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SUICIDE, ASSISTED SUICIDE AND EUTHANASIA: WHEN PEOPLE CHOOSE TO DIE, DOES IT MATTER WHAT WE CALL IT?

In this article, I raise some questions about two human phenomena—suicide and euthanasia, in which people choose to die, and take steps to arrange their deaths. I am concerned with these phenomena at three levels:

- With the language that we use to describe and talk about them.
- With the ways in which the words we use impact on how we relate to those who wish for death or who act in ways that suggest that they do, even if they don't.
- With some ethical issues that arise in relation to them.

I begin with a discussion of the impoverished language and conceptual landscape of suicide and suicidal self harm, and suggest that this poverty of language is unhelpful, because it frequently leads to the mislabelling of deliberate self-harming and apparently self-harming acts. Through discussion of some problems with the current language, and of some real and hypothetical stories about suicide and acts that resemble suicide, but are distinct from it, I introduce some new ways of thinking about and labelling these most distressing of human phenomena.

Later, I turn to the way in which the term 'assisted suicide' has begun to be used to label 'arranged deaths' that are more properly referred to as 'euthanasia'. Nowadays, in many countries, including mine, more and more people not only want to have the opportunity to decide on the time of their dying, but want to arrange their deaths with the blessing of the legal system. The wishes of these people are important, because they concern the balance between life and death; between suffering and release; between care and its lack; between the public good and the private will, and between liberty and constraint. Most discussions of 'assisted suicide' and euthanasia focus on particular cases in which people wish to die, or on the way in which 'arranged deaths'—whatever we call them—are viewed and treated legally in different countries. By contrast, I say a little about the reasons for the growing popularity of the term 'assisted suicide'. En route I try to answer the question 'When people choose to die, does it matter what we call it?' I end with some comments about suicide, euthanasia and human dignity.

Key Words: suicide, language, cosmic roulette, gestured suicide, ethics, euthanasia, 'assisted suicide', human dignity.

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I want, in this article, to raise some ethical questions about two human phenomena—suicide and euthanasia, in which people choose to die and take steps to arrange their deaths. Most people who write about ethical issues in this area focus on disputes between:

- Those who believe in the value of life so much that they cannot conceive of situations in which a life could cease to have positive value, and who hence believe that it is always wrong for a person to end their life or to arrange that someone else ends it.
- Those who believe that the value of a life can only be determined by those living it (or dying it) and who hence believe that everyone has the right to end his or her life, whether by their own act or by another person's act.

By contrast, I do not intend to talk in detail about particular cases in which people have asked for euthanasia or 'assisted suicide'. Nor do I intend to offer detailed arguments about whether people have the right to arrange their deaths. Rather I shall focus on the language that we use to refer to occasions when people die as the result of their own actions, or survive actions that look as though they may have been aimed at achieving death.

I will begin with suicide and a range of related acts that resemble, but are distinct from suicide, and end by discussing the use of the term 'assisted suicide', which is now often used interchangeably with 'euthanasia'. In this way I hope to show that there are compelling reasons—conceptual, ethical and professional, for thinking carefully about the language we use, not only to refer to occasions when people choose to die, but also to occasions when their behaviour suggests that they may have acted with the intention of achieving their death. Before doing so, however, I want to set the scene by saying a little about some of the reasons that I am interested in these questions, and about my experience of the kinds of human situations I shall be discussing.

PHILOSOPHICAL REFLECTION ROOTED IN PRACTICE

My interests in suicide and euthanasia are rooted in practice and in life. However, they are philosophical in nature. For example, I am interested in the motives and intentions that can underpin actions that might look suicidal to others, even when they do not constitute acts by which a person intends to take his own life. I am also interested in the personal and professional importance of the language that we use to label and describe such acts. In par-

ticular I am interested in the ethical importance of getting the language right, if we are to make the most helpful decisions about how to relate to and/or treat those who act in such ways.

Suicide

My interest in what suicide is, in the meanings it can have, the language we use to describe it, and the human experiences that can motivate a person to suicide or to behave in ways that resemble suicide, arose during my experience as a practitioner in mental health. I guess that in this I am different from many other philosophers who have written about suicide.

For example, as a teacher in child and adolescent psychiatry, and as a social worker in adult psychiatry, I had significant contact with people who successfully ended their lives. One of these, the mother of a young man with learning disabilities with whom I had contact as a social worker, set fire to herself in the garage, while her husband and sons ate the lunch she had just prepared and served. Supporting Sophie's family in their loss helped to form my strongly held views about the morality of suicide. On another occasion, I was woken in the middle of the night by a telephone call from the police who, having established who I was, asked me to go to a hospital to identify the body of one of my clients, who had died. Earlier in the day Ann had jumped in front of a car and been killed. The obsessive compulsive behaviour in which she had engaged for many years, had been partly to blame for the ending of her marriage. Since then, however, Ann's behaviour had been greatly exacerbated by the fact that her ex-husband, who had legal custody of their young daughter, seemed intent on cutting her off from any contact with the girl whatsoever. In the end she had decided that no life was preferable to life without her daughter. She had left a note saying what she intended to do and why. As with Sophie's story, supporting Ann's family in their loss helped to form my strongly held views about the morality of suicide.

Sophie died because she wanted to, and acted so as to achieve her death; so did Ann. Each seems to have been meticulous in her plans. Sophie had taken some days to gather together the equipment she needed—buying a petrol can and then some petrol, though she didn't drive, and a lighter, though she didn't smoke, in the few days before she enacted her plan. The testimony of a number of witnesses to Ann's death suggested that she had timed her running into the road and throwing herself in front of a car carefully. No one had any doubt about the intentional nature of her final act.

Ann and Sophie were alike, in that each acted with the intention of dying and had been successful in achieving her wish. However, in other ways they differed. For example, whereas Ann had threatened to kill herself in the past, and had made what seemed like half hearted attempts to do so, Sophie had not.

As well as contact with people who in the end killed themselves (and in Ann's case, with someone who arranged that another person killed her—the driver whose car took her life away) I have had significant professional contact with others who tried to kill themselves, but failed. One of these—Lily, a woman I had supported as she set up home on her own after an extended stay in a psychiatric hospital, was surprised to discover, after surviving a serious suicide bid, that she was glad to be alive. Actually she survived because, having gone to her flat for an unannounced visit and discovered her unconscious and lying in a pool of blood, I called the emergency services and had her taken to hospital; she had taken a massive overdose and vomited up the contents of her stomach. Lily was unconscious for ten days, but survived.

Finally, I have worked with a number of people who acted at times in ways that looked as if they were intent on dying, but who survived so frequently that I developed the idea that perhaps, after all, death was not really their aim.

Suicide is devastating. It is an assault on our ideas of what life is about; that is why we find it so difficult to contemplate the possibility that someone we love or care about could want to end everything by arranging his death. For the person who dies, suicide solves the problems he is experiencing. However, it does so at the expense of his ability to experience anything at all. Importantly, it also does so at the expense of pain to those he leaves behind, because suicide inevitably harms those who survive the suicide of a loved one. This is well documented.(see, for example, Wertheimer, 1991 and Hill, 1995) Suicide creates emotional and ethical ripples that affect everyone who knew the person who died, some of whom may suffer the adverse effects of closeness to his self inflicted death for many years, and perhaps even for ever. These ripples extend far beyond family members and close friends and associates, taking in individuals whose acquaintance with the deceased person was more slight.

I have seen, at first hand, the effects that suicide can have on others. I know from personal experience, as well as from contact with friends, colleagues and students, who have been affected by suicide, that dealing with the aftermath of a suicidal death is unpleasant and distressing, not only for the relatives, but also for the professionals who are involved. I recall, for ex-

ample, the devastation of one of my undergraduate students who I had already supported through the suicide of two family members, when she came to see me on the day that she received the news of the suicide of a third relative. It seemed to this young woman that her family must have a genetic predisposition towards self-destruction. Attending the Coroner's Court to support the family of Ann, the woman who arranged her death by jumping in front of a car, I saw at first hand the effects that being involved in a suicide as the unwilling agent who brings it about, can have on innocent person. I was struck by the effect that Ann's suicide seemed to be having on the seventeen year old boy who was driving the car that killed her. He had just passed his driving test, and the testimony both of other drivers and of pedestrians who witnessed what had happened, supported his view that he had been driving carefully and that there was nothing he could have done to have avoided hitting Ann as she ran and threw herself in his path. In spite of that, however, he had caused her death, and it was plain that he felt guilty even though he was not at fault. For many years afterwards, every time I passed the spot where Ann died I found myself wondering whether, had I been better at my job—a more empathic and caring person, I could have spotted some indication of what she had been planning on the last occasion I had met with her, a couple of days before she acted to end her life. And though these events happened twenty five years ago, every time I pass the traffic lights that have since been erected where she died, I think of what happened there. I can only begin to imagine what that driver—who is by now in his forties, feels and perhaps sees when he drives that way—if he ever does.

My experience of the pain and distress that suicide typically causes those that survive a suicider to whom they are related in some way, led me to believe that in general it is not only a bad idea, but morally wrong. And yet a growing number of people in the UK and other developed countries, argue in favour of the right to assist another in suicide, and more importantly, for the right of those who wish to die, to be assisted in suiciding. Or at rate that is what seems to be the case. Actually, I think that in most cases talk of 'assisted suicide' is a mistake, and the right for which they campaign, is in fact the right to euthanasia. Later in this paper I shall say more about the mixing up of these two terms.

Euthanasia

By contrast to the way in which I developed my professional and philosophical interests in suicide, my interest in euthanasia has arisen largely as a result of philosophical exploration of imagined situations in which people (including myself and those that I love) suffer interminably in circumstances in which medicine cannot help, except by means that would harm their autonomous personhood. That said, it is important to note that I have had a little experience of situations in which people wanted to die to avoid the dreadful deaths they foresaw for themselves as the result of painful terminal illness. Indeed it was meeting someone who was subsequently helped to arrange his death by both his wife and the health worker who provided the necessary medication, that first persuaded me that euthanasia could be morally acceptable at times. It would have been difficult not to be moved by the plight of this fellow human being, whose courage in the face of his dying was extraordinary, as was the care that he and his spouse took to document their thinking and the plans to which it led. They were meticulous in their approach so that should it prove necessary, she could provide evidence that in acting to help his dying, she had been responding to his wishes, which were carefully thought through and did not result either from irrationality on his part or from pressure from others. However, it was neither simple sympathy for a human being in his pain, nor the attempt to empathise with him that persuaded me to move away from my former belief that euthanasia was never morally acceptable, but the realisation that there can be human pain that medicine cannot ameliorate sufficiently without, at the same time, affecting the ability of the subject of that pain to experience anything in a personal sense.

SUICIDE, CONNOISSEURSHIP AND THE INADEQUACY OF 'SUICIDE TALK'

Connoisseurs understand and appreciate their area of expertise better than those who do not share their expert knowledge and understanding, because they have access to its meanings and values through its specialised language, which allows them not only to taste, look, touch, listen, feel, experience and appreciate in different and more precise ways, but to communicate more clearly about their area of connoisseurship. That is why those who do not have access to an area's specialised vocabulary are likely to be forever cut off from understanding it in the same way that its initiates can.

There are very few connoisseurs of suicide, even clinicians and others whose work regularly brings them into contact with suicide and other acts of self-harm that are not aimed at death. In the case of lay people, this is hardly surprising, since being able to discriminate between different varieties of life endangering self-harm is not, for them, a high priority. However, in the case of those whose work makes contact with suicide and other related phenomena more likely, it is more surprising. It is also a source of both practical and ethical concern, because having an inadequate language in terms of which to speak and think about suicide and related acts, means that our ability to understand and relate helpfully to those who engage in such acts, is significantly reduced. Unless we learn to speak in more nuanced ways about the destructive acts that people perform with themselves as targets, whether they end up alive or dead, we are in danger of misunderstanding them and those who perpetrate them, and thus of acting in inappropriate and unhelpful ways.

The thin-ness of the lexicon available for the discussion of lethal and potentially lethal self harming acts in which people engage, including those that are aimed at death and range of acts that are not, is a reflection of impoverished thinking about the nature of such acts. Other than 'suicide' we have words and phrases like 'parasuicide', 'failed suicide' and 'threatened suicide'. Though 'parasuicide' began life as a label for a particular species of non-fatal suicidal action, some people now use it as a generic term for occasions when a person apparently tries to kill himself, which are sometimes labelled as 'failed suicide', but are more often referred to using the unsatisfactory term 'attempted suicide'. I am not alone in believing that there is an urgent need to develop a more nuanced natural history of suicide and related self harming acts, and to refurbish the terminology with which we approach the problems of suicide and other related phenomena. For example, Kreitman (1977) writes:

> (…) there are conceptual issues which arise at the very beginning of any study of suicidal behaviour and which must be clarified if any progress is to be made. Even a term like 'suicide' is by no means free of ambiguity; the position is far worse with that form of behaviour which is still widely, loosely and regrettably designated as 'attempted suicide'. (4)

There is no doubt that some people who end their lives, intended to do so because life for them was so bad that they came to a conscious decision that they would rather be dead. I am convinced that this was true of Sophie, who

set fire to herself in the garden while her family ate lunch, and of Ann, who threw herself in front of a car. And it was certainly true of a bullied teenager, discussed by Marr and Field (2004) who spun a coil of the copper wire that she used in making junk jewellery and, attaching it to a metal bracelet on her wrist, threw it over the 24,000 volt electric line at a nearby railway station, dying as the result of 75% burns. However, it is clear that at least some of the apparently suicidal acts in which people engage are not aimed at death, and it is thus important to remain aware of the possibility that a person might die as the result of his own deliberate and intentional act, and yet not be a suicide. Such a person might, for example, have intended no more than to draw the attention of others to his distress, whether to engage their sympathy and thus enlist their support in ways that they might not have given it otherwise, or to punish them for some real or imagined offence. And his death might have resulted from accident or miscalculation of risk, rather than from the intention to die.

It is because it is clear that many people who act in apparently suicidal ways were not attempting to kill themselves, but rather to change their lives, that I think the overworked, tired and unhelpful term 'attempted suicide', should be pensioned off and replaced by terms that more accurately fit the human acts in question. Elaborating the language of suicidal self harm in this way will involve developing our understanding of the natural history of such acts by thinking carefully about their meanings and the reasons they are performed. One person who has attempted to develop the language of suicidal behaviour is Lester (1990) who, alongside a very significant body of empirical work on suicide and related phenomena, proposed a classification of different varieties of 'attempted suicide'.

LESTER'S CLASSIFICATION OF 'ATTEMPTED SUICIDE'

Lester's classification of acts of 'attempted suicide' is interesting, because it focuses, at least to some extent, on the intentions of the protagonist. He sets out five categories:

- 'Failed suicides', who intend to die, but fail to achieve their intention;
- 'Deliberate self-harmers', who wish to harm themselves, but do not wish to die;
- 'Subintentioned self-harmers', who are willing to trade off damage to themselves in order to achieve some positive consequence;

- 'Counterproductive self-harmers', who act without thinking too clearly and as a result do not, for example, foresee the harmful consequences of, for example, overdosing;
- 'Pseudoself-harmers', who do not intend to die and as a result only cause themselves minimal harm.

Though this classification offers food for thought I think it is significantly flawed.

The term 'failed suicide' is widely used, in just the way that Lester suggests, to refer to people who genuinely did attempt to kill themselves, or to the acts they perform. I have no problems with its use to refer to people who try to arrange their deaths, but fail in doing so. However, odd though it might sound, I much prefer the term 'non-fatal suicide', both because I think this is a more accurate and better description, and because it clarifies the fact that the protagonist really did intend to die, even though he ended up alive. I shall say more about 'non-fatal suicide' later.

The main problem with Lester's classification is that though it purports to be a classification of acts of 'attempted suicide', most of the categories that he proposes are not acts of attempted suicide at all. For example, he is clearly mistaken in including 'deliberate self-harmers' as a category of 'attempted suicide'. Some of those who deliberately self-harm, for example, by cutting and scratching themselves, hair pulling, head banging and so on, will in the end set out to suicide and succeed in doing so. At that point they will properly be referred to as 'successful suicides'; some will in the end set out to kill themselves, but fail to do so; they will then be properly referred to as 'failed suicides' or to use my term, as 'non-fatal suicides'. However, those that Lester refers to as 'deliberate self harmers', do not wish to die, but merely to harm themselves, and thus they are in no sense 'suicide attempters'. When one of them arrives—alive, though harmed in some way, in an accident and emergency room, he will do so, not because he wanted to be dead and failed to kill himself, but because he was successful in harming himself. If, on the other hand, such an individual ends up dead, it will be because he was unsuccessful in his self-harming act, which was not aimed at death, rather than because he has succeeded in suicide. Since he did not intend to die and did not act with the intention of dying it would thus be a mistake to say of such a person that he suicided, or that he was a suicide. There is more to the definition of suicide than that a person should end up dead as the result of his own intentional act; he must have died because he wanted to die and set out to arrange his death.

Lester's remaining three categories also have problems. First, from his own definition, 'subintentioned self-harm' is clearly not about attempting to be dead, but about trading gain for pain, while 'counterproductive self-harmers' are not suicide attempters, but merely people who act on a whim, probably because they hope to change someone else. His classification of what he calls 'pseudoself-harm' as a variety of 'attempted suicide' also seems mistaken, because by his own account, pseudoself-harmers 'do not intend to die' and thus could not be attempted suiciders, because they do not act with the intention of ending up dead.

I am conscious that my critique of Lester's classification might be viewed as lacking in generosity. This view might rest, for example, on the idea that in delineating the categories with which he has presented us Lester has helped to elaborate the conceptual landscape of suicidal self harm, and has thus carried out part of the work I am arguing is necessary. However, it is important to remain aware that he has not pointed to problems with the term 'attempted suicide', or proposed replacing it. Rather he has suggested that the over-arching term 'attempted suicide' currently brings together a range of acts that can be differentiated, according to what the protagonist has done. My view is that while 'attempted suicide' remains in use, it will continue to confuse people. That is why I propose consigning it to the linguistic waste bin.

ELABORATING THE LANGUAGE OF SUICIDE AND SUICIDAL SELF HARM

Many years ago a friend (Mair, 1992) and I were discussing some ideas that later appeared in my book *Contemplating Suicide: the language and ethics of self-harm* (1995) in which I began to develop a natural history of suicide and other related phenomena. My friend—a psychotherapist, was sceptical about my aim to elucidate the conceptual landscape of suicidal self-harm, and to develop a richer language for speaking about the destructive acts that people perform with themselves as targets. His view was that the language we use makes no difference and that hence that my project amounted to little more than 'linguistic tinkering'. 'After all', he said, 'It doesn't much matter whether you call suicide, "suicide" or "cotton socks", it's still the same thing.'

My friend was mistaken in thinking that what I was doing amounted to little more than playing with words He was also mistaken in thinking that it makes no difference what words we use to refer to suicide and related phenomena, because the way in which we think about them is affected, both by the labels we use to refer to them, and by the expectations to which such la-

bels give rise. In any case what I am concerned with is only partly about sorting out the labels. More importantly, it is about encouraging clinicians and lay people alike to explore the wide range of possibilities, both moral and psychological, for meanings and reasons and intentions that might underpin each individual's self-harm or suicide. Unless we develop a more sophisticated language in which to discuss the potentially self destructive acts in which people at times engage, we may mistreat them; in other words, we may treat them in ways that are unhelpful.

WHAT TERM(S) SHOULD WE USE TO REPLACE 'ATTEMPTED SUICIDE'

I have made plain my view that we should stop using the term 'attempted suicide', because in its current usage to refer to any situation in which a person survives an act that resembles an attempt to end his life, it is not only inaccurate, but unhelpful. Doing so will help to avoid confusion and mistreatment. However, it is clear that if we abandon its use, we will need to find a new term or terms to replace it and I want, now, to propose some possibilities that take account of what the protagonist intended when he acted. It is important to note that in doing so I am being selective. For example, I say nothing about self harm that may be labelled as 'attempted suicide', even though it is clear that the intention of the individual could not possibly have been to do with ending his life.

A. '*Failed suicide*' *and* '*non-fatal suicide*'

I want to begin with acts in which a person fails to die when he acted with the intention of doing so. In such circumstances, the term 'failed suicide' offers an accurate description, just as the term 'successful suicide' offers an accurate description of occasions when a person acts with the intention of ending his life and achieves his aim. Another alternative, and the one that I favour, is to refer to his act as 'non-fatal suicide', which has an opposite—'fatal suicide'. Of course, the idea of 'non-fatal' suicide may seem odd, because of the common belief that suicide is always and necessarily fatal. However, I think it is useful, because it draws attention to the fact that though he has survived, the protagonist acted with the intention of ending up dead, and allows us to acknowledge that a person who fails in an earnest attempt to procure his death performs the same act as one who succeeds in his attempt to die. It depends on a view of suicide in which intention is central, rather

than outcome, and recognises that the difference between a person whose suicidal act does not end in death, and one whose suicide succeeds, relates not to what he wanted or tried to achieve, but to the result of his act.

Consider, for example, a man who jumps from the roof of a high building, intent on achieving his death and unaware that even as he was preparing his death a marquee was being erected below so that rather than crashing to the ground, his fall is broken and he survives intact. The fact that he fails in his bid for death has nothing to do with his intention or with the nature of his act and everything to do with his luck (or lack of it) when he acted with death in mind. That is why he was a suicide when he jumped; it is why his act was suicide even though he lived.

B. *Gestured suicide*

In situations where when an individual feigns suicide by acting in a way that looks as if it was aimed at death, in the hope and expectation that others will come to his aid in ways that they might not have done otherwise, I favour the use of the term 'gestured suicide'. Some at least of those that Lester refers to as 'psudoself-harmers', engage in acts of this kind, even though if they don't calculate very carefully what they can safely do, they might end up dead.

The writer, Laurie Lee (2002) refers to situations that are clearly suicide gestures in his book *Cider with Rosie*, demonstrating remarkable insight, not only about the fact that certain people who act in what seem to be suicidal ways do not intend to die, but merely to have an effect on others, but about the fact that some people act in such ways as a matter of habit:

> He committed suicide more than any other man I know but always in the most reasonable manner. If he drowned himself, then the canal was dry; if he jumped down a well, so was that: and when he drank disinfectant there was always an antidote ready, clearly marked to save everybody trouble. (Laurie Lee, *Cider with Rosie*, 181)

A suicide gesture is like a one person play in which the actor creates a dramatic effect, not by killing or even attempting to kill himself, but by feigning an attempt on his life. A suicide gesturer does not aim to achieve his death, but to change his life, by changing the ways in which others act towards him. If he ends up alive, having managed to persuade those he aimed to impress that he actually wanted to die, he is a successful suicide gesturer;

if, on the other hand, he ends up dead, he will be an unsuccessful suicide gesture. Whatever a coroner might decide, his death will not be a suicide, but an unsuccessful suicide gesture, or perhaps, a self inflicted death by accident. Consider, for example, a man who is unhappy with his life, but unhappier still with his wife:

> One day he says to her that if she does not give up her lover, and start being a better and more attentive wife, he will kill himself. Late that afternoon, while his wife is at work, he writes a note saying. 'I told you I would do it. Now you know it was true.' Then he takes an overdose of sleeping pills, and lies down in front of the front door to wait for his wife to come home from work.

This man does not expect to die when he takes the pills. He does not want to die. Unfortunately on her way home his wife's car breaks down and as a result she does not get home at her usual time and he does die. He dies as the result of his own intentional act, but he is not a suicide, but a suicide gesturer, because he did not intend to kill himself.

Suicide gestures are often referred to somewhat disparagingly as if they are no more than 'cries for help' and no doubt sometimes they are, because they are calculated to do little more than draw attention to the protagonist's plight, alerting others to the fact that he is unhappy and needs to be cared for. However, it is important to realise that the actions of those who gesture suicide can be underpinned by a wide range of motivations and intentions and that the distress of an individual who survives such an act, might be just as severe as that of a person who survives an act that was aimed at bringing death.

C. *Cosmic roulette/cosmic gambling*

Sometimes people who act in apparently suicidal ways do so without a clearly formed intention. They may act 'on a whim', not thinking before they do so, what they are actually doing, or what the outcome might be. Sometimes, such behaviour becomes habitual, as in the case of people who become regulars at accident and emergency departments of hospital, because whenever there is a crisis in their life, they reach out for a bottle of pills or act in some other way that draws attention to them by feigning suicide. There is a blurry distinction between such acts and some suicide gestures of the 'cry for help' variety. Often such acts are accompanied by more alcohol than thought. How-

ever, there are other acts that from the outside look like suicide, in which, though the person acts intentionally in ways that have some chance of killing him, he is not clear about the result that he wishes to achieve. Such acts may usefully be labelled using the terms 'cosmic roulette' and 'cosmic gambling'.

I am thinking of occasions when a person acts in a way that has some possibility of ending his life, though he neither intends to live nor to die, but rather to take a gamble on the wheel of life and death. Cosmic gambles resemble suicide and may be physically identical with it. However, they have an entirely different set of possible meanings. In effect, the cosmic gambler turns to either God or the cosmos and says 'Do what you will.' With luck he will win, whatever the outcome—dead or alive. If he ends up dead, he wins, because he will no longer be suffering whatever pain and problems in living have taken him to the point of his gamble. If he ends up alive, on the other hand, he may well win, because as a result of his gamble other people are likely to rally round to support him and to offer him help; in other words, if he survives the cosmic gambler may end up better off, because rather than ending his life he improves it by changing for the better the ways in which others act towards him.

Cosmic roulette comes in a number of forms. For example, in 'suicidal cosmic roulette' the protagonist tips the odds towards the likelihood that he will die, while in 'whimsical cosmic roulette' he does not think too carefully about the odds that his chosen method and circumstances will lead to death, but simply acts on impulse. I have discussed the varieties of cosmic roulette in a little more detail elsewhere. (Fairbairn, 1995)

It is easy to imagine how some people might view cosmic roulette as a 'win-win' option. If they die they will no longer be suffering whatever led them to spin the wheel, while if they live, others are likely to rally round, offering support and care, thus helping—at least for a time—to make their life better. However, it is important that potential cosmic gamblers should take account of the possibility that cosmic roulette can go horribly wrong, and that when it does the love and help and support that is attracted from others might not altogether compensate a protagonist for the fact that his act has resulted in significant and lasting physical problems.

WHAT'S IN A WORD? THE ETHICAL IMPORTANCE OF 'SUICIDE TALK'

The words we use are ethically important because they can affect our beliefs and understandings, and the ways in which we care for one another. Lack of

clarity can lead to mistaken clinical and personal judgements. Both misconstruing (and hence mislabelling) and mislabelling (and hence misconstruing) an apparent suicider's actions can lead to inappropriate and unhelpful treatment. This is a matter of real ethical significance, because unless we develop a more sophisticated language in which to discuss the potentially self destructive acts in which people at times engage, we may mistreat those who need help as the result of their own suicidal or apparently suicidal, self-harming actions. In other words, we may treat them in ways that are unhelpful and hence unethical. It is clearly unhelpful for clinicians or for family members, friends and colleagues, to treat a person who has acted in a way that has caused him harm, as if he intended to end his life, if he did not actually intend to do so. And it is unhelpful to treat someone who wanted to die and acted in ways that he hope would kill him, as if his actions were no more than 'a cry for help'; failing to regard such a person as someone who wants, for whatever reason to be dead, could clearly have disastrous results.

Ask yourself what would you think and how would you feel if you heard that a friend or a loved one had attempted suicide, and how you would respond. A person who is labelled as having 'attempted suicide' may be treated as if she really wanted to be dead, whether she did or not, especially if the act that ended up with her being giving this label happened in a hospital in which she was an inpatient, or if she was an inmate in a prison. The bad publicity that follows on from incidents of suicide in hospitals or prisons is such that anyone who is thought to have attempted to kill himself is likely to end up being 'specialled' or put on 'suicide watch'—that is, placed under close observation in an attempt to prevent her having further opportunities to take suicidal action. The problem is that that being under such close supervision and observation can, in itself, cause stress that might, at worst, lead a person to act suicidally.

The problems caused by our impoverished language for suicide and related acts, arise—at least partly, because too little heed is usually paid to the intentions that underpin the actions of those who act in ways that could be viewed as an attempt to kill themselves. This also explains why some people find my proposed use of the terms 'fatal suicide' and non-fatal suicide' rather odd. Emphasis tends to be placed on the physical facts of the matter: the presence or absence of a corpse. That is why a person who has died as the result of a suicide gesture that has gone wrong may mistakenly be judged to have suicided, especially, for example, if she has written an apparent 'suicide note'. It is also, incidentally, why someone whose suicide bid was un-

successful might be viewed as having made a 'cry for help', rather than as having failed in a serious attempt to end his life.

This might happen, for example, if his chosen method of ending his life seemed destined to fail—if, say, he chose to overdose but ingested a relatively small quantity of drugs that realistically had no chance of killing him. In delineating what he means by 'pseudoself-harm' Lester (1990) uses a situation of this kind. He clearly believes that a person who takes a small number of analgesic tablets, cannot be a suicide, on the grounds that since his action could not kill him, he could not have acted with the intention of dying. But this is too simplistic, because it is clear that a person could seriously intend to kill himself, but be misguided in his understanding of what it would take to do so. He could thus take a handful of mild analgesics fully expecting not to waken up again. The point is that just because the chosen method could not succeed, this does not mean that the intention to die was not a true one. I have even known of people who have taken an overdose of vitamin pills in a serious attempt to end their lives. When he wakes up such a person, to my mind, will be a failed suicide, or a non-fatal suicide, because he wanted to be dead, acted so as to achieve his death, and merely failed to do so.

It is important to note that none of what I have said about gestured suicide, cosmic roulette and 'cries for help' is intended to suggest that a person who acts in a seemingly suicidal way without the intention of ending up dead does not warrant our care and support. However it does make it likely that the support and attention he requires might be rather different. I want to suggest that this is of great ethical importance, because it concerns the day to day practice of countless professionals in medicine, nursing, psychology, counselling and so on, and the welfare and care of countless people who are in need of well grounded help

'ASSISTED SUICIDE/OR 'EUTHANASIA'?

I want, finally to turn to a topic that is of urgent importance in many countries—to the ongoing debate about euthanasia and 'assisted suicide'. Euthanasia or 'arranged dying', need not involve the direct act of a medical practitioner, but in a number of places in the world doctors are now legally permitted to assist patients in dying—in Switzerland, Belgium, the Netherlands, and the State of Oregon in the United States. That is perhaps why the possibility of ending one's life with the help of others has come to the forefront of public consciousness increasingly frequently in recent years in many parts of

the developed world, as more and more people who are dying dreadful deaths or anticipating doing so, publicly express their wish, not only to die sooner rather than later, but to do so with the blessing of the law. Their wishes are important, because they concern the balance between life and death; between suffering and release; between care and its lack; between the public good and the private will, and between liberty and constraint. The preservation of human dignity is sometimes pointed to as a moral reason for allowing them legally to have their wish, and I shall say something about my view about this idea, in the last section of this paper.

Some of those who successfully arrange their deaths, along with some of those who don't, achieve heroic status through media coverage of their stories. One example is Diane Pretty, a 43 year old British woman suffering from Motor Neurone Disease, who went to the European Court of Human Rights in the attempt to win the right for her husband to assist in arranging her death. Mrs Pretty died in May 2002 (*BBC News*, 2002) a few days after the Court rejected her case. For some years now it has been possible for anyone who can get access to sufficient funds, to get help in dying from the Swiss organization Dignitas, which has increasingly been used by UK citizens who want to arrange their deaths. Indeed in the UK, arranging one's death seems to be becoming fashionable for at least some people who are suffering painful and distressing illnesses.

Around 100 people to date have gone from the UK to die at Dignitas, and there has been great public interest in those who have done so, including Reginald Crew (*BBC News*, 2003a) who died with Motor Neurone Disease in January 2003, and Dr Anne Turner, who had supranuclear palsy, a progressive and incurable degenerative disease and died in January 2006 (*BBC News*, 2006). The services that Dignitas provides have provoked considerable controversy at times, as when Robert and Jane Stokes (*BBC News*, 2003b) were helped to die, though neither was suffering from a terminal illness. In late 2008, controversy was created by the case of Daniel James, a 23 yr old ex rugby player, paralysed from the chest down, was taken to Switzerland by his parents, because he chose to die, rather than living the life he foresaw for himself.

'Assisted suicide' or 'euthanasia': Does it matter what we call it?

In my view it is deeply regrettable that over perhaps the past 15 years, the term 'assisted suicide' has become popular as a way of referring to acts by

which people who are suffering greatly as the result of terminal illnesses hope to achieve their death, because it blurs the distinction between suicide and euthanasia, which I characterise like this:

- In suicide a person arranges his death in order to avoid a life that he does not wish to live.
- In euthanasia a person arranges his death in order to avoid a death that he does not wish to die.

This distinction focuses on the motivation that underpins a person's decision to arrange his death. It recognises that in most cases those who suicide, wish to escape from life. It recognises, also, that most of those who seek euthanasia, would prefer to live as fully and as well as they can until they die, but choose to die earlier than they might, in order to make their dying as comfortable and as positive an end to their life as possible. In drawing up this distinction I wanted to sidestep the common idea that whereas in suicide a person kills himself, in euthanasia he is killed by someone else, which is clearly mistaken. After all, a man who wanted to escape from his life could suicide by arranging that someone else does whatever is necessary (this is what those who jump in front of trains do) while another, wishing to die to escape a dreadful death, could—if he was well enough, consume a potion, or inject himself with an drug that would secure his end via self administered euthanasia.

Most people with whom I share this way of differentiating suicide and euthanasia seem readily to accept it. Indeed, most seem to find it helpful. Occasionally, however, I meet with questions about why I have chosen to characterise euthanasia in a way that excludes human acts that many people would refer to as 'non-voluntary' and 'involuntary' euthanasia, in which people are killed because someone else decides either that their lives are not worth living or that death for them would be a blessing.

In so-called 'involuntary euthanasia' a person is killed even though he does not wish to die, and would not agree to be being killed, if he was asked. It is perhaps illustrated by the Nazi killings of disabled people who were considered by them to be 'Lebensunwerten' (unworthy of life). In so-called 'non-voluntary' euthanasia a person is killed even though he has not, and cannot now, express his wishes in the matter, perhaps because he is comatose or in a so-called 'persisting vegetative state'. A celebrated example in the UK is the case of Tony Bland, a man in his twenties who died in 1992 after Sir Stephen Brown, President of the Family Division of the English

High Court, ruled that artificial feeding through a tube should count as 'medical treatment' and that it would be in accordance with good medical treatment to discontinue it in Bland's case, since it was treatment from which he could not benefit. (*BBC News*, 1992) He had been deprived of oxygen during a tragic incident at Hillsborough football ground in 1989, when a large number of people were crushed by the crowd when a fence collapsed. Many died, and Bland was severely injured.

The reason that I define euthanasia in terms of a person arranging his death 'in order to avoid a death that he does not wish to die', thus excluding so-called 'non-voluntary euthanasia' and 'involuntary euthanasia' is that I take euthanasia to be about a good and peaceful death, and I don't believe an arranged death can be a good one unless it is decided on by the person who dies. And so what some people would refer to as involuntary or non-voluntary euthanasia I would refer to more simply as *homicide* or *murder*.

Whereas the aim of those who suicide or want to suicide is to escape from life, those who enact or wish to enact euthanasia would typically prefer to continue living, but do not want to do so at the expense of suffering a death that is full of pain, indignity and distress caused by illness and disease.

Why would anyone use the term 'assisted suicide' to refer to euthanasia?

Why would anyone use the term 'assisted suicide' to refer to euthanasia, thus muddling these two very different human acts? Three possible explanations suggest themselves.

First, it is clear that some people do not comprehend the difference between suicide and euthanasia. This is understandable on the part of lay people who have no reason to think deeply about the distinction between those who wish to avoid a distressing and perhaps painful death, and those who want to forsake life. Things are different in the case of highly qualified professionals, such as the senior doctor I heard on a British radio programme a year or two ago, characterizing the difference between suicide and euthanasia in terms of who does the killing, with no mention at all of the meaning of the act for the individual who dies, or of the intentions and motivations that underpin it.

Part of the problem is that most people associate euthanasia with individuals who are unable to act on their own behalf, which is often true, since most people who want euthanasia are very ill and many of them will be unable to take the actions that are necessary to secure their death. However, if my characterisation of the distinction between suicide and euthanasia as be-

ing located not in the question of who is the agent that brings death, but in the reason that death is sought and arranged, is accepted, it will be clear that it is perfectly possible for a person to be the instrument of his own death by euthanasia, just as it is possible for a person to suicide through the act of another person (whether that other person is driving the train that kills him, or pulls the trigger that unleashes the bullet that does so).

I first realised that euthanasia need not involve anyone other than the person who dies, about twenty years ago, when I was watching a television chat show in which the audience were being given the opportunity to share their views about euthanasia. Mid-way through the discussion a young man who was living with AIDS, said that he intended to choose euthanasia when the time was right for him. He was a nurse and he explained that his chosen route to death would be drugs. He did not want to die slowly and suffering. His one regret was that given the state of the law, he would have to die alone, because he did not feel that it would be sensible for his family and other loved ones to be with him when he took the drugs that would kill him, or to stay with him while he died, for fear that they might be prosecuted.

The second possible explanation for the use of 'assisted suicide' and 'euthanasia' as if they are synonymous, is that it suits some of those who would like to legalise self arranged death, to conflate 'assisted suicide' and 'euthanasia'. In other words I think it is at least possible that some of those who use 'assisted suicide' and 'euthanasia' as if they are the same thing, are conscious of the fact that by doing so they might be able to move forward the attempt to change public attitudes to euthanasia.

Whereas euthanasia is illegal and generally frowned upon in the UK, suicide has not been illegal since the Suicide Act of 1961. It thus suits those who want to change the law to allow euthanasia to use the term 'assisted suicide' instead of 'euthanasia', because it sounds as if it is a species of 'suicide', which is not illegal.

The third possible explanation begins with the twentieth century preoccupation with freedom, autonomy, choice and self determination, which have become central values in most developed countries. It is as a result of this preoccupation with autonomy and choice that, for example, there is nowadays a moral taboo against being anti-abortion, or at any rate against sharing the fact that one is anti-abortion or disagreeing publicly with those who believe that women have the 'right to choose' in this matter. It is also as a result of our pre-occupation with autonomy and choice as human values, that some people for whom 'euthanasia' remains tainted with thoughts of the Holocaust, might

view 'suicide' in a more positive light, because it can be viewed as the ultimate expression of these values. Given this, those who want to legalise arranged deaths would certainly have a reason to conflate euthanasia with suicide by using 'assisted suicide' as if it was a synonym for 'euthanasia'.

Assisted suicide, euthanasia and human dignity

In drawing what I have to say about 'assisted suicide' and euthanasia to a conclusion, I want to touch briefly on the question of whether these acts can ever be about human dignity, before returning to the question of whether it matters what we call it when people choose to die.

Though conservative by the standards of many of those who argue in favour of the right to die in some circumstances, my own view is that euthanasia, in which a person arranges her death in order to avoid a death that she does not wish to die, is sometimes morally acceptable, and thus that it is sometimes morally acceptable for one person to kill another, because that other wishes to die. More than that, I think that killing another person because they want to die is not only morally acceptable, but morally required at times. In other words I believe that if you are asked by a loved one to kill her, it may be morally required that you should do so. Circumstances in which I would think this are, however, likely to be rather rare. One would be where the person who wanted to end his life was suffering dreadful pain, that could not be controlled without rendering him unable to function as a person in relation to others, so that he faced a death that for him seems to lack in human dignity. The other would be a situation where a person's reason for wishing to die before his body was ready to do so, was the indignity that he would suffer due not only to pain, but also to other aspects of a long drawn out death that disturbed him beyond the wish to live. I am talking here about, for example, the loss of dignity that for many people will accompany the long term loss of control of bodily functions and the consequent and ongoing needed need to be cleaned and tended by others. (Fairbairn, 1991)

Many people who request euthanasia cite their dignity as a human being as the main reason for doing so. It is clear that in doing so they are each referring to something that is very important, that is somehow central to their idea of who and what they are, even though they have different conceptions of what constitutes that dignity. That is why I think human dignity is an important consideration in thinking about situations in which individuals want to arrange their death.

I am conscious that in talking about 'human dignity', as if each individual human being can decide what for them is a and a dignified way to die and a dignified way to live whatever life is left to them, I seem to be ignoring the fact that there are a wide range of views about the nature of human dignity, including the Christian idea that human dignity arises from the fact that we are made by God in his image. The truth is that I am more concerned to take account of the wishes, aspirations and feelings of those want to die earlier rather than later, because they feel their dignity is compromised by pain or distress from which they have no hope of recovery, than I am to argue about the nature of dignity.

The term 'assisted suicide' is used to refer to a range of human phenomena, only some of which would fit with my definition of euthanasia in which '…a person arranges his death in order to avoid a death that he does not wish to die.' The problem is that though 'assisted suicide' seems to have begun life as a synonym for 'euthanasia' as I have characterised it, it seems now to be used to encompass acts of killing (or of 'helping to die') in which individuals who are not yet dying, wish to die. I am thinking, for example, of at least some individuals who are living with motor neurone disease or similar conditions, and whose knowledge of the likely trajectory of their disease leads them to wish to die before they reach the stage at which they are suffering so awfully that it would be reasonable to think of them as wanting to avoid the death they are dying. Their wish, in other words is not to avoid the death they are dying and which they do not wish to die, but to avoid living the life they are living, before they turn the corner towards death. The story of and Robert and Jane Stokes who sought and, in April 2003, were granted help in dying by Dignitas, seems a clear example of this kind, because neither was suffering from a terminal illness when they died. But it also seems to me that the story of Dr Anne Turner, who was living with supranuclear palsy and sought and in January 2006 was granted help in dying as a pre-emptive strike aimed at avoiding the later stages of her disease, was rather like this. Rather than wishing for euthanasia it is accurate to say of such people that what they wish for is suicide (or 'assisted suicide' if they are seeking help to die from others).

I would like to see the use of 'assisted suicide' limited to refer to situations in which people seek and/or are given help in arranging their deaths in order to avoid lives that they do not wish to live. In relation to such situations my view is that since suicide can never be a dignified end to a life, because it involves the rejection of life and its possibilities, they could never be about human dignity.

SO DOES IT MATTER WHAT WE CALL IT WHEN PEOPLE CHOOSE TO DIE?

In this article I have drawn attention to some of the problems that can be caused by the labels we use to refer to self harming acts of different kinds. In doing so I showed that it matters what we call it when people act in ways that look as if they may have wanted to die, even if they did not, in fact, intend to do so. After that I discussed the use of the term 'assisted suicide' to refer to occasions that would more properly be referred to as 'euthanasia', because they are about people wanting to end their lives in order to avoid deaths that they do not want to die. In doing so I suggested that one way of thinking about this conflation of suicide and euthanasia is to view it as a device in the attempt to persuade people to support the legalisation of euthanasia.

In spite of my view that some people who wish to die should be helped to arrange their deaths, I believe that it would be a mistake to legalise arranged dying. I think it is helpful that those who are considering whether to help another to die, should have to do so in awareness of the fact that they may be legally called to account for their actions. Without the threat of legal action, I fear that 'euthanasia' might become more common, not because more people actively want to die, but because less care would be taken in thinking about whether there really were compelling reasons for arranging their deaths, and in trying to find alternatives that would allow and encourage them to live as well as they could for as long as they could.

Finally, I am also unhappy about the conflation of 'assisted suicide' and 'euthanasia'. Not only do I think that arranging one's death has probably become more popular as a result of the conflation of these two terms, but I also fear that it might somehow help to ignite a wave of enthusiasm—a fashion even, for the idea that choosing suicide is a good thing, whether one is ill or not, simply because it is the ultimate expression of one's right to choose and to determine the course of one's life.

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