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1. Introduction

1.1 The 2025 Conference received a brief report from the Faith and Order Committee on assisted dying. This followed the longstanding public debate regarding this issue, and the introduction of a Private Member's Bill[1] on the subject in the UK Parliament.

1.2 By resolution 15/2, the Conference directed "the Secretary of the Conference, in consultation with the Faith and Order Committee, relevant members of the Connexional Team and appropriate partner organisations, to establish a task group to review the Conference's position with regard to assisted dying and to report to the Conference not later than 2028."

1.3 As the Faith and Order Committee report outlined, the question of assisted dying is not new, and the Methodist Church has had cause to consider it previously. A statement[2] issued by the Secretary of the Conference on 14 November 2024 set out this background. It stated:

> *"A Bill to legalise a form of assisted dying will be debated and voted on in the UK Parliament on 29 November. This follows the introduction of a proposed Bill in the Scottish Parliament in March 2024 which would allow terminally ill adults in Scotland to end their own lives, and the approval of similar plans to proceed with the drafting of legislation to enable assisted dying in Jersey in May 2024, and on the Isle of Man in July 2024.*
>
> *Historically the Methodist Church has opposed any change to the law on this issue. In 2015, when assisted dying was last seriously considered in the House of Commons, the Methodist Conference discussed the issue and heard contributions on both sides of the debate. While there was consensus around affirming the intrinsic value of human life and the importance of high-quality palliative care, two extracts from the motions put forward illustrate the very sincere beliefs held both by those who*

1 Terminally Ill Adults (End of Life) Bill, available from https://bills.parliament.uk/bills/3774
2 https://www.methodist.org.uk/about/news/assisted-dying/

believe the law should change to allow assisted suicide, and those who see that as a slippery slope:

"[Assisted dying] would have a seriously detrimental effect on the wellbeing of individuals and on the nature and shape of our society, and can only add to the pressures that many vulnerable terminally ill people will feel" [Notice of Motion 2015/212]

"where death is considered both certain and imminent, a compassionate due judicial dispensation to allow assisted end-of-life could be appropriate" [Notice of Motion 2015/221]

The Methodist Conference referred the matter to the Methodist Council, which decided not to revisit the Church's position, but requested the production of resources to enable the Church better to respond to the needs of those requiring palliative care and understand the issues involved, in the wider context of the subject of death and dying.

These are available on the Methodist Church website here: https://www.methodist.org.uk/faith/life-and-faith/death-and-dying/

As this issue is debated in Parliament again, we commend those resources for study and informed reflection. The web pages will be updated with additional resources and information over the coming days.

We also urge that this important issue is debated with sensitivity and kindness, recognising its potential to prompt pain and strong feelings in the people most closely affected by it.
Revd Dr Jonathan Hustler
Secretary of the Methodist Conference"

1.4 A Methodist Statement on Euthanasia[3] was adopted by the Conference in 1974, expressing its opposition to any steps which would intentionally end a patient's life. This statement can be found at Appendix 1. Whilst the Statement uses dated language and terms, it demonstrates that this issue has been subject to continued debate for over 50 years. It is also worth noting the Statement's emphasis on the importance of the view of the medical profession. It referred to the British Medical Association's (BMA's) opposition to assisted dying. Since then, in 2021, the BMA adopted a neutral position on physician assisted dying.[4] The 1974 statement is flawed in many other ways, including:

3 https://media.methodist.org.uk/media/documents/pi_euthanasia_74_bNiGJld.pdf
4 https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying

- The notion that 'painkillers shorten life' – pain relief is given to relieve the various different experiences of and types of pain and when these work (which is usually the case) this is generally aimed at improving the quality of life. It is not legal to give analgesics or any other medication with the intention of shortening life. However, doctors can provide strong pain relief, even if that might risk hastening death, provided the intention is to relieve the patient's suffering, and the dosage is proportionate to that intention. This is often referred to as 'the doctrine of double effect'.
- Good symptom control by skilled palliative care healthcare professionals can bring about positive improvements for people living with a life limiting illness.
- Language such as 'handicap' and 'the elderly' are undefined, lack clarity and can be offensive.
- Terminology such as 'terminal' tends to sound final and works against the objective of maintaining hope and quality of life when someone has a life limiting illness.
- The statement refers to the 'patient and their family' assuming that everyone has a family.
- Hospices are not the only specialist teams supporting people who are nearing the end of their life. There are also specialist palliative care teams working in NHS Foundation Trusts and community-based teams, including Macmillan nurses, working with local GP practices. Specialist palliative care and end of life care is now delivered by a range of different services.
- There is an implication that a child or a person with a disability has no value when their life expectancy is shorter than the 'norm'.
- The statement focuses heavily on 'elderly patients' when children and adults can face life limiting illness.

1.5 The debate in the Conference of 2015 reflected the changing position in views on this subject and the two notices of motion[5] referred to the Methodist Council demonstrated the spectrum of genuinely held beliefs. Recognising these different positions, the Council resolved not to revisit the Church's position but instead to produce resources to enable the Church better to respond to the needs of those requiring palliative care and understand the issues involved, in the wider context of the subject of death and dying. As a result, the 1974 Conference Statement remains the position of the Conference.

1.6 Following the 2025 Conference, a working group was established. The membership and declarations of interest can be found at Appendix 2.

5 https://www.methodist.org.uk/documents/6674/conf-2015-daily-record-complete-0715_zZyxNHX.pdf

2. Context

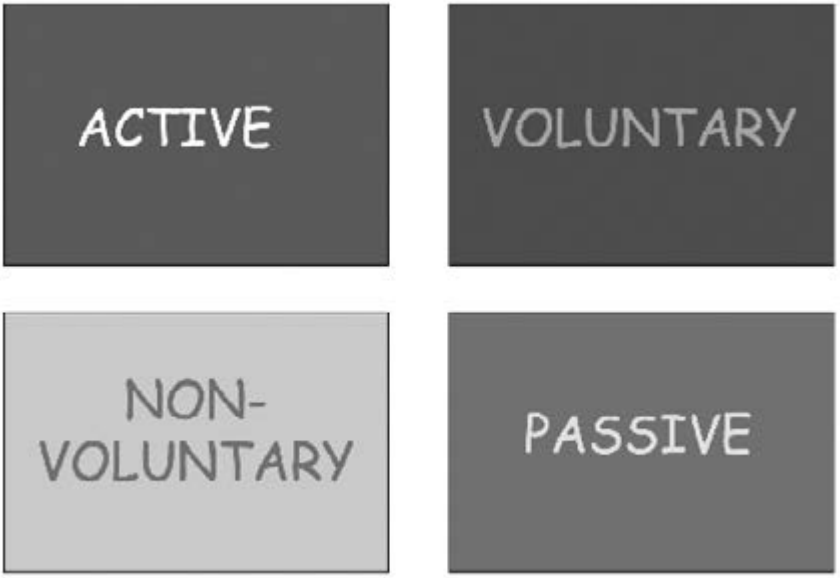
2.1 There is no agreed consensus on which terminology to use when debating the issue of whether people should be legally permitted to seek assistance with ending their own lives. The terms and their definitions describing people seeking assistance with ending of their life can vary and can also be influenced by underlying views. These include assisted suicide, assisted dying and voluntary euthanasia.

Assisted suicide is the act of intentionally assisting another person to kill themselves. The person requesting this help may not be dying or have a terminal illness.

Assisted dying is the act of intentionally assisting another person to end their own life, at that person's voluntary request, subject to eligibility criteria and safeguards.

Physician-assisted dying is the act of a healthcare professional assisting another person to end their life and includes prescribing lethal drugs for a patient to self-administer, and healthcare professionals administering lethal drugs – which is often referred to as 'voluntary euthanasia'.

Euthanasia is the act of deliberately ending a person's life to relieve suffering.



Active/voluntary = assisted dying
Active/non-voluntary = murder/manslaughter
Passive/non-voluntary = removal of medication/nutrition/hydration
Passive voluntary = refusal of medication/nutrition/hydration

2.2 Assisting someone, or encouraging someone, to commit suicide, whether or not that person commits suicide or attempts to commit suicide is illegal in England and Wales under the terms of the Suicide Act (1961) and is punishable by up to 14 years' imprisonment. The amendments introduced by the Coroners and Justice Act 2009 show that this is a wide-ranging offence. Trying to kill yourself is not a criminal act. Depending on the circumstances, euthanasia is regarded as either manslaughter or murder. The mandatory penalty for murder is life imprisonment, while the maximum penalty for manslaughter is life imprisonment. A prosecution for an offence can only be brought by, or with the consent of, the Director of Public Prosecutions (DPP). More information on the DPP policy for prosecutors can be found at https://www.cps.gov.uk/prosecution-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide A decision on whether or not to prosecute will be taken after a report, written after an investigation, has been submitted to the DPP. Whilst the DPP has said that all the circumstances will be taken into account, and in some cases a prosecution will not be authorised, it is not possible to predict in advance those cases which will not result in prosecution. The position is similar in Northern Ireland. In Scotland, there is no specific offence of assisting suicide. Those who do assist suicide, however, could potentially find themselves liable for more general offences such as murder, culpable homicide, reckless endangerment, assault, breach of the peace, or various offences under the Misuse of Drugs Act 1971.

2.3 There is a morally significant distinction between assisted dying and allowing a person to die through the withholding or withdrawal of treatment that would otherwise preserve life. Allowing a person to die involves recognising when treatment has become burdensome, futile, or disproportionate, and permitting death to occur from the underlying illness. Assisted dying, by contrast, involves the provision of medication with the direct intention of bringing about death. Maintaining this distinction matters ethically and clinically. It gives grounds to affirm that good end-of-life care does not require treatment at all costs, while also recognising that deliberately ending life represents a different moral act. If the distinction is collapsed, there is a risk either of obligating continued intervention regardless of benefit, or of treating all end-of-life decisions as morally equivalent. Neither reflects careful moral reasoning or good care for those who are dying.

2.4 The four main approaches to ethics are deontology (duty, rule-based), consequentialism (focus on outcomes or 'utility' – 'the greatest good for the

greatest number'), virtue ethics (based on character, virtue-focused), and justice ethics (based on 'rights' or 'fairness'). Each approach has its advantages and disadvantages. When applied to medical ethics these are often characterised as beneficence (doing good or acting in a person's 'best interest'), non-maleficence (characterised by the phrase, 'first do no harm'). autonomy (the right to self-determination), and justice (both individual and societal).[6] These approaches are seen as the basis of human rights, though few 'rights' are considered to be absolute (ie admitting to no exceptions). There are other approaches to ethical thinking such as 'ethical emotivism', which can be characterised by, 'I don't like X; therefore, X is wrong…'. When we express a view about a subject, it is important to consider not just *what* we think about something but *how* we arrive at what we think.

Assisted dying legislation worldwide

2.5 A UK Parliamentary briefing paper on assisted dying,[7] published in 2022, noted that at that time some form of assisted dying is legal in at least 27 jurisdictions worldwide. Legislation on eligibility and governance of assisted dying varies. In almost all places, it is restricted to adults (including Canada, Oregon, Switzerland and Victoria), while in a few it can also include children with parental consent (including Belgium and the Netherlands). In some places, assisted dying is restricted to people with terminal illness (including Oregon and Victoria). In others, it can also be accessed by those experiencing "constant and unbearable" suffering that cannot be relieved, but who are not terminally ill. This can be restricted to suffering arising from serious physical illness only (including Canada until 2023) or also include those whose suffering arises from psychiatric illness (including Belgium, Canada from 2023 and the Netherlands). In many jurisdictions where it is a legal option, assisted dying is provided as part of the healthcare system, although this is not the case in Switzerland. Recent official data shows that use in different jurisdictions varies. For example, recorded deaths from assisted dying were 0.59% of the total deaths in Oregon in 2021 and 4.2% of the total deaths in the Netherlands in 2019. Research suggests that there is underreporting of assisted dying in some jurisdictions where it is a legal option. Official figures show increasing use over time.

6 T L Beauchamp and J F Childress, (2019) *Principles of Biomedical Ethics* (9th ed). Oxford University Press.
7 https://researchbriefings.files.parliament.uk/documents/POST-PB-0047/POST-PB-0047.pdf

Assisted dying legislation in the UK and Crown Dependencies

2.6 In the UK and the Crown Dependencies, assisted dying is a devolved matter, except for in Wales.

Jersey

In November 2021, the Jersey Parliament approved legalising assisted dying in principle. In May 2024, the States Assembly decided to proceed to consider passing a law drafted to permit assisted dying for those in Jersey with a terminal illness, and this was approved in February 2026. This legislation now awaits Royal Assent. It is anticipated that the earliest date the law could come into effect would be spring 2027.[8]

To meet the eligibility criteria, a person must have been diagnosed with a terminal illness expected to cause death within six months, or 12 months if diagnosed with a neurodegenerative condition. A person must also have decision-making capacity, have a voluntary, settled and informed wish to end their own life, be at least 18, and have been a resident in Jersey for at least 12 months.

The proposals state that a Jersey Assisted Dying Service will be delivered by the Government of Jersey's Health and Care Jersey. An Assisted Dying Assurance and Delivery Committee will oversee the clinical and corporate governance of this service.

Under these proposals, health professionals will be able to choose (opt-in) to work in the assisted dying service, but they must meet certain criteria and be able to demonstrate required competencies.

One of the roles delivering this service will be a 'Coordinating Doctor', who undertakes the first assessment of the person who has requested an assisted death and coordinates the assessment process. They make the decision to approve or decline the request. There will be an 'Independent Assessment Doctor', who undertakes a second assessment. There will also be an 'Administering Practitioner' role, which will be a doctor or registered nurse who will directly administer the substance used in assisted dying or support the person to self-administer the substance.

8 https://www.bbc.co.uk/news/articles/c62dnwwgryeo

Details of how it is expected assisted dying would be provided in Jersey can be accessed here: https://www.gov.je/Caring/AssistedDying/pages/assisteddying.aspx

2.7 Isle of Man

An Assisted Dying Bill completed its passage through the House of Keys and Legislative Council in 2025.[9] Royal Assent is now required, which will be followed by secondary legislation. An assisted dying service could be in place by 2027. The Bill, as amended, includes an 'opt-in' system for doctors to choose to participate, a comprehensive 'conscientious objection clause', and the removal of the prohibition on doctors initiating discussions on assisted dying with patients. The Bill also confirms that doctors would not be under any duty to raise assisted dying with patients.

More information about assisted dying legislation progress in the Isle of Man can be found here: https://tynwald.org.im/business/bills

2.8 Scotland

The Assisted Dying for Terminally Ill Adults (Scotland) Bill was introduced on 27 March 2024. However, in the final debate on 17 March 2026, members of the Scottish Parliament voted 69 to 57 against legalising assisted dying, with 12 MSPs who had backed the bill in principle at an earlier stage deciding at the third reading that they still had too many concerns to finally support it.[10]

The Bill proposed to make it lawful for a terminally ill adult to request, and be provided with, assistance by health professionals to end their life. The eligibility criteria stated that the person must be aged 16 or over, have mental capacity, not be suffering from any mental disorder which might affect the making of the request, have been a resident in Scotland for at least 12 months, and be terminally ill (defined as having an advanced and progressive disease, illness or condition from which they are unable to recover and that can be reasonably expected to cause their premature death).

The Bill set out a framework for how assisted dying would be carried out. This process would have involved a person making a first declaration, indicating to a registered medical practitioner that they wish to be provided with assistance to end their life. This practitioner would have taken on the role of 'coordinating registered medical practitioner' (CRMP) and the responsibility for overseeing

9 https://www.bbc.co.uk/news/articles/c62zpj6mp2eo
10 https://www.bbc.co.uk/news/articles/c33j3nd1kvko

the process from beginning to end. The explanatory notes of the Bill state "it is expected that this will usually be the terminally ill adult's GP or primary care doctor." The CRMP must assess the eligibility of the terminally ill adult against the criteria and be satisfied that the person is making the decision without coercion. These assessments would have been made by the CRMP at multiple stages through the process. If satisfied, they would have referred the person to another independent registered medical practitioner (RMP), who cannot have provided care to the person, or be a relative, partner or colleague of the CRMP.

The RMP would also have assessed if the person is terminally ill, has capacity, and is not being coerced - but does not assess other eligibility criteria of age or residency. The RMP must also discuss matters relating to diagnosis, prognosis, available treatment and care options, and explain that the substance will end their life. The RMP may have referred the adult to an appropriate medical specialist if they are unsure of either prognosis or capacity.

After this process, there would have been a mandatory 14-day reflection period (this would be shortened to 48 hours if death is imminent). After this period, the CRMP must remain satisfied that the person is eligible, and the person may then make the second declaration. If all assessments and declarations are made, a life-ending "approved substance" would be prescribed to the patient by the CRMP to be self-administered. The CRMP or authorised health professional must remain with the person until they have decided whether to take the substance, and if they do, remain in the same premises and 'not too distant' until they have died.

The Bill included provision that no one is under any duty (whether arising from any statutory or other legal requirement) to play an active, participatory role in anything authorised by the Bill to which they have a conscientious objection. It stated that in any legal proceedings, the burden of proof of conscientious objection is to rest on the person claiming to rely on it. However, during the passage of the Bill the Scottish government determined that these aspects of the legislation were beyond Holyrood's powers, and tabled amendments to remove them.

More information about the legislation in Scotland can be found here: https://www.parliament.scot/bills-and-laws/bills/s6/assisted-dying-for-terminally-ill-adults-scotland-bill

2.9 England and Wales

The Terminally Ill Adults (End of Life) Bill 2024-25 was a Private Members' Bill sponsored by Kim Leadbeater MP. It was supported by MPs[11] in June 2025 but ran out of time in the Committee Stage in the House of Lords and therefore will not become law. It is, nevertheless, described in detail here as it is not unlikely that similar legislation might be tabled in the near future.

The broad aim of the Terminally Ill Adults (End of Life) Bill was to allow adults aged 18 and over, who are residents of England and Wales and have lived there for the previous 12 months, are terminally ill and are in the final six months of their life, to request assistance from a registered practitioner to end their life. The Bill made it clear that a person is not to be regarded as terminally ill by reason of them being mentally ill or having a disability.

The Bill set out a framework for how assisted dying would be carried out. This would involve an independent assessment by two doctors (named in the bill as "coordinating" and "independent") to confirm that the individual meets the eligibility criteria, including that the person has the capacity to make the decision to end their life, has a clear and settled wish to end their own life and has not been coerced into requesting assistance to do so. If both doctors state, independently of one another, that the eligibility criteria have been met, the person may apply to a three-person panel composed of a senior legal figure, a psychiatrist and a social worker which will review the application. The original proposal that a request be approved by the High Court was amended by the Bill committee.[12]

There would then be a mandatory 14-day reflection period (this would be shortened to 48 hours if death is imminent) to give patients time to reflect on their decision and withdraw their request if they wish. A person who has made a first declaration or a second declaration may cancel it by giving oral or written notice of the cancellation to either the coordinating doctor or any registered medical practitioner from the person's GP practice.

If the coordinating doctor continues to be satisfied that the person meets the eligibility criteria set out in the Bill, a life-ending "approved substance", would be prescribed to the patient for self-administration.

11 https://www.bbc.co.uk/news/articles/c8rpdxz11d8o
12 https://www.bbc.co.uk/news/articles/cly6gz9j3rno

The Bill stipulated that assisted dying could only occur under the supervision of a registered medical professional, referred to as the "coordinating doctor". It did not specify who it was anticipated would take on the roles of co-ordinating independent doctor, but stated that registered medical practitioners taking on these roles must have had "such training, qualifications and experience as the Secretary of State may by regulations specify." The independent doctor is not allowed to be a partner or colleague in the same practice or clinical team as the co-ordinating doctor. The Bill stipulated that no registered medical professional or other health professional is under any duty (whether arising from any contract, statute or otherwise) to participate in the provision of assistance in accordance with the legislation. However, the Bill stated that where a person indicated to a registered medical practitioner that they wish to end their life under the provisions of the legislation, if that practitioner is unwilling or unable to conduct a discussion with the person concerning the requirements that would need to be met, the practitioner must, if requested, refer them to another practitioner who would be willing to do so.

There was nothing in the bill itself about how an assisted dying service might be delivered, only that the Secretary of State must ensure arrangements are in place for assistance to be provided in accordance with the Bill, including arrangements for the funding of any provision made. This would potentially have enabled the Secretary of State to provide for services to be provided through existing NHS services or via a separate service.

More information about the legislation can be found here: https://bills.parliament.uk/bills/3774

On 16 October 2024, the UK chief medical officers and NHS England National Medical Director published advice to help doctors wanting to take part in the assisted dying debate.[13] The advice notes that whatever the UK Parliament decided, they believe the medical profession will be unanimous on two things: that the provision of good end-of-life care for all including the outstanding work done by palliative care clinicians must not be undermined, and that individual doctors and other healthcare workers should be able to exercise freedom of conscience as, for example, happens with abortion care currently.

13 https://www.gov.uk/government/publications/assisted-dying-bill-debate-advice-to-doctors/assisted-dying-bill-debate-advice-to-doctors-from-the-uk-chief-medical-officers-and-nhs-england-national-medical-director

3. The assisted dying debate

3.1 There are many strongly held views on both sides of the debate on assisted dying. Many of these views have been expressed in previous Conference debates and were reflected 50 years ago in the 1974 Statement. The British Medical Association in 2021 produced a summary of the key arguments used in the debate on physician-assisted dying[14]. Key arguments against changes in legislation on assisted dying include:

- Laws send social messages. An assisted dying law, however well intended, would alter society's attitude towards the elderly, seriously ill and disabled, and send the subliminal message that assisted dying is an option they 'ought' to consider. It could exert pressure on vulnerable people to end their lives.
- So-called 'safeguards' are simply statements of what should happen in an ideal world. They do not reflect the real-world stresses of clinical practice, terminal illness and family dynamics. It is impossible to ensure that decisions are truly voluntary, and that any coercion or family pressure is detected.
- For most patients, high-quality palliative care can effectively alleviate distressing symptoms associated with the dying process. We should be calling for universal access to high quality generalist and specialist palliative care, rather than legalising assisted dying.
- The option of assisted dying could be promoted by NHS and social care services under financial pressures.
- Licensing doctors to provide lethal drugs to patients is fundamentally different from withdrawing ineffective life-sustaining treatment and crosses a Rubicon in medicine. The role of doctors is to support patients to live as well, and as comfortably, as possible until they die, not to deliberately bring about their deaths.
- Currently, seriously ill patients can raise their fears, secure in the knowledge that their doctor will not participate in bringing about their death. If doctors were to have the power to provide lethal drugs to patients to end their lives, this would undermine trust in the doctor-patient relationship. Some patients (particularly those who are elderly, disabled or see themselves as 'a burden') already feel that their lives are undervalued and would fear that health professionals will simply 'give up' their efforts to relieve distress, seeing death as an easy option.
- Once the principle of assisted dying has been accepted, the process becomes normalised and it becomes easier to accept wider eligibility criteria or to widen eligibility through the use of anti-discrimination legislation.

14 https://www.bma.org.uk/media/4394/bma-arguments-for-and-against-pad-aug-2021.pdf

- In modern clinical practice, many doctors know little of patients' lives beyond what the busy doctor may gather in the consulting room or hospital ward. Yet the factors behind a request for assisted dying are predominantly personal or social rather than clinical. Assisted dying is not a role for hard-pressed doctors.

3.2 Key arguments in support of changes to legislation on assisted dying include:

- Even with universal access to specialist palliative care, some dying people will still experience severe, unbearable physical or emotional distress that cannot be relieved. Forcing dying people to suffer against their wishes is incompatible with the values of 21st-century medicine.
- Assisted dying would provide "emotional insurance" for those who take comfort in knowing that the option exists.
- Assisted dying is a legal option for over 150 million people around the world. In jurisdictions where it is lawful, there are eligibility criteria, safeguards and regulation in place to protect patients.
- Guidance in the UK for end-of-life practices, such as the withdrawal of life-sustaining treatment, already contains safeguards to ensure that decisions are made voluntarily, coercion is detected, and potentially vulnerable people are protected. There is no reason why these safeguards could not be used effectively in assisted dying legislation.
- The current law is not working. UK citizens travel to Switzerland, to facilities like Dignitas, to avail themselves of assisted dying, but this option is only available to those who have the funds to do so. This often leads people to ending their lives sooner than they would have wished because they need to be well enough to travel. There is no oversight under UK law about who travels abroad for an assisted death; anyone who provides assistance – doctors, family or friends – is breaking the law, which can lead to criminal investigations.
- There is widespread public support for, and tacit acceptance within society of, assisted dying. Given this, it would be fairer and safer to have a properly controlled and regulated system within the UK.
- Some people, knowing that they are dying, want to be able to exercise their autonomy and determine for themselves when and how they die, but need medical advice and support to achieve this. Doctors should not be able to impose their personal beliefs on competent, informed adults who wish to exercise this voluntary choice. Legislation would contain a conscientious objection clause to protect those healthcare professionals who did not want to participate.
- The existence of legislation allowing assisted dying brings reassurance and peace of mind for many people with terminal illness and their loved ones, even though only a small percentage actually use it when the time comes.

3.3 In 2005, the House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill observed that the ethical debate centred on two "first principles": personal autonomy and the sanctity of human life. Debates focused on questions about which of those principles should be given precedence when they conflict.

3.4 In 2015, the BMA undertook a major project seeking views from doctors and the public on their experiences, views, and perceptions of end-of-life care and physician-assisted dying. The comprehensive final three volume report[15] outlined some of the factual information about the provision of end-of-life care in the UK, and the current legal and political context around assisted dying in the UK and internationally; provided a detailed analysis of 21 dialogue events across the UK, through which they heard from more than 500 doctors and members of the public; and made recommendations aimed at addressing the current shortfall in end-of-life care provisions as well as offering some reflections on the potential impact legalisation might have on the doctor-patient relationship.

3.5 The 1974 Methodist Statement on Euthanasia stated that "the attitude of the medical profession, while it may not be decisive, is of extreme importance. Nevertheless, euthanasia is a matter of great personal and social significance, and the public must be fully involved in the debate." It noted, "The antipathy of the medical profession to the principle of voluntary euthanasia" and gave emphasis to the BMA's and World Medical Association's position of opposition. However, in recent years the positions of many medical and healthcare worker representative bodies have shifted.

3.6 In 2021, the BMA adopted a neutral position,[16] a policy position also adopted by the Royal College of Nursing,[17] Royal College of Physicians,[18] and Royal College of Surgeons in England.[19] In 2025, the Royal College of GPs adopted a position of neither supporting nor opposing assisted dying being legal.[20] Whilst the Royal College of Psychiatrists also has a neutral position, they raised serious concerns

15 https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/end-of-life-care-and-physician-assisted-dying-project
16 https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying
17 https://www.rcn.org.uk/About-us/Our-Influencing-work/Position-statements/RCN-Position-on-Assisted-Dying-in-the-UK-and-Crown-Dependencies
18 https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/rcp-position-statement-on-the-terminally-ill-adults-end-of-life-bill-9th-may-2025/
19 https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/assisted-dying/
20 https://www.rcgp.org.uk/representing-you/policy-areas/assisted-dying?utm_campaign=3029972_Chair%27s%20news%20and%20headlines%20with%20Prof%20Victoria%20Tzortziou%20Brown&utm_medium=email&utm_source=Dotmailer&dm_i=49LX,1SXXW,GC9L7,8HYPR,1

prior to the final vote of MPs on the proposed legislation in England and Wales that terminal illness is a risk factor for suicide and warned that a treatable mental illness could be a cause for a person wanting to end their life.[21]

Disabilities

3.7 Several peers with disabilities contributed to the debate on the (recent) Terminally Ill Adults (End of Life) Bill. They included disabled peers who oppose the legislation because of the fear of coercion, and those who support it based on the grounds of autonomy.

3.8 Peers with disability who opposed the legislation include Baroness Tanni Grey-Thompson, a crossbench peer and Paralympian, who has been a leading voice against changing the law, arguing that assisted dying poses significant risks to disabled people, particularly those with learning difficulties or autism who may feel they have a 'duty to die'; Baroness Jane Campbell, a crossbench peer and founder of 'Not Dead Yet UK' who has led opposition among those with disabilities to assisted suicide, arguing that it signals to the sick that their lives are less valuable than those normatively abled, and that universal, high-quality care should be the priority. Lord Kevin Shinkwin is a Conservative peer who argued that the legislation would, in effect, put a 'price on his head' as a person with a severe disability, and Baroness Masham, a crossbench peer, has raised concerns that the Bill puts fear into vulnerable, elderly, and disabled individuals.

3.9 Nonetheless, there are other Peers with disabilities who were supportive of the legislation including Baroness Sal Brinton, a Liberal Democrat peer and co-sponsor of the Bill, who argues that legislation is needed to provide a safe and robust alternative to the current law, which she claims is dangerous and cruel, and Lord Colin Low, a crossbench peer, who has argued that the *status quo* is more dangerous to disabled people than the proposed safeguards.

3.10 Among the issues raised by these peers were the 'duty to die' argument which maintains that as disability services fail and care is underfunded, people with disabilities may feel pressured to end their lives to avoid being a burden. Concerns were also raised about the risk to people with intellectual disabilities, or those lacking capacity, and questions of medical inequality, including a sense that assisted dying cannot be introduced while access to high-quality palliative care and social support is inconsistent.

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21 https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/06/19/assisted-dying-bill-risks-preventable-deaths-of-people-with-treatable-mental-illness-warns-rcpsych?searchTerms=PRICE%20ISSUE

3.11 The writing of ancient Judaism contains some difficult passages on disability. Scholars are clear that these examples are found primarily in the priestly literature, such as the Deuteronomistic History. These texts reflect a particular understanding of physiognomic (disability) insights of Babylonian origin. For example, priestly restrictions regarding temple worship concern the need for unblemished sacrifices and the avoidance of physical blemishes (Leviticus 21:16–18; 22:17–25). Scholars have connected these passages to disability. As Samuel Balentine has noted, 'In Israel's priestly system, the concern for wholeness and integrity of the physical body is an extension of the understanding that God's holiness is perfect and complete. Holy and unblemished persons (sacrifices) are external expressions of the requirement to be holy as God is holy'.[22] There is some debate among scholars over whether these priestly restrictions apply only to temple priests with disabilities or to all temple worshipers.[23] In later Qumran writings, worshippers with disabilities, as well as those holding offices (cf. 1 Aqsa 2:409), were excluded from the assembly. For example: 'The maimed, the lame, the deaf, and minors, none of these may enter the midst of the community' (4QD 171:6-9).

3.12 Against this difficult background of exclusion, God's promise in Isaiah 54:4-5 and 61:1-2 regarding the social inclusion of disabled persons marks a significant shift from exclusion to inclusion. Whereas priestly attitudes in ancient Judaism marginalised those with deformities or disabilities, these passages specifically embrace eunuchs, the lame, the deaf, and others as part of God's liberative coming kingdom. This transformation signals not only a theological reversal but also offers hope: the vision of Isaiah anticipates a future in which all, regardless of physical difference, are welcomed into full participation in the community, in the relationship with God, and in social embrace.

3.13 Whilst in the ancient world some cultures engaged in practices such as the exposure of disabled infants on hillsides and the social exclusion of the disabled, from its earliest times the Christian community eschewed such practices, and the New Testament shows Jesus' particular attention to those excluded from everyday personal and social life (eg, Matthew 11:2–6; 25:35–40; Luke 4:16–30; 10:31–37; 5:17–26; 13:10–17; 19:1–10) The early Christian community likewise made particular economic provision for the disadvantaged and those with, in the broadest sense, disabilities (eg, Acts 2:44–47; 4:32–37, 20:18–35; James 1:22 – 2:26; 2 Corinthians 8–9; Galatians 2:6–10; 6:9–10; Romans 12:9–19; 1 Timothy 5:3–16; Philemon 1–22).

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22 Samuel E Balentine, *Leviticus* (Louisville: Westminster John Knox, 2002), p. 169.
23 Saul M Olyan, 'Anyone Blind or Lame Shall Not Enter the House': On the Interpretation of Second Samuel 5:8b', *Catholic Biblical Quarterly* 60 (1998): 218-27.

3.14 A number of contemporary theologians have addressed the question of the status and value of those with disability. Among these are the Methodist, Prof Frances Young[24] whose son Arthur was born with profound disabilities. Young describes Arthur both objectively (Arthur in himself) and relationally (Arthur as a part of a network of relationships). She raises quality of life arguments and acknowledges her questioning of the aggressiveness of modern medicine in keeping children like Arthur alive, arguing the 'life at any price' is not an essentially Christian position but often 'the panic reaction of those who cannot face death because they have no hope in God' which avoids moral responsibility of making appropriate judgements.[25]

3.15 Young eschews as fundamentally un-biblical the soul-body dualism of later Christian thought that allows for the concept of a 'soul' trapped inside a damaged body and appeals rather to a holistic view of the person as a psychosomatic whole. Similarly, David Pailin questions the relationship between God and people who are considered severely 'disabled'.[26] Pailin concludes that 'we are of worth not because of what we contribute to God' (or, we might add, to the world) 'but because of the value which God bestows on us' and therefore '(a)n understanding of faith in God which does not make sense of the lives of all people… shows itself to be mistaken.'[27] Thus Pailin argues that belief in God as loving and the duty to love one's neighbour, whatever their particular needs, are inseparable at both the individual and corporate (community) level. Others who address questions of disability in theological perspective include Nancy Eiseland,[28] Stanley Hauerwas[29] and Thomas Reynolds.[30]

4. Biblical reflections on assisted dying

4.1 As is the case with many contemporary complex ethical issues facing us today, the Bible says little directly about cessation of life or assisted dying in the way the issue is framed today. Oliver O'Donovan points to the Bible's ambiguity on euthanasia, noting that 'the practice of euthanasia is unconditionally inconsistent with biblical ethics, even though not explicitly condemned in the biblical text'.[31]

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24 Frances Young, *Face to Face: A Narrative Essay in the Theology of Suffering*. 1990, Edinburgh: T&T Clark
25 *Face to Face*, pp.43 and 156.
26 David A Pailin, *A Gentle Touch: From a Theology of Handicap to a Theology of Human Being*. 1992, London: SPCK.
27 *A Gentle Touch*, pp.13, 14, 15.
28 Nancy Eiseland, *The Disabled God: Toward a Liberatory Theology of Disability*, Abingdon Press,1994.
29 Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped and the Church*. Edinburgh: T&T Clark, 1988 and *Naming the Silences: Medicine and the Problem of Suffering*. Edinburgh: T&T Clark, 1993.
30 Thomas Reynolds, *Vulnerable Communion: A Theology of Disability and Hospitality.* Brazos Press, 2008.
31 Oliver O'Donovan, *Resurrection and Moral Order: An Outline for Evangelical Ethics,* (Grand Rapids: Eerdmans, 1994), p. 175.

While O'Donovan asserts this inconsistency, he does not elaborate on specific biblical principles or passages that support his conclusion, leaving his reasoning implicit.

4.2 However, his comment about the lack of explicit condemnation of euthanasia in the Bible is an important insight that requires further reflection in the light of the current debate. What follows is a brief elucidation of what are commonly identified as texts relating to suicide or euthanasia in the Bible.[32] These biblical examples, especially Old Testament accounts of 'honouring suicides' among military figures, stand in marked contrast to the complex moral, legal, and pastoral issues in contemporary assisted dying debates. Taken together, these suicide texts show that there is no definitive biblical condemnation of suicide as sin.[33] Nevertheless, theological ethicist Allen Varhey cautions against reading Scripture's silence as implicit approval or divine indifference to suicide.[34] In light of this, it is argued that any hermeneutical principles drawn from these biblical texts must be shaped by our present contexts and pastoral sensitivities.

4.3 Judges 9:50–56 narrates the death of King Abimelech during his assault on the tower of Thebez, in which a 'certain woman' at the top of the tower throws a 'millstone' and crushes his skull. Fatally wounded, he ordered his armour-bearer, 'Draw your sword and kill me, so people will not say, 'A woman killed him.' The attendant complied, and Abimelech died. So, his attendant stabbed him, and he died' (v.53–54). The narrator presents Abimelech's death as divine punishment for his violence.[35] Notably, the narrative does not condemn the act but instead shows Abimelech's concern for his honour, even in death.[36] Ancient Jewish sources describe his death as suicide; modern commentators agree.[37] However, since Abimelech requested his attendant to deliver the fatal blow, technically, the death is an 'assisted killing' from today's legal reasoning. This distinction invites

32 See Allen Verhey, *Reading the Bible in the Strange World of Medicine,* (Grand Rapids: Michigan, 2003), p. 304. See in particular footnote no.4. Verhey's treatment only focuses on the suicide of Judas.
33 Ibid., p.306.
34 Ibid, p.306.
35 Dennis T Olson, 'Judges' in *The New Interpreter's Bible Commentary,* vol. 2 (Nashville: Abingdon, 2015), p.209.
36 Yairah Amit 'Judges' in *The Jewish Study Bible* (Oxford: OUP, 2004), p.534.
37 Some scholars attribute Abimelech's death not to his armour-bearer but to the woman who dropped the millstone and fatally cracked his skull. Uriah Y Kim notes, 'An Israelite woman humiliated Abimelech when she killed him with a millstone' (Uriah Y Kim, 'Postcolonial Criticism: Who Is the Other in the Book of Judges,' in Gale A Yee (ed.), *Judges and Method: New Approaches in Biblical Studies, 2nd ed.* [Minneapolis: Fortress Press, 2007], p.178). For a similar perspective, see Ken Stone, 'Gender Criticism: The Un-Manning of Abimelech' in the same volume, pp.183-201.

deeper consideration of how agency, responsibility, and consequences were understood in ancient Judaism at the moment of death.[38]

4.4 Judges 16:23–31[39] is detailed and concerns Samson's death. After revealing the secret of his strength to Delilah and losing it, Samson is captured, blinded, and humiliated by the Philistines. Eventually, as his strength returns with his hair's regrowth, Samson prays for revenge and collapses a Philistine temple, killing himself and thousands of others. The narrative emphasises that Samson is primarily motivated by revenge, rather than straightforward military objectives or traditional suicide. Augustine later refers to Samson's act as divinely sanctioned and considers it an exception to homicide, highlighting Christian debates about the boundary between martyrdom and suicide. He writes, 'When Samson destroyed himself, with his enemies, by the demolition of the building, this can only be excused on the ground that the Spirit, which performed miracles through him, secretly ordered him to do so'.[40]

4.5 1 Samuel 31:1–5 records the death of Saul in a similar manner to the death of Israel's first king, Abimelech. During a battle with the Philistines and their troops, Saul was wounded, and his death was now inescapable. He commands his trustworthy personal armour-bearer, 'Draw your sword and thrust me through with it, so that these uncircumcised may not come and thrust me through, and make sport of me. But his armour-bearer was unwilling; for he was terrified' (v.4). When that request was declined, Saul fell on his sword and committed suicide. The armour-bearer also falls upon his sword and dies with him.[41] As with Abimelech's, Saul's suicide is not viewed by the narrator negatively but as an act 'committed to escape being killed by the enemy in battle'.[42] The Old Testament scholar, Bruce

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38 In Carol Newson's study on agency in Ancient Israel and Second Temple Judaism, the amour-bearer's action would constitute what she calls 'proxy agency'. As she explains, 'In proxy agency the actor cannot secure his or her role directly but can only succeed by means of the agency of another', Carol Newson, *The Spirit Within Me: Self and Agency in Ancient Israel and Second Temple Judaism* (New Haven: Yale University Press, 2021), p. 27. For a helpful study on law in Ancient Israel see, Yochanan Muffs *Love and Joy: Law, Language and Religion in Ancient Israel* (Cambridge, Massachusetts: The Jewish Theological Seminary of American, 1992).

39 Scholars differ about whether to regard Samson's action as suicide. See Allen Verhey, *Reading the Bible in the Strange World of Medicine*, p.304.

40 Augustine, *Concerning the City of God Against the Pagans.* Translated by Henry Bettenson (London: Penguin Classics, 1984),1.21, p.32.

41 2 Samuel 1:5-16 also tells of Saul's death, but the details of the account are different from 1 Samuel 31:3-5. There is no suggestion here that Saul committed suicide. His leaning on his spear was no more than an attempt to support himself, and there is no mention by an amour-bearer mentioned here to assist the suicide. Saul was simply taken by 'chariots and horsemen' (v.6), and his death is reported as a divine judgement.

42 Shimon Bar-efrat, '1 Samuel' in *The Jewish Study Bible*, p. 618.

C Birch in reflecting on this text cautions that one 'should resist coming to this text for moral reflection on suicide, for the tradition makes no moral comment about the means of Saul's death. He did not have the choice of life or death, only the choice of further humiliation for Israel through his capture and execution or a kingly act that brought an end to this moment of Israelite defeat'.[43]

4.6 2 Samuel 17:23 narrates the suicide of Ahithophel. He was King David's adviser who later switched allegiance to David's son Absalom and advised him in a military plot against his father. When Absalom rejected Ahithophel's advice as unworkable, Ahithophel committed suicide. The episode is narrated in a matter-of-fact way: 'When Ahithophel saw that his counsel was not followed, he saddled his donkey and went off home to his own city. He set his house in order and hanged himself' (v.23). The Biblical scholar Gwilym Jones points out that Ahithophel's decision to take his own life was not based on 'wounded pride' but 'more from fear of cruel death at the hands of David'.[44] As we shall see, scholars see a parallel with Judas hanging himself in the Gospel.

4.7 1 Kings 16:18–19 records the death of King Zimri. When he saw that his short reign was about to be ended by force, he locked himself in the royal palace, 'burned down the king's house over himself with fire, and died— because of the sins that he committed, doing evil in the sight of the LORD'. In a similar fashion to that of King Abimelech in Judges 9, the narrator does not condemn the suicide itself but emphasises the king's desire to protect his honour and dignity in war.

4.8 Matthew 27:3–10 tells of the demise of Judas, the one who παραδιδωμι/*paradidōmi* ('handed over') Jesus to the Jewish authorities.[45] After unsuccessfully attempting to return the thirty pieces of silver to the chief priests and elders, Judas throws the money into the temple, leaves, and απηγξατο/*apēgxato* ('hangs') himself in a field that came to be known as the Field of Blood. For Matthew, Judas' demise must be interpreted as the fulfilment of another of Jesus' prophecies. The thirty pieces of silver recall Zechariah 11:13 ('So I took the thirty pieces of silver and threw them into the treasury in the house of the Lord'). Judas' suicide is reminiscent of 2 Samuel 17:23, as we have seen, where Ahithophel, the betrayer of David, goes away and hangs himself. Matthew's Jewish audience may

43 Bruce C Birch, '1 & 2 Samuel' in *The Interpreter's,* p.494.
44 Gwilym H Jones '1 and 2 Samuel' in *The Oxford Bible Commentary,* edited by John Barton and John Muddiman (Oxford: OUP, 2007), p. 225.
45 The Greek word *paradidōmi* is generally understood as 'betrayed'. It means to 'hand over' someone. For a helpful study of the word and Judas in particular, see William Klassen, *Judas: Betrayer or Friend of Jesus* (London: SCM, 1996).
46 W D Davies and D C Allison, *Matthew 19-28* vol.3 (London: Bloomsbury, 2004), p. 560.

have also attached to the manner of Judas' death, Deuteronomy 21:23, according to which the body of a hanged person is cursed by God. Jewish writings largely saw death by hanging as the appropriate punishment for a traitor, and therefore Judas is here seen as enacting that curse upon himself. For our purposes, it is significant to note that there are three versions of the account of Judas's death, and while there are some similarities, they differ on the exact manner of his death.[46] Matthew's account, which is the shortest version, attributes hanging. According to Acts 1:16–20, he 'died accidentally'[47] (he fell in a field and burst open). Two fragments attributed to Papias, Bishop of Hierapolis, in the second century, state that a wagon ran over Judas.[48] These discrepancies imply that the exact cause or manner of Judas' death was probably unknown.[49] The judgement by W D Davies and D C Allison is appropriate: 'As for what really happened, we must, in view of the discord of the sources, suspect that not much, if anything, was known about Judas' end and so imagination used the Bible and folklore to clothe the dry bone of fact with the living garments of fiction. Just as it is prudent to remain silent on why Judas betrayed Jesus, so should we admit that we do not know how – or even when – Judas died'.[50] Matthew's account, which draws on the Old Testament story of Ahithophel, is primarily designed to show how Judas' tragic end fulfils the scriptures. Yet as Davies and Allison show, 'there are no biblical condemnations or prohibitions of suicide; Jewish tradition excused or justified the suicide of Saul (1 Samuel 31:4–5), Samson (Judges 16:28–30), Zimri (1 Kings 16:18)'.[51] Matthew's account, in contrast to Acts and Papias, mentions Judas' μεταμέλομαι/*metamēlomai* (repentance),[52] which, however one interprets the manner of his death, points to the wideness of God's mercy and that the last word never belongs to us but to God.[53]

4.9 Acts 16:25-29 presents a unique story of suicide prevention. Luke describes how, after harsh treatment, Paul and Silas are placed in solitary confinement with their feet locked in stocks (v24). At midnight, while Paul and Silas are praying and singing, a violent earthquake shakes the prison, loosening their chains and freeing them and the other inmates. When the jailer awakens and sees the open

47 Ulrich Luz, *Matthew,* Hermeneia, vol, 3 (Minneapolis: Fortress, 2005), p. 469
48 Davies and D C Allison, *Matthew*, p.560.
49 Ibid., p.560.
50 Ibid., p.560.
51 Ibid., 561-2.
52 Davies and D C Allison, *Matthew*, p.560.
53 Since Augustine, Christian tradition has linked suicide to Judas. Augustine writes of Judas: 'We rightly abominate the act of Judas. When Judas killed himself, he killed a criminal, and yet he ended his life guilty not only of Christ's death, but also of his own; one crime led to another', *City of God,* 1.17, p. 27. Augustine's judgement does not reflect the silent reservation of the biblical texts themselves on this matter.

prison doors, he assumes the worst and prepares to kill himself (v27). Paul, however, shouts in a loud voice, 'σεαυτω κακόν/seautō kakon' ('do not harm yourself,' v28). Presumably, if Paul and Silas had left, no one would have stopped the jailer from taking his life.[54] After witnessing this event, the jailer becomes a follower of Christ. Robert W Wall suggests that the jailer's decision to take his life may stem from his belief that 'living is a fate worse than death', a feeling that resonates sometimes with some individuals contemplating suicide.[55] More likely, as Ben Witherington explains, the jailer tries to commit suicide because he would be held responsible for his prisoners and would rather die than face public shame, beating, or execution for his failure.[56] Although Luke's main goal in Acts 16 is to display Christ's superior power over pagan religion,[57] the story of the jailer's prevented suicide may suggest early Christian understanding of the value and sanctity of human life in light of Christ's coming.

4.10 Philippians 1:21–26 has intrigued some scholars and has led to the suggestion that the apostle Paul contemplated suicide or voluntary death. This interpretation partly arises from Paul's use of the word 'αποθανειν/apothanein,' ('dying') which reflects not only the transition from life to death but also the process of dying.[58] The main debate centres on whether Paul is expressing a personal struggle with the desire for death or simply addressing the meaning and implications of dying as a Christian. Reflecting on this text, James Tabor and Arthur J Droge write in their book, *A Noble Death,* that Paul wrestled with his own mortality, the prospect of his death, and the continuance, or perhaps the termination, of his life's work. They point to the lack of a clear biblical prohibition against suicide, the fact that many of Paul's contemporaries found the notion of suicide quite acceptable, and also that 'death was often seen in the Greco-Roman world as a release from a miserable life'.[59] However, given that Paul saw himself as a slave of Christ, 'he was not free to do with his body as he wished; he would need God's approval to take his own life'. Nevertheless, Tabor and Droge conclude that 'Paul could conceive of killing himself and of glorifying God with his body by doing so'.[60] They write, 'Given the widespread acceptance of voluntary death among Paul's contemporaries, whether pagan or Jewish, is it so surprising that

54 Robert W Wall, 'Acts' in *The Interpreter's Bible,* p.184.
55 Ibid., p.184.
56 Ben Witherington III, *The Acts of the Apostles: A Social-Rhetorical Commentary* (Grand Rapids: Eerdmans, 1998), p. 497.
57 C Kavin Rowe, *Reading Acts in the Graeco-Roman Age* (Oxford: OUP, 2009), p. 26.
58 Lidija Novakovic, *Philippians: A Handbook on the Greek Text* (Waco, Texas: Baylor University Press, 2020), p. 29.
59 Stephen E Fowl, *Philippians* (Grand Rapids: Michigan), p.55.
60 Cited in Fowl, *Philippians,* p.55.

he would espouse a similar view?'[61] By contrast, N Clayton Croy thinks that Paul is using a rhetorical trope known as 'feigned perplexity', raising a question 'as a way of strengthening or dramatising an argument'[62]. From a different perspective, Stephen Fowl notes that the theme of joy in the letter undermines the suggestion of Paul's suicide and his rhetoric in this passage.[63] Thus, whether or not Paul contemplated suicide is difficult to ascertain. As Croy further notes, we do not know whether Paul condoned suicide under any circumstances. Moreover, we do not have sufficient evidence in the New Testament to determine whether the early Christians at this point specifically decided on the question of whether suicide might ever be justified. Commenting on this passage and Polycarp's view that Paul was a martyr removed from this life and went directly into the presence of God, Fowl wisely cautions that 'one must always keep in mind that all our speculations in this area are provisional. They are motivated by a well-grounded hope in God's resurrection power but constrained by human finitude and ignorance in this area'.[64]

4.11 These biblical texts relating to suicide thus far provide only a limited view; they are not comparable or applicable to our more complex situation concerning ageing, severe mental or physical decline, and decision-making when turning off life support for someone in a nearly vegetative state.[65] Within Christian tradition, euthanasia or suicide is closely tied to the injunction 'You shall not murder' (Exodus 20:13), which addresses the intentional and illicit taking of life. Michael Coogan notes, 'The commandment is narrow, prohibiting what in our legal system is first-degree, premeditated murder'.[66] Coogan concludes, 'the commandment's original sense prohibits murder but not other ways of causing death'.[67]

4.12 In general, first-century attitudes toward suicide were mixed. Some Jewish texts like the ones discussed above suggest that suicide is acceptable—or even honourable—in hopeless situations, while others view it as wholly negative.[68] The Jewish historian, Josephus articulates this negative position well: 'God has given humans an immortal soul. We may not ourselves dispose of this endowment

61 Cited in Fowl, *Philippians,* p.55.
62 N Clayton Croy, 'To Die Is Gain (Philippians 1:19-26): Does Paul Contemplate Suicide?' *Journal of Biblical Literature,* vol. 122, no. 3 (2003), p. 525.
63 Fowl, *Philippians,* p.55.
64 Fowl, *Philippians,* p.51-52.
65 See Anthony C Thiselton, *The Hermeneutics of Doctrine* (Grand Rapids: Eerdmans, 2007), p.182.
66 Michael Coogan, *The Ten Commandments: A Short History of An Ancient Text* (New Haven: Yale University Press, 2014), p. 80.
67 Ibid., p. 81.
68 Luz, *Matthew 21-28*, p. 472

entrusted to us, for that would be an offense against the Creator'.[69] Luz notes that this negative view appears mostly in philosophical writings, especially Platonic ones, rather than in biblical texts.[70]

4.13 A broader biblical understanding of ageing, death, and dying is that personhood is rooted in the biblical concept of 'high anthropology', viz, humans are created by God with inherent dignity and worth. As Psalm 8:5 states, 'You have made human beings a little lower than God, and crown them with glory and grandeur.'[71] This idea is widely understood to be grounded in Genesis 1:27, which asserts that humans are made in the 'image of God.' This concept is reinforced after the flood when God prohibits the shedding of human blood (Genesis 9:5-6). Scholars note that this context primarily concerns intentional killing. The prohibition does not create a right to life, but instead affirms the immense value of human life: people must not destroy those made in God's image.[72] Furthermore, scholars on disability justice, such as Amy Kenny, emphasise that all humans, including disabled persons, equally bear God's image.[73] Early Christians reinterpreted this idea through Christ, understanding being in God's image as being in the image of Christ.[74] Early Christian logic held: 'because Jesus Christ is human, every human is Jesus Christ.'[75] Rowe notes this vision, based on Jesus' teaching on mercy and compassion (Luke 10:25–37; Matthew 25:25–40) shaped a compassionate Christian ethic, evident in later Christian actions such as founding hospitals and hospice caregiving for the sick during plagues (165 and c 250–260CE).[76] Seeing humanity as remade in Christ's image also transformed perspectives on death and dying: 'Jesus' pattern is ours: life, death, then resurrection. Which is to say

69 Ibid., p. 472.
70 Ibid., p. 472.
71 Brian Brock, *Joining Creation's Praise: A Theological Ethics of Creatureliness* (Grand Rapids, Michigan: Baker Academic, 2022), p. 490. Reflecting on the relevance of this verse to disability, Brock writes: 'The Hebrew resists the common (mis) understanding that God values human life because of its rather amazing functional capacities – which angels, at least, far surpass. The Hebrew אֱנוֹשׁ/ *enos* instead means human weakness and frailty, which the creation story narratively dramatizes by presenting human beings as being derived from dust'.
72 John J Collins, *What Are Bible Values: What the Bible Says on Key Ethical Issues* (New Haven: Yale University Press, 2019), p. 47.
73 Amy Kenny, *My Body Is Not A Prayer Request: Disability Jesus in the Church,* (Grand Rapids, Michigan: Baker Publishing Group, 2022), p.60.See also Brock, *Joining Creation's Praise,* chapter 14: 'This One: This One – *This One!* Recognizing Persons (Genesis 2:21-23a), pp 474-502; Nonna Verna Harrison, *God's Many-Splendored Image: Theological Anthropology for Christian Formation* (Grand Rapids, Michigan: Baker Academic, 2010).
74 C Kavin Rowe, *Christianity's Surprise: A Sure and Certain Hope* (Nashville: Abingdon Press, 2020), p.39. See also Michael Welker, *In God's Image: Anthropology of the Spirit* (Grand Rapids: Eerdmans, 2021).
75 Rowe, *Christianity's Surprise,* p.40.
76 Kavin Rowe, *Christianity's Surprise,* p.72ff. See also Elizabeth A. Johnson 'Sacred Ground at the Bedside: The Hospice Caregiver and Divine Compassion' in *Abounding In Kindness: Writings for the People of God* (Maryknoll, New York: Orbis Books, 2015), pp. 150-4.

that his future is our future and that our link to him through our humanity is our hope. In him, we see our future beyond death'.[77]

4.14 The Bible presents a complex, mixed view of suicide and euthanasia. Perhaps the main conclusion from this reflection is that, regardless of how death arrives, the last word belongs not to us but to Christ Jesus, in whose image we are remade. Broader theological reflection on death and dying is needed in light of medical advances. As Margaret A Farley explains: 'Insofar as these issues are moral or ethical issues, they have to do with not just *whether* we are free to choose our own way of dying, but *when and how* our choices regarding death are good choices, choices able to be justified in relation to the value of human persons and the value of human life in this world'.[78] Biblical reflection on assisted dying must acknowledge the breadth of God's mercy—God's compassion, love, and readiness to embrace, heal, restore, and reconcile all things in Christ.[79] Frederick William Faber captures this in his hymn 'There's a wideness in God's mercy':

> For the love of God is broader
> than the measures of the mind;
> and the heart of the Eternal
> is most wonderfully kind.[80]

5. Assisted dying in historical and theological perspectives

The Ancient World (Greek and Roman custom)

5.1 The practice of euthanasia (literally ευθανατος– '*a good death*') was well known in the ancient world, and the means of death was sometimes administered by physicians.[81] Zeno, the founder of Stoicism, took his own life in old age prompted by the pain of an injury. Pliny the Younger writes about his friend in 1st century Rome, Titius Aristo, and says that having fought against great pain he sent for his closest friends '*and told us to ask the doctor what the outcome of his illness would be, so that if it was to be fatal, he could deliberately put an end to his life*.'[82]

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77 Kavin Rowe, *Christianity's Surprise,* p.48.
78 Margaret A Farley, *Changing the Questions: Explorations in Christian Ethics* (Maryknoll, New York: Orbis Books, 2015), p. 278.
79 For a thoughtful theological reflection on God's mercy see Christopher B Hays and Richard B Hays, *The Widening of God's Mercy: Sexuality Within the Biblical Story* (New Haven: Yale University Press, 2019).
80 From *Singing the Faith,* no. 416.
81 V Zimmermann, *Die Heiligkeit des lebens – Geschichte der Euthanasie in Grundzügen.* (Frankfurt: Campus, 2000) p,27
82 Pliny. *Letters and Panegyericus I* (Cambridge Mass.: Harvard University Press, 1969), xxii.

Thus in the ancient world the concept of euthanasia on request and suicide by the sick were closely related concepts and were ones which, despite the opposition of some philosophers, generally carried little, or no, social opprobrium. Although Socrates committed suicide by drinking hemlock as a state sanctioned punishment, nonetheless he opposed suicide in principle, arguing that the individual was '*a prisoner who had no right to open the door of (his) prison and run away*.'[83] Plato, in his *Republic*, argued that those who were chronically sick and with no hope of recovery had a moral duty to refuse treatment although he opposed suicide *per se*.[84] Aristotle, argued that the person who brought about their own death committed a crime, although this was not against themselves but against the state.[85] The Roman writer, Seneca, who felt it to be an act of reason to euthanise disabled infants, provides moral instruction about dying since he equates human dignity with living well, not merely living.[86]

5.2 It is clear, therefore, that self-inflicted death, whether assisted by another or not, had clear social, as much as individual, connotations in the ancient world. An exception to the widespread acceptance of euthanasia in ancient Greek and Rome was Hippocrates (460–370 BCE), the author of the 'Hippocratic Oath', which includes the words, '*I will never give a deadly drug to anybody if asked for it, nor…make a suggestion to this effect.*'[87] The Hippocratic School followed the precepts of Pythagoras who opposed the notion of suicide because it disrespected human life that was valued by the gods (a notion that was to influence later Christian perspectives), as they sought to build public trust in physicians.

Although the early Christians lived in a secular milieu in which suicide by the ill was frequently practiced, and was often assisted by physicians, its appropriateness was seldom questioned, and the patristic literature offers no written record of ill Christians committing suicide or being offered assistance by others to do so.

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83 Van Rensselor Potter, 'On Dying with Personhood: Socrates' Death'. *Perspectives in Biology and Medicine,* 43:1, (Autumn1999), 103.
84 Plato, *The Republic*.
85 Aristotle, *Nicomachean Ethics 5, II.*
86 Seneca, *Moral Letter to Lucilius, no.70*. This letter is titled, 'On the proper time to slip the cable'. It is of note that in Philippians 1:23 where Paul says, '*my desire is to depart and be with Christ*' the word used for '*depart*' is ἀναλῦσαι, the same word that is used in Greek for letting go of the mooring ropes on a ship so that it can set sail on a new voyage.
87 Hippocratic Oath

Self-inflicted death in the early Christian era (Patristic writings)

5.3 Among the earliest reference in the Christian era are those contained in the works of Justin Martyr[88] (c100–165CE), the anonymous Letter to Diognetus[89] of the same period and the writings of Clement of Alexandria[90] (155–222CE), all of whom argue that taking one's own life opposes the will of God and for this reason is not lawful for Christians. All these sources offer a Christianised version of the Platonic, and Pythagorean, position that a self-inflicted death marks an abandonment of one's divinely assigned position. In the 3rd century CE Lactantius states unequivocally that '*nothing can be more wicked than suicide*'[91] whilst Jerome (c342–420), writing in the 4th century CE, goes even further in attesting that Christ will not accept the soul of one who takes their own life.[92] His near contemporary Ambrose (339–397CE) argues that '*scripture forbids Christians to lay hands on themselves*'.[93] Similarly, in the Eastern Church, John Chrysostom (349–397CE) says that '*God punishes suicide more than murder*'.[94] Both John Chrysostom and Basil the Great (330–379CE) emphasise that while the soul may be the 'driver' of the human person, nonetheless the body is the indispensable 'vehicle', which participates fully in the human journey towards salvation. Thus, they refute the dualistic tendencies which sought to diminish the value, and role, of the body in the spiritual life of the Christian.[95]

5.4 The most enduring and influential condemnation of self-inflicted death, however, is found in the writings of Augustine (c354–430CE), whose theological position on this was generally accepted in the Western Church for the whole of the first millennium and offers the first codification of the church's condemnation of self-inflicted, or self-sought, death. Augustine writes against suicide in arguably his greatest work, *The City of God*.[96] For Augustine, life is a gift from God and therefore to take, or to seek to take, one's own life is self-murder and is in violation of the fifth commandment. Augustine goes so far as to argue that people have a moral imperative to accept and endure suffering as an essential component of God's sanctifying work.[97] Augustine's grounds for the condemnation of suicide can be summarised thus:

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88 Justin Martyr, *Apologia 4*.
89 Anon. *Letter to Diognetus, 6*
90 Clement of Alexandria, *Stromateis, 6.9*.
91 Lactantius, *Divine Institutes, 3.18*.
92 Jerome, *Letters 39.3*.
93 Ambrose, *Concerning Virgins, 3.7.32*.
94 John Chrysostom, *Commentary on Galatians, 1.4*.
95 See T-C Giogan, 'Towards a theology of compassionate release: Orthodox Christianity and the dilemma of assisted dying'. *Dialogo Journal, 10, 2 (2024), 221-240*.
96 Augustine, *The City of God, 1.20*.
97 Ibid., *19* and his treatise *De Patientia.* Augustine was not alone in this view, which can also be found in the writings of Cyprian of Carthage (c200-258) – Cyprian, *Mortality, 8*.

- Scripture does not specifically permit it
- It violates the commandment, 'Thou shalt not kill'
- Taking one's own life is murder since it is not an 'authorised' killing
- Taking one's own life offers no opportunity for repentance

Augustine's codification of the teachings of the Christian church in opposition to seeking, or wilfully surrendering, one's own life held sway into the Middle Ages when they were expanded by the work of Thomas Aquinas (1225–1274).

The Medieval Period (Aquinas and Natural Law)

5.5 The ascent of Christianity, with its view that human life was a trust from God, reinforced opposition to both suicide and euthanasia and culminated between the 12th and 15th centuries in the consistent opposition to euthanasia by both the Church and physicians. For Thomas Aquinas any act which prevented the potential fulfilment of human life, or failed to preserve it, was an evil and so to be resisted (teleology).[98] For Aquinas the taking of a life, whether one's own or that of another, was contrary to both the love and the duty that people should have for themselves and others as constituent of God's creation – the taking one's own life, as much as that of another, always therefore constituted a mortal sin because it is contrary to Natural Law.[99] Aquinas embraced the earlier Platonic philosophical position that our lives are not ours to dispose of because they are created by, and therefore belong to, God and therefore taking a life, either one's own or another's, is a violation of the divine gift and deprives God of God's possession. Aquinas also embraced the Aristotelian view that every person is part of the greater whole and therefore the taking of a life is injurious to the community as a whole. Aquinas' position continues to be the predominant view in current Roman Catholic moral theology.

5.6 In the 1400s printed texts known as *ars moriendi* (the 'art of dying') began to be produced which offered advice on 'dying well' (ie according to the Christian precepts of the later Middle Ages). This was a period which experienced the high mortality of the Black Death and its aftermath and the *ars moriendi* became popular reading. The phrase, '*but he* (ie the dying person) *should take his situation gladly and willingly… conforming and submitting his belief to God's will alone*'[100]

98 T Aquinas, *Summa Theologica, II,II.64.*

99 Ibid.

100 See R N Swanson, *Catholic England: faith religion and observance before the Reformation.* (Manchester: Manchester University Press, 1993) p. 20 and Beaty, N.L. *The Craft of Dying: A Study of the Literary Tradition of the Ars Moriendi in England*. (Yale: Yale University Press,1971). The second chapter of the long version of the *ars moriendi* establishes five temptations that afflict the dying – *lack of faith, despair, impatience, spiritual pride* and *avarice* – and how to avoid them. Although these works do not address the issue of 'assisted dying' *per se* it is clear that they maintain the earlier Christian tradition which opposed the taking of one's own life by whatever means.

shows how both the time and manner of death lay with the will of God and was not of a person's own choosing. It also underscores the understanding that what was considered most important was not the *means* of death but the state of the dying person's *mind* and *soul* (cf Augustine's argument that taking one's own life offered no opportunity for repentance). The popularity of the *ars moriendi* and other literature on what constituted a 'good death' persisted for at least the following two centuries and finds its central tenets in books like the Puritan divine, Jeremy Taylor's (1613–1667), *Holy Living and Holy Dying*[101], a book that John Wesley (1703–1791) found influential for its spiritual precepts and moral guidance.

The Early Modern Period

5.7 Possibly the first direct reference in English literature to voluntary euthanasia (though difficult to interpret and certainly not advocating for the practice) appears in Sir Thomas More's (1478–1535), *Utopia* (1516) where he writes of the incurably ill in his 'ideal' world:

> 'Should life become unbearable for these incurables, the magistrates and priests do not hesitate to prescribe euthanasia… When the sick have been persuaded of this, they end their lives willingly either by starvation or drugs that dissolve their lives without any sensation of death. Still, the Utopians do not do away with anyone without his permission, nor lessen any of their duties to him.'[102]

5.8 Overall, the period of Renaissance and the Reformation brought about changes in the views about suicide as the taking of one's own life and with the move from religious and moral absolutism to personal and individual responsibility, the view gradually emerged that each suicide had to be assessed individually. Martin Luther (1483–1546), for example, refutes the prevailing (Catholic) opinion that people dying by suicide are guilty of mortal sin. His reason is '*that they do not wish to kill themselves but are overcome by the power of the devil. They are like a man who is murdered in the woods by a robber*.'[103] Nonetheless, he feels that such views should not be generally communicated in case it sees a rise in self-inflicted deaths among the populace. He contends therefore that *'(m)agistrates should treat them quite strictly, although it is not plain that their souls are damned…'*[104]

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101 J Taylor, *Holy Living and Holy Dying.* (Cosimo Classics, 2007) – This edition combines the two volumes of *The Rules and Exercises of Holy Living* (1650) and *The Rules and Exercises of Holy Dying* (1651).
102 T More, *Utopia and Other Writings* (New York: New American Library, 1984).
103 M Luther, *Table Talk no. 222.* April 7th, 1532. (Luther's Table Talk (*Tischreden*) was a compilation of informal conversations and personal reflections by Martin Luther, which were recorded by his students and dinner guests between 1531 and 1546).
104 Ibid.

5.9 In the early 17th century, Francis Bacon (1561–1626) expounded the belief that science had a positive duty to relieve human suffering to the extent that it was a physician's duty, '*not only to restore the health, but to mitigate pains and dolours; and not only when such mitigation may be conducive to recovery, but when it may serve a fair and easy passage.*'[105]

5.10 Over the next 200 years, as part of the general attack on religious authority, writers such as John Donne (1572–1631) in England and Montesquieu (1689–1755) in France attacked the traditional prohibitions on suicide. In the eighteenth century, the Scottish Enlightenment philosopher, David Hume (1711–1776), wrote an essay, '*On Suicide*', in which he argued:

> 'that suicide may often be consistent with interest and with our duty to ourselves, no one can question, who allows that age, sickness, or misfortune, may render life a burden, and make it worse even than annihilation…'[106]

5.11 Despite continued opposition from the Church, and the continued practice of excluding those who died by their own volition from the rites of Christian burial (a practice that continued well into the twentieth century), and the opposition of philosophers such as the German Idealist Immanuel Kant (1724–1804) whose notion of *duty* precluded such acts of self, or other, harm, such opinions are nonetheless increasingly to be found.

The Modern Period

5.12 Though not directly addressing the issues of suicide or euthanasia, and certainly not assisted dying, theutilitarian and libertarian philosophies of Jeremy Bentham and John Stuart Mill would have raised little philosophical objection to the emerging 'right to die' arguments.

5.13 Despite the lessons to be learned about the abuse of power by the State from the forced euthanasia programme of the National Socialists in the mid-twentieth century which had its roots in the social eugenics of the nineteenth century, a policy which included both infants and adults with disabilities, it is dangerous to infer, as some have done, a simple correlation between this and the current debate, especially in relation to those with disabilities (see section 3.7ff). This is often called the 'slippery slope' argument. There is no evidence from the countries which permit assisted suicides that this is happening.

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105 F Bacon, (1623) *De Dignitate et Augmentis Scientiarum.*
106 D Hume, *The Philosophical Works*, vol. 4. (Boston: Little, Brown 1854), pp. 535-46.

5.14 There is little empirical evidence from countries in which assisted dying is legally practised that they have seen a *de facto* increase in those to whom such practices may be available since the introduction of such legislation. However, legislation has expanded provision in several countries. The Netherlands extended its legislation[107] to decriminalise assisted dying for children under 12 months (2005), and for people with dementia who had previously given written consent (2020), Belgium extended its law to include those with mental illness or distress (2013). Canada has extended its legislation to include, from 2027, those whose sole underlying medical condition is a mental illness.[108]

5.15 The Enlightenment trajectory into modernism and post-Modernism has meant that many traditional Christian values on the sacredness of human life have continued to be supplanted by a more secular milieu in which the focus has shifted from divine obligations to the obligations of human autonomy. It has been argued that *'the consequences of the Enlightenment, Modernism and Post-modernism seem to raise 'homo hedonis' on a privileged pedestal in which his own person and his autonomy are the most important goals*.'[109]

5.16 The contemporary emphasis in the field of medicine and medical ethics, as in wider society, on the autonomy of persons, is one of the primary drivers in the current debate over assisted dying and the 'right' to die. This emerged as a reaction to the paternalism of medical practice of previous eras, as well as the ecclesiastical sanctions which underpinned (and in some ways continue to underpin) the social and legal framework of Western society.

5.17 Since the birth of modern medical ethics as a discipline in the 1960s Christian ethicists like Paul Ramsey[110] have sought to define death and end of life care from a Christian ethical perspective and to provide a theological framework for ethical decision making in which moral considerations act as a check on unfettered technical possibilities and the hegemony of individualism. Theologians like Alastair McFadyen[111] who identifies the personal, social and political framework which is required for 'persons' to live in community and

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107 The initial 2002 Dutch legislation already allowed for the euthanasia of minors (12 year and older) with parental consent. The 2005 Groningen Protocol decriminalised euthanasia for infants (under 12 months). In 2020 the Dutch government approved legislation to allow euthanasia for children between 1-12 years following similar legislation in Belgium in 2014.

108 https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s1_1

109 L Turner, 'Euthanasia and distinctive horizons of moral reason', *Mortality, vol 2, no 3 (1997),* 193.

110 P Ramsey, *The Patient as Person: Explorations in Medical Ethics*. (New Haven: Yale University Press, 1970).

111 A I McFadyen, *The Call to Personhood: A Christian Theory of the Individual in Social Relationships.* (Cambridge: CUP, 1990).

re-establishes personhood in a social context have similarly sought to challenge the individualism of contemporary society and its institutions.

5.18 In the twenty-first century, many physicians and theologians alike have argued that a more relational view of the vulnerable and dying, which embeds their support and care in societal structures which affirm the *inter*dependence of persons would mitigate much of the concern expressed by proponents and advocates of assisted dying alike.[112] For this reason it has been argued that an increased emphasis on, and resourcing of, palliative care presents a more humane, and less morally fraught, option to end of life provision than the legalisation of assisted dying.

6. Implications for the Methodist Church in Britain

6.1 With legislation currently progressing through two and possibly three legislative assemblies in areas covered by the Methodist Church in Britain, it is likely, possibly as early as 2027, that some Methodist people, churches and/or ministers will need practical support and guidance when faced with the reality of requests for assisted dying by people in their communities.

6.2 In response to the 2025 Conference resolution "to review the Conference's position with regard to assisted dying and to report to the Conference not later than 2028" the working group considered the options for doing this. A consultation could be carried out that included some of or all Conference members, District Synods, and/or all the Methodist people. However, this could have significant resource implications and as the debate at the 2015 Conference found, could simply demonstrate the wide spectrum of deeply held views on this subject. Gaining a consensus position on opposition to, support for or neutrality about assisted dying may be fraught with difficulties and could cause significant distress. Instead, as the Conference and Church have done with other significant issues in recent years, we should spend time actively listening to one another and seeking to understand all perspectives.

6.3 As stated earlier (1.4), the 1974 Methodist Statement on Euthanasia, is out-dated, inaccurate and, in the opinion of the working group, should no longer have the status of a Conference Statement. The working group considered the timescales involved in carrying out a robust and valid consultation on this issue, as well as

112 See, for example, A Gawande, *Being Mortal: Illness, Medicine and What Matters in the End.* (London: Profile Books, 2014) and J Pye, 'When you grow old…': Can we only choose between autonomy and dependence in older age?' *Crucible,* July 2018.

the time required to agree a new Conference Statement. The group concluded that it would not be possible to complete this task in advance of legislation being potentially enacted in 2027. A long consultation would therefore not help those requesting advice, guidance and support at that time.

6.4 The working group noted that in 2015 when the Methodist Council was presented with two Notices of Motion outlining carrying positions on the issue of assisted dying, it chose to focus on the production of resources: for end of life: https://www.methodist.org.uk/faith/life-and-faith/death-and-dying/ and for pastoral ministry: https://www.methodist.org.uk/for-churches/guidance-for-churches/pastoral-care/.

6.5 The working group therefore presents to the Conference a number of resolutions both to facilitate conferring and enable decisions to be taken about the Methodist Church in Britain's position on assisted dying. Should the Conference pass resolution 2, to change the status of the 1974 Methodist Statement on Euthanasia, it then has the opportunity to maintain the historic position of opposition to assisted dying by passing resolution 3. Resolution 4 provides an opportunity to decide whether or not to initiate a Connexion-wide consultation on changing the Church's position on assisted dying when death is considered both certain and imminent in competent adults, and if so, what safeguards would be required. Such a consultation would provide evidence for any future Conference discussion about assisted dying, particularly if a move away from a position of opposition was contemplated. However, as indicated earlier, the Conference should be aware that this would be a significant piece of work and the necessary resources would be needed to complete it. Resolution 5 provides an opportunity to revisit whether to develop a new Conference Statement on assisted dying in the future. It is the view of the working group that it is currently not the right time to do this, but when the legislative position is more settled it may be appropriate to reconsider this in the future. Finally, resolution 6 recognises the need to support all people nearing the end of life, including, within the limits of relevant legislation, those seeking an assisted death.

6.6 Regardless of whether legislative changes are enacted in any part of the UK and the Crown Dependencies, as a justice-seeking church the Methodist Church should continue to focus on those who are most vulnerable. This was articulated by the Archbishop of Canterbury and former Chief Nursing Officer for England, the Most Revd Dame Sarah Mullally, in a BBC interview[113] in which she said that with respect to amendments to the proposed legislation in the House of Lords at that

113 https://www.bbc.co.uk/news/articles/cx2lgge2jd3o

time, nothing would make the bill safe enough to "protect the most vulnerable in our society". She said, "We don't properly fund palliative care. I am worried people may make a decision for assisted dying because they are not having the right sort of palliative care or the right social care. I also have a worry that there is a whole group of people who haven't had choice in life, they are people who, because of inequality, are more likely to get cancer and late diagnoses and to die of it. My worry is that a group of people may be given options and feel because of other people's value judgements the option is assisted dying and not chemo and to fight for it (life)."

6.7 Whilst free will is a central concept in Christian theology, and the undoubted importance of personal autonomy and the ability to make fully informed personal choices are at the heart of the arguments made to enable assisted dying, the Methodist Church should be mindful that some people could remain vulnerable to coercion, could feel they are a burden to their family, the NHS or society, or could be left with a sense that their life is worth less than others. Should legislation for assisted dying be enacted the Church will need to continue to do all it can to demonstrate that all are equally valued by God and to ensure all necessary safeguards are not only in place but are actively monitored and reviewed.

6.8 As a justice-seeking church the Methodist Church should campaign for properly funded social care, both for people living in their own homes as well as in residential or nursing care homes, palliative care services, and sustainable funding for hospices, noting the significant financial challenges many currently face. For instance, in 2023, total UK hospice income of £1.8bn comprised of around £0.5bn of state funding and the remainder from charitable sources,[114] and MHA's 2025 annual report highlighted "The not-for-profit health and social care sector were included in the changes to employer National Insurance contributions. which added a further £4.6 million burden to MHA, and comes in the context of several years of unprecedented financial pressures, including the pandemic; a recruitment crisis which increased our spend on agency staffing; a cost-of-living crisis, that saw our energy bills triple to £18m in 2022 and this is all on top of a long-standing funding gap between the costs of delivering care and the rates that local authorities are able to pay per resident."[115]

114 https://committees.parliament.uk/work/9279/financial-sustainability-of-adult-hospices-in-england/
115 https://mha.org.uk/about-us/annual-report-accounts

7. Position of the Methodist Church in Britain on assisted dying

7.1 The Methodist Church in Britain believes human beings are created in the image of God, with all people truly valued and loved by God. This means all human life has dignity and worth.

7.2 A gift of human creation is the capacity to consider options and make free choices. However, the choices made by an individual can have consequences for others, and as Christians we are called to love our neighbour as ourselves.

7.3 Modern palliative care and treatment can provide great benefit, and at the end of life give help, support and dignity to most people. There are, though, times when even with the best palliative care and treatment it is not possible fully to alleviate pain and suffering for some people who are dying.

7.4 Whilst the Methodist Church has been historically opposed to legalising assisted dying, we recognise the diversity of views held by our members on this issue.

7.5 The Methodist Church seeks to offer pastoral care to all who are at the end of life. This would include those who have requested assistance with dying.

7.6 As a justice-seeking church, the Methodist Church believes all people, and particularly the most vulnerable, should be safeguarded from coercion or encouragement, whether direct or indirect, to request assisted dying. We therefore call on all governments across the UK to provide the necessary resources and reforms for high quality social, mental health, palliative and hospice care, so that no one feels a burden, all are valued, and everyone can access the best possible care and support when they need it.

8. Resources for the Church

8.1 The death and dying resource (https://www.methodist.org.uk/faith/life-and-faith/death-and-dying/) that can be found on the Methodist Church website was prepared in response to a request from the Methodist Council, following a discussion at the Conference of 2015. While that related specifically to the Assisted Dying Bill, then before Parliament, the request from the Council was to "resource the Church better to respond to the needs of those requiring palliative care and understand the issues involved." In parallel with this, 3Generate, the Methodist Children and Youth Assembly, also requested more guidance on the topic of death and dying. It was intended as a flexible resource that can be developed further in the future and to which new links can be easily added.

8.2 The site contains the following resources:

- Practical sources of help for people with a terminal diagnosis and those close to them.
- Resourcing the conversation about death and dying.
- Theological and spiritual perspectives on death and dying.
- Caring for those approaching death – chaplaincy and palliative care.
- Bereavement – the loss of a loved adult or child.
- What can we do? – responding as individuals and churches.
- Advance decisions and planning for death.
- The debate over assisted dying (physician-assisted suicide).
- Death and dying – a short bibliography.
- Christian reflections on being mortal – a personal view by Sarah Rowland Jones.

8.3 The Methodist Church website (https://www.methodist.org.uk/for-churches/guidance-for-churches/pastoral-care/) provides more general pastoral care resources, but does not focus specifically on death and dying.

8.4 There is a wide variety of prayer and pastoral resources online related to death and dying, both from the UK and internationally. Examples of resources produced by partner churches include, prayer and pastoral care resources have been produced by the Uniting Church of Australia,[116] the United Church of Canada[117] and the United Methodist Church.[118] [119]

8.5 An essential part of the Church's ministry is to be alongside people at times of death and dying. This should include when decisions have been made about an assisted death. Therefore, the Church should produce specific prayer and liturgical resources that could be used by people and their families at times when a decision is made to request an assisted death. This may include liturgical resources for before, at the time of, and after death.

116 https://victas.uca.org.au/resources/end-of-life-pastoral-resource/
117 https://united-church.ca/worship-theme/death-and-dying
118 https://www.umc.org/en/content/ask-the-umc-valuing-life-threats-to-life
119 https://www.umc.org/en/content/book-of-resolutions-faithful-care-for-persons-suffering-and-dying

*****RESOLUTIONS**

35/1. The Conference receives the Report.

35/2. The Conference resolves that the 1974 "A Methodist Statement on Euthanasia" shall no longer have the status of a Conference Statement.

35/3. The Conference maintains its historic position of opposition to assisted dying.

35/4. The Conference directs the Council to facilitate a period of consultation across the Connexion to seek opinions on whether assisted dying could be appropriate when death is considered both certain and imminent in competent adults, and if so, what safeguards would be required.

35/5. The Conference directs the Council to monitor legislative activity relating to assisted dying and at an appropriate time consider whether a new Methodist Statement on assisted dying should be developed.

35/6. The Conference directs the Council, in conjunction with the Faith and Order Committee, to produce appropriate prayer and liturgical material for people nearing the end of life, including, within the limits of relevant legislation, those seeking an assisted death, and for those providing pastoral care at times of assisted deaths.

Appendix 1

The **Methodist** Church

A METHODIST STATEMENT ON EUTHANASIA

Adopted by the Methodist Conference of 1974

Definitions

1. Although 'euthanasia' strictly defined means 'a good death', it now bears the special sense of taking deliberate steps to end life, usually with the intention of avoiding a prolongation of pain, distress or helplessness. It will be used in that sense in this statement. The proposal is frequently made that individuals should be allowed to make a statement indicating that in certain medical crises their lives should be terminated. This proposal is known as 'voluntary euthanasia'.

2. The campaign to legalise voluntary euthanasia has strong roots in a compassion which seeks to end suffering or overwhelming incapacity in terminal cases. It seriously questions the justification for permitting life to continue when the patient's pain and distress cannot be controlled and a return to improved health and a significant enjoyment of life is no longer possible.

Painkillers which shorten life

3. There are two categories which ought not to be classed as 'euthanasia'/ The first occurs in terminal cases when the treatment necessary to control pain also has the effect of reducing the remaining span of life. As the patient's illness is mortal and the doctor's basic intention is to alleviate suffering, it is appropriate for the treatment to be given.

Prolonging survival

4. Circumstances arise in which medical intervention, aimed at prolonging physical existence, must be questioned. Most often these will involve patients who may survive physically but who will permanently lack any significant capacity to enjoy or even to respond to their environment. Typical of these situations are the following examples.

    (a) A child is born with so severe an abnormality or handicap that without the intervention of surgery or other intensive treatment his life expectancy is minimal. Surgery or other treatment would greatly extend his lifespan but could not overcome the massive dimensions of handicaps, physical or mental.

(b) A road accident victim sustains very severe brain damage. Even the lower brain functions have to be maintained artificially by intensive care. Hopes of recovery to a significant level of physical and mental activity recede and finally disappear. The decision must then be taken as to whether or not to continue the intensive care which is maintaining the patient's life.

(c) An elderly patient has a condition of chronic ill-health (senile dementia, for example) the severity of which can only increase. He then suffers an additional illness (perhaps, bronchial pneumonia) which will prove fatal unless promptly treated. Successful treatment of this additional illness cannot, however, hope to do more than return the patient to his previous condition of chronic sickness.

5. The view may well be taken that medical interference is not appropriate in these and similar circumstances. The total needs and interests of the patient are not served by intervention, although any pain or other distress must be controlled by proper terminal care. The decisions not to intervene in these situations is compassionate and responsible. It is not euthanasia.

6. There are therefore occasions when doctors may have to use a painkiller which is also a life-shortener or may have to refrain from fighting for a patient's physical survival when this is inappropriate in the light of his total situation. Doctors should have the support of society and, if necessary, the protection of the law when they take these decisions.

The legalisation of euthanasia

7. The campaign for the legalisation of voluntary euthanasia asks for a good deal more than this. It presses for laws which will permit the deliberate ending of life when the patient has requested this, and a medical crisis justifies it. It is significant that no country has yet found it possible to legalise euthanasia. This may be explained in part by the difficulty of drafting laws of sufficient clarity – a difficulty which was exposed by the unsuccessful Parliamentary motions of 1936, 1950 and 1969. Legal complexities can be over-emphasised, and, in any case, they do not settle the basic moral issues. Nevertheless, legislation which is dangerously imprecise does itself pose ethical problems.

The medical profession

8. The antipathy of the medical profession to the principle of voluntary euthanasia must be faced. The British Medical Association, supporting the World Medical Association, specifically rejects euthanasia. There is no doubt that it represents the views of the overwhelming majority of the profession.

9. The impulse of the doctor and the nurse is to heal. Inevitably, therefore, they have an antipathy to the deliberate precipitation of death. They are sensitive too, to the importance of the relationship between them and their patients and fear that its vital dimension of trust would be eroded by the legalisation of euthanasia. The scientific character of medicine sets standards by which the profession recognises that there is a degree of inaccuracy inherent in diagnosis and prognosis. While this is extremely small, its very existence would create hesitancy in basing the decision to administer euthanasia on marginally inaccurate evaluation of the medical condition.

10. The attitude of the medical profession, while it may not be decisive, is of extreme importance. Nevertheless, euthanasia is a matter of great personal and social significance, and the public must be fully involved in the debate.

Advantages of euthanasia

11. It is often claimed that the legalisation of voluntary euthanasia would have several positive results. One of the advantages lies in the indication it would give to the doctor of the patient's wishes – an indication which would diminish to some extent the heavy burden resting on the doctor. The initial decision about euthanasia is made when the individual is not under the stress of immediate suffering or anxiety. For the sake of doctor, patient and family, it is useful to avoid the taking of decisions in the physical and emotional tensions of a critical medical condition. Euthanasia would also shorten the period of anguish often suffered by the family during the course of the patient's illness. Not least, by removing that agony from the patient himself, it also removes the prospect of it from the whole of the population. There are people whose lives are consciously or unconsciously shadowed by the fear of a painful and difficult death.

The advantages disputed

12. Most of these arguments in favour of euthanasia are, however, disputed. Although it would give a useful indication to the doctor of the patient's wishes, the doctor still has to decide when the medical situation warrants the administration of euthanasia, and he has also to carry it out. The advantage that the initial decision is not made under stress is diminished if, as seems necessary, the patient retains the right to withdraw his request when the crises occur. Confirming the decision in that condition of stress is hardly less difficult than having to make an initial decision in the same circumstances. While euthanasia would help families to avoid certain situations of distress and tension, it has less attractive aspects. Elderly people often have a sensitive (frequently unwarrantable) fear of being useless or becoming burdensome to their family and to others. It may well be

that there would be no deliberate abuse by relatives exerting direct pressure, but indirect and unconscious pressure is almost inescapable. The very possibility of this might well create in relatives a real (again, often unwarrantable) sense of guilt.

13. Those who oppose euthanasia often do so because they regard it as eroding that high regard for human life on which the safety of the individual depends. They fear that once the principle of euthanasia is accepted – perhaps in order to help a small number of extreme cases – the qualifying categories will be easily and dangerously extended. It may also have the effect of diminishing the vital impetus to discover new ways of conquering illness and controlling pain.

14. If it were impossible in any other way to deal with the problems of suffering and distress, the legalisation of euthanasia might have to be considered. There is, however, a new sense of urgency in developing better methods of caring for the dying. Throughout the medical profession and in Government circles there is an awareness that change is needed. Medical education must equip its students in the special skills needed in caring for terminal cases. There have occasionally been failures in doctor / patient relationships, and in the degree to which the families of patients are involved in the appropriate decisions. The final stage of illness is not one which need represent the ultimate defeat for the doctor or nurse but a supreme opportunity to help the patient at may levels, not least those which relate to his spirit and total personality. Thus, when the illness cannot be defeated, the symptoms (pain, nausea etc.) must be overcome. The experience of dedicated workers in this field, including that of the hospices which specialise in this work, suggests that it is possible to deal with all the symptoms which cause distress to the patient. This is a claim which, if justified, would do much to remove any argument in favour of introducing euthanasia. Of course, it may entail an increase in personnel and expenditure, but it would be a poor argument for euthanasia which insisted that it must be legalised because it is cheaper.

15. It is necessary to develop a sensitivity towards the inappropriateness of some medical treatment and procedures which are currently followed in a certain number of cases. There is a variety of situations which need careful consideration in this way. They include the following:

    (a) indiscriminate surgery in the case of all children born with spina bifida regardless of the severity of predictable handicap;
    (b) resuscitation of patients whose survival will involve them in a further period of weakness and discomfort before final collapse;
    (c) the indefinite maintenance by extraordinary means of the physical phenomena of life in a person whose medical problems have resulted in a permanent loss of consciousness and response to external and internal stimuli;

(d) the treatment of a critical condition in a patient whose 'normal' condition is one of distress, severe incapacity or pain (e.g. bronchial pneumonia in a person with an advanced condition of senile dementia).

These are all circumstances in which the body is moving with a certain appropriateness towards death. Much better reasons than are often advanced are needed to justify interfering with this process. Restraining such interference is not euthanasia, which essentially consists of an interference aimed at precipitating death.

A Christian approach

16. The life of man bears the stamp of God who 'made man in his own image'

(Genesis 1:27). This is the source of man's basic dignity, made astonishingly 'little less than God, crowned with glory and honour' (Psalm 8:5). It is also part of the Biblical basis for the sanctity of human life:

He that sheds the blood of man
for that man his blood shall be shed;
for in the image of God
has God created him. (Genesis 9:5-6)

17. Man is meant to have fellowship with God, and this relationship is an essential aspect of his life. It is, in fact, the possibility of an utterly unbreakable fellowship with God that gives man's life its eternal dimension. Death is an event in that life, marking a transition rather than a terminus. For a Christian in fellowship with God, there is no 'terminal condition.' Death is part of life.

18. Man is not only called to relationship with God, but he is also given responsibility before God, 'dominion over every living thing' (Genesis 1:28), a theme vividly taken up in Psalm 8. This 'dominion' now includes the discoveries of science and technology. One part of the Biblical view of human sin is, however, that he fails to use with real responsibility the gifts which God has entrusted to him.

19. Turning to the New Testament we find Jesus often intervening in sickness in order to restore health. He is also heard insisting that death is not a final disaster and demonstrates by his resurrection its episodic rather than catastrophic nature.

20. Above all, Jesus pleads for and epitomises the love-motive of all actions. He speaks of compassion, of the call to seek the welfare of others, of the need to fight against those things which demean either human relationships or the significance of the individual.

21. The Christian, therefore, approaches the euthanasia debate with many biblical strands in his hands: the dignity of man as made for unbroken fellowship with God; the eternal; dimension of life which sets death in perspective the call to use responsibly all God's gifts including the powers man has over the lives of others; and above all the need to find in every situation the way of compassion.

22. Some steps which can be immediately taken are obvious. Compassion must be shown in a much more energetic onslaught on the problems of terminal care. Responsibility must be shouldered in a new consideration of the appropriateness of certain forms of medical intervention. Despite its high cost in terms of time, money and pastoral care, this compassion and responsibility must be exercised by the medical services, the churches and society as a whole.

23. The need is not so much to change the law as to alter the attitude of society towards death. This is an event which must be talked about and prepared for physically, mentally and spiritually. The families of the dying must be supported not only by the statutory services but also by the community. Predeath loneliness must be relieved and those who are in the latter days of life must feel that they are still (perhaps, especially) part of the family of God. The use of drugs and the increasing skills of medicine must be coupled with an understanding of the needs of the whole person. The spirit of man also requires care, and the Christian must be ready to respond to the need for this personal ministry.

24. It is not merely that the artificial precipitation of death is likely to remain abhorrent to many people, not least to very large numbers of Christians. The approach to the death event which has been indicated in this statement makes euthanasia, in the sense intended by its proponents, both inappropriate and irrelevant.

Appendix 2

Membership and declarations of interest of the working group:

The Revd Moses Agyam – a member of the Faith and Order Committee

Simon Birks – a barrister and member of the Law and Polity Committee.

The Revd Sam Cowling-Green – MHA Chaplain and has worked within NHS chaplaincy, working particularly with adults with disabilities.

Professor Alan Gillies – a Local Preacher and a member of the Faith and Order Committee. A professor of healthcare management and worked in end-of-life care.

The Revd Dr Jonathan Hustler - Secretary of the Conference.

Helen Press – MHA Senior Nurse Advisor and lead on the MHA end of life care working ground. Has a background in working in oncology and palliative care.

The Revd Dr Jonathan Pye – a supernumerary minister, former district chair and honorary research fellow in medical ethics/ senior teaching associate in social and community medicine, University of Bristol.

Dr Richard Vautrey (Chair) - member of the British Medical Association and the Royal College of General Practitioners.