“...there should be a booth on every corner where you could get a martini and a medal.” 1

No doubt, the novelist, Martin Amis, was exaggerating for stylish effect, but he was not joking. After watching Alzheimer’s disease reduce Iris Murdoch to spending her days gazing at infantile television, and after witnessing his stepfather dying “very horribly,” Amis’s support for legalizing assisted suicide has stiffened. “There should be a way out for rational people who’ve decided they’re in the negative that should be available, and it should be quite easy,” he said in a 2010 interview in The Sunday Times Magazine. 2

Pressed by the relentless stream of cases of “rational” suicide and mercy killing recently publicized by a story-hungry, analysis-shy British media, even long-time defenders of the legal status quo might be forgiven for weakening, and wondering if Amis is not right, after all.

The truth is that some of us face dreadful ways of dying. Sufferers from motor neuron disease, for example, might have to look upon the prospect of suffocating to death. Others with obstructive tumors might have to contemplate spending their last days vomiting their own feces.

Nevertheless, it is not just the dying who have reason to fear, some of the living are burdened with lives that are severely restricted. In recent years, among the clients of the Swiss clinic for assisted suicide, Dignitas, was a chronically disabled Irishman who could not swallow. His only means of feeding was a tube inserted into his stomach, and his capacity to communicate was very limited. 3 Another was Daniel James, the young victim of a rugby accident, who refused to reconcile himself to life as a quadriplegic. 4 Then there was Sir Edward Downes, the frail octogenarian who had no appetite for soldiering on alone after the death of his wife. 5

Under conditions as difficult and miserable as these, how can human life be worth persevering in? Why on earth should we endure it to the bitter end? What could possibly be the point?

Surely, therefore, compassion obliges the law to let us seek an efficient escape from unbearable suffering, whether through help in killing ourselves (physician-assisted suicide) or through someone else killing us upon our request (voluntary euthanasia). Besides, do we not have a right to autonomy? After all, an individual’s life is his own property, for him to use as he sees fit. He is the sole arbiter of its worth, and he alone is competent to decide when it has become intolerable." 6

As for opposition to changing the law, that is mainly based on a dogmatic obsession with the absolute “sanctity of life,” which makes sense only to the dwindling minority of religious believers. To shore up their case, opponents manufacture the fear that legalizing assisted suicide or voluntary euthanasia will send us down a slippery slope to murder, but hard empirical evidence from Oregon and the Netherlands now shows this fear to be irrational.

In a nutshell, we have a real problem, to which there is a rational solution: Give mentally competent individuals the legal right to decide that their lives should end. Give medical experts the legal right to assist in ending their lives painlessly. Then put in place strict procedural safeguards against abuse.

So, at least, runs the liberalizing story. The problem it identifies is real enough, but its solution is not so deeply rational. Closer inspection reveals several flies stuck deep in its ointment.

One of the largest is the problem of eligibility. As things now stand, the law in Scotland and in England and Wales—as in most jurisdictions—prohibits the intentional killing of one person by another, except in proportionate self-defense. Since 1961, it has ceased to regard suicide as a crime, not because it does not care whether or not citizens kill themselves, but because it recognizes that punishment is not an appropriate response to failed attempts at doing so. Nevertheless, the law has continued to criminalize assistance in suicide, partly to discourage suicide itself, and partly to deter malicious help.

If we were to decide to breach the law’s current absolute prohibition of intentional killing, in order to allow some to assist others to kill themselves, we would then have to decide who should qualify for assistance. We might well all agree that dying patients whose suffering is unbearable, and beyond adequate
relief, should be eligible. Beyond that, however, plenty of room would remain for disagreement about when suffering is unbearable, and when relief is inadequate. Moreover, it would not be very long before someone reminds us that unbearable and irremediable suffering is not confined to the dying. What about the chronically ill and disabled? Then someone else would point out that one doesn’t even have to be physically ill or hindered to experience life as an intolerable burden. What about the chronically and severely depressed, the bereaved, or the philosophically gloomy? Don’t these too deserve the right to die, come the day when they “decide they’re in the negative” and conclude that soldiering on simply isn’t worth the candle?

Further, once we have decided on a set of conditions under which people have the right to assistance in suicide, attention will shift to cases that meet those conditions, but where the individuals concerned are incapable of killing themselves. Then we will confront the cruel inconsistency of our granting the benefit of a merciful release to the stronger, while withholding it from the weaker. The logic that brought us to assisted suicide will push us toward voluntary euthanasia.

Once we decide to breach the absolute prohibition of intentional killing, we might agree upon the need to limit the conditions under which assistance in suicide and euthanasia are permissible, but we will find that there are no very compelling reasons to draw the line in one place rather than another. Given the intrinsic difficulty of deciding where to draw the line, given the propensity of the media to focus on graphic personal stories rather than the larger social context, and given the popularity of the libertarian rhetoric of arbitrary autonomy, there is good reason to fear that any liberalization of the law will tend toward granting death on demand.

If this should seem fanciful and alarmist, then consider the Netherlands, which has had over a quarter of a century’s worth of experience of trying to design a suitably stringent legal framework for regulating assisted suicide and voluntary euthanasia. Since 1984, Dutch law has in effect permitted doctors to assist patients to die or to be killed upon request under certain conditions. These conditions do not stipulate terminal illness. They do not clearly stipulate physical illness. They only require that the candidate’s suffering be unbearable and without hope of improvement. Accordingly, in the Chabot case of 1994 the Dutch Supreme Court judged that a fifty-year-old woman, who was physically healthy but in persistent grief over the death of her two sons, was subject to ‘unbearable suffering’ and legally eligible for assisted suicide.7 Six years later in the Sutorius case a trial court in Haarlem judged it legal to give assistance in suicide to an elderly patient who felt his life to be “empty and pointless.”8

Now it is true that an Amsterdam appeal court later overruled the trial court’s judgment, arguing that doctors have no competence to judge ‘existential’ suffering resulting from loneliness, emptiness, and fear of further decline.9 It is also true that the Supreme Court denied Dr. Sutorius’ subsequent appeal to have his conviction quashed, holding that a patient must have “a classifiable physical or mental condition” to be eligible for medical killing.10

These judgements have settled nothing, however, and the debate rumbles on. In 2004, the KNMG (Royal Dutch Medical Association) published the “Dijkhuis Report,” which argued that someone who is no longer able to bear living any longer and has a hopeless outlook on their future could be said to be “suffering from life” and should therefore be eligible for assisted suicide or voluntary euthanasia.11 This view has not yet won the support of a majority of the KNMG’s members. Nevertheless, it is being championed by the Dutch Right to Die Society (NVVE), which is often taken by public bodies to be the representative of patients’ interests. If the NVVE should get what it wants, then the Netherlands would be well on its way to enshrining in law the principle of arbitrary autonomy. “Suffering from life” is not a medical condition. There are no medical grounds on which doctors would have the authority to contradict an individual’s claim that he feels such suffering to be unbearable and hopeless.

The Dutch model is not the only one, of course. We could adopt stricter arrangements here. We could permit only assisted suicide and not voluntary euthanasia, and we could limit eligibility to the terminally ill—as they do in Oregon. Indeed, that is exactly what the major British campaigning body, Dying in Dignity, is currently pressing for. However, there are two reasons to think that if we start with Oregon, we will not stop there. The first is cultural. Oregonians, being American, are typically allergic to the state and analogous institutions and zealously protective of individual liberty. Therefore, whereas they are willing to grant individuals medical assistance in killing themselves, they refuse to give doctors the authority to kill their patients under any conditions. Britons, however, are not American. They have a more benign, European view of the state, of state-run health care, and of those who provide it—just like the Dutch.

The second ground for doubting that we would rest with the Oregon model is logical: The reasons for restricting the right to die to those terminally ill who are capable of suicide are not at all strong. Indeed, one of the liberalizing campaign’s leading lights, Lord Joffé, has stated in public on several occasions that the rationale for the currently proposed restrictions is simply political: as things now stand, a more cautious bill has a greater chance of winning sufficient support to become law than a less cautious one. He fully hopes and expects that sooner rather than later the restrictions would be
lifted. That he would not long be disappointed is suggested by the fact that, of the recent cases, which have been seized upon by much of the British press to promote a change in the law, several already fall outside the tacitly cautious arrangements proposed by Dying in Dignity. Neither Daniel James nor Edward Downes were terminally ill, nor were they suffering unbearable physical pain. They were just “tired of life.”

But why should not we go the whole libertarian hog and grant all rational adults the right to die or be killed on demand — as the director of Dignitas, Dr Minelli, enthusiastically recommends? So long as the decision for assisted suicide or euthanasia is made freely by the individual concerned, what reasonable objection could there be?

One objection emerges when we roll libertarian logic out to its logical conclusion. If we were to reform the law to allow competent adults absolute, arbitrary autonomy over their own lives, then it would have to permit consensual vivisection and killing. In other words, should an individual consent to being mutilated and killed — say for sexual gratification — then the law could have no objection. In its eyes, the individual would be master of his own life and if he should choose to spend it in what other people consider a macabre fashion, then that would be his business and his alone.

In case this sounds just too bizarre to be worth considering, we should remember that in 2004 Armin Meiwes was tried in Germany for mutilating, killing, and eating a 43-year-old computer engineer, who consented because, according to the judge, “he wanted to get the kick of his life.” The fact that Meiwes was convicted of manslaughter, and not just acquitted, is witness to the commitment of German law — as of all traditional Western law — to some concept of the objective worth of human life that is independent of the subjective preferences of individuals. In spite of the consent of the engineer, his life had a worth that both he and his killer violated: that is why Meiwes was punished. It follows from this that if English and Scottish law wishes to maintain a commitment to upholding the objective worth of human life, then it cannot grant to individuals absolute, arbitrary autonomy over their lives.

I could let this part of the argument rest there. I could presume that every reader agrees that it would not be desirable for Britain to become a society where consensual cannibalism is regarded as a permissible lifestyle; and that therefore the principle of arbitrary autonomy is not one that English and Scottish law should incorporate. Nevertheless, let me push the argument one stage further, and try to explain my position. First, I appeal to the common sense notion that someone can choose to squander or waste his own life. Such a notion certainly makes sense in terms of my own experience; and from what others say and write, it would appear to make sense in terms of theirs too. However, if

it does make sense, then that is only because we recognize that our lives might actually have an objective worth that we sometimes choose to ignore — that it has an objective worth that can stand over and against us in judgment upon our own free choices. Otherwise put, namely, it makes sense only insofar as our autonomy is not arbitrary, but is responsible to a given moral context.

Further, if we were to regard the individual as the sole arbiter of the worth of his or her life, then how could it continue to oblige the care and commitment of other people? If the worth of your life is entirely contingent upon your judgement, and if I view your judgement as wrong-headed, why should I expend my time and energy in supporting your life? Suppose that you value your life rather more than I value it. Why should I prefer your judgement to my own? Perhaps indifference or self-interest would move me to “respect” your judgement in the thin, negative sense of not interfering with it; but such arm’s-length respect falls a long way short of positive care. One problem with dissolving human worth into individual freedom, instead of making individual freedom serve objective human worth, is that it becomes very hard to see why that worth should command our neighbor’s love. Another problem is that when arbitrary autonomy severs itself from responsibility, it hemorrhages its own value.

A third reason why the law should not incorporate the principle of absolute, arbitrary individual autonomy is because the private and the public realms are not in fact sealed off from each other. What we do and how we form ourselves in our so-called ‘private’ relations does inform how we behave toward others in ‘public.’

If society tells its members, through the law, that a life spent in drug addiction or lethal masochism or ended early in suicide is quite as acceptable as any other — so long as it is freely chosen — then those who choose such lives will become prey to passions that will drive them to abuse and violate their neighbors. The drug addict’s passion for a high and the suicide’s passion to escape and the sado-cannibal’s erotic passion to penetrate and consume renders them incapable of respect for the legitimate claims of other people. The drug addict will assault and rob to get money for his next fix, the suicide will end his own life no matter how many other lives he ruins as a result, and the Armin Meiweses of this world will not be as solicitous of their victims’ consent the second time around.

The notion that we are all rational choosers is a flattering lie told us by people who want to sell us something. They want a free hand in making a profit out of our fears and desires. The less flattering truth is that much of the time we are driven by social and psychic forces that we barely understand — and even less control — and that hinder us from paying attention to other people. We creatures of passion need the support of legal and social constraints to become the kind of
people who are capable of looking beyond their own felt needs to heed the claims of their neighbors. The problem with the libertarian principle of arbitrary autonomy is that it would rob us of this support.

The champions of lawful assisted suicide tend to have sunny dispositions. They assume that all is basically well with society. They assume that the legislation they propose will operate in a fundamentally humane social context, where patients can usually rely on the generous support both of health care services and of relatives. They assume that procedural safeguards are all that is needed to guarantee genuine patient autonomy. In addition, they assume that one can tell an authentic, free choice by its persistence.

But, this is largely a well-heeled fantasy. According to Help the Aged, about half a million older people are being abused in the UK at any one time, two thirds of them at home by someone in a position of trust. Over half the theft and fraud against older people is committed by their own children. The scale of the problem has been confirmed by Britain’s most senior policewoman, Barbara Wilding, who reported “an increase in abuse of the elderly, which often takes place behind the closed doors of the family home.” She predicted that it will become “the next social explosion.”14

As for the quality of professional care, Julia Neuberger reports in her 2009 book, Not Dead Yet, that those ‘care-assistants’ who deliver most of the hands-on care of the sick and elderly are poorly trained and poorly paid — “short-term employees doing dirty work for little money and no emotional and ‘respect’ reward.” This “miserable reduction of care workers into harried, time-watching automatons — with no time for human interaction — is corroding the quality of care all the time”.15

This is the actual social environment in which the legal right to assistance in suicide would often operate: one where the elderly and the chronically ill are neglected, malnourished, isolated, and even resented. This inhumane social context would inform the autonomy of ailing individuals, and move them to persist in an authentic choice to stop wasting space and die. Formally speaking, of course, such choices would be entirely free; but theirs would be a freedom evacuated of hope by a characteristically impatient, often callous, and sometimes-hostile society.

The proponents of the right to assistance in suicide are naïve to suppose that the humanity of British society can be taken-for-granted. They are also naïve to imply that the granting of a legal right to die would legislate patient suffering away. It will not. Mistakes will be made, and even assisted suicides will be botched. After all, we are talking about the world of human activity, where perfect solutions are not known to dwell.

In sum, the flies that stain the rational ointment of a mooted right to assisted suicide are as follows: Very likely, it would be just a temporary Oregonian stopping-place on the road to Dutch-style voluntary euthanasia. It would open up intractable arguments about the conditions of eligibility, which would invite the libertarian solution of granting arbitrary individual autonomy and killing on demand. This would serve to undermine positive care for the lives of others, lift legal and social prohibitions that protect individuals from self- and socially destructive passions, and jeopardize such a humane social ethos as we now have. This ethos is neither as extensive, nor as deep, nor as secure as the sunny liberalizers suppose. Nor would their preferred solution to the problem of patient suffering be as perfect as they imply. Certainly, the concern to maintain society’s commitment to supporting human worth in adversity, which underlies this argument’s opposition to changing the law, is one that many religious people will share. But it is also one that fuels majority opposition in non-religious bodies such as the House of Lords, the Royal College of Physicians, the Royal College of General Practitioners, and the British Geriatrics Society. Opposition to making assisted suicide lawful really cannot be brushed disingenuously aside as the manipulative child of religious conspiracy.

All right, so legalizing assisted suicide is seriously problematic, but so is the plight of those who now live and die in distress. If we refuse them the right to assistance in killing themselves or to be killed upon request, what alternative solutions are available?

Insofar as the problem is the fear of being kept alive in intolerable circumstances, current law does not oblige patients to strive to stay alive at all costs, and it already grants them a right to refuse treatment that doctors must respect. This should not be read as sanctioning suicide. It merely recognizes that some may reasonably prefer to conserve their limited energies for the process of dying rather than expend them in straining to stay alive.

It is true that some doctors are overzealous in striving to ‘save’ their patients, which implies a need to reform medical education. Doctors need to be educated to see their proper role as including helping patients to die well, and not simply as fending off death. Certainly, that should involve their being made far more aware of the considerable resources of palliative medicine and care. In addition, this also requires more than technical training. It requires a spiritual formation in which doctors are made into the kind of people who, when faced with death in the eyes of the dying, have the moral strength to resist the natural instinct of mortal human beings, and not to turn away.

The provision of palliative care in the UK is still very patchy. The availability of in-patient palliative care beds, for example, varies dramatically from region to region — and not because of varying levels of demand. If we really care to improve the conditions under which most people die, then there remains plenty
of scope for investing more energy and money in building more hospices, multiplying specialist palliative care teams, and integrating palliative expertise more thoroughly and universally into the health-care system.

What about that small minority of patients whose suffering cannot be managed by normal palliative means? In those rare cases, recourse can be had to palliative sedation, which renders patients unconscious. Sometimes doctors try to avoid this measure, because they fear killing the patient. Given the contemporary sophistication of drug-management, this fear is very largely misplaced. Nevertheless, were sedation to hasten a patient’s death, it would raise no moral or legal objection, so long as it had been proportioned to the relief of distress.

Together these measures would go a long way to reducing the suffering of patients. Nonetheless, they comprise no perfect solution. They offer no answer to the frustration of a Daniel James or the prospective loneliness of an Edward Downes. Nor do they offer an end to the sufferings of the grievously bereaved, or the chronically depressed, or the long-term unemployed, or the wretchedly poor. Neither do they offer relief to those sentenced to spend the rest of their lives behind prison walls — at least one of whom, according to his personal correspondence with this author, would jump at the chance of assisted suicide, were it on offer. Compassion obliges us to do what we can and what we may to relieve human suffering. Still, there are some things that we could do, which we should not — because they create more problems than they solve, or because they jeopardize more people than they relieve. Prudence obliges us no less than pity.

If the law remains as it is, of course, criminal sanctions would continue to threaten those who help others kill themselves. Since assistance in suicide can be malicious or culpably negligent, it is right that the law should continue to seek to deter it. In difficult, gray cases, however, where neither malice nor negligence is evident, the Director of Public Prosecutions (DPP) has the liberty to decide that prosecution would not be in the public interest. He has, in fact, exercised this liberty on many recent occasions, with the result that Daniel James’ parents and their like have suffered no penalties. The current arrangement is not perfect: well-intentioned helpers in suicide are presumably subject to a measure of anxiety until the DPP reaches his verdict. All the same, precedent should reassure them: none of those accompanying the more than one hundred British citizens who have killed themselves with Dignitas’ assistance have been prosecuted. Likewise, the fact that the DPP’s criteria have been made public, should reassure them further. In the end, the law has consistently and wisely refrained from bringing its threats to bear in such fraught cases, and it will continue to do so.

The human suffering that assisted suicide proposes to solve needs to be taken seriously. On the other hand, the relaxation of the law prohibiting intentional killing would give us a radically libertarian society at the cost of a socially humane one. Besides, there is another way — no more perfect, but a lot more prudent.

Endnotes

1 “The novelist Martin Amis has called for euthanasia booths on street corners, where elderly people can end their lives with ‘a martini and a medal’” […] “How is society going to support this silver tsunami?,”’ he asks in an interview in The Sunday Times Magazine; “‘There’ll be a population of demented very old people, like an invasion of terrible immigrants, stinking out the restaurants and cafes and shops. I can imagine a sort of civil war between the old and the young in 10 or 15 years’ time.’” See: Maurice Chittenden, “Martin Amis Calls for Euthanasia Booths on Street Corners,” The Sunday Times, January 24, 2010.


3 “A chronically disabled man was brought by his family from Dublin to Switzerland for an assisted suicide late last year… He died in Zurich with the assistance of the Swiss right-to-die organization, Dignitas […] The man, who needed to use a wheelchair, was in his 30s. He was taken from the Dublin hospital where he was a long-term resident for a routine weekend visit home. However, when he did not return as planned, the hospital authorities were told by his family that he had passed away in Switzerland…The man was involved in an accident some years ago which led to severe neck and brain injuries. While able to breathe unaided, he was unable to swallow and had a tube inserted into his stomach so that he could be fed. The man was fully dependent on nursing staff for dressing and toileting. As a result of his brain injury, his communication skills were poor. It is understood that he had
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expressed a wish to die on a number of occasions during his care in two separate hospitals. Following a neuropsychological assessment in 2000, the single man was deemed ‘intelectually competent.’ But it was also established that his wish to die had been inconsistent and that when acutely ill with infection, he had both requested and accepted treatment.” See: “Disabled Man Went Abroad for Assisted Suicide,” The Irish Times, March 30, 2005, http://www.irishtimes.com/news/disabled-man-went-abroad-for-assisted-suicide-1.427409.

4 “The parents who helped their paralyzed rugby player son to commit suicide will not face charges because they had pleaded with him ‘relentlessly’ to change his mind, prosecutors have said.” “[…] Daniel James, 23, became the youngest Briton to die at the Dignitas clinic in Switzerland in September, in a procedure paid for by his mother and father, Mark and Julie. They admitted to police that they had helped him achieve his ‘wish’ to end “a second-class existence” - despite praying “to the last second” that he would change his mind. His friend had even bought him a return ticket from Zurich, in case he decided to reconsider.” See: Richard Edwards, “Assisted Suicide: Parents of Daniel James Will Not Face Charges,” The Telegraph, December 9, 2008.


6 Editor’s Note: The use of he and him in this context and following is neuter and not male.


8 Tony Sheldon, “The Doctor Who Prescribed Suicide: Was the Dutch Psychiatrist, Dr. Boudewijn Chabot, Right to Help a Sane, Healthy Woman to Take Her Own Life? Tony Sheldon Reports,” The Independent, October 22, 2011.

9 “An appeals court in Amsterdam found the doctor, Philip Sutorius, guilty on Thursday but did not give him a jail sentence, said a court spokeswoman, Liesbeth Dubois. Supporters of assisted suicide criticized the verdict, saying that it too narrowly defined the medical justification for euthanasia. Dr. Sutorius helped a former senator, Edward Brongersma, to take his life in 1998. Mr. Brongersma was suffering from incontinence, dizziness, and immobility and said he was tired of life. ‘The reason he was found guilty was because he did not act for medical reasons, but rather because the patient was tired of life,’ Ms. Dubois said.” The New York Times, December 9, 2001.

10 “The Dutch Supreme Court has ruled that a doctor who helped an elderly man “tired of living” to die was guilty of assisted suicide. The ruling upholds strict medical guidelines for mercy killing in the Netherlands, which was the first country in the world to legalize euthanasia. Had Dr Philip Sutorius won the case, it would have made mental suffering a legal reason for seeking euthanasia.” BBC News, December 24, 2002. See also, Tony Sheldon, “Being “tired of life” is not grounds for euthanasia,” British Medical Journal. 2003 Jan 11; 326(7380): 71.

11 “In the Brongersma case, physician-assisted suicide was carried out in an 86-year-old man who was tired of life. The Dutch Supreme Court ruled that physician-assisted suicide may not be carried out if the suffering of the patient is not mainly determined by a medically classifiable disease. The Royal Dutch Medical Association set up a commission headed by J. Dijkhuis to advise them on determining their position in similar cases. This commission proposed a broader medical domain than had been determined by the Supreme Court. The commission was of the opinion that each physician should be able to manage requests for physician-assisted suicide from patients who are ‘suffering from life’ in terms of treatment that could influence the situation of the patient or his or her experience of it. If the patient continues to request physician-assisted suicide in spite of this, physicians are free to set their own individual limits, which may be stricter than those set by the medical profession nationally. It is necessary to acquire scientifically underpinned knowledge of how to manage requests from patients who are ‘suffering from life.’” Mette L. Rurup, “The role of the physician in requests for physician-assisted suicide in patients who are ‘suffering from life’: abstract the Dijkhuis Report commissioned by the Royal Dutch Medical Association.” KNMG. Op zoek naar normen voor het handelen van artsen bij vragen om hulp bij levensbeëindiging in geval van lijden aan het leven: verslag van de werkzaamheden van een commissie onder voorzitterschap van prof. J Dijkhuis. Amsterdam: KNMG, 2004:14 [Norms for the Behavior of Doctors in the Case of Requests for Assistance in Suicide due to Suffering from Continued Life.] Report of the Dijkhuis Committee, Utrecht.


12 “A packed courtroom heard how 42-year-old Meiwes first experienced cannibal feelings as a young boy. These got stronger after the death of his ‘domineering’ mother in 1999 and eventually led him to place an advert on the internet seeking someone to ‘slaughter and eat.’ He got a reply from Bernd Brandes, a successful manager with Siemens in Berlin. Brandes had secret masochistic fantasies. ‘The victim offered up his body because he wanted to get the kick of his life. It was to be the final act,’ the judge said. In March 2001, Brandes took the day off work and travelled down to Rotenburg by train. He met Meiwes and went back to the isolated farmhouse where he lived alone. Meiwes showed Brandes the ‘slaughter room’ he had constructed upstairs. Later […] Brandes had knocked back 20 sleeping tablets. At 3.30 am, Meiwes laid his unconscious victim on the slaughter table and stabbed him. He hung the body on a hook, cut out some of his organs and went to bed. The cannibal filmed the entire episode, and had told the dying Brandes, ‘I can’t do anything else.’ The next day Meiwes set about cutting off parts of Brandes, which he put in his freezer. By the time detectives finally arrived at his farmhouse in December 2002, he had eaten ‘about 20 kg of his victim, the judge said.” See: Luke Harding, “Now Cannibal Will Tell His Story,” The Guardian, February 1, 2004.

13 Richard Edwards, “Assisted suicide could be excuse to kill burdensome elderly, says police chief,” The Telegraph, August 28, 2009;

Richard Edwards, “Barbara Wilding Interview: ‘The Growing Rift between Young and Old,’” The Telegraph, August 28, 2009;

Caroline Grant. “Top Police Officer Warns over Danger of