

# PREPARING TO LEAVE



Michael Irwin



Michael Irwin, with his mother, grandmother and great-grandmother. Hove, August 1939.

## June 2018

On the cover is the derelict West Pier in Brighton and Hove, once a place of great excitement and pleasure.

## INTRODUCTION

Like everyone else, I did not ask to be born, Like everyone else, I really have no definite idea why I am presently living on a tiny planet, rushing through this vast Universe.

My father died at ninety. My mother at ninety-five. So, regarding longevity, I have good genes. However, now in my 88th year, while still enjoying this wonderful journey called “Life”, I am making preparations for my departure without causing myself, or anyone else, too much discomfort.

In Summer 2018, I am well aware that my increasingly decrepit body is getting to the stage when it will eventually be heavily dependent on others for its continuing existence. Of course, it is possible that I might die – from some presently undiagnosed condition (or the worsening of an existing disease) – before this happens. But, having had the good fortune to have, so far, a very “Good Life”, mainly in the Western world, I am now prepaing for a very “Good Departure” .

While everyone, as they age, usually focuses on how their bodies deteriorate, I have – for very many years – always considered that “Michael Irwin” is basically my brain. Essentially, I am three pounds (or 1,400 grams) of billions of active nerve cells inside my skull – my brain is ME, my existence.

Every human brain is perhaps the most amazing grouping of cells in this amazing Universe. There are at

least sixty billion neurons in the adult brain – this is seven times the number of people on Earth today.

Of course, my body is a vital part of who I am. It is what the rest of the world sees as “me”. It is my obvious identity. It is the physical being that took me to work many years ago, and accompanied my brain to the theatre last month.

But, I am my brain. It is the source of all my thoughts and dreams. It studied to be a doctor, and then it worked in the “UN System” for thirty-three years. It loved several wonderful women (and, lived with four of them). Like my parents’ brains which created me, my brain was involved in being the father of three beautiful daughters. It campaigned for a sensible right-to-die law in the UK, and, getting to the end of a very satisfying existence on this unique planet, my brain is now preparing for a dignified departure – and, for perhaps discovering what might survive when my body ceases to exist.

## **OLD AGE RATIONAL SUICIDE**

This booklet is defending the right of mentally competent, elderly individuals, not yet terminally ill, but increasingly suffering from various medical conditions, to have the rational option of asking a doctor to end their lives when all the wonderful pleasures they used to enjoy have gone – when their lives have been “completed”.

My mother, who always spoke frankly, often said, “Call a spade, a spade”. There are many right-to-die campaigners, around the world, who prefer to use euphemisms like “assisted dying” and “dignity in dying”, when essentially they mean “doctor-assisted suicide” or “voluntary euthanasia”. Like my mother, I regard these expressions as being wishy-washy, rather feeble, sanitizing the truth. I see nothing wrong with saying “rational suicide” – especially when this can be a sensible and positive act for an elderly, competent individual who is suffering unbearably and has carefully considered the main pros and cons for wanting to stay alive. In fact, when someone in their late 80s and 90s decides to die this way, it should make others think not why did this happen, but why did it not.

Individuals have often resorted to suicide – sometimes, these have been the acts of mentally disturbed persons, while, for others, these have been heroic deeds. For centuries, religious organizations have stated that suicide is forbidden, that it is a sin as “God gave us Life, and only God can take it away”. When I have been involved in such

discussions, I have always been delighted to state that “it was my parents who gave me life several months before they were married, and not some man-invented religious entity”. The announcement of my birth, in The Times, stated that when I was born, on June 5, 1931, that I was “premature” (in fact, I weighed 7lbs).

Is it only humans who think of suicide? I still remember the seventeen-year old cat, the close companion of my second wife, who, while undergoing radiation treatment for a cancerous growth in a nasal sinus, went missing for several hours in our New York apartment, only to be discovered by me, tightly wedged and completely silent, behind the refrigerator. He was telling us that he had had enough of his treatment and wished to die – which he did the next day, with the assistance of a caring vet.

The possibility of old age rational suicide will be increasingly considered as the population of the world – especially in Europe and North America – gets older. At the present time, in the UK, there are about 1.5 million people – in a total population of some 65 million – who are at least 85 years old (incidentally, I like the definition in Mosby’s Medical Dictionary, published in the United States, of those who are 85 years and older as being “old-old”). And, it is forecast that, within twenty-five years, one person in twenty, in the UK, will be old-old.

Many elderly people die slowly, with different parts of their bodies breaking down at varying rates. According to the Office for National Statistics, in the UK, for the vast majority of elderly people, death is currently preceded by an average of ten years of chronic ill health. There is no

recovery from being old-old. And, many old-olds, if they had the choice, do not want to live to the bitter end. They realize that they have very few natural years left to them – and they become very realistic and philosophical about dying. Many of them will have enjoyed their long lives on Earth, but, now, they know that it is time to leave the party. Sensibly, they balance their quality of life against the remaining quantity of life. Some, having lived lives where they had considerable control over what they did, may even compile a “balance-sheet”, a final “stock-taking”, to evaluate everything (especially their health, their degree of energy, and their self-esteem) at the end of their Completed Life.

For so many people today, death – for someone who has passed the “old-old” stage – is rarely dignified. Many will die in hospitals or care homes, where their lives are shaped by rules and regulations. Gradually, the number of “bad days” will increasingly exceed the number of “good days”. Why should such competent, elderly people – who so wish to continue to be in charge of their existence – be forced to hang on?

Could we even think the unthinkable, and see Governments, around the world (but, especially in Europe and North America) become willing to help determined, elderly individuals to have the legal option of “old age rational suicide”, while, at the same time, saving a great deal of money in not having to provide all kinds of unwanted care and health services?

Fortunately, today, in Belgium, Luxembourg, The Netherlands, and Switzerland, there is no distinction

between “the terminally ill”, “the severely disabled” or “suffering elderly people” when it comes to providing medical assistance to die for these individuals, if this is their expressed wish.

To focus on the concept of “old age rational suicide”, and to begin a discussion on this subject, with three close friends, I established the Society for Old Age Rational Suicide (“SOARS”) on December 10, 2009. This date was chosen because December 10th is recognized globally as international Human Rights Day, and what might be called the “legal basis” for SOARS’ existence was a statement from the European Court of Human Rights which, on April 29, 2002, declared that “In an era of growing medical sophistication, combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity”. The SOARS logo was the derelict West Pier in Brighton and Hove, a city on the south coast of the UK, which was once a place of great excitement and pleasure – like the lives that many old-olds have led.

Of course, for an old age rational suicide to legally happen, it would be essential to have strict procedures in place – such as the following:

Two doctors certifying that the individual is mentally competent, and had extensively considered all possible options.

Every elderly person, requesting a doctor-assisted suicide, being interviewed by an official, independent legal witness, experienced in family matters, to ensure that they are acting on their own free will and not being pressured by relatives or friends.

There would be a two-month waiting period between the request for suicide being made and the necessary medication being provided, and, for this to be taken in the presence of an experienced healthcare professional (it is very important to stress this – if only an inexperienced relative or friend is present, there is a great danger that mistakes will occur).

And, detailed reporting to a central government office, by all those involved, would be necessary.

The main activities of SOARS were to provide speakers to interested groups throughout the UK; to hold six-monthly public meetings in London; to produce a newsletter twice a year; to help those of its supporters, who qualified for such assistance, to travel to Switzerland to end their lives; and to determine the degree of public support, for the concept of old age rational suicide, by commissioning regular opinion polls.

In general, the British public seems to support the possibility of old age rational suicide. Between 2010 and 2013, there were three national opinion polls – these were conducted by ICM Direct (an organization which does extensive research for the media, such as The Guardian newspaper and Channel Four TV News, as well as many businesses and institutions in the UK), with the

assistance of Kindle Research (which provides further analysis of the data collected).

The first of these national polls was in July 2010, at the request of the BBC for a radio programme it was making called “Choosing a Time to Die” (which was broadcast on September 20th). This telephone poll, of 1,009 adults throughout the UK, showed that – as expected – 78% were in favour of terminally-ill, mentally competent adults being legally allowed to receive medical assistance to die. But, of particular interest to SOARS, regarding whether very elderly, competent individuals who are suffering from a variety of medical problems (that they would not die from) should also be legally allowed to have medical help to die, there was a 67% support, with only 19% opposed, and the rest uncertain.

Then, in March 2011, two further ICM Direct-Kindle Research national polls were undertaken. The first, of 1,008 individuals interviewed by telephone, showed that 76% were in favour of a competent, terminally-ill adult receiving medical assistance to die (only 12% were opposed). And, most importantly, 66%, of this group, agreed with the possibility of old age rational suicide, with only 18% opposed (the rest were uncertain). The second poll, of 2,024 individuals, was conducted online. This revealed 73% support for helping those who were terminally-ill, and 60% in favour of similar assistance for the very elderly with serious medical problems. Two possible explanations for less support, from the online poll, are that those participating in this poll were considering the moral and legal implications more carefully and that the lack of an interviewer (as in a

telephone poll) removed any pressure to give a socially correct answer.

In March 2013, ICM Direct and Kindle Research repeated both telephone and online polls nationally. The first, of 1,002 individuals interviewed by telephone, showed that now 70% agreed with the possibility of old age rational suicide. And, the second poll, involving 2,000 persons online, repeated the 60% result of March 2011.

This degree of support for old age rational suicide, over three years, was much greater than had been expected – these particular questions had never previously been asked in any poll in the UK. Then, in *The Economist*, on June 27, 2015, there was an extensive report on “The Right to Die” which gave the results of polls in several countries – its findings, for the UK, should that 60% were in favour of doctor-assisted dying for non-terminally ill patients with incurable conditions that caused unbearable suffering.

Furthermore, whenever an elderly individual decides to publicly talk about their rational suicide, mainly for medical reasons, this event receives extensive media attention. One of the three close friends, involved with me in the establishment of SOARS, was Nan Maitland, who, in her 85th year, because of severe osteoarthritis, courageously ended her life in Switzerland on March 1, 2011 – this event was initially reported exclusively on the front page of *The Sunday Times*, on April 3rd, with the title “I choose death over dwindling old age” (within a few days, similar reports appeared in newspapers around the world).

One area of increasing concern, especially in the Western world, is the fear of dementia. And, SOARS campaigned for doctor-assisted suicide being a serious option for all elderly individuals who develop dementia as long as they still have the mental capacity to make this choice. In March 2013, I was involved in assisting an 83-year old man, already suffering from early dementia, to travel with his wife, to Switzerland, for him to die there. When his death became public two months later, there was extensive media coverage. For example, on May 31, 2013, The Daily Mail had the headline “Man of 83 is the first UK dementia patient to end life at Dignitas”, and The Times headline was “Aided suicide will increasingly be choice of dementia patients”. During the last week of February 2014, Channel Five TV News had a week-long coverage on dementia, and a Channel Five/YouGov poll showed that 61% of its viewers agreed that competent individuals, suffering from early dementia, should have the option of a doctor-assisted suicide.

I was the Coordinator of SOARS from its beginning up to August 2015 when I was very pleased to hand over to Phil Cheadle who had been the Associate Coordinator. Then, in April 2016, following an extensive national discussion among its supporters, it was decided that SOARS should be renamed as My Death My Decision. Fortunately, its main objective is “To campaign for a change in the law in the UK to allow medical assistance to die to be given to mentally competent adults, with incurable health problems that result in their perceived quality of life falling permanently below the level they are able to accept, providing this is their own persistent request (most of the people who the proposed change

in law will apply to will be relatively elderly, feeling that their life is complete)”. Also, another main objective is “To create and maintain communities of members who can give each other support and guidance in examining options for a legal medically-assisted death abroad, until such time as there is a satisfactory law in the UK”.

At its AGM, in October 2014, it was decided that SOARS should appoint a few Patrons, and it was agreed that the first would be Libby Wilson, a very close friend of mine who was the main founder of Friends At The End (the Scottish right-to-die organization). Then, at the AGM in October 2015, I was delighted to be named as the second Patron. Unfortunately, at the age of 89, Libby Wilson died in March 2016. Among the Patrons appointed, at the MDMD AGM in April 2018, were Anthony Grayling, Virginia Ironside, Martin Rees and Polly Toynbee.

# WHAT SURVIVES?

The most fundamental questions of all, for those living on this planet, must surely be – “Why is there something when there could be nothing?” “Why am I here?” “What happens when I die?” Of course, at present, we do not know the answers – but, we do usually realize that, on Earth, we are a very minute part of this amazing Universe. Or, as the cosmologist, Carl Sagan, has noted – “We inhabit an insignificant planet of a humdrum star tucked away in a forgotten corner of the Universe”.

The Universe is generally reckoned to be about 14 billion years old. Our galaxy – the Milky Way – has at least 100 billion stars (one of which is our sun) – yet, it is only one galaxy among perhaps 100 billion others.

Our Earth, travelling through space at some 67,000 miles an hour, only appeared about 4.5 billion years ago. Initially, there was no life at all on our planet. Eventually, single cell organisms apparently evolved from chemical reactions in the warm pools on the surface, and so the long road of evolution began, and is still continuing today (in fact, sometimes, I wonder how long the human thumb might eventually grow with so much texting and tweeting nowadays?).

On Earth, many thousands of species have developed in the past, and died. Dinosaurs existed for about 150 million years. Our earliest ancestors only appeared about 5 million years ago, eventually evolving into us, homo sapiens, in the past 250,000 years. If we can imagine that the history of all life on Earth is equal to the 365 days of

one year – with each day representing 10 million years – then homo sapiens arrived about 11.30pm on December 31st. For those who believe in the existence of “souls”, I wonder when they think such entities entered our bodies during our extensive evolutionary process?

Our planet is a very small speck in this vast Universe. Yet on it, every creature that has ever lived – in the air, on the land, or in the ocean – has called it their home. Thinking only of humans, every emperor and peasant, every hero and coward, every father and mother, and every saint and sinner have existed on this tiny planet.

All living creatures are related – some, of course, are closer than others. Our human DNA is estimated to be 98.5% identical to that of a chimpanzee. Nine-tenths of our genes are similar to those of a mouse. And, at least a third of the genes of the lowly nematode worm is shared with us.

In our busy, daily lives, we tend to ignore the vastness of the Universe around us, and we easily forget that everyone is sentenced to die. Yet these two facts alone should remind us that our concerns and thoughts about our worldly possessions, about our regular ups and downs, should not really worry us too much – such matters are relatively insignificant, especially when measured against our destiny.

In the history of this Universe, our individual life is a momentary flicker. Our existence is for a relatively short period of time, basically between two periods of darkness. We arrive on Earth as a stranger, with no

understanding of this world. We learn something of the ways of life here – and, like all visits, this one has its delights, its boredom and its ordeals. But, being a visit, our stay is limited.

Of course, there was a time, before we were born, when we did not exist. However, very few of us are concerned about this – especially as we have no memory of this. So, why do so many of us, especially as we become old, worry about there being a time when we cease to exist as humans? Perhaps to die is simply to return to the state we were before we were born?

On the day that we do die, thousands and thousands of others, around the world, make the same journey. In the UK alone, about 600,000 people die every year. Every person one has ever met, everyone we pass on the street today, is going to die. Nearly the only thing that we can be certain of, in this life, is that one day, we will die, and leave everything behind us. We start to die once we are born – both are really natural events. Everyday, we travel towards our death, until, on our last day, we arrive at the terminal. We are all equal in having to face this eventuality. Thinking of chess, after the game, the king and the pawn, go into the same box. Fortunately, we die only once. Therefore, it is surely wise to plan how we leave this existence?

Our earliest ancestors, when those around them died, must have felt abandoned in such situations. But, after the dead had been disposed of in various ways – by fire, by burial, or by been thrown into the nearest river or ravine – the survivors gradually begun to wonder about

the possibility of an afterlife. Therefore, myths arose, and, as various forms of worship began to develop and become formally organized, there have been oracles and seers, and then preachers, priests, rabbis, imams, and bishops, together with writers and poets, all wondering and discussing what might happen when those around them leave this world.

The development of organized religions around the world was largely based on trying to find some meaning or explanation of death in our lives – with providing a possible understanding of what happens when someone dies. Generally, most religions view death not as an ending but as a beginning or as a transition. And, the fear of death is still one of the main reasons for organized religion. The concept of heaven or paradise (the latter word comes from the Persian for “royal park”) was hijacked by the major religions to keep the allegiance of their followers. Religion panders to the desire of many for immortality.

Unfortunately, many organized religions – with their elaborate power structures and holy books – tend to use unchallengeable authority to control their followers. So often, religious organizations have done more harm than good in this world. The beliefs and ideas which divide one group of humans from another, both in the past and still today, only perhaps to unite them in slaughter, often have their roots in religion.

Most religious organizations have become somewhat distorted from their basic principles as they have developed over the centuries. For example, Christ would

surely not like to see the ornaments and decorations, or hear the rituals and the sacraments, and become aware of the various saints and idols which are to be found in many Christian churches today?

Even those who believe in an afterlife often have trouble coping with an image of themselves gone from this world. Where will we be? How do we continue to exist? Such believers are frequently not calm about the process of dying and surprisingly they nearly always want to delay making the transition.

So, what happens when we die, beyond our lifeless corpse remaining on Earth? Surely we do not just disappear in a matter of seconds? Plato's view – expressed in the fourth century BC – was succinct: Death is either annihilation (and the dead are then unaware of anything) or it is the migration of a "soul" from this world to another. Does something, some feature of our body, presently already part of us, survive our physical demise or, when we die, is that the end?

Dying is perhaps like falling into a dreamless sleep? I can anticipate falling asleep, getting drowsy, while still awake: only on waking up, do I discover what has actually happened. But, I am unaware of the precise moment of falling asleep. When asleep, consciousness can be extinguished as simply as turning off a light switch. When a light is turned off, it apparently no longer exists. Likewise, when I fall into a dreamless sleep, my thoughts seem to stop (in a sense, I no longer exist).

Perhaps falling asleep is like a short death? The word "cemetery" comes from the Greek for a "sleeping place". So, perhaps we can think of death as an extremely long sleep (although, of course, it cannot be because we eventually awake from sleep, but never from death)? And, as most of us spend at least one third of our lives asleep, perhaps we are actually preparing for our death as we live?

Generally, in the Western world today, we shield people from death. In fact, we often avoid mentioning the word. Rather than say that someone has "died", we use words like "passed away", "the departed", or, especially in speaking to children, "joined the angels". Nowadays, we make death as invisible as possible. The coffin is often closed. In fact, unlike past generations, we do not really know, or see, death anymore – especially as it is more likely to occur in a hospital, a nursing home, or in a hospice, rather than at home (where, in fact, most people would prefer to die).

No one else can really share my perspective of this world. No one else can experience my feelings or have my consciousness. But, my life – one among some eight billion others on this tiny planet – is of momentous significance to me.

So, when I die, does my personal "soul" enjoy an eternal reward – depending on how I have lived? Or, am I going to be recycled or reincarnated (energy is never lost)? Or, do I totally disappear, snuffed out like a candle?

The idea of something surviving our earthly deaths has obvious appeal – or, is it just wishful thinking? One person who tried to prove the existence of a soul was Dr. Duncan McDougall who, in 1907, at the Massachusetts General Hospital, in Boston, in America, constructed a bed mounted on a frame supported by platform beam scales “sensitive to two-tenths of an ounce”. When he recorded the death of a terminally-ill tuberculosis patient, he noticed that there was a sudden weight loss of “precisely three-quarters of an ounce”. To my knowledge, this experiment has never been repeated!

Of course, if someone believes in a life after death, that individual might experience the “fear of God”, the “Day of Judgement”, or even of hell (which used to be that “great abyss of terrible flames”). The prospect of an afterlife can produce thoughts of guilt, sin and punishment – not attractive prospects for many of us.

Perhaps heaven and hell have really only been located inside the brains of certain dogmatic, religious humans, sometimes claiming infallibility? However, it was perhaps real progress when, in July 1999, Pope John Paul declared that heaven was not “a physical place among the clouds”, but was only “a state of being” with God? And, a BBC poll, at Christmas 1999, revealed that 40% of Anglican clergy shared the Pope’s view.

I was raised as a Church of England Christian (my maternal grandfather, when he was the vicar of Lodsworth, a Sussex village, baptized me). I believe that, morally, like many others, I still follow what are generally regarded as “Christian principles”. But, since my early

adulthood, I consider myself to be a Humanist, essentially trying to make this world a better place. And, I was so very pleased to become an Honorary Associate of the National Secular Society in 2011, and then a Patron of Humanists UK (formerly the British Humanist Association) in 2015.

I have always stated that it is really a matter of personal choice whether someone believes in “God” or not. When, in discussions with religious people, I have been asked, “Do you believe in God?”, I have replied “Yes”, but then quickly added that, for me, “God” is the wonderful, ongoing, creative force of this mysterious Universe, starting with the “Big Bang”. Alternatively, one can think of “God” as being another word for “Nature”. And, fortunately, I strongly believe that there is no “entity” watching over me, my family and my friends, carefully recording what we are thinking and doing. This simple “belief” definitely allows me to still sleep well at night.

Personally, today, I believe that there is some form of “energy” – which exists in all living creatures – that enters at conception and leaves when we all die. How else to explain the essential difference between a living body and a dead one at the moment of death? There could easily be something that is still beyond the capacity of contemporary science, or the present laws of Nature, to explain. It is important not to fall into the trap of believing that what cannot be detected, at the present time, does not exist. Failure to find something is not evidence that it is not there.

In the first seven months of 2005, I contacted 1,600 individuals, picked at random from “Who’s Who”, to obtain their views of what they thought survived when we died. When I analysed the 761 replies that I received – which I have been told was a very good response – I discovered that 46% believed that nothing at all survived death (except, of course, one’s descendants, personal documents and photographs, etc); that 29% believed that a “soul” continued to exist after death; and, 5% felt, like me, in the possibility of a non-specific “life force” continuing to exist in some form after death. Only 20% were uncertain what survives when someone dies. The results of my survey were of sufficient interest to The Times newspaper that it reported on them, on November 23, 2005, under the title of “Great and good have little truck with God”

Several years ago, I became interested in the existence of neutrinos, which were discovered in 1956. Originating from the sun, billions and billions of these extremely tiny particles (which are about one ten-millionth the mass of an electron) pass through our bodies – and also all other living creatures – every day, without appearing to do us any harm. Why do neutrinos exist? What is their purpose? Can they be the “energy”, the “life force”, that I believe enters all of us when we are conceived? And, in the July 2004 issue of the Paranormal Review, I suggested that this entity could be called a “psyche-anima” (a combination of Greek and Latin, this word can represent our mind, spirit, and vitality).

So, what survives after we physically die, and our families and friends are simply left with only a corpse to look at?

Is there a “soul”, travelling somewhere else, is there a “psyche-anima”, or is there simply nothing?

To be frankly honest, nobody on Earth today can be one hundred per cent certain of the answer. Life is a wonderful mystery, with so many possible answers. But, when death comes, the mystery might be gone for the one who dies. Upon dying, that individual might possibly know more about death than anyone presently on this planet. Perhaps for those of us alive, it is best to suspend absolute judgement, and refrain from either strongly believing or disbelieving? Although I presently do not believe it myself, if there is an afterlife, it is likely to be an even stranger existence than being born alive, on this planet. And, as I love having an issue for which one can campaign (like supporting the United Nations or seeking a right-to-die law), I wonder if I will be able to campaign there?

## NEARING A COMPLETED LIFE

My father (William Knox Irwin) came from Drumquin, in Northern Ireland, from a farming family. As the first person to go to college, he qualified as a doctor at Aberdeen University in 1908, and then obtained his post-graduate surgical degree (FRCS) at Edinburgh University. He specialized in urology, and was the senior surgeon at St. Paul's Hospital, in London, when he retired in 1950. He was a passionate supporter of a "United Ireland" (resisting the opinions of his staunchly Protestant family) – I can still remember him taking me to a private meeting with Eamon de Valera, the Irish Prime Minister, in Dublin, in 1944.

My mother (Edith Isabel Mary Collins) was proud to say that she was born in prison because, when that happened, her father was the chaplain at the Lancaster jail (then, the prison governor, the prison doctor, and the prison chaplain usually lived, with their families, in or near the prison). My parents met in London, and lived their lives together in the capital or in a neighbouring county. They are buried in the same grave (my father dying in 1973, and my mother in 2005) in Cockerham, a village near Lancaster.

I was born in London (just off Baker Street), and lived there until 1941 when, because of the war, I was evacuated to Sussex. Three years later, now living in Hertfordshire, I went to Merchant Taylor's School. There, I began my lifelong interest in politics and foreign affairs,

and I joined the United Nations Association when I was sixteen. Academically, I was better at Science than other subjects, which was fortunate as I gradually decided to consider a career in Medicine.

In October 1949, I became a medical student at St. Bartholomew's Hospital, in London. I can still remember the Dean of "Barts", saying, on the first day, "During your time here, you will learn not so much how to cure people, you will learn not to kill them", and "As many of you will become GPs, you must remember that, in general practice, many of your patients will get better if you do nothing – the secret to success is to identify those that you must treat".

Because of my interest in the UN, I soon became active in the UN Student Association. And, from 1951 to 1953, I was elected as the UNSA Treasurer, then the Vice-President, and finally the President of this national student organization (at that time, when there was so much interest in the UN, it had about five thousand members around the UK). Also, I was naturally keen on the activities of the World Health Organization (a UN Specialized Agency), and, in 1954, I helped to establish the UK Committee for WHO (being one of its two Honorary Secretaries).

In spite of these extra-curricular activities, I was able to successfully pass all my medical examinations, until it came to my "Finals". I should have qualified in April 1955. But, I failed the "Surgery" part of the "Finals" that month, and had to wait until October, later that year, to pass in this subject. However, fortunately, during that Summer,

I was awarded a two-month internship to work at the UN Headquarters, in New York, where I was assigned to UNICEF. And, while there, I met the Medical Director at the United Nations (Dr. Szeming Sze, who had studied at St. Thomas's Hospital, in London) who encouraged me to consider joining the Medical Service, located in the UN Building, in January 1957.

In December 1955, I began a six-month assignment at the Prince of Wales Hospital, in Tottenham, in North London, in its Casualty Department. Nowadays, this would be known as "A&E", with very sophisticated equipment and specialist staff. But, in the mid-50s, the Casualty Department in this fairly small hospital was run, day and night, and every weekend, by two young doctors, straight out of medical school, and several nurses (with the occasional supervision of the hospital's Surgical Registrar), and the essential involvement of the hospital porters (who decided, during the night, whether or not to wake which of us who was "on call"). As a Casualty Officer, I handled all kinds of emergencies (from simple injuries to possible heart attacks) – this was wonderful, practical experience for a future GP or a UN Medical Officer.

Then, in June 1956, I began a second six-month assignment at the Prince of Wales Hospital, as a House Physician. At the end of this, I was considered – by the procedures then in place in the UK – to be a fully-qualified doctor. And, during this time, I had formally applied, and been successfully appointed, to be a UN Medical Officer, on an initial two-year contract, to start in New York, in January 1957.

On January 1, 1957, only twenty-six, now a UN civil servant, I flew from London to New York – on that date, I did not expect that I would remain in the "UN System" for the next thirty-three years! While I would always be proud to be British, it was a wonderful feeling to think that, working at the UN, I was almost a "world citizen".

The UN Medical Service is located on the fifth floor of the main Secretariat building. When I started, there were two full-time doctors (Dr. Sze and myself: when I left in 1989, there were four doctors), five nurses, a laboratory technician, an x-ray technician, and ten administrative and clerical staff. In addition, there were five consultants who each came half-a-day every week (a cardiologist, a general surgeon, a chest physician, a gynaecologist, and a psychiatrist). In total, we were eleven different nationalities. The laboratory could undertake all the usual haematological and urinary tests, with Pap smears: and, in addition to chest x-rays, we could do mammograms and skeletal x-rays.

We were available for the UN staff and their families, and also for members of the UN delegations in New York. Also, we saw the visiting public if any of them suffered a medical emergency while in the UN buildings (in 1964, I had to deliver a visitor's baby).

Basically, as the Medical Officer, I was the GP to the UN. While the nurses took care of many who came to the Medical Service, I would see those with more serious illnesses and injuries. In an average month, there were at least two thousand visits to the Medical Service. Naturally, we worked closely with the staff and delegates' family

doctors throughout the New York area. And, as the UN is located close to the New York Hospital (useful for very serious emergencies that might happen, requiring urgent hospitalization), I was also appointed as an Assistant Physician to Out-Patients at this institution (and spent every Tuesday afternoon there).

In the 1950s, 1960s, and 1970s, the United Nations was a very important influence in the world and much respected, especially in the United States. For example, in those days, the New York Times had three reporters assigned to cover the Organization's activities: when I left the UN, in 1989, it had only one reporter working there.

On November 1, 1958, I was married to Elizabeth Naumann – born in England, I had met her, in Manhattan, in March that year. Together, we had three wonderful daughters (Christina, Pamela and Diana) – who, later, gave us six granddaughters and two grandsons – perhaps this evolutionary legacy is the essential reason for our own existence on Earth?

My first two years, working at the United Nations, went well, and, at the end of 1958, my contract was extended, and I was promoted (I was given a permanent UN contract in 1962).

In October 1959, I took nine months special leave from the United Nations in order to study at Columbia University (in upper Manhattan) for the degree of Master of Public Health, with the emphasis, in my case, on occupational health.

In April and May 1961, I spent six weeks in Western Samoa – along with ten UN colleagues – to supervise the holding of a plebiscite there regarding this country's desire for independence (at that time, it was a UN Trust Territory, supervised by New Zealand). I was one of the two official observers who visited all the villages on Upolu (one of the two main islands), meeting with the elders and others to discuss what was involved with becoming an independent country. It was a fascinating experience. Later that year, Western Samoa formally joined the United Nations.

In addition to my work in the Medical Service, and being involved in other UN activities (for example, I had been elected to the UN Staff Council), I wrote a booklet for the Public Affairs Committee, a non-profit educational organization, in New York, on "Check-Ups: Safeguarding Your Health", which dealt with the importance of periodic medical examinations, especially to detect asymptomatic diseases such as diabetes and hypertension. This was published in 1961, and, during the next twenty-six years, I wrote a further nine booklets for the Public Affairs Committee, with titles ranging from "AIDS: Facts and Fears" to "Overweight – a Problem for Millions" (the latter was the most successful, being reprinted fourteen times, and selling about one million copies).

Later in 1961, the opportunity arose of going to Pakistan to become the Deputy Resident Representative for the UN Technical Assistance Board (later, renamed the UN Development Programme) for two years. Because this would have the great advantage of obtaining

useful experience of working “in the field” (rather than “at Headquarters”, in New York), I accepted, and, on September 16th, I arrived in Karachi (Elizabeth, Christina and Pamela joined me in mid-November). My DRR work was essentially meeting and coordinating the activities of the many UN and Specialized Agency experts (from WHO, UNESCO, FAO, etc) working in the country, and writing reports. Sometimes, the Resident Representative was absent from Pakistan, and then I was the “Acting Res. Rep.” – a great experience as this involved dealing with senior Government officials.

I returned to the UN Medical Service in September 1963, to my previous activities. Then, because of an increasing workload (there were now more staff and delegates, and their families, in New York), a third doctor joined the Medical Service, and I became the Senior Medical Officer in 1966 (with another promotion).

When I started at the UN, in 1957, the Secretary-General was Dag Hammarskjöld – in my opinion, the best “SG” of them all. Tragically, he died in a plane crash in Africa in September 1961. His successor was U Thant, who also took a keen, personal interest in staff welfare, and, for this reason, would occasionally invite both Dr. Sze and myself to have lunch with him, in his private dining room on the 38th floor of the Secretariat building (which had an amazing view overlooking midtown Manhattan). On one occasion, we were joined by Ralph Bunche – a Nobel Peace Prize winner, and a key aide to U Thant – and I still remember him saying, during this lunch, that “There are no warlike peoples, only warlike leaders” (Bunche had received his Nobel Prize because of his efforts to obtain

several successful ceasefires between Israel and its Arab neighbours).

As my three daughters were gradually growing up, it was becoming increasingly difficult to live within the confines of the usual Manhattan apartment – in fact, Elizabeth and I were sleeping on a Castro convertible bed in the living room. By good fortune, at a parents’ event at Christina’s school, in October 1968, I met another parent who owned several apartment buildings, and, hearing of our cramped living conditions, he offered us an eight-room, rent-controlled apartment on the corner of 89th Street and Central Park West, overlooking Central Park. This 1895 building – with just two apartments on each of its seven floors – then became our home. And, this was my “New York base” until I retired back to the UK in 1993. Having such space – which was only a forty-minute bus ride from the UN building – made living in Manhattan such a pleasant experience.

At the end of 1968, Dr. Sze retired, and I became the UN Medical Director on January 1, 1969 (at 37, I was then the youngest Director in the UN Secretariat). In this position, one of my main responsibilities was supervising the medical institutions and facilities which were available for both United Nations and the Specialized Agency staff, and their families, globally. And, to assist me in doing this, I would rely greatly on the advice of carefully selected doctors working in the main cities around the world – there were about 350 of these UN Examining Physicians. This meant that I had to travel extensively – to meet these doctors and to see where they, and others, worked. Often, when I might be asked what I

did at the UN, I would say that “I travel a great deal and I know the best cardiologist in Kathmandu and the best gynaecologist in Ouagadougou”. Fortunately, I love travelling (in total, during my UN career, I spent time in seventy-eight countries – throughout Africa, Asia, the Middle East and Latin America).

Some of these trips can be remembered more easily than others. For example, one of the very early ones, in 1969, took me to Egypt and to Israel, essentially to check on the medical services available for the UN military observers based along the borders of Israel, from the Golan Heights (looking into Syria) to the Suez Canal. While driving along the Egyptian side of the Canal, I had to wear body armour as “sometimes the Israeli gunners fire at all moving vehicles even when they show the UN flag”.

But, I felt it was still important – in addition to my administrative responsibilities – to continue with some clinical work in the Medical Service, especially to cover for emergencies. In particular, I still remember, on November 2, 1971, being called suddenly to the 38th floor as U Thant had been discovered unconscious, lying on the floor of his office. This was due to a previously undiagnosed bleeding stomach ulcer. I had to set up an IV drip and get him rushed to hospital. Afterwards, during his recovery, we had frequent discussions, and, on one occasion, he told me that, every evening before going to sleep, he thought what had been the best thing he had done that day, and what had been the opposite, with the hope that he could repeat the former, and not the latter, on future days – I still often do this myself before going

to sleep. (In April 1975, when I was in Rangoon, I went to U Thant’s grave – he had died in 1974. There, I was suddenly accosted by a soldier, who was guarding this site, who pointed his rifle at me – I remember shouting to the UN driver, fifty yards away, to come quickly to explain to this soldier, who did not speak English, that I was only paying my respects to a former Secretary-General).

One of the fascinations of working in the Medical Service, in New York, was the opportunity to meet well-known individuals who had, unfortunately, a medical emergency. For example, on April 10, 1972, I met George Bush (then, the US Ambassador to the UN) in order to remove a dust particle which had stuck to the surface of his right eye. I can remember saying to him – “These foreign bodies in the eye, Mr Ambassador, can be quite nasty” – to which he commented, “Are foreign bodies the right expression to use in the UN”?

In March 1973, I was invited to become the Director of Personnel at the UN Development Programme (its headquarters were across the road from the UN, on First Avenue) – an interesting, but rather unusual, position for someone with a medical background. But, as I contemplated remaining as Medical Director until my retirement, from the UN, at sixty (eighteen years away), I thought that this could be a fascinating challenge – so, I accepted.

In September 1973, I transferred from the UN to UNDP, and headed a department of sixty-three individuals. And, I was promoted to the D-2 Director level which is the

highest permanent step that one can reach in the UN Secretariat (the next level – Assistant Secretary-General – is a political appointment, when someone is nominated by one's Government, and is limited to fixed-term periods).

Globally, UNDP had offices in 130 countries, coordinating the local activities of the UN and all its Specialized Agencies (ranging from the World Health Organization to the World Bank). Again, as Director of Personnel, I had to travel a great deal.

I will never forget one particular trip. In April 1975, when I was in Bangkok, I had to suddenly go to Saigon where UNDP had a small office (with an American Resident Representative, and ten local Vietnamese staff). At that time, the Vietcong were very close to Saigon. I flew there, on April 11th, in a plane with only one other passenger (a TV reporter). During the next two days, I met with the local staff, mainly to reassure them that UNDP would want them to return to our Office when conditions were “normal” again, and I accompanied Pierre Sales (the Res. Rep.) to the Foreign Office for him to receive a medal, thanking him for his services to South Vietnam – all this time, one could hear artillery firing close to the city (it was all rather surreal). When I left, my plane was so full (some were standing in the central aisle) that it took some time for it to get off the ground. At the end of April, Saigon was captured by the Vietcong (who quickly closed the UNDP Office).

After three and a half years at UNDP, I was asked to become the UNICEF Representative in Bangladesh, and

I arrived in Dacca on February 13, 1977. Because many of Asia's problems were still carried to their extremes in this country (for example, 80% of the population – then, 120 million – lived below the poverty line, and there was insufficient food production), this was, at that time, UNICEF's largest country office (there were twenty-two international staff, and nearly two hundred Bangladeshi staff), and we consumed about ten percent of this organization's financial resources. While there, I travelled all over the country – in so many villages and small towns, one could find a project supported by UNICEF, ranging from a local school to a small medical centre.

One particular incident that I will never forget occurred on September 29, 1977 when a JAL passenger plane was forced to land in Dacca after it had been hijacked by a Japanese Communist group. I went to the airport where I saw Wing Commander Choudhury, of the Bangladesh Air Force, who I had previously met. As the UNICEF Representative, I felt some responsibility for the women and children on this plane (there were 156 passengers) and so I offered to be a hostage to take their place. The Wing Commander was in negotiation with the hijackers and he told me to return the next day. That evening, I wrote letters to Elizabeth and my three daughters to explain what might happen. Fortunately, without any deal, the women and children were released the following day, and later the plane flew to Algeria, where the six hijackers escaped.

UNICEF was (and perhaps today, may still be so) the most decentralized of all the various UN organizations. For example, near the end of my first year, I sent a cable to

our Headquarters in New York to say that the unused one million US dollars, still available to us in Dacca that December, could still be utilized by providing urgent school supplies throughout the country (such as blackboards, chalk, exercise books, and pencils) – within forty-eight hours, I received a quick approval, with just one question – “Do you need sharpeners for the pencils?”

While in Bangladesh, I became very interested in the plight of blind children in this country – it was estimated to be at least 200,000 of them. With several Bangladeshi friends, I established a local charity (Assistance for Blind Children). Quite separate from UNICEF, we received funds from all over the world (especially from UNESCO, the Royal Commonwealth Society for the Blind, and Helen Keller International). ABC focused on young children who needed cataract operations (because they had been born blind as their mothers had contracted rubella during the early months of pregnancy), and on older children, in the rural areas, where their status in their local village community could be much improved if they were given a sheep, to look after, or raise poultry. In the New York Times, of April 29, 1979, there was a report on these ABC activities.

I left Bangladesh in October 1980 and, for the next two years, I was the UNICEF Senior Adviser on Childhood Disabilities, based in New York. Essentially, my work involved working with the UNICEF country offices in developing programmes for the prevention of disabilities as well as creating suitable projects for disabled children, especially in rural areas.

The UN International Year of Disabled Persons was throughout 1981 – for three months of this year, I was a consultant to the IYDP Secretariat in Vienna, and I was also the UNICEF Representative on the WHO Expert Committee on Disability Prevention and Rehabilitation. One special IYDP activity was to be a co-author of the “Leeds Castle Declaration on the Prevention of Disablement” which was drafted at an international seminar held in Leeds Castle, in Kent, in mid-November (there, I asked Prince Charles, who attended this event, if his fiancée, Diana, had had rubella in childhood: three months later, via the UK Mission to the UN, in New York, I received a letter to say that she had had this infection).

On the personal side, my marriage to Elizabeth was unfortunately coming to an end. We had had many wonderful years together but, slowly, we had simply become “friends”, and in June 1981, we signed a separation agreement. Officially, with the involvement of only one lawyer, we were divorced in November 1982. We remained in fairly close contact, and still met occasionally – in fact, in October 2011, she, with her second husband, stayed with me when they were visiting the UK.

Then, as my successor as the UN Medical Director (Dr. Peter Gatenby, from Ireland) was due to retire in November 1982, I was asked to return to my former position – which I did on November 15th.

Soon afterwards, I met Frederica Harlow, and we were married on April 9, 1983. The biggest “adjustment” that we had to make was to ensure that her cat (Slitz) and

mine (Tibs) became friendly – which, after a fortnight of careful negotiation, happened fairly peacefully.

Although I had enjoyed the “break” from administrative and clinical medicine, I was pleased to be back in the UN Medical Service. I continued to travel extensively. One trip was a return to China and India in 1986, with an additional visit to Nepal. In Kathmandu, while sightseeing in this city, a photograph was taken, without my knowledge, as I stood in front of the Eden Hashish Centre – this appeared later in the UN staff magazine with the caption “Where is our Medical Director getting his drugs these days?” Then, in October 1987, I spent a fortnight in Abidjan helping to establish a new Medical Centre at the African Development Bank. One of my final trips was to Namibia for a fortnight in October 1988 travelling throughout this country, looking at various medical facilities, in preparation for the large UN mission that would soon be present to assist in the development of this new UN member state.

During this return to the UN, I developed a particular interest in blood donation – one reason for this was the global appearance of the HIV virus which could cause the acquired immune deficiency syndrome (AIDS). In 1984, I initiated the establishment of “ABC Clubs” in the UN/UNDP/UNICEF country offices around the world, encouraging all staff (everyone, potentially, being a blood donor), if required, to make an “annual blood contribution” locally. And, from that year to 1990, I served as a consultant to the American Association of Blood Banks.

Also, as the Medical Director, I had various administrative roles, ranging from being the Medical Adviser to the UN Joint Staff Pension Board (which covers all UN and Specialized Agency staff globally) to being the Chairman of the UN Health Insurance Review Committee. And, non-medical positions varied from being the Vice-Chairman of the UN Recreation Council to being a Director of the UN Federal Credit Union. Working at the UN was a wide-ranging experience – which I always greatly enjoyed.

The most protected politician in the world is the US President. Whenever he comes to speak to the UN General Assembly, every Autumn, security arches are placed at all the entrances into the Assembly Hall. A VIP, like this President, is allowed to wait in a small room behind the podium, in the GA Hall, before speaking to the delegates. The only others usually allowed into this room are a few aides to the President (such as the Secretary of State, and the White House physician, along with the military officer who carries the “nuclear button” box – bringing the latter into the UN building always seemed rather obscene to me), and the UN Heads of Protocol and Security. In 1984, I suggested that someone from the Medical Service should also be present. When Ronald Reagan spoke to the General Assembly, I was present in this waiting area. It was really fascinating to be so close to the so-called “most powerful man in the world” – and, he was so friendly, shaking hands with everyone.

Two memorable medical experiences during this period involved two well-known ladies. First, when Margaret Thatcher attended the 1984 session of the UN General

Assembly, she had a bad cold, and I was asked to see her. I examined her, but could find no complications of this infection. However, she wanted an “antibiotic”. I tried to explain that, as her infection was due to a virus, antibiotics were unnecessary. But, she insisted – and vaguely suggested that a complaint might be made if I refused her request. Therefore, I arranged for a nurse to give her an injection. Next day, when I called the UK Mission to the UN, I was told that “the Prime Minister is much better and is most grateful”. When I replied that Mrs Thatcher had received an injection of distilled water on the previous day, I heard a gentle laugh – I am certain that nobody told her about this. Then, when Nancy Reagan accompanied her husband to the General Assembly in September 1987, she had an eye infection. At the request of the White House physician, Colonel Hutton, who was travelling with her, I produced a bottle containing the eye-drops that we used in the Medical Service which were the same medication that she had already received – but, she refused to take them as the bottle was “a different shape” to the one that she had seen, earlier that day, when she had been treated at the White House.

And, thinking of non-medical experiences, I remember meeting Yasser Arafat when he came to the General Assembly in December 1988, as it was considered advisable, for security reasons, for him to stay, during his time in New York, in one of the bedrooms in the Medical Service – we had several friendly chats, ranging from Manhattan’s traffic congestion to the cold weather outside.

In the 1980s, many people were concerned about having personal contacts with those who had become HIV positive. Within the UN community, it became known that a close aide to the Secretary-General (now, Javier Perez de Cuellar) was HIV positive, and some of his colleagues were expressing their concern. In order to help handle this situation, the SG requested me to have lunch with this individual at his special table in the UN Delegates’ Dining Room – I can still remember the crowded restaurant, on this day, carefully watching the two of us very closely as we enjoyed our meal.

In addition to my various activities as Medical Director, I became passionately involved with the global anti-nuclear weapons campaign at that time. In June 1983, I represented the UN at a conference, in Amsterdam, of the International Physicians for the Prevention of Nuclear War. And, in June 1985, in Budapest, and in May 1987, in Moscow, I attended further IPPNW conferences, on behalf of the UN. Also, I became active in a similar organization known as Physicians for Social Responsibility (when I was in Washington in 1989, I was on its Executive Committee).

In early 1984, with several UN colleagues, I started an internal group called the UN Staff Movement for Disarmament and Peace, mainly campaigning for a ban on all nuclear weapons. We showed films to UN staff and delegates, hosted talks for external speakers, and signed petitions – all rather unusual for international civil servants who are meant to be neutral on such matters. And, from 1985 to 1995, I was on the Editorial Advisory Panel of the British journal “Medicine and War”.

In December 1988, I was invited to become the Medical Director at the World Bank and the International Monetary Fund, in Washington (the two organizations, located close together, shared the same Medical Service). There were two reasons why such a move was of special interest to me – firstly, I could work until I was 62 (this was the retirement age for World Bank and IMF staff, whereas one had to retire from the UN, in those days, at 60); and, secondly, I could now take “early retirement” from the UN, receiving an attractive UN pension, and earn a generous World Bank salary as well. Plus, an additional attraction was that, always being interested in politics, I could get the experience of living in Washington.

I retired from the UN on March 16, 1989, with mixed feelings – as it had been such a wonderful life, with so many interesting experiences. I know that the following sentences are rather personal, but I was delighted to receive a note from Kofi Annan (then, the Assistant Secretary-General for Personnel – and a future Secretary-General) which said, “I, and all your colleagues and friends in the Organization, shall miss your untiring efforts to promote a healthy Organization both at the medical and managerial levels, and your wit and sense of humour so scarce in our bureaucratic setting”. And, Javier Perez de Cuellar wrote, “I wish to thank you for the invaluable contribution you have made to the Organization over the past 32 years...you became a familiar and trusted figure whose sound advice and counsel was always available. You will be remembered especially for the quiet concern you shared on behalf of sick and troubled colleagues and for the fairness with which you treated all staff”.

I began working in Washington on April 3, 1989. It is important to remember that both the World Bank and the International Monetary Fund are officially UN Specialized Agencies. However, in reality, these two organizations often ignore this fact – for example, by paying their staff more, and providing greater allowances, than that received by UN staff or those in other UN Agencies (such as WHO, UNESCO and FAO). In previous years, when I had travelled the world, I had often noticed that the World Bank and IMF country offices were usually much larger than those of UNDP and the other Agencies. Over the main entrance to the World Bank, in Washington, there were two flagpoles – on one, the World Bank flag flew daily; but, on the other, the UN flag was flown, in those days, only once a year, on UN Day (October 24th).

Compared to my workload at the United Nations, my activities at the World Bank and the IMF took only about one-third of my time – its Medical Service was overstaffed and not very busy. In addition to my medical responsibilities, I occasionally deputized for William Cosgrove – the Bank’s Vice-President for Personnel – which gave me further insight into the activities of the institution. As the year progressed, I gradually became more and more aware of various major internal failures of the Work Bank, and, to a lesser degree, of the IMF.

During February 1990, I visited several World Bank and IMF offices in Africa. Normally, for such a trip, Bank and IMF staff would fly in “first class” (at the UN, only two officials then flew this way – the Secretary-General and the UNDP Administrator). I decided to make this trip in

“business class” (what I saved was used for a short training programme for two of my nursing colleagues), and, upon my return to Washington, I wrote in the World Bank staff journal that others could possibly follow my example, especially as the World Bank’s goal is “the reduction of poverty”. The reaction from my colleagues was 100% negative, with comments such as “an end to first-class travel could lead to an increase in travel-related strokes”. In the April 14, 1990 issue of *The Economist*, there was a half-page report on this; and, in the June issue of *The Washington Monthly*, four pages were devoted to quoting many of these negative staff comments.

During March, I realized that I did not enjoy working any more at the World Bank, and, on March 30, 1990, I publicly resigned, from this organization, with *The Wall Street Journal* publishing a lengthy statement from me, on its editorial page, entitled “Why I’ve had it with the World Bank” – in this, I referred to the Bank’s “bloated and overpaid bureaucracy, wasteful practices, poor management, and unjustified arrogance”. To support my views, it was useful to quote William Cosgrove who had recently stated that the Bank “could do twice as much with its present staff or only needed half the staff for the present workload”. During the following months, news of my resignation surprisingly appeared in various publications, with the biggest report being in *The Washington Post* on September 25th (timed to appear on the opening day of the annual meeting of the World Bank and IMF), under the title “Breaking Open the World Bank: former official’s public attack on the privileges of fighting poverty” – this was reprinted around the world, from Indonesia to the UK (here, *The Sunday Times*, of

September 30th, used the headline of “The man who broke open the World Bank”).

During the Summer of 1990, back in New York, I wrote a novel called “Talpa” – which promoted the anti-nuclear cause and considered the possibility of a “mole” (or “talpa”, in Latin) infiltrating the United Nations in order to assassinate a warmongering American President. The plot was so realistic that two US Secret Service officers unexpectedly arrived at my Manhattan apartment one evening, but, after an extensive interview, being satisfied that this was a fictional story, nothing further happened.

From October 1990 to January 1991, I had a four-month assignment with ActionAid, in London (I consider this to be one of the best British non-governmental organizations, spending little on administration costs). My main responsibility was to develop closer links between this NGO and the UN and its Agencies for the development of the former’s grass-roots projects around the developing world. It was also very pleasant to be living in London again.

During this time, my second marriage was gradually coming to an end – for a variety of reasons, but, a major one was financial as Frederica was very concerned about us living in central New York “on a UN pension”. We had a “friendly divorce” in April 1991 – several months later, she married one of the richest men in Atlanta (tragically, soon afterwards, due to a major car accident, she suffered considerable permanent brain damage).

After ActionAid, back in New York, I did not want to do nothing except “enjoy retirement”, without any specific focus, forgetting which day of the week it was. Often, at the UN, when someone was close to retirement, and thinking about their future life, I would advise that person to do some specific “working/intellectual activity” on the same day each week – then, “the rest of the week falls into place”.

So, in June 1991, I became a (voluntary) director for West Side Action (a community service organization, active in the Upper West Side of Manhattan) and worked in their office (only a short walk from my apartment) every Monday and Thursday, mainly responsible for membership and financial matters. This was very interesting work, getting to know much more about the problems faced by some residents (especially the elderly) in the city.

However, during the following year, in spite of enjoying seeing my three daughters (who were now living in nearby Connecticut and Massachusetts) regularly, I was increasingly drawn to the possibility of further retirement in the UK, especially to be in or near London (still, for me, the best city in the world). I had three good personal reasons. Firstly, as I was an only child, I felt increasing responsibility to be close to my mother in her final years (in fact, she died in February 2005); secondly, to live in a more enjoyable climate (New York is too cold in Winter, and much too hot in the Summer); and, thirdly, a preference for British medical care as one aged (from considerable professional experience, I did not like the financial motivation, and the excessive over-treatment,

of the American system). I discussed these reasons with my daughters because, obviously, I would not see so much of them if I would be three thousand miles away. Fortunately, they were supportive of my returning to the UK as we could visit each other for many more years, and the telephone could be extensively used (after all, I could have stayed in the States and retired to, say, California, also three thousand miles from the East Coast).

Finally, on March 31, 1993, my American life ended and I returned to the UK. The hardest “farewell” to my life in New York was handing over my beloved cat, Tibs, to Dee, who lived nearby, because I knew that, at his advanced age, he would not easily survive six-months’ quarantine in the UK. Tibs had been such a wonderful dear pet – often I felt that we communicated just by looking into each other’s eyes. I would telephone Dee every couple of months, to check on him. Tibs died in June 1995.

Once back in the UK, I soon renewed my previous link with the United Nations Association, and I spoke to UNA branches throughout the country about my UN experiences. I was elected to the UNA Executive Board in November 1994, and, in May 1996, I became the UNA Chairman. It was a great pleasure, on February 26, 1997, to have a private meeting, at his London hotel, with Kofi Annan, who was now the Secretary-General, and was making his first official visit to the UK. Then, in 1998, I became a UNA Vice-President.

In association with my UNA activities, I served as a Vice-President of the National Peace Council (from 1996 to

2000), and I was also the Chairman of the UK Committee for the UNHCR, from 1997 to 2002.

Keeping in touch with my daughters was extremely important, and, in October 1993, I visited the States to see them – the first of many regular trips. Fortunately, they would also travel to the UK, often with their families. Also, when each of my grandchildren became sixteen, they would make individual trips, without their parents, to stay with me in the UK, giving me the opportunity to remind them of their British roots.

In December 1993, I met Patricia Walters – and, we were married on May 13, 1994. We lived in Chelsea, in central London, which fortunately was nicely situated between the UNA office and also the VES office. And, twice a week, I would travel down to Hove, to see my mother.

I had joined the Voluntary Euthanasia Society soon after I returned to the UK in 1993 – initially, because of my support for Living Wills (important documents which, basically, state the medical care one would like to receive if one was unable to communicate with one's personal doctors because of a serious disease or accident), which had began when I was in the UN Medical Service and encouraging UN colleagues to complete them (living wills were the initial concept of Luis Kutner, a Chicago lawyer, in 1967).

At the VES AGM, on October 22, 1994, I met John Olver, the Society's General Secretary. Three weeks later, I began working as a volunteer, in the VES office, going there every Wednesday. I would stuff envelopes, answer

the telephone, and generally help the four VES staff. And, on December 1st, I appeared on the BBC TV Esther Rantzen programme, which, that evening, discussed the "right-to-die", especially the "double effect" concept (giving drugs in increasing dosages "to relieve a dying person's distressing symptoms" rather than openly stating that the intention was to end that person's life). Later that month, I joined the VES medical sub-committee – which, in 1998, I developed into Doctors for Assisted Dying ("DAD") – the forerunner to Healthcare Professionals for Assisted Dying (now, part of Dignity in Dying).

In March 1995, I was invited to join the VES Executive Committee, and I was elected to be the Vice-Chairman on November 16th that year, becoming the VES Chairman on May 10, 1996, and remaining in this position until 1999. However, as one could not continuously be Chairman for more than three years, I became the Vice-Chairman again in 1999, until 2001; and then, the VES Chairman again from November 27, 2001 to December 2003. I felt that it was a great honour to be so trusted by the other members of this VES Executive Committee,

From 1994 to June 2018, I did a total of 289 radio interviews and 122 TV interviews on the need to legalize "assisted dying". One popular BBC Radio Four programme which I have always enjoyed is "The Moral Maze" – my first appearance was on December 5, 1996 and the last, nearly twenty years later, on June 16, 2016. Also, since the mid-1990s, I have given 141 talks and participated in 53 debates. The best debates have been at the

Cambridge University Union (on November 9, 1996 and on January 16, 2014), in the European Parliament, in Brussels (on September 5, 2012), and at the Oxford University Union (on May 14, 2009, and again on October 18, 2012).

While my VES activities were at the national level, internationally, I was elected to be the Vice-President of the World Federation of Right-to-Die Societies (an international body representing 50 national organizations in 26 countries) from 2000 to 2002; then, its President for the next two years; and finally one of its Directors from 2004 to 2006. Nearer home, I was a Director of Right-to-Die Europe from 2011 to 2013. These international activities reminded me of my UN life as, with many like-minded colleagues and friends around the world, we met at conferences regularly, ranging from Tokyo (2004) to Toronto (2006), and from Melbourne (1996 and 2010) to Zurich (1998 and 2012). Among these various conferences, I always remember the first one – in Melbourne, in 1996 – because there I gave a plenary speech on “Palliative Care and Voluntary Euthanasia: Cooperation or simply Coexistence?” in which I stressed that someone should always consider all the alternatives which good palliative medicine can provide before accepting a doctor-assisted suicide or voluntary euthanasia (today, it is wonderful that, in Belgium, the latter procedures are essentially part of the excellent palliative care available in that country).

In 2006, I proposed that the World Federation should have a Health Professional Award, to be given, every two years, to the healthcare professional who had set an

example for others (and, I provide the funds for this) – among the winners were Dr. Pieter Admiraal (the “father” of legalized voluntary euthanasia in The Netherlands) and Dr. Libby Wilson (the founder of Friends At The End). In September 2014, at its Chicago conference, the World Federation of Right-to-Die Societies presented me with the Tenrei Ohta Award – its main award given, every two years, to someone who has had much influence on the international right-to-die movement.

Returning to personal matters, my marriage to Patricia was becoming more and more platonic – and, having separated in May 1999 (I moved down to Hove), we had a “friendly divorce” in August 2000.

While, of course, my official career was with the United Nations, in many ways, my right-to-die activities, from 1994 onwards, became a second career, occupying my mind almost on a daily basis and fulfilling so many satisfactions. I knew that I would never have been content to have had the usual activities of retirement, such as reading or going on cruises (although I did find time for these as well).

Thinking back now over the past twenty-five years, I will describe some of my most interesting right-to-die activities in the following paragraphs.

On July 20, 1997, in an interview with The Sunday Times, I stated that many doctors, around the world, assisted their terminally-ill patients to die by using the doctrine of the “double effect”. On the same day, having seen this report, Dr. Dave Moor, a GP in Newcastle, told the

Press Association that he had helped his dying patients in this way, “including two only last week”. This resulted in much media attention – in fact, on July 21st, I did ten radio and TV interviews, ranging from BBC Radio Four to Sky News. On July 30th, Dave Moor was arrested for the “murder” of George Liddell, one of his cancer patients, on July 19th.

Dave Moor and I became good friends, meeting both in London and in Newcastle. Almost two years after his arrest, on April 16, 1999, Dave went on trial in Newcastle. I attended the first day. However, without much thought, I interrupted the opening prosecution statement by shouting from the public gallery, “You are persecuting a wonderful, compassionate doctor – this is a disgraceful trial”. I was ordered by the judge to leave the court, and my departure was reported on the BBC TV News that evening. Fortunately, on May 11th, Dave was cleared of murder.

On September 5, 1999, the MP in the London constituency of Kensington and Chelsea, Alan Clark, died, and I decided to stand, in the subsequent by-election, for the legalization of Living Wills. In fact, I was the first (and, perhaps, will be the only?) “Living Will Legislation” parliamentary candidate in the world. The 60,000 constituents in this area each received a sample Living Will with my election leaflet. Because of the unusual nature of my campaign, there was considerable media interest. For example, the (London) Evening Standard noted that this campaign “gave a whole new meaning to the use of ‘Exit Polls’ in elections”. And, in the British Medical Journal (on October 30, 1999), I proposed that

Living Wills should be “pro-choice” – not traditionally just refusing all treatment (apart from “being kept painfree and comfortable”) but “could also be written to state that one wants to stay alive with life-prolonging measures for as long as possible” – and, soon afterwards, the forms, available in the UK, were modified to cover this possibility. In this by-election, held on November 24th (when a former Cabinet Minister, Michael Portillo, returned to the House of Commons), I came ninth out of eighteen candidates – the only other “single issue” candidate to beat me was one supporting the legalization of cannabis (obviously, a more important issue for many voters in this part of London). Fortunately, the necessary legislation for Living Wills – now called Advance Decisions – was eventually incorporated into the 2005 Mental Capacity Act.

During this by-election, I had the good fortune to meet Angela Farmer, and I moved into her home, in Cranleigh, in Surrey, in June 2000 (while keeping my flat in Hove – always a pleasant place to visit, especially in the Summer). Essentially, Angela became my fourth “wife” as, by mutual consent, we decided against getting married. And, most importantly, our children have been delighted by this arrangement (Angela had three sons – Tim, Rupert and Giles: tragically, Tim died in August 2014, from cancer).

Being arrested by the police is not something that one easily forgets. Early in the morning of December 13, 2003, two Isle of Man policemen (with two Surrey policemen) came to my Cranleigh home and arrested

me, still in my dressing gown, for “conspiring to help a terminally-ill man to commit suicide”.

I had known Patrick Kneen, a retired farmer on the Isle of Man, for six years. He had begun a campaign to introduce a right-to-die law on this island (which has its own parliament), and, while the VES Chairman, I had made four visits there to assist him. In early 2003, he was diagnosed with prostate cancer, and, when I saw him during the second week of July, with the full support of his wife, Patricia, I had agreed to provide him with the necessary medication to end his life more quickly, whenever he asked me. But, when his wife called me to return to the Isle of Man on October 19th, he was already too ill to swallow anything that I had brought with me, and he died two days later (after his GP had provided terminal sedation). Patricia gave an interview to the Isle of Man Examiner, the main island newspaper, in which she referred to Patrick’s campaigning activities for a right-to-die law, and stated that he had hoped for a quicker death himself “with the help of a friend from the mainland” – and, on November 17th, she was arrested for “conspiring to help a terminally-ill man to commit suicide”. It was my turn a few weeks later.

Patricia and I were on bail for only two months, and then nothing further happened. But, I was given a “police caution” by the Surrey police because of obtaining sleeping pills for Patrick from my local chemist, in Cranleigh. Much later, on September 27, 2005, the General Medical Council removed my name from the medical register as I “expressed no remorse” for trying to help a close friend, and also I admitted that I “would be

willing to assist another terminally-ill friend in the future” (I believe that I am perhaps the oldest British doctor to have been so treated by the GMC – a rather dubious honour).

Accompanying someone to Switzerland – to witness their doctor-assisted suicide – is an unforgettable experience. In August 2005, I accompanied May Murphy, a 75-year old widow, from Glasgow to Zurich, to Dignitas. She was suffering severely from multiple systems atrophy. She was so relaxed on the flight to Switzerland – for example, as she had a sandwich, she joked that “Perhaps this is my last meal, and I only have one disciple with me”; and, as our plane landed, when a flight attendant wished everyone a “safe, onward journey”, she said loudly, “If only you knew where I am going”. Later, in the Dignitas flat, as she raised the glass to swallow the nembutal – that would very quickly end her life – she toasted her son (who had joined us in Zurich) and myself, thanking us for being with her.

Indirectly connected to “right-to-die”, in October 2005, from funds left to me by my mother, I agreed, with the National Secular Society, to sponsor the Secularist of the Year award (£5,000 and a trophy) for twelve years. This was often called the “Irwin Award” – and among its winners have been Professor Steve Jones (who has strongly opposed creationism), Lord Avebury (campaigner against our old-fashioned blasphemy laws), Peter Tatchell (long-term gay rights campaigner), Sophie n’t Veld (a leading Dutch member of the European Parliament), and Safak Pavey (a Turkish politician who defends secularism in her country). Then, in December

2006, I founded the Secular Medical Forum, and I was its Coordinator for three years – the first such organization of its kind in the world, the Forum “campaigns for a secular approach to major health issues”, ranging from abortion to religious surgery on children. In 2017, the SMF became a section of the National Secular Society.

In November 2006, I again witnessed a doctor-assisted suicide. Dave Richards, aged 61, was suffering from advanced Huntington’s disease. As he did not wish anyone in his family to see him die, I was asked to accompany him. Before we left Gatwick airport, to fly to Zurich, we had dinner with Sarah-Kate Templeton, the Health Editor of The Sunday Times – her subsequent report, in that newspaper, was headed “Last meal with the man who chose death” (and there was an unforgettable photograph of me pushing Dave, in his wheelchair, on to the plane, with his left hand raised slightly – a final farewell). He was also very relaxed during his final day – our discussion ranged from the nature of the Universe to motor racing – and, just before he drank the lethal nembutal, he removed his wristwatch and asked me to send this to his wife when I returned to the UK.

My third visit to Dignitas was in February 2007. Seriously ill with cancer of the pancreas, Raymond Cutkelvin lived in a council flat in London, with Alan Rees, his partner for twenty-eight years. Because they were not well off financially, I agreed to contribute £1,500 towards all the costs involved in getting to Switzerland. After Raymond’s death, Alan became an active right-to-die campaigner, frequently describing how his partner had died, and

even challenging to be arrested for assisting in a suicide. In fact, this happened in July 2009, and, because I had helped financially, I was also arrested. We were both on bail for eleven months – but, then, no further action was taken (however, there was this headline in the Daily Telegraph, on June 25, 2010 – “Dr Death ruled too old to stand trial”. Several British newspapers, opposed to any right-to-die law, sometimes refer to me this way – fortunately, this title never bothers me).

Throughout 2007, I had the pleasure of working with the two Humanist Associations in Ireland (one based in Belfast, and the other in Dublin) to produce, after reviewing the living wills then in use in twenty other countries, the first Irish “Advance Healthcare Directive”. On December 10, 2007, with several other humanists, I established the Living Wills Trust in Dublin, which distributes this document throughout the island. Later, in 2010, the Trust became the first Associate Member of the World Federation of Right-to-Die Societies.

During the first half of 2009, because I was increasingly interested in the concept of “old age rational suicide” – especially because of our ageing population – I wrote a booklet on this subject, which was published in October that year. Then, on December 10th (international Human Rights Day), in the London home of Nan Maitland, a close friend, along with Liz Nichols, another good friend, and Angela, the Society for Old Age Rational Suicide was established – in so many ways, I consider this to be the best achievement of my right-to-die activities (which is why SOARS is described in such detail elsewhere in this booklet). And, it was exciting to be the Coordinator of

SOARS from its beginning until August 2015 when I was pleased to be replaced by Phil Cheadle, who had become the Associate Coordinator during the previous year.

It was a very special and personal trip that I made to Switzerland, on February 28, 2011, with Nan Maitland and Liz Nichols, knowing that Nan would end her life the next day, because, in her 85th year, she was increasingly suffering from extensive osteoarthritis. Again, it was amazing to see how someone, determined to die, can be so relaxed. For example, about twenty minutes before she would drink the nembutal solution, Nan asked Liz for a nail file as the edge of one of her fingernails was “rather sharp” (fortunately, Liz had a file). Then, I sat next to Nan prepared to offer her some sweet chocolate to take, if required, when she had drunk the rather bitter nembutal – but she did not want this (“it is not too bad” were her final words).

During June 2014, around my 83rd birthday, I wrote “Approaching Old-Old”, which was a personal account of my views on “life” and religion, details of various right-to-die activities, my health, and planning ahead as one got older. “Old-old” has become one of my favourite expressions.

Next year, in January 2015, “I’ll See Myself Out, Thank You” was published. This was a collection of essays written by thirty right-to-die supporters (ranging from Anthony Grayling to Mary Warnock, and from Will Self to Chris Woodhead), which was edited by Colin Brewer (a retired psychiatrist, and a friend for twenty years) and myself – I wrote three chapters and, with Colin, co-wrote

two more. There were extensive, positive reviews of this book in The Times (on February 5th) and in The Oldie magazine.

I made another trip to Switzerland, on February 28, 2016, to witness the doctor-assisted suicide of John Hofsess, a Canadian friend since we met at a right-to-die conference, in Boston, in 2000, who was suffering severely from cancer of the prostate. For many years, he had been a leading campaigner for what is generally called “self-deliverance” (that is, bringing about one’s own death by taking responsibility for the whole procedure, including acquiring one or more of the means to do so), but, when it came to his own death, he preferred to involve a Swiss doctor, at Lifecircle, then based in Basel.

I believe that I have, so far, witnessed more doctor-assisted suicides than any other British physician. Being able to help others in these situations is a great privilege. And, seeing how dignified and professionally these deaths are handled by the Swiss has only increased my determination to campaign more and more for the same possibility, one day, in the UK.

During 2015, with Phil Cheadle, and several members of the Society for Old Age Rational Suicide, I was much involved in preparing a detailed statement on what constitutes a “Completed Life” – an abridged form of this document appears as an appendix to this booklet. And, at the 2016 conference of the World Federation of Right-to-Die Societies, held in May in Amsterdam, Phil presented a joint paper from both of us, entitled “When

is a Life Complete?”. This concept of a “completed life” can be easily used – especially by elderly people – when someone wants to discuss their end-of-life plans with their family, friends and personal doctors.

More recently, on December 10, 2017, I established The Last Choice – Switzerland which provides information on what is involved in going to either Dignitas or Lifecircle. At that time, while it was most unlikely that any legal authority, in the UK, would any longer be concerned if someone, acting compassionately, would accompany a relative or friend to Switzerland, for a doctor-assisted suicide, it was still uncertain whether regularly providing details on what is involved in travelling to Switzerland, for this medical procedure (which occurs in a country where it is not illegal) was actually breaking existing UK law? It will be interesting to see if there is any official reaction to the activities of TLC- Switzerland especially as, during 2018, a small Trust Fund was created to provide occasional grants to those suffering individuals, accepted by either Dignitas or Lifecircle, who, because of limited financial resources, found it very difficult to travel to Switzerland for a doctor-assisted suicide.

Becoming eighty-seven in 2018 reminds me that soon I can expect to reach a “completed life”. At present, I certainly do not feel my age. My father lived to ninety, and my mother was close to ninety-six when she died. Now, I look forward to getting to at least June 2021, and then being the same age as my father when he died – hopefully, with all my marbles intact and fairly steady on my feet.

## MY AGEING BODY

In December 2009, Newcastle University produced an “85 plus” study which stated that nine in ten of those over this age had at least three definite medical conditions, especially involving someone’s sight, heart and bones. Today, I have a cataract in my left eye (fortunately, this is in an early stage of development, and therefore does not yet bother me), high blood pressure (first detected when I was 53, and still apparently well controlled), gout (also, well controlled), and increasing difficulty in walking (as the result of a serious car accident in 2007).

During my childhood, and my working life, I was fortunate to have very few illnesses or accidents. Before I left New York, to retire to the UK in 1993, the only serious medical problems that I had experienced were a mild detachment of my left retina (suddenly developing while I was shaving one morning, and quickly corrected by laser treatment that afternoon), a “slipped disc” in my lower back (which only incapacitated me for two weeks in 1980) and high blood pressure (detected at a routine UN medical examination in 1984).

I have already referred to my parents’ longevity. I am a great believer in the importance of one’s genetic history. And, as I age, I see myself becoming more and more like my father as he approached ninety – from my degree of baldness to how I bend my head to hear someone speak to me, across the table, in a noisy restaurant. And, I am slowly developing an inguinal hernia on the lower right side of my abdomen – he had one in the same place.

Having parents who reached ninety and beyond is fortunate because I really do very little to stay healthy beyond watching my weight (weighing myself on the first day of each month). Compared to my contemporaries, I eat much too much butter and cheese, and I drink a pint of normal milk every day (personally, I prefer a glass of really cold milk to any form of alcohol) – luckily, my cholesterol level remains below normal. And, I eat chocolate throughout the day, both at meals (even just after breakfast) and in between – again, my parents were chocoholics. Also, since my car accident, I take little exercise – although I do climb the stairs, at home, as often as possible.

It is advisable, especially as one progresses through one's 80s, to remind oneself that every day is increasingly important because one is getting closer and closer to the last on this planet. Not to be at all morbid about this, but to be realistic. And, above all, to realize that the unexpected can so easily happen.

My initial fourteen years, back in the UK, were without any serious medical problems. But, on March 5, 2007, at 11.30 in the morning, when I was driving from my home in Cranleigh, near Guildford, to Hove, in fine weather, the front left tyre on my car (a modest Corsa) suddenly burst as I was going around a corner in the road, and I ended up in a ditch about ten yards away. Fortunately, a lorry driver, travelling in the opposite direction, saw what had happened and quickly called both the police and an ambulance. I can still remember the policeman standing very close to me, asking me some routine questions, to determine whether or not I had been drinking. I was

taken, most efficiently, to the Worthing Hospital. Being a Monday morning, the A&E department was relatively quiet and I was quickly examined.

Because of this accident, I had fractures of the sternum (there was a vague impression of the seat belt across my chest), two ribs, and the upper end of the tibia (which extended into the knee joint) in the left leg. Also, I broke a molar in my left lower jaw (I must have clenched my jaws tightly as I crashed), and, worst of all (because of the permanent effect), I very severely damaged a congenital spinal stenosis in my lower back. This latter injury, affecting the nerves to my lower legs, has resulted in some permanent stiffness and numbness in my feet, which, over the years since then, has increasingly affected my walking, and my ability to stand still for more than fifteen minutes or so (at parties, I am always looking for the necessary chair to sit down). Nowadays, when outside my home, I have to use a stick (which, when I bought it, I was told was “unique”, being made of three different woods – at least, I have yet to see one exactly like it). Today, I have become the international sign for being “elderly” – a rather bent figure with a stick.

I was in the Worthing Hospital for eight days – essentially, receiving good nursing care because it was decided not to operate on my left leg (instead, a brace was fitted). Then, I was transferred to a “good” nursing home, near Cranleigh, where I spent a most unpleasant week, with several difficult staff, a faulty call system, and frequent noises from the nearby rooms. I had to remain housebound for ten weeks, gradually getting used to crutches.

My next, unexpected, emergency occurred on April 16, 2014 when I suddenly vomited a large amount of blood and fainted. The ambulance quickly came and I was admitted to the Royal Surrey Hospital, in Guildford. It was discovered that I had a gastrointestinal stromal tumour (a “GIST”), in the upper part of the stomach, which was fortunately benign (many GISTs are malignant) – this was removed a week later (wonderful keyhole surgery). Again, I recalled my genetic history as my father had a gastric ulcer which also required surgery.

To continue with my fairly recent medical history, two unexpected periods of hospitalization occurred in 2016. On May 5th, I was admitted to the Nuffield Hospital, in Guildford, because, after suffering from “chronic gastritis” for several weeks, it was discovered, from a CT-scan, that I had a ruptured appendix (there had been none of the usual abdominal pains associated with appendicitis). Again, keyhole surgery removed this problem. Then, when on holiday in Devon, on October 4th, I fainted while having my dinner. An overnight stay in the Royal Devon and Exeter Hospital revealed nothing specific, and I then had a series of investigations back in Guildford (ranging from an electroencephalogram to a 24-hour heart monitor) which provided no explanation – fortunately, what was strangely described as a possible “absence seizure” has not recurred.

Last year (2017) lacked any further medical drama. However, in late August, I did have the interesting experience of seeing my GP because of sporadic pains in my left hip, over several weeks, which suggested the possibility of early osteoarthritis in that joint. He moved

the leg around a great deal and then suggested that I should consult an orthopaedist. After I left him, the hip discomfort never recurred.

In fact, it is wonderful how the body can sometimes heal itself without any specific treatment being necessary. In 2012, a wart appeared on my right index finger which was painful when pressure was applied – fortunately, after several months, it disappeared without any treatment being necessary. Then, in the following year, I was referred to a dermatologist for the removal of a “basal cell carcinoma” over my left eye. However, before the time came for this minor operation, I had picked this off my face, with my fingers, and it never returned (of course, if I was still “in practise”, I would never advise a patient to do this!)

Whenever I am asked today, “How are you?”, I usually reply that “I am like Tower Bridge, up and down”. This famous London landmark, built across the Thames about 120 years ago, has two giant moveable roadways which can be raised for passing ships. A reply like this usually produces a laugh, or at least a smile – but, it does easily explain how someone, aged 87, can often experience a variety of emotional and physical feelings.

At the present time, I know that I am very fortunate to be able to make a rather flippant remark about my health. Writing this booklet in June 2018, while I do have increasing difficulty with walking, and occasionally stumble on the stairs, I certainly do not feel like I assume the average person, in their 88th year, should feel. Keeping my brain (which I regularly remind myself

is actually “me”) active is so very important for me – whether this be writing and talking about right-to-die issues, or going to political and literary events.

Of course, I do realize that I am living on borrowed time as so many other Britons, born in 1931, are no longer alive – using a popular expression, I am now past my “sell-by date”. It is important to remember that there are many parts of my body over which I definitely have no control. For example, I do know that, in association with my long history of high blood pressure, various blood tests, for at least ten years, have revealed progressive kidney failure. Also, other blood tests do indicate the possible development of an early cancer in the prostate (this cancer, of course, is to be found in many men of my age) – fortunately, there are no symptoms yet from either condition.

As I progress through my late 80s, I can see the gradual physical decline of my body. And, from personal remarks (meant to be supportive) from relatives and close friends, these changes are sometimes more obvious to others than to me. “Old age is not for wimps” – I wish that I could remember who first made that remark? Of course, it is rather flattering when someone says, “You don’t look your age” (as if the most unpleasant thing in the world is to look old). The most obvious change that I feel now (apart from walking much less – essentially due to my car accident) is dwindling physical energy. Since working in Asia, I have always enjoyed an afternoon nap (“a siesta”) – and, I was pleased to write an article, which appeared in the January 1994 issue of *The Oldie* magazine, on the benefits of naps

Eventually, at some point in the coming years, I will obviously realize that, rather than struggling on, it is better to depart this world. It is likely that not one specific ailment will be responsible for reaching this conclusion, but several increasingly unpleasant medical conditions. I will have completed my life. I will have reached a tipping point when death will be the preferable option. I certainly never want to reach the stage where I have to be fed, washed and dressed by others – that would be such a painful indignity.

It is surely my basic human right, when I am old and suffering, but still mentally competent, to be able to decide when is the best time to die – both for me and also for those around me. And, I would hope that many, knowing of my long campaign as a right-to-die activist, would agree with my decision. It is essential to consider old age rational suicide – with the involvement of a doctor – to be a positive act.

# PREPARING TO LEAVE

In the August 2017 issue of The Oldie magazine, there appeared the following question – “As I get older and older, I find it increasingly difficult not to think that life is absurd. For example, I never asked to be born. I have no personal knowledge of my existence before I was born. But, then, I spent 25 years growing up and becoming a physician. I worked until I was sixty. I know that, in a few years’ time (I am presently 86), I am likely to be dead, and then I will return to the ‘existence’ of which I have no certain knowledge. How do I explain this absurdity to my descendants?”

In her reply to me, Virginia Ironside (The Oldie’s “Agony Aunt”), wrote, “Don’t let on you’re baffled. Confuse the young by giving gnomish smiles and exuding a slightly unreal serenity, implying great wisdom. All too soon, they will discover for themselves that life is completely meaningless and that all we can do is totter on to the best of our ability until we drop. Why? Who knows”

When one thinks about it, there are so many other examples of the absurdity of “life”. Allow me to note a few:

The surface of our planet is about seventy per cent water – does that mean that “our creator” preferred fish to humans?

If there is a “god”, why did this entity wait so long to create humans? Dinosaurs existed for about 150 million years – then, like thousands of other species, which

have appeared in the past, they died out. Will the same happen to us?

So far as we presently know, human life and our present animal kingdom only exist on our tiny planet. The rest of the vast, still expanding universe seems to be empty of “life” – for what purpose?

So, how do I plan to leave this absurdity of living? Of course, no plan might be necessary. Because of my long history of high blood pressure (although apparently still well controlled), I could die suddenly, without any warning, from a major heart attack or a very severe stroke. Or, due to the same cause, I might be struck down, partially paralysed, unable to communicate with those around me – then, I would expect that what is stated in my Advance Decision would be respected by the doctors looking after me.

Of all the events that can happen to us, the thought of one’s death is usually the most overwhelming – I have always believed that this is why so few people in the UK (perhaps only five per cent) have, so far, completed an Advance Decision. This is so unfortunate as this document could be most important to an individual as well as their family and close friends if that person becomes unable to express their wishes regarding their medical treatment (such as, for example, if someone develops dementia). Individual GPs, health centres and hospitals should do much more to encourage everyone to have an Advance Decision.

And, it is important to remember that Advance Decisions are fully supported by the British Medical Association, the General Medical Council (which issued guidelines, in 2009, stressing that doctors must respect their patients' last wishes, as expressed in these documents), the Royal College of Nursing, and the Law Society.

In my case, if I am ever unable to express my wishes regarding my future medical care, there should be no doubt of what I would want. In fact, in my latest seven-page, legally-binding Advance Decision (written in August 2013, and regularly revised since then), I have stated the following – “I am a secular humanist: while I believe ‘God’ created this wonderful universe, I do not believe any god now personally looks after me, or is concerned by my actions. I do not fear death – but I do not want to be in any situation which leaves me out-of-control (beyond two weeks) with a very poor quality of life to follow – this would be unbearable suffering. I do not want my daughters or Angela to have to remember me in this state. As I have been a Chairman of the Voluntary Euthanasia Society (now, DiD), a President of the World Federation of Right-to-Die Societies, and the founder of the Society for Old Age Rational Suicide (SOARS), my personal views – on a right-to-die (at the right time) – should be obvious! I ask that my Advance Decision should be respected at the end of my natural/conscious life”.

At the present time, my ideal exit from this world – when I have completed my life and do not want to experience further suffering from my medical conditions – would be to travel to Switzerland with Angela and one of her friends (for the latter person to assist Angela on the

return journey to the UK) for a doctor-assisted suicide. I have been a member of Dignitas since 2003, and I joined Lifecircle soon after it was established in 2012. Jokingly, I have been told that belonging to these two organizations is like a man having both braces and a belt to hold up his trousers. But, I want to also show my support for both of them.

However, it is necessary to be prepared for the possibility that this planned exit in Switzerland might not happen – for example, because of a sudden major medical emergency, I might be unable to make the journey there. In that situation, I might then have to consider the option of “continuous deep sedation” or refusing food and fluids in order to end my life.

Continuous deep sedation (also often known as “terminal sedation”) is a procedure which is performed extensively throughout the world in hospitals, nursing homes, hospices, and in private homes. This is carried out under the doctrine known as the “double effect” by which a doctor may lawfully administer increasing dosages of analgesic and sedative drugs that can hasten someone’s death as long as the declared intention is to ease pain and suffering – of course, the key word is “intention”.

I can still remember, when I was a House Physician at the Prince of Wales Hospital, in Tottenham, in 1956, that I had a patient, in his 50s, who was terminally-ill with lung cancer, and further treatment was futile. When the Consultant and I informed him of our opinion, he asked us to help him to die. Then, with the support of his wife, he was given increasing doses of morphine and

a sedative until he died forty-eight hours later. This was regarded as normal medical practice in those days – essentially, no one really knew whether the drugs or his cancer had killed him.

In the famous 1957 Court case of Dr. Bodkin Adams, a GP in Eastbourne, Judge Devlin stated that “If the first purpose of medicine – the restoration of health – can no longer be achieved, there is still much for the doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life”.

Fast forward forty years to 1997, when Annie Lindsell (who had motor neurone disease) went to the High Court as she wanted assurances that her GP, Dr. Simon Holmes, “could render her unconscious when her ability to swallow food became affected” – she had already made an Advance Decision refusing tube feeding. She withdrew her application for a High Court ruling after the lawyers involved agreed that the course of action she sought from her GP was “good medical practice”. In a report of this case, in the British Medical Journal on November 8, 1997, Dr. Holmes is quoted as saying that he believed in the “forthright and unhesitating relief of distress and pain”, and that he would treat Annie Lindsell so that she would “go to sleep and therefore there would be no eating and drinking: the decline into death is quite predictable”.

In the April 2009 issue of Palliative Medicine, there is an article by Professor Clive Seale (then, at the Centre for Health Sciences at Barts and the London School of

Medicine and Dentistry) in which he reports on a 2007-2008 survey that he had made of 2,869 doctors, in the UK, which showed that 16.5% of all deaths, at that time, were due to continuous deep sedation. Of course, this procedure is unregulated, and generally occurs within the last few weeks of someone’s expected death (when that person may be suffering unbearably).

But, there is anecdotal evidence that continuous deep sedation is also provided at earlier stages. In fact, in a statement, updated by the General Medical Council in June 2015, entitled “Patients seeking advice or information about assistance to die”, it is noted reassuringly, in paragraph 6, that “this does not prevent a doctor from agreeing in advance to palliate the pain and discomfort involved for such a patient should the need arise for such symptom management”.

Continuous deep sedation is sometimes regarded as “slow euthanasia”. For example, in 1996, in the (American) Journal of Palliative Care, in an article, written by Dr. Andrew Billings and Dr. Susan Block, from the Harvard Medical School, frankly entitled “Slow Euthanasia”, the opening sentence states that “Slow euthanasia is the clinical practice of treating a terminally-ill patient in a fashion that will assuredly lead to a comfortable death, but not too quickly”. Later, in the same article, it is noted that “This form of euthanasia in end-of-life care may be more acceptable to patients, family members, and health professionals than rapid mercy killing”. And, finally, there is this comment – “Such practices seem to indicate a tacit acceptance by the medical community of voluntary euthanasia

under particular circumstances, but they also reflect professional reasoning that may be ethically muddled”.

Although, of course, it would be very much better if a terminally-ill individual could have the legal option of been given a lethal substance which would provide a much quicker death, I believe that continuous deep sedation provides an acceptable temporary measure until the law can eventually be changed in the UK.

The voluntary stopping of eating and drinking, to end someone’s life, has always been a possibility. In fact, in India, members of the Jain religion have performed what they call Sallekhana for many centuries, in order to obtain ‘moksha’ or liberation – and, even today, an average of 250 Jains die this way every year.

Refusing food and fluids is a means of death which is potentially available to everybody. Its advantages are that it is legal (as long as someone is mentally competent, they cannot be force-fed); one can decide for oneself when the process should start; and, one can die at home. However, of course, it requires very strong perseverance on the part of an individual to undertake this particular course of action – which, therefore, is a very good indicator, to all concerned, of someone’s determination to die this way. The main disadvantages are that unpleasant symptoms (such as dryness of the mouth, headaches, insomnia, and cramps) can occur – then, it is important that appropriate medication is provided.

Abstaining from all fluid intake is much more effective at hastening death than in refusing food. But, obviously,

it is best for both to happen together. Dying this way can take an uncertain period of time, depending a great deal on the clinical circumstances – varying from possibly several days to several weeks.

In recent times, in the UK, right-to-die activists Debbie Purdy, Tony Nicklinson and Jean Davies have died this way. I had known Jean for many years since we were both on the VES Executive Committee, in the 1990s, and I saw her on three occasions, in her Oxford home, as she slowly ended her life in the Autumn of 2014. Jean was not terminally ill, but she was increasingly concerned about several episodes of unexplained fainting (including once when she was at the opera) as well as severe chronic back pain. For her, at 86, “it was time to bring my life to an end”. It took Jean five weeks to die – mainly because, until the last week, she still wanted to swallow sips of water. But, during this period, with her GP providing symptomatic care, and her family supporting her, she intentionally found time to contact many friends, all over the world, for a final conversation. Several newspapers highlighted Jean’s death – for example, The Sunday Times, on October 19, 2014, had the front-page headline of “Right-to-die granny, 86, starves herself to death”. (Incidentally, a legal problem could potentially arise in these situations. If someone, such as a carer or a GP, provides symptomatic treatment for the associated unpleasant symptoms, which can occur when someone stops all food and fluids, does this amount to assisting in a suicide? To my knowledge, no legal authority, in the UK, has even raised this question).

Of course, as a right-to-die activist since 1994, I naturally hope that, eventually, legalized doctor-assisted dying (whether this is an assisted suicide or voluntary euthanasia) will be fully incorporated into our palliative care system in the UK – as one sees today, so successfully, occurring in Belgium. It is interesting to note that palliative care practitioners and advocates for assisted dying already have much in common. For example, enthusiasts for both will speak about “death with dignity”, about the need for “compassion”, and the importance of a “good death”. And, both sincerely believe that they have the best interests of suffering individuals at the centre of their concerns.

From my own personal experience of talking with medical friends and colleagues, since I returned to the UK, I think that British doctors would prefer a law that allows doctor-assisted suicide to one permitting voluntary euthanasia. I have two main reasons for believing this: firstly, as the patient is actively involved, in having to swallow a lethal substance, this reduces any concerns about what the suffering, mentally competent individual wants; and secondly, doctors are not directly ending a life, but merely providing someone with the opportunity to do so.

## FINAL THOUGHTS

In June 2018, as I type these words on my old laptop, sitting at my desk in my home in Surrey (some forty-five miles south of where I was born), many may think that it is rather strange to be considering how my life could possibly end.

And, yet, if one considers everything carefully, it should be a very natural thought process. I have had a wonderful life – fortunately, with few regrets – and, now, it is getting close to the time to leave, to spare myself unnecessary suffering which could also mean becoming a burden on those close to me.

Every life, and every death, is special. Every life is different from any that has gone before it – but, it is a narrative, with a beginning, a middle and an end. It is so important that the end is appropriate for each individual (as Gandhi once noted – “Be the change you want to see”), and therefore is best when it is planned – and does not trail off pitifully into a mere existence (simply becoming an old buffer in a chair – sleeping, eating and waking; sleeping, eating and waking). For me, it is so important to leave this world as much like my normal self as possible – I would not want those closest to me to remember me as a severely incapacitated, perhaps mentally confused, individual.

Of course, when it comes time to depart, I will greatly miss living every day with Angela; of talking regularly, on the telephone, with my daughters in the United States (hearing about their activities and also those

of my grandchildren); of campaigning for legalized doctor-assisted suicide; and of having good discussions on a variety of subjects, ranging from the stupidity of the UK in leaving the European Union to the nature of the Universe. But, in the meantime, I can enjoy these activities with an increased intensity, knowing that they cannot continue for ever.

On the other hand, I suppose that one will be fortunate, when dead, not to have to worry any more about international political problems (such as peace in the Middle East, and the potential difficulties that might arise between the United States and China); increasing religious confrontations; climate change; the annoying dependency of so many on smartphones, Facebook, and Twitter; and, the growing obsession with the activities of so-called “celebrities”..

I have always believed that talking about one’s death, openly with family and close friends, is very important – setting an example for them and perhaps helping them to face up honestly to the greatest and most challenging of all certainties.

So far, as I write these “Final Thoughts”, my brain has fortunately been able to avoid the ravages of dementia. But, it is the rest of my body which is getting gradually to the stage of advance physical decrepitude. After I die, I want to be cremated with as little fuss as possible, with only Angela and perhaps one of my daughters (they can draw lots to see which one travels from America) present – I definitely do not want any religious minister anywhere near my corpse, and definitely no eulogies. If I should

get my final wish of having a doctor-assisted suicide in Switzerland, then my cremation quickly happens there with no one present (so sensible and practical).

I want my ashes to be scattered into the sea as close as possible to the derelict West Pier in Brighton and Hove. In spite of our unique gifts, as humans, we are all part of the one ecosystem, like any other creature on this tiny planet.

Finally, returning to thinking about our wonderful, unique, individual brains, what happens to the “essence” in each of these (perhaps what we can label as the “mind”) when we die? Is the interconnection of my body and my mind and consciousness really one entity – all of which, one day, die together, without any separation? Or, does something continue, somewhere, to discover what is the meaning of our present earthly existence? It would be so wonderful and amazing to really understand if this “life”, on this planet, is absurd or not?

# WHAT IS A COMPLETED LIFE?

There comes a point in the lives of many people when they feel that life no longer has the pleasure or value that it once did, especially for reasons arising from incurable, deteriorating medical conditions. The future is not something that they can face optimistically, based on their realistic assessment of their worsening symptoms. They reach a point where they feel that they would prefer to go to sleep one night and never wake up. This feeling becomes increasingly persistent, and is not the result of a treatable depression.

During 2015, following an extensive email discussion among several members of the Society for Old Age Rational Suicide, there was agreement on the following definition for a “Completed Life” -

“Elderly, mentally competent individuals may consider that their lives are complete when they have a chronic health problem (or a combination of more than one condition) which is causing them increasingly unbearable, irreversible suffering, with the additional loss of independence, purpose and meaning in their lives, so that they would now prefer to die rather than stay alive, especially as they dread what the future will soon bring”.

The following list identifies several factors that someone may find useful in considering when making their own personal decision regarding, whether or not, their life may be close to this stage of being “complete”. Of

course, everybody’s situation is different. This is not a “tick list”, but, hopefully, it does provide some guidance when an individual wants to evaluate their own position.

**(a) Elderly** – It is difficult to decide how old is “elderly”. An individual’s health and mental and physical ability can be separate to a specified number of years. But, in general terms, nowadays, one is thinking of an individual over eighty-five.

**(b) Mentally Competent** – Naturally, an individual must be able to properly comprehend the nature of their medical condition(s), and the expected progress of these conditions over time.

**(c) “Loss of Energy”** – With advancing years, it often becomes increasingly difficult to overcome a tendency to want to be physically less active.

**(d) Chronic Health Problem(s)** – These can be mental as well as physical. In particular, poorer mobility, hearing difficulties, weaker vision and declining memory can contribute to a withdrawal from normal activities.

**(e) Increasingly Unbearable, Irreversible Suffering** – Of course, this is for an individual to determine. It is a very personal matter, and can be both physical as well as mental.

**(f) Loss of Independence** – This is a very variable factor, with some people not wanting to be “looked after” by others on anything other than a temporary basis (when perhaps they are recovering from a treatable illness).

**(g) Loss of Purpose and Meaning** – What gives someone a purpose in their life is naturally a very personal matter, and, of course, changes as someone ages with different responsibilities (a job, being a parent, and then a grandparent, etc). When chronic health problems result in activities, which previously kept someone busy and enjoying life, being no longer possible, and other pleasures cannot be found, then it is natural to feel something very important has been lost.

**(h) Dreading what the Future will Bring** – Deteriorating gradually can be a very unpleasant and undignified process. Many people do not want to suffer this way, nor have their family and friends remembering them becoming more and more decrepit. And, when someone's partner dies, there can be an increased feeling of isolation.

This concept of a “Completed Life” can be useful when someone is elderly and wants to discuss their own end-of-life plans (ranging from the completion of an Advance Decision to considering a possible doctor-assisted suicide in Switzerland) with their family and close friends.

