**Assisted dying and suicide prevention**

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*The paper presents two examples of suicide by disabled people, one unassisted, one assisted. There are points of dissimilarity but also points of similarity. The language of “assisted dying” is misleading especially where the person is not terminally ill. In contrast, the language of “assisted suicide” is appropriate and is used in Switzerland and the Benelux countries. Guidance is needed for media reporting of assisted suicides. In addition to avoidance of certain details and ways of framing stories, the media should also seek to tell more positive stories about life with disability, counteracting the Werther effect with the Papageno effect.*

**Scope of the paper**

This paper concerns suicide prevention in relation to the practice and the reporting of assisted dying. Its focus is the situation of people who are suicidal and who have a physical disability and/or a mental health condition. The aim of the paper is not to consider the current or possible future shape of the law in different jurisdictions in relation to determining, assisting and encouraging, or preventing suicide. It aims, rather, to call attention to danger of suicide, whether assisted or unassisted, among people who would be eligible for euthanasia in the Low Countries or for medical assistance in suicide in Switzerland. Irrespective of the shape of the law, the fundamental challenge remains, to live well together despite the vicissitudes of life.

**Two cases**

It may be useful to begin with two cases.

The first was a colleague and disability rights activist whose work remains important and illuminating. For the purposes of this article I will call him John.[[1]](#footnote-2)

John had suffered from multiple health complaints from childhood which were compounded by the long-term side effects of medication. This resulted in limited mobility, severe asthma and chronic pain requiring narcotic analgesia. Due to his complicated regime of medication, an imbalance could easily result in periods of deep but transient depression which might last for 48 hours or so. During these episodes John’s thinking and perception were distorted and he would have difficulty coping even with the ordinary stresses of life.

While his wife was away visiting relatives, John suffered a professional setback and during a telephone conversation told his wife he thought he had “nothing to live for”. On her return she found him in the kitchen. He had taken a quantity of tablets and his breathing had become suppressed. An ambulance was called.

The psychiatrists who first examined John after his admittance to hospital decided to discharge him home into the care of his wife. John expressed his agreement with this saying, “he would be safe there”. Nevertheless, he was kept in hospital overnight for observation. The following day John was assessed by two more psychiatrists. Other than the probability of the medical notes being available, there is no evidence that these psychiatrists were aware of the discussions and agreements made the previous day. Without consulting their colleagues who had previously spoken to John, and without speaking with his wife, they formed the opinion that John was no longer suicidal and allowed him to leave hospital unescorted. In the view of the coroner, John, who was familiar with healthcare law and practice, “told medical practitioners what he believed they needed to hear”.

When John did not return home that morning his wife reported him missing. Three days later his body was discovered. The cause of death was multiple drug toxicity. The conclusion of the coroner, taking into account the circumstances surrounding his death, including an email sent shortly before he died, was that it was likely that John had intended to take his own life. He was 44 years old.

John’s death was a tragedy, a loss felt hardest by his family and those closest to him, but also felt much more widely by friends and colleagues. It seems clear that John’s physical ill-health was a cause of stress and one reason that he sometimes found it hard to cope. Nevertheless, physical health problems were not the only stressor nor, seemingly, the immediate trigger for his actions. The occasion for this crisis was experiencing a professional setback at a time when he was at home alone. It may also be that his medication was adversely affecting his mood or that he was experiencing an undiagnosed depressive episode. It may be that John might have regained his sense of meaning had he been supported through this crisis. It is now not possible to know.

The second case is that of Daniel James, a young man who suffered a spinal injury in March 2007 and who took his own life at the *Dignitas* clinic in Switzerland in September of the following year. Daniel was 23 years old at the time of his death. The following account is taken from the Director of Public Prosecutions, explaining his decision not to prosecute the parents for assisting or encouraging suicide. It is edited for length but all words quoted are verbatim.

Daniel was injured in a training session at Nuneaton Rugby Club on 12 March 2007. Despite every effort to alleviate the situation, Daniel was diagnosed as tetraplegic, paralysed from the chest down. By November 2007, the Consultant had concluded that it was unlikely that there would ever be any significant improvement in Daniel’s neurological status, saying “there is no treatment available to either aid or produce recovery”.

The impact of his injuries on Daniel was profound. In the early months he gave his all to prove the medical prognosis incorrect, but ultimately he came to accept that his condition would never improve. Daniel described himself as a “dynamic, active, sporty young man who loved travel and being independent” and [stated] that “he could not envisage a worthwhile future for himself now”. Daniel frequently stated his wish that he had died of his injuries on the rugby field and that he was determined to end his own life. He made several attempts to do so.

One week after a third failed suicide attempt, Daniel contacted *Dignitas* in Switzerland on 20 February 2008 asking for assistance in dying. As he put it, “The primary reason I wish for your help is simply that I want to die, and due to my disability I am unable to make this happen... I do not want another failed attempt”.

On 9 May 2008, *Dignitas* wrote to Daniel to inform him that a local doctor [in Switzerland] had considered his case and had given consent for the necessary barbiturate prescription to be written. Daniel chose to meet the local doctor twice in three days, then undertake the assisted suicide procedure on the following day.

Daniel’s parents were particularly distressed by his wish to end his own life. They tried relentlessly to persuade him not to do so. As Daniel’s father put it in interview, “We pleaded with him not to do it and change his mind and live... we were all so upset but at the end of the day it was what he wanted”. Later he added, “Even up to the last second... I hoped he’d change his mind”.

However, Daniel’s parents came to accept his wish to travel to Switzerland to commit suicide. Once Daniel had determined that he wanted to travel to Switzerland to commit suicide, his parents took up the offer of assistance [from a friend]. The friend arranged a flight to Zurich returning to Bristol. He also booked Daniel a return flight in case he changed his mind.

Daniel and his parents attended the two consultations. It remained clear that Daniel would not change his mind. On 12 September 2008 Daniel attended the clinic with his parents where a doctor helped him to take his own life. His parents were with him when he died. A death certificate confirmed that Daniel’s death was “non-natural”. (CPS 2008)

In deciding not to prosecute, the Director of Public Prosecutions noted that neither Daniel’s parents nor the family friend had influenced Daniel’s decision to end his life. On the contrary, his parents tried “relentlessly” to persuade him against this course of action. Nor were they motivated by the prospect of any advantage consequent on Daniel’s death. On the contrary, “for his parents, Daniel’s suicide has caused them profound distress” (CPS 2008).

**A tragic and untimely loss of life**

These two accounts are taken from legal judgements. They are not case reports in a clinical sense and do not provide an adequate basis to comprehend the complex of cause and effect special to the death of John and of Daniel. Nevertheless, there is value in beginning with the stories of particular people, however briefly described, as an anchor for discussion, lest it pass too quickly to generalities. These accounts are also helpful to illustrate some fundamental points that are not special to the particular cases.

These cases demonstrate the need to consider suicide prevention not only among people who are physically healthy, but also among people who live with disability. It may well be that physical disability, dependency, or chronic pain present particular challenges that make it more difficult to cope with life. These are stressors and just as with unfulfilling work, or lack of work, or difficult relationships, or isolation, or emotional difficulties with religion, or lack of religious faith, they may be part of the background to understanding someone’s suicidal feelings. In some respects, then, the presence of disability gives a distinct character to these particular stories. On the other hand, John’s description of feeling that there is “nothing to live for” and Daniel’s inability to “envisage a worthwhile future” seem to transcend their particular circumstances. These words express something common, if not universal, in those who contemplate suicide.

These stories also illustrate the way that death by suicide can compound grief. Death at one’s own hand is “non-natural” and, as such, untimely. This is one reason why the issue of suicide prevention, when raised at a political level, so typically begins with suicide among teenagers who are physically fit and whose life is tragically and unnecessarily cut short (e.g. Usborne, 2017). Whereas death always robs the world of someone who is irreplaceable, the death of a child or of a young adult is even harder to bear. It seems doubly unfair that life should be lost before the person has had a chance to flourish.

Without denying the importance of suicide prevention in young and physically healthy people, it should be noted that rates of suicide are in fact higher among middle-aged people than among younger people (Caine, 2017; Snowdon et al. 2017) and they are higher among those with physical health problems than among those who are physically fit and healthy (Erlangsen, Stenager & Conwell, 2015; Kim, 2016). Suicide prevention is as important for those, like John or Daniel, who live with disability, as it is among other groups.

As the theologian Herbert McCabe once remarked “in one way, every human death is the death of a child: every death cuts off a story that has infinite possibilities ahead of it” (McCabe, 2003, p. 21). It is for this reason that the World Health Organisation affirms that “every suicide is a tragedy” (WHO, 2014, p. 2). It would be naïve to imagine that all lives are in fact valued equally and it is clear from the way that the media report death that people of different ages, nationalities, social status or celebrity status are not given the same level of attention. Nevertheless, it can at least be recognised that every suicide represents an irretrievable loss to society which society has failed to prevent.

This more compassionate understanding of suicide is a modern achievement. In earlier ages suicide tended to be thought of, not only sometimes but often, as the deliberate and selfish act of an individual for which he or she should be subject to moral criticism. Some schools of thought praised suicide in exceptional circumstances, for example suicide to avoid the shame of military or political defeat (Pierre, 2015). The history of attitudes to suicide is complex. However, commonly and repeatedly in different periods and cultures, suicide has been regarded as a moral failure bringing dishonour upon the person’s memory (Murray, 1998; Murray, 2011).

It was in the eighteenth century that suicide came to be regarded as an expression of psychological and social problems that could be and should be addressed (Goldney & Schioldann, 2000). This is not to deny that suicide can be a deliberate act or to deny that people who end their lives are ever responsible for their actions. Nor is it to address any philosophical claim that, in some exceptional cases, ending one’s life could be morally licit or even morally required. There is a place for philosophical and theological reflection on ending one’s own life as a deliberate choice (see, for example, Jones 2007). Nevertheless, a problem with abstracting the individual action and subjecting it to praise or blame, valorisation or stigmatisation, is that such analysis may obscure a wider range of social and psychological phenomena which influence, and which could help to prevent, suicide. The focus of the present paper is to situate within this wider context vulnerability to suicide, whether assisted or unassisted, among disabled people who are not terminally ill.

**Is “assisted dying” assisted suicide?**

There are similarities between the deaths of John and of Daniel but also dissimilarities. While each died at his own hand, John’s death seemed to be the result of an impulsive decision and he died alone, as is frequently the case in suicide. In contrast, Daniel’s death was more orderly and sanitised: it reflected a disposition that had endured for several months, it involved medical assistance, and it enabled his parents to be present. Given these differences, is it helpful or accurate to use the same term, “suicide”, for these quite different endings?

In the past twenty years or so a small number of jurisdictions have changed their laws and/or established organisations to end someone’s life on request (euthanasia), or to help someone end his or her own life (assisted suicide), where the person is chronically sick and no longer wishes to go on living. These practices, in slightly different forms, have been accepted in the Benelux counties and in Switzerland. In North America euthanasia (in Canada) or assisted suicide (in Canada and some states in the United States) have been legalised for persons who are terminally ill.

Over time supporters of such laws, especially in Anglophone countries, have shifted the language of the debate. Instead of advocating the legalisation of “euthanasia” or of “assisted suicide” proponents have argued for “death with dignity”, “compassion in dying”, “choice in dying”, “medical assistance in dying”, or perhaps most commonly, “assisted dying”.

As early as 1997, the year that Oregon legalised assisted dying, it was asserted that terminology involving the word “suicide” was partisan and that such language was rejected by proponents of such laws.

Those who believe that taking one’s life in certain circumstances can be morally valid and should be legally protected reject the “suicide” label, giving the act some other name that evokes notions of personal autonomy. (Harris, 1997, p. 268)

This sentence may be taken in an exhortatory sense, discouraging the language of “assisted suicide”, but if it is taken as a description of how people have written or spoken, then it is evidently false. The term “physician assisted suicide” remains the most common term to describe the kind of practice legalised in Oregon. Even the author of the passage quoted above, despite exhortations to the contrary, repeatedly uses the phrase in a neutral way to describe the law in Oregon, including in the very conclusion of her paper:

The Ninth Circuit's reversal of the holding in Lee v. Oregon a decision which the Supreme Court declined to review, leaves the Oregon statute allowing *physician-assisted suicide* standing. Oregon is left free to experiment with *physician-assisted suicide*, as are other states. (Harris, 1997, p. 291 emphasis added)

It is also noteworthy that the terms “euthanasia” and “assisted suicide” are the standard in most jurisdictions where these practices are legal and well established. In Belgium and Luxembourg the laws are framed by the term *euthanasie*, while the Swiss government reports on rates of *suicide assisté*, alongside rates of unassisted suicide.

Katheryn Tucker and Fred Steele argue that the language of “assisted suicide” is inaccurate in that “the suicidal patient has no terminal illness but wants to die; the DWD [Death with Dignity] patient has a terminal illness and wants to live” (Tucker & Steele, 2007, p. 316). However, both sides of this contrast are open to challenge.

The first side of the contrast ignores the fact that “even under the current legal system many terminally ill people are committing suicide or attempting to commit suicide” (Tallis 2014). A study in the United Kingdom in 2011 estimated that over 10% of cases of non-assisted suicide involved someone with a terminal or serious chronic condition (Bazalgette, Bradley, & Ousbey, 2011, p. 17) and a freedom of information request in 2014 estimated just over 7% of people who died by suicide were terminally ill (Bingham, 2014). Similarly, research in Switzerland found that in relation to unassisted suicide over 20% of death certificates indicated the presence of some concomitant physical disease (FSO, 2012, p. 4). The vulnerability of people with serious physical disease or disability to depression, self-harm and suicide is, indeed, the focal concern of the current paper.

The second side of the contrast seeks to confine the term “assisted dying” to assisted suicide for the terminally ill. This narrow definition reflects the shape of legislative proposals in the United Kingdom in 2015 and the legislation passed in a handful of states in the United States. However, the term “assisted dying” is also used very commonly as “a compendium that can refer to voluntary euthanasia and/or assisted suicide” (Falconer 2011, p. 37 citing Lewis, 2007 p. 6). Neither in the Benelux countries nor in Switzerland is assisted dying restricted to people who are already dying from a terminal illness. Daniel James, who died by his own hand in Switzerland, was not dying. The lack of any requirement for terminal illness before obtaining euthanasia or assisted suicide in these countries is shown most dramatically in the case of people who have no *physical* illness at all but who suffer from a psychiatric condition such as depression, Post Traumatic Stress Disorder or autism (Thienpont 2015). In Switzerland or the Low Countries people with such conditions, who are suicidal, can legally obtain the means of suicide from a doctor. The phrase “assisted dying” is clearly misleading where those obtaining it would not otherwise be dying.

It is true that the procedures of medically assisted suicide differentiate it somewhat from impulsive, secretive and sometimes violent forms of unassisted suicide. Assisted suicide procedures may also allow people to say goodbye and may help the managing of pain or distress during death itself. Nevertheless, there remains much in common in the deaths of John and Daniel. Death brought about by their own hand, whether by unassisted or assisted suicide, in each case reflected the limits of their ability at that time to feel hope or to find meaning in life. Furthermore, their deaths irrevocably deprived them, and their loved ones, of the possibility of future rediscovery of hope or meaning. It is surely for this reason that “Daniel’s suicide caused [his parents] profound distress” (CPS 2008). Thus, while the parents of Daniel acquiesced to his wishes, “even up to the last second ... [they] hoped he’d change his mind” (CPS 2008).

The evident link between suicidal feelings and suicide, whether assisted or unassisted, shows that reflection on this topic should go beyond consideration of the law and whether it should restrict or tolerate reluctant and non-selfish assistance in suicide of a kind exemplified by Daniel’s parents. Even if the law tolerates such a practice, and even if it were permitted domestically and not only when provided by another country, the fundamental question would remain: how can people with long term disabilities be helped to find hope in life and to cope with the challenges that each life brings? What the parents of Daniel wanted, most of all, was for him to rediscover hope in life, albeit that his life would be radically different from life before his injury.

The same factors may thus contribute to the desire to end one’s life in the case of assisted and unassisted suicide, and the same factors may be protective against assisted and unassisted suicide. For example, research has shown that “the protective effect of a religious affiliation, and particularly of the Catholic faith, is evident both for assisted and non-assisted suicides” (Steck et al., 2014, p. 621 citing Spoerri, Zwahlen, Bopp, Gutzwiller, & Egger, 2010). Those with physical illness, older people, and those living alone are also more vulnerable both to assisted and unassisted suicide.[[2]](#footnote-3)

**Assisted suicide as a form of suicide prevention**

Some advocates of assisted dying present assisted suicide as an ideal death, a desirable means of ending life which should be culturally sanctioned, praised and even encouraged rather than disparaged or resisted. However, it is possible to be in favour of legalising some forms of assisted dying while acknowledging that death at one’s own hand is, at least in general or for the most part, something that society should seek to prevent. It may be thought, for example, that the law should favour liberty, and should therefore tolerate some forms of assistance in suicide, while also recognising that society has a duty to tackle the causes that dispose people to seek death.

It might also be disputed that legalising assistance in suicide would increase the number of people taking their lives. Dying and disabled people are already taking their own lives. Indeed, perhaps, were assisted suicide to be legal, this might lead to *fewer* people ending their lives. This paradoxical argument, that access to assisted suicide could act as a means of suicide prevention, has been invoked repeatedly in recent debates about the law on assisted dying. To understand how this might work, it is useful to consider an example provided by Lord Mitchell during a debate over this issue in the House of Lords in 2014. Speaking of the double-suicide of his parents-in-law, Lord Mitchell highlighted the secrecy which surrounded the decision:

If there had been assisted dying legislation at that time, I am certain that things would have turned out differently. First of all, we could have talked about it openly without the fear of legal consequences. We could have engaged all sorts of professional help. My father-in-law would have been able to die in circumstances not clouded by a veil of secrecy and subterfuge. I believe that we would have been able to say our goodbyes to him in an open and loving way, as opposed to being harshly rejected.

I will never be certain why my mother-in-law decided to join him. Was it for love? Was it for duty? Was it because she was frightened? Or maybe, as I suspect, they both knew that she could well run the risk of being charged with committing a crime as an accomplice. I simply do not know. But had this Bill been law then she might have chosen to live. (Lords Hansard 2014, Column 906)

Generalising from this example it may be argued that, for those people who are intent upon suicide, a legal form of physician assisted suicide would be preferable, allowing loved ones “to say [their] goodbyes”. This was some small solace given to Daniel’s parents that John’s loved ones did not have. However, the argument of Lord Mitchell is not simply that assisted suicide is preferable to unassisted suicide. For people who are ambivalent about their suicidal plans, he claimed that the opportunity to explore the possibility of legal physician assisted suicide would enable open discussion through which some might decide against suicide: “had this Bill been law she might have chosen to live”.

Having heard similar arguments, the Supreme Court of Canada concluded that “the prohibition [of assisted suicide] deprives some individuals of life” (Carter v. Canada 2015, [58]). The same argument is put succinctly by EXIT, the main Swiss right-to-die society, on its website:

EXIT’s option of physician-assisted suicide is actually an effective form of suicide prevention. Living in the certain knowledge of a way out has motivated more than half of the people originally intent on dying to keep enduring their painful lot until they passed away the natural way. Also, EXIT's physician-assisted suicide keeps people from dying violently at their own hand and alone by themselves. (EXIT 2018)

Notice again the two aspects to this claim: in the first place, the availability of lethal medication from a physician is said to function as a form of suicide prevention, reducing the total number of self-inflicted deaths; in the second place those who die by physician-assisted suicide are saved from a violent, painful or lonely death by unassisted suicide.

What is missing from these claims is any recognition that promoting assisted suicide, whether by a change in the law or by suicide tourism or by the activities of right-to-die societies, might also incite suicide and hence increase the risk of death. To present assisted suicide as preferable to unassisted suicide assumes that, for some people at least, suicide is inevitable: that it cannot be prevented. This is a counsel of despair. Everyone will die but no one need die by suicide.

The available evidence does not support the claim that giving access to assisted suicide reduces the overall number of deaths by suicide. An extensive study of rates of assisted and unassisted suicide in Switzerland from 1991 to 2008 showed that, in women, rates changed little in the younger age groups but in 65 to 94 year-olds the rate increased significantly due to an increase in suicide by poisoning (Steck, Zwahlen, & Egger, 2015). Physician assisted suicide was at that time classified together with other suicides by poisoning. An increase in suicides by poisoning was also observed in older men. These increases were due to “a tripling of assisted suicide rates in older women, and the doubling of rates in older men” (Steck, et al., 2015, p. 1). There is thus no evidence that the activities of EXIT have reduced rates of suicide; quite the opposite.

The availability of assistance in suicide can also influence the method of suicide. Australia, for example, has seen an increase in deaths of young people using the assisted-suicide drug Nembutal (Pentobarbital). Some of these deaths are known to have been counselled by the organisation Exit International (Butt, 2015). A similar influence of right-to-die advocacy on the method of unassisted suicide was demonstrable after the publication of *Final Exit*, a book by Derek Humphrey, the founder of the largest right-to-die society in the United States (Marzuk et al., 1993; Gilson, Parks, & Porterfield, 2003).

These data cohere with what is known more generally about suicide contagion and mechanisms that encourage suicide (Jones & Paton, 2015; Kheriaty 2015). Positive “suicide role models” reinforce high rates of suicide in a population (Stack & Kposowa, 2008;). This raises the question as to whether stories of assisted suicide, as reported in the media, may also encourage assisted (or indeed unassisted) suicide (Neuner, Hübner-Liebermann, Hajak, & Hausner, 2009).

**The Werther effect and the valorisation of assisted suicide**

There is good evidence that reporting of celebrity suicide can encourage unassisted suicide, depending on how the suicide is reported. This effect is sometimes termed the Werther effect after the eponymous hero of a book by Goethe in which the romantic hero ends his life. The publication of the book was associated with a spate of suicides using the same method. Concern over the dangers of reporting non-fictional suicide has also been expressed since the early nineteenth century, though it is only in the late twentieth century that the putative phenomenon of “suicide contagion” has been subject to sustained empirical investigation. This empirical research has in turn led to guidance to the media on the reporting of deaths by suicide.

In the first place this research makes clear that the media reporting of non-fictional suicides sometimes influences subsequent suicides. This is easiest to see in relation to the means used in suicide. For example, a number of studies demonstrate the role of the media in diffusing a new form of suicide, by charcoal burning, in Honk Kong, Taiwan and Korea (Chen, Yip, Lee, Gunnell, & Wu, 2015; Ji, Hong, Stack, & Lee, 2014; Lee, Ahn, Lee, Park, & Hong, 2014). Again, there is an association between the reporting of train accidents and an increase of suicides by this method (Kunrath, Baumert, & Ladwig, 2011; Too, Milner, Bugeja, & McClure, 2014), an association that is perhaps anticipated by Tolstoy’s *Anna Karenina*. Other research shows similar effects of media reporting on the prevalence of particular methods of suicide (Hagihara, Abe, Omagari, Motoi, & Nabeshima, 2014; Shoval et al., 2005).

Studies of the impact of media reporting of celebrity suicides have sometimes found an effect but sometimes found no effect, or if they have some effect, the effects are not necessarily equal in strength. Meta-analyses and systematic reviews (e.g. Gould, 2001; Stack, 2005; Niederkrotenthaler et al., 2012; Sisask & Värnik, 2012) have shown that whether reporting has an effect (and if so, how large) depends on features of the report, on characteristics of the original suicide, on “dose” (that is level of reporting), and characteristics of the audience. For example, suicide contagion is more likely among younger or older audiences and less likely among middle aged audiences. Reporting of celebrity suicide is more likely to have an effect if the person is a well-liked entertainer than someone who is well-known for some other reason (as a politician or an infamous criminal). Stories that are shared on social media have a greater effect (Ueda, Mori, Matsubayashi, & Sawada, 2017). Very negative reporting, such as the reporting of the suicide of Kurt Cobain (through the lens of an emotionally charged speech by his wife, Courtney Love, see Jobes, Berman, O'Carroll, Eastgard, & Knickmeyer 1996; Martin & Koo, 1997) or the horrifying spectacle of the Jonestown mass suicides (Stack 1983), seems to inhibit copycat effects. By the same token, reporting that glamorises or romanticises suicide, or which shows it as a normal reaction to a stressful situation, increases the likelihood of imitation.

Drawing together the available evidence, it seems that media reporting is more likely to lead to suicide “contagion” if the story is repeated, if it describes the means of suicide, if it romanticises suicide or presents it as a normal reaction to adverse circumstances, or if it stigmatises suicide, which may compound feelings of isolation and discourage people from seeking help (WHO 2008; Potter et al. 1994).

In contrast with research into reporting of unassisted suicide there is a dearth of research into the reporting of assisted suicide. A paper published in 2003 by Andreas Frei and colleagues provides a rare example of original quantitative research on this topic published in a peer review journal (Frei et al., 2003). They considered the impact of the media reporting of the double assisted suicide of a celebrity couple who were particularly well known in Basel. Their suicides were facilitated by the organisation EXIT. In contrast with the caution shown in the reporting of unassisted suicide, this double assisted suicide was reported repeatedly and in detail, mentioned the method and named the organisation that facilitated the suicide, failed to discuss any alternatives to suicide, and glorified the double suicide as a means for the couple to stay together after death and as the expression of a strong personality. Subsequent to this reporting, the rate of people dying by assisted suicide rose sharply, there was an increase in the number of married women seeking suicide and there was a rise in double suicides. The authors also cite the memoirs of a former manager and “death companion” at EXIT who discusses a case of double suicide where the wife asked for assisting suicide “mentioning unequivocally” the celebrity case (Frei et al., 2003, p. 197).

A similar effect seems to have occurred with the traditional and social media reporting of the assisted suicide of Brittany Maynard, a terminally ill young woman from California who moved to Oregon to obtain assisted suicide in that state in 2014. She was active in the campaign to legalise assisted suicide in California and, while she was dying, was filmed for a series of videos which were shared widely on social media in the weeks leading up to her death. The possible impact of these events on rates of assisted suicide in Oregon has been analysed in a white paper entitled “Assisted suicide and contagion”.

In October 2014, during the height of the attention and advocacy surrounding Maynard, the number of lethal prescriptions written in Oregon rose 39.4 percent higher than the 2014 monthly average. The October total was the second highest of any month in the past five years. Moreover, the number of actual deaths from assisted suicide in Oregon was 37.1 percent higher in October than the 2014 average. The death total then spiked in November, following Maynard’s own death, rising 71.4 percent above the 2014 average. The number of assisted suicide deaths in November 2014 was higher than that of any other month in at least the last five years. (MNAAS, 2015, p. 4)

There is also anecdotal evidence for the impact of the Brittany Maynard videos on a decision to seek assisted suicide. This is evident, for example, in the case of Valentina Maureira, a 14-year-old Chilean girl with cystic fibrosis who made her own YouTube video begging her government for assisted suicide (BBC, 2015; Dearden, 2015). Her idea to end her life was influenced by watching a video of Brittany Maynard. Maureira sought to imitate Maynard not only in the manner of her death but also in her use of YouTube to express this wish.

There is an urgent need for more systematic research on the impact of media reporting of assisted suicide. Nevertheless, the evidence in relation to reporting of unassisted suicide is sufficient ground for raising the concern that inappropriate reporting of assisted suicide may also lead to Werther effects. There is no good a priori reason to believe that assisted suicide would be immune from such effects. Unless and until it is demonstrated that such effects do not occur, it is irresponsible not to follow the same evidence-based guidance that applies in the reporting of unassisted suicide (Saunders, 2011; Frei et al., 2003; Neuner, Hübner-Liebermann, Hajak, & Hausner, 2009; Kheriaty, 2015). Such stories should not be repeated excessively, should not give details of the method nor advertise the organisations involved, should not present this as a heroic decision or as a normal reaction to adverse circumstances, should not present death at one’s own hand as necessary or inevitable. Reporting should present alternatives to suicide, should balance such stories with positive representation of disability and should signpost places to seek help.

**The Papageno effect and the rediscovery of meaning in life with disability**

It should also be noted that the media effect on suicide can be positive as well as negative, and this is true of the newer social media just as much as the traditional media (Marchant et al., 2017). The positive effect of the media in helping prevent suicide is sometimes called the Papageno effect after a character in *The Magic Flute* who is feeling suicidal but who is persuaded by his friends that life is worth living (Niederkrotenthaler et al., 2010).

The Papageno effect was seen, though imperfectly, in the story of Valentina Maureira. Among those who responded to her video was a woman in her 20s with the same condition. They met and through this woman Maureira saw the possibility of something to hope for. She changed her mind and no longer sought help to die (Brennan 2015). Valentina died of natural causes on 14 May 2015. However, the frustration of her father was that politicians only took notice when Valentina was requesting assistance in dying. At an earlier stage in her illness when she might have benefitted, these same politicians had ignored repeated requests for help to access treatment for her cystic fibrosis (Torres, 2015).

A clearer and unalloyed example of the Papageno effect is that of Alison Davis. She was born with spina bifida and hydrocephalus and developed a severe spinal condition and other medical problems (she also used a wheelchair fulltime). She suffered tremendous pain which was only partially alleviated by morphine. She also found that the morphine had very disturbing mental side effects and chose to endure higher levels of pain to avoid these effects. For ten years she wanted to die, and for five years had a settled wish to end her life and repeatedly sought to do so. The following account is in her own words.

My greatest piece of good fortune was that I had friends who did not share my view that my life had no value. It took them, and particularly Colin, now my caregiver and also my closest friend who has shared both my house and my life for the last 23 years, a very long time to help me just “give life another try.”

Those efforts and another trip to India in 1995, during which I visited a small project for disabled children, helped to turn my life around. Seeing these children I felt motivated to do something for them, so Colin and I subsequently set up a charity for them. The night after leaving the project I said to Colin “Do you know, I think I want to live.” It was the first time I had thought that for over ten years.

I wanted to die for over ten years, though my actual attempts to end my life lasted only five years, after which Colin and other friends helped me in every way possible to see a way of facing the future. Over the years since then, I have taken part in many interviews on TV and radio. I have forgotten all but one of them. That one was on a radio station called Radio Northampton and I remember it for two reasons. First the interviewer was very rude and offensive, and was unwilling to listen to me. Secondly, I was very tired, and spoke badly, not putting over well what I wanted to say.

After the interview I felt very “down” and thought that all the effort had been in vain. Shortly afterwards, however, the programme’s producer phoned me to apologise for what she called the “unacceptable behaviour” of her interviewer. I was slightly placated.

Then less than twenty minutes later she phoned me again. This time she said that she had just had a call from a young man who said his name was John. He had that very day decided to take his own life, but after hearing what I had to say, he had decided that, after all, he would not do so.

This was certainly not due to any merit on my part, as I knew I had spoken very badly. But somehow this desperate young man had heard a message of hope. Somehow my stumbling and inadequate words had been transformed so that John heard something quite different – something that helped him decide to give life another chance. This experience has reoccurred several times since then, though rarely so dramatically.

Often all desperate people, disabled or not, need is to be given hope. What they definitely don’t need is to be told they are right to feel so unhappy and that they would be better off dead. (Davis, 2013)

Alison, like Papageno, reacquired the will to live with the support of friends and by finding a particular way to help others. This happened not suddenly but over a long time. In turn, her example, mediated through media interviews, had an impact on others, not always “so dramatically” but several times of which she was aware and surely many more of which she was not aware.

The presentation of inspiring true stories,[[3]](#footnote-4) which do not hide the reality of disability but show the possibility of life and hope, is not simply an issue of balanced reporting. It is an important element of suicide prevention. If the media presentation of assisted suicide portrays this as a culturally sanctioned means of ending life (Pierre, 2015), then it will undermine the shared commitment to viewing “every single life lost to suicide [as] one too many” (WHO, 2014, p. 2).

This is a separate question to the question of legality. Whether the law prohibits, restricts or tolerates assistance in suicide, the fundamental question will remain: how can people with long term disabilities be helped to hold on to, or to rediscover, hope in life and supported so that they can cope with the challenges that every life brings? With or without disability, where there is life there is hope, and where there is hope there is life.[[4]](#footnote-5)

“Now my liege, Tell me what blessings I have here alive, That I should fear to die.” (W. Shakespeare, *The Winter's Tale* Act 3, Scene 2).

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1. The following account is taken from the investigation by the coroner after his death, paraphrased to preserve anonymity though with some direct quotations retained. [↑](#footnote-ref-2)
2. Steck et al., 2014; Webb et al., 2012. These findings confirm earlier work done by the New York State Task Force on Life and the Law, (1994). The New York Task Force also found that depression was prevalent in these vulnerable groups but was largely undiagnosed and untreated. The report remains exemplary for considering assisted dying in the context of an extended discussion of suicide and the factors that can contribute to and that can ameliorate the wish to die. [↑](#footnote-ref-3)
3. Others who have inspired me personally, in the manner of their living and of their dying, and with whom I have had the privilege of working, would include Nicholas Tonti-Filippini and Kevin Fitzpatrick (see Tonti-Filippini, 2012; Campbell 2015; Jones & Fitzpatrick, 2017; Campbell 2016). [↑](#footnote-ref-4)
4. The sustaining of hope is, of course, not only a matter of media presentation of assisted and unassisted suicide or of societal attitudes to disability but is also a matter of practical support. The need for an integrated approach across government to suicide prevention among disabled people is highlighted by evidence of an association between the recent programme of reassessment of people on disability benefits and an increased rate of suicide in this group (Barr et al., 2016). [↑](#footnote-ref-5)