assisted dying or voluntary euthanasia, Badham’s position is based upon what he believes is a due Christian concern for intolerable suffering (Badham, 2009). He states, at the very outset, his position regarding the value of suffering and “the Christian hope of eternal life with God and hence a potential readiness to let go of this life in confidence and hope”

(Badham, 2009: xiv). But, he argues, the very concept of aiding someone's death, rather than constituting a betrayal of faith, can be considered in some circumstances the very expression of that faith—exercising “that loving compassion which is supposed to be the hallmark of Christianity” (Badham, 2009: 121).

While ‘compassion’ is reliably evoked when faced with another's suffering, as MacIntyre has pointed out it is not so easy to determine what exactly constitute compassionate practices (MacIntyre, 1984). Practicing Christian compassion, at least as Badham sees it, means that “love might require us to assist a person to die if that were their wish even if it were not ours” (Badham, 2009: 121). Others are more skeptical arguing that the compassion associated with assisted death is more appropriately located within the politics of neoliberalism, rather than the Christian tradition (Fleming, 2019). Others would even disagree with the implicit elevation of compassion as ‘the highest virtue’ trumping all other considerations but Badham's position is to frame assisted dying very much within a Christian rather than a medical ethics framework. Arguing that faced with the presence, or indeed the prospect of unbearable and intractable suffering, enabling a person to die offers a more Christian, more compassionate passing than that of either terminal sedation or the “present lonely extension of the dying process” in the clinical context of a hospital bed where those in attendance are mostly trained to prevent death.

While much of the debate over unbearable suffering and assisted dying was initially between religious and secular institutions and communities, Badham suggests that “it is fast becoming a debate among and between Christians” and, it would seem, among and between other faith groups as well (Badham, 2009: 4; Chakraborty, El-Jawahri, Litzow, Syrjala, Parnes and Hashmi, 2017). Acknowledging that there are indeed limits to suffering and that some, at least, of the “suffering of old age is not life as it was meant to be by God” can make an equal claim in reflecting respect for human dignity just as much as does denying such limits (de Lange, 2013: 180). However difficult it may be to define determine and judge the nature and degree of suffering, it still seems important to bear witness not just to suffering, but crucially to acknowledge the intractability and unbearability that suffering in later life can sometimes be.

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