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REFORMING ASSISTED DYING IN THE UK

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ABSTRACT

Current English law on assisted suicide is inflexible and fails people involved in assisted dying scenarios and who would desire to benefit from the services of a physician. A cross-jurisdictional analysis of case-law, bills and enacted legislation concludes that judicial routes have limited scope and reform is desirable on a legislative basis consisting of amendments to the Suicide Act 1961 and the establishment of proportionate procedure. Compared to previous proposals, such a procedure must include a waiting period after the court order to mitigate prognosis difficulties. A clean redrafting of s 2 SA 1961 should be preferred over creating new offences.

EXECUTIVE SUMMARY

Today's blanket ban on assisting suicide coupled with the exercise of discretion by prosecutors on a case-by-case basis fails to adequately help patients with terminal illnesses seeking to end their lives. The uncertainty affecting them, their relatives and medical professionals is deplored in public opinion surveys, highlighting the need for legal reform.

Judicial attempts to change UK law have been impeded by the need to yield to Parliament's role. Political initiatives similarly failed due to the perceived dangers posed by any proposed model to the preservation of life. Nevertheless, experience from other jurisdiction, most notably legislation entering into force in Victoria (Australia) in 2019, shows changes can be put in place addressing these difficulties.

Based on an assessment of the substantive, procedural, and policy implications of such reforms, the paper proposes:

- **A <u>clear definition of qualifying patients and terminal illnesses</u>, limiting access to assisted dying to those having no other genuine solutions.** The minimum age for making a request to die under the subsequent conditions should be 18. The applicant patient should have resided in the United Kingdom for at least five years before making the request. the following categories should be excluded:

  (i) patients with degenerative diseases who would like to specify in a document while they have mental capacity that assisted dying should be performed once they have lost that capacity – including them would frustrate the safeguard of the request's revocability,

  (ii) patients who are not terminally ill,

  (iii) patients suffering from psychiatric illnesses.

  No criterion of unbearable suffering should be included.

  The required prognosis should be a maximum of twelve months flowing from the date of the request.

- **A <u>step-by-step procedure</u>, including medical and judicial oversight, to ensure the qualifying criteria are met.** The request to die should be made exclusively by the individual concerned. It should be made in writing on a prescribed form (with alternative arrangements of similar formality for persons unable to make a request in writing). It should involve two doctors: the first doctor would know the patient and his medical history and would evaluate the patient's physical and mental state; the second (independent) doctor would be called specifically for this phase of the process and would offer an external second opinion on the fulfilment of the requirements. Mental competence should be certified:

  (i) at the time of submitting the request to die, by the first doctor,

  (ii) if the first doctor is of the opinion that all required elements are fulfilled, by the second doctor,

  (iii) conclusively, by the High Court (Family Division) when issuing an order approving the request.

All medical professionals should be accordingly required to offer all available information.

The procedure should not be open to the patient unless the first doctor, the second doctor, and the court are satisfied there was no other reasonable solution. The test for reasonableness should be objective, and regard must be had to all possible forms of care, including palliative care.

Revocability should be available from the moment of the request, including after the issuance of a court order approving the request. Unlike request, revocation should be recognised whichever manner it is made (oral, written, or otherwise).

The last step in the process should be the issuance of a court order, to be made in no more than 14 days since the request, endorsed with the certificates of the first and the second doctors, is submitted to the court.

- **Safeguards designed to exclude extraneous influence from patients' decisions as far as possible.** The request should be countersigned by two witnesses. The two endorsing doctors should be unable to serve as witnesses. The witnesses may not be relatives, nor may they have financial or other types of interest.
- **Minimum delays calibrated to strike a balance between inconclusive prognosis and the need for the procedure to be workable.** The request should expire twelve months after it was made. The court order should not be acted upon, viz. by bringing about the assisted death, earlier than two months after it was issued. After completion of every stage, the next stage in the process should not commence unless the patient, on their own initiative and without being so notified by any other person, requests in writing the advancement of the process.
- **Streamlined amendments to criminal legislation, enabling all persons involved to know where they stand.** Section 2(1) of the Suicide Act 1961 should have the following wording:

(1) A person ("D") commits an offence if:

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide, and either

(c) D's act was intended to confer an advantage financially or otherwise on D or anyone else except the person committing suicide arising out of the suicide or attempted suicide, or

(d) D's act is not one of the authorised acts in pursuance of assisted dying by the Assisted Dying Act.

- **A post-implementation review and monitoring mechanism, allowing Parliament and stakeholders to have their say and improve the process, so that anyone can access it regardless of socio-economic barriers.** The implementation of the new system should be monitored by an independent Supervisory Commission, which would present regular reports to Parliament on the system's functioning. It would draft secondary legislation to be approved through the usual executive and parliamentary procedures, as well as codes of conduct for medical professionals. Reports made by the Commission should contain an assessment as to how the complexity of the procedure may be reduced without prejudice to the safeguards in place.

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I. INTRODUCTION

In recent years, the debate around assisted dying has become one of the most prominent in public discourse. With regular legal challenges and reform in an increasing number of jurisdictions, the pressure for change in the UK is only set to grow further. This paper aims to consider this debate before reaching conclusions on what reforms to the law on assisted dying should be made in the UK.

The recommendations for a future legal framework are set out at the outset. In support of these proposals, we begin by outlining the underlying ethical debate by considering arguments from autonomy, the balance of harm and behavioural economics. The paper then examines the current position. As well as considering the current legislative position, we also take account of the European Convention on Human Rights, CPS guidelines and practice, judicial views, and, finally, public opinion on the matter. Reasons for and against reform are considered, with arguments from legal, social and practical perspectives being considered. The substantive argument of the paper is then concluded by examining possible approaches to reform. Such approaches have come from a wide range of places, including proposed legislation, commission reports and reforms in foreign jurisdictions.

II. RECOMMENDATIONS

II.I. General Principles

All previous proposals are underlain by a set of general principles:

(1) the enhancement of individual autonomy by excluding, as much as possible, extraneous influence factors,

(2) ensuring the mental competence of the individual concerned,

(3) clearly defined eligibility criteria,

(4) the participation of professionals, medical or otherwise, who are entrusted with the assessment of the fulfilment of these criteria,

(5) the patient's adequate information about his condition and alternative treatment,

(6) detailed regulation of the procedure and the monitoring system to be put in place.

Most of these have been correctly outlined by the Falconer Report. Beyond these principles, various jurisdictions have adopted frameworks with different levels of complexity and safeguards. Given the concerns expressed by medical professionals and members of the public, we find appropriate to adopt the following further policy principles:

(1) assisted dying must only be used when, on balance, it is the sole remaining solution for the patient,

(2) the process must be checked and authenticated by a court order, as the only option to ensure proper assessment of criteria fulfilment is carried out,

(3) the system must contain a built-in waiting period to address the uncertainty and unreliability of current prognosis attempts.

II.II. Qualifying Patients

The fundamental qualifying criteria are (i) age, (ii) residence. The meanings and choices of these criteria differ between jurisdictions and between English proposals. Still, the preference for an informed decision made by an adult and for the avoidance of the Swiss ‘assisted dying tourism’ model can be plainly observed in abovementioned sociological studies. Therefore, we recommend that **the minimum age for making a request to die under the subsequent conditions should be 18.** The applicant patient should have **resided in the United Kingdom for at least five years** before making the request. Allowance should be made for the possibility that some devolved jurisdictions within the United Kingdom may consider restricting the procedure; we propose that in such cases, a requirement of at least five years of residence in a UK jurisdiction not having such restrictions should be required.

II.III. Terminal Illness

The requirement of a terminal illness is found in all English proposals, as well as in the Netherlands, Belgium, Oregon, France, and Victoria. The only analysed jurisdiction allowing a larger list of conditions is Switzerland. The latter model offers insufficient protection to patients, particularly given the uncertainties any medical diagnosis involves. The general policy of this proposal is to reduce the number of circumstances generating these uncertainties, leading to the disavowal of the said model. We believe **the following categories should be excluded:**

(i) patients with degenerative diseases who would like to specify in a document while they have mental capacity that assisted dying should be performed once they have lost that capacity – including them would frustrate the safeguard of the request's revocability,

(ii) patients who are not terminally ill,

(iii) psychiatric illnesses.

It is common amongst the proposals to establish a limit for the prognosis (6 months, 12 months). There has been evidence that these forms of prognosis are highly approximate, do not increase in accuracy when the patient is close to death, and are frequently outlived by patients. Even in these circumstances, a definition akin to that given by Lord Joffe ('a disease likely to be leading to death within a few months') is too indeterminate. Certainty should be privileged in such circumstances and upon enactment of legislation, courts would be very prone to fix an interval for themselves. We recommend **the required time should be twelve months (as in Victoria) flowing from the date the request is made.** This would enable a timely application whereby all procedures may be completed, and which would accommodate the built-in waiting period which will be detailed below.

II.IV. Procedure

i. The Initial Request

It is common ground that **the request to die must be made exclusively by the individual concerned.** This element is of extreme relevance in ensuring assisted dying is based on the personal uninfluenced choice made by a person of sound mind (see below on competence) and as fully as reasonably possible informed of their condition and of alternative forms of treatment. All proposals also provide for the **request to be made in writing on a prescribed form (with alternative arrangements of similar formality for persons unable to make a request in writing).** Both requirements should be adopted.

ii. The Number and Qualifications of Physicians Involved, Methods

Several models emerge in this area. One prescribes the involvement of a medical professional only for the prescription of lethal medication. That could be self-administered (Oregon) or administered by staff of a non-profit clinic (Switzerland). The second requires the involvement of doctors in approving the procedure, as well as in prescription and administration of medication. Most of the assessed laws and proposals specify lethal medication as the only available procedure, which is necessary in the interest of certainty. In pursuance of the second model, the requirement of **two doctors** has emerged: **the first doctor would know the patient and his medical history and would evaluate the patient's physical and mental state; the second (independent) doctor would be called specifically for this phase of the process and would offer an external second opinion on the fulfilment of the requirements.** The consultees have also mentioned that an independent doctor was called on in the context of withdrawing life-supporting treatment even without a legal requirement to do so, although doubts were expressed about the need to consult two doctors. We can be sympathetic with the contention that the second doctor would not fully eliminate the psychological strain and responsibility incumbent on the first doctor, but we nevertheless find the argument that including two doctors is likely to reduce the chance of 'selfish motives' prevailing more compelling. Lord Falconer's bill and the subsequent bills based on it explain the qualifications of the consultant and independent doctor in detail, and we endorse those explanations, particularly underlining the necessity that the independent doctor must have expertise in end-of-life care.

iii. Certifying Competence

For the purposes of English legislation, competence is defined in ss 2 – 3 of the Mental Capacity Act 2005. This should undoubtedly be the starting point (a person has a mental impairment if at the material time he is unable to make a decision for himself due to mental impairment, whether permanent or temporary; not being able to make a decision for oneself is determined by inability to: understand the information relevant to the decision, to retain that information, to assess it, or to communicate the decision). The addition that mental capacity should not be, as ordinarily, presumed, suggested by the Falconer Report, is welcome.

Mental competence should be certified:

(1) at the time of submitting the request to die, by the first doctor,

(2) if the first doctor is of the opinion that all required elements are fulfilled, by the second doctor,

(3) conclusively, by the High Court (Family Division) when issuing an order approving the request.

iv. Should Unbearable Suffering Be A Criterion?

In some proposals and legislation (Lord Joffe, Belgium, Victoria), there is a requirement of 'unbearable suffering' or 'suffering that cannot be relieved in a manner the person deems tolerable'. This criterion is ambiguous and ineffective in limiting instances of assisted dying. On a practical level, this is due to the disagreement that may appear between the patient (subjective view) and the doctors who assess it. Legally, the court may develop an *objective* test (suffering that, according to the evidence, would be regarded by an ordinary person as unbearable, risking a failure to consider circumstances of the patient), or a *subjective* test (which would tend to rely too heavily on the patient's often distorted opinion as opposed to the doctors'). These potential disputes are best avoided, in our view, by **not including the criterion of unbearable suffering.**

v. Adequate Information on Diagnosis, Prognosis, and Absence of Alternatives

The patient should be able to make their decision being as fully as reasonably possible informed as to their diagnosis, prognosis, and alternative treatment. Such a step is closely connected with the principle of autonomy, whereby no medical action can be undertaken without the patient's consent, and no consent of the patient is valid without full information being disclosed to them (cf. tort liability for treatments without consent – *Chester v Afshar*[1]). If the principle applies to ordinary treatment, *a fortiori* it should apply to assisted dying procedures. **All medical professionals should be** accordingly **required to offer all available information.** Independently of this step, we note legislation in the Netherlands provides the first doctor must certify the patient is convinced there was no other reasonable solution, while English proposals merely require the patient to be *informed* of alternatives. We also observe English proposals, irrespective of their restrictiveness, have failed largely due to their perceived potential excessive broadness. Therefore, it is proposed that **the procedure should not be open to the patient unless the first**

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[1] [2004] UKHL 41

doctor, the second doctor, and the court are satisfied there was no other reasonable solution. The test for reasonableness should be objective, and regard must be had to all possible forms of care, including palliative care.

vi. The Form of Request and Its Revocability

The English proposals, Oregon and Victoria legislation require a written request (as discussed above) which is revocable at any time after it was made. **The request (similarly to the declaration in the English proposals) should be countersigned by two witnesses. The two endorsing doctors should be unable to serve as witnesses. The witnesses may not be relatives, nor may they have financial or other types of interest** (see below). **Revocability should be available from the moment of the request, including after the issuance of a court order approving the request. Unlike request, revocation should be recognised whichever manner it is made (oral, written, or otherwise).**

vii. Waiting Period and Expiration

Lord Joffe's bill provided that a declaration would expire after six months from being made. It is noteworthy this was correlated first with the unclear definition of a terminal illness, and later with the six-month prognosis. Following the same reasoning, we recommend **the request should expire twelve months after it was made** (consistently with the prognosis). In the Falconer Report, depositions have been made to the effect delays within the process are undesirable. Nevertheless, we believe this should be considered only against the uncertainties of predicting death. Hence, a waiting period between different stages of the process is desirable to ensure it is justified not only by predictions but also factually. However, during consultation it has been revealed that the countervailing argument against waiting periods is that a decision by the patient to begin the process is in any event not taken lightly and, therefore, waiting periods are less necessary than apparent at first sight to ensure a settled wish to continue. In addition, it has been stressed that too long waiting periods may render the process completely inapplicable in practice, as patients may die before it ends. These factors have been taken into account in the recommendation which follows. We propose that:

(1) the court order should not be acted upon, viz. by bringing about the assisted death, earlier than two months after it was issued,

(2) after completion of every stage, the next stage in the process should not commence unless the patient, on their own initiative and without being so notified by any other person, requests in writing the advancement of the process.

viii. Court Approval

Legal approval for the determinations made by the medical professionals has been proposed in two variants, most notably Lord Joffe's, in the form of a solicitor, and Lord Falconer's bill as amended by Lord Pannick, in the form of a court order, with judgment to be given in 14 days or as soon as practicable after submission of the matter to the High Court. The first form of Lord Falconer's bill and the other jurisdictions discussed exclude legal approval from the process. The second view seems to be drawn from the opinions of witnesses, expressed inter alia in the British Medical Association's studies already considered which show the court, although seen as impartial, is thought to lack the empathy and celerity required in such moments. The same testimonies also associate courts with crime and wrongdoing. While solicitors do not offer the same guarantee of impartiality, these contentions are not sufficiently substantiated with respect to judges. The main ground is that if courts are considered apt to decide in mental capacity cases, there is no reason they should be unable to in more serious assisted dying ones. Moreover, this measure would serve to reassure all persons involved that their conduct is not illegal. These considerations lead to our recommendation that **the last step in the process should be the issuance of a court order, to be made in no more than 14 days since the request, endorsed with the certificates of the first and the second doctors, is submitted to the court.** The Family Division or Court of Protection are wisely chosen as the appropriate courts, for they allow closed hearings. Alternatively, we submit the procedure could be conducted in a specialist statutory tribunal.

During consultations on the proposal the point has been re-expressed eloquently and forcefully by James Catmur and Dignity in Dying that subjecting the patient's decision to court approval is excessively burdensome, hampers the process and undermines its viability and the patient's trust in the outcome. As previously noted, when dealing with this concern, the authors acknowledge the social perception that judicial proceedings and associated expenses must be avoided as far as possible. We nevertheless observe that less intrusive procedures (e.g. in the mental health context) are subject to a court decision and, furthermore, there is a supervisory jurisdiction of the court in withdrawal of treatment cases which are presently lawful. With respect to Dr Palmer's contention that the law on positive acts on this matter should be brought in line with the law involving omissions, it is to be noted that treating omissions less strictly is pervasive within criminal and tort law, and her argument is not forceful enough to justify the elimination of the court approval stage. Should this stage ultimately not be considered necessary, we submit **some form of supervisory jurisdiction should be available as a bare minimum.**

II.V. PROTECTION OF MEDICAL AND LEGAL PROFESSIONALS

Expert evidence in the British Medical Association Report reveals a considerable strain and pressure to which medical professionals who engaged in this process would be subjected. Consequently, in virtually all options doctors have been granted the opportunity to be conscientious objectors to any stage of the proceedings. The issue which arises is whether doctors should be allowed to withdraw from the process. English bills all provide that doctors may do so, but they would be obliged to refer the patient to a willing medical professional. In order to further relieve doctors who routinely treat the respective patient from this responsibility, we submit the following:

(1) if a doctor conscientiously refrains from acting as first doctor, they must notify the requesting patient to this effect,

(2) the patient may petition the Supervisory Commission (see below) which within no more than three days would refer the patient to an available doctor, to serve as first doctor.

The protection of legal professionals is less relevant and practicable, for it would risk hampering the functioning of the process.

II.VI. CRIMINAL OFFENCES AND CPS POLICY

Currently, assisted suicide is criminalised under s 2 of the Suicide Act 1961, this section including assisted dying in its ambit. Legalising the process in any manner would require amending this provision. The English bills all create an array of supplementary offences in relation to the process. It has been argued in the assessment of previous bills that these criminal sanctions are unclear, overlapping, and unlikely to be effective. We find, however, impressive clarity in the

Swiss Criminal Code, whose Art. 115 criminalises assisted suicide if it is conducted out of 'selfish motives'. It is obvious this concept and approach to criminal law does not fit the common-law tradition and would create difficulties if replicated. For this reason, we propose **s 2(1) of the SA 1961 should have the following wording:**

(1) A person ("D") commits an offence if:

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide, and either

(c) D's act was intended to confer an advantage financially or otherwise on D or anyone else except the person committing suicide arising out of the suicide or attempted suicide, or

(d) D's act is not one of the authorised acts in pursuance of assisted dying by the Assisted Dying Act.

Prosecutions under s 2 are subject to approval by the Director of Public Prosecutions, who applies a specific policy, discussed in previous sections of this paper. It is desirable that the policy would continue to apply after the enactment of reforms to maintain the existing leeway for non-terminal illness and other cases.

II.VII. MONITORING

We mirror the Falconer Report recommendation that **the implementation of the new system should be monitored by an independent Supervisory Commission, which would present regular reports to Parliament on the system's functioning.** A further task for this Commission would be to **draft secondary legislation to be approved through the usual executive and parliamentary procedures, as well as codes of conduct for medical professionals.** A significant implementation difficulty is likely to be the correlation between income, availability of legal advice, and the willingness to undertake the procedure by potential beneficiaries. To this extent it would be desirable that **reports made by the Commission contain an assessment as to how the complexity of the procedure may be reduced without prejudice to the safeguards in place.** Consultees have adamantly suggested that, although they agreed the proposal needed to be cautious, the process was too long-winded. Taking note of this stance, we nonetheless lean towards the position that this should be addressed on review rather than on initial implementation.

III. DEFINING TERMS AND UNDERLYING VALUE JUDGMENTS

It is important to note that the outset that assisted dying is distinct from assisted suicide generally, euthanasia and suicide pacts.

III.I. Differences between assisted suicide, assisted dying, and active euthanasia

Assisted *dying* refers to the practice in which the physician would provide the means of death, most often with a prescription.[2] It is to be contrasted with assisted *suicide,* which is the act of deliberately *assisting or encouraging* another person to kill themselves.[3] An example of assisted suicide would be a relative or friend of a terminally ill person obtaining and providing strong sedatives knowing that the person intended to use the sedatives to kill himself. Therefore, assisted dying may be included in assisted suicide, but must not be understood as encompassing any activities outside those conducted by a physician within a regulated framework. Changes to legislation criminalising encouraging or assisting suicide will accordingly be considered in this paper only to the extent they allow assisted dying. In assisted dying, the patient (not the physician) is the one who is in complete control of the process that leads to death because he is the person who performs the act of suicide. The person assisting death simply provides the means for carrying out the action. To qualify as 'assisted dying, it is essential that the patient is the one who performs the last act- for example, intentionally swallowing an overdose of drugs provided by a

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[2] 'Is Physician-Assisted Suicide the Same as Euthanasia?' (*World Federation of Rights to Die Societies*) <http://www.worldrtd.net/qanda/physician-assisted-suicide-same-euthanasia> accessed August 2017.

[3] 'Euthanasia and Assisted Suicide' (*NHS*) <www.nhs.uk/conditions/Euthanasiaandassistedsuicide/Pages/Introduction.aspx> accessed August 2017.

physician for the purpose of causing death, or pushing a switch to trigger a fatal injection after the doctor has inserted an intravenous needle bearing a lethal drug into the patient's vein.[4]

On the other hand, *euthanasia* generally means that the physician would act directly, for instance by giving a lethal injection, to end the patient's life.[5] Rather than merely providing the means of death as in assisted dying, euthanasia is an intentional act of one person to end the life of another person in order to relieve that person's suffering.[6] The most common example is that of a doctor injecting a patient with a lethal substance to relieve that person from unbearable physical pain. Further, euthanasia can be further categorised into *active* and *passive* euthanasia. Active euthanasia refers to the deliberate intervention to end someone's life – for example, by injecting them with a large dose of sedatives; whereas passive euthanasia refers to causing someone's death by withholding or withdrawing treatment that is necessary to maintain life.[7]

III.II. Suicide Pacts

A *suicide pact* usually involves two people (usually in a close relationship in which one is dominant, and the other is passive) agreeing that at the same time each will die by suicide.[8] It is different from assisted suicide and assisted dying in that suicide pacts would involve the simultaneous deaths of both parties.

Such doctrinal differences between different concepts must be highlighted because this endeavour is concerned only with the regime of assisted dying.

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[4] R L Marker, K Hamlon, 'Frequently Asked Questions – Euthanasia and Assisted Suicide' (*Patients' Rights Council*) <www.patientsrightscouncil.org/site/frequently-asked-questions/> accessed September 2017.

[5] See n 1.

[6] 'End of Life Law in Australia' (*Queensland University of Technology*) <https://end-of-life.qut.edu.au/euthanasia> accessed September 2017.

[7] See n 2.

[8] J Geddes, P Jonathan and R McKnight, *Psychiatry* (4th edn, OUP 2012) 64.

III.III. The autonomy argument in support of assisted dying

i. Autonomy

A central value in both Kant's moral philosophy and Mill's utilitarian liberalism, individual autonomy refers to the capacity to carry out actions according to reasons and motives that are taken as one's own without interference by others and without other limitations such as inadequate understanding and information which prevent meaningful choice. In a medical context, patient autonomy can be more narrowly defined as the requirement for a patient to have an autonomy of "thought, intention, and action when making decisions regarding health care procedures." This means that not only must the patient be free from coercion or coaxing, he must also understand all the risks and benefits (both medical and non-medical) involved in the particular procedure in order to make a fully informed decision. The value of individual autonomy is an intrinsic one - it empowers one with a sense of ownership, control and expression of his own life.

ii. A doctrinal point of view

Choice in dying can be seen as an extension of society's freedom in lifestyle choices such as education, career, family etc. As Peter Singer puts it: "the principle of respect for autonomy tells us to allow rational agents to live their own lives according to their autonomous decisions, free from coercion or interference; but if rational agents should autonomously choose to die, then respect for autonomy will lead us to assist them to do as they choose",[9] as long as the harm principle is not violated. Research has shown that patients' desire for death stems not from the need to relieve themselves from pain, but from the desire to free themselves from anxieties about autonomy: losing control, being a burden, being dependent and losing dignity.[10] As Biggs argues,

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[9] P Singer, *Practical Ethics* (2nd edn, CUP 1993) 195.

[10] A L Back, J I Wallace, H E Starks, R A Pearlman, 'Physician-Assisted Suicide and Euthanasia in Washington State' (1996) 275 Journal of the American Medical Association 919; L Ganzini, and S Block, 'Physician-Assisted Death – A Last Resort?' (2002) The New England Journal of Medicine 346; Oregon Department of Human Services, Sixth Annual Report on Oregon's Death with Dignity Act (2004) <www.dhs.state.or.us/publichealth/chs/pas/pas.cfm> accessed September 2017.

patient autonomy has a 'pivotal role' in end-of-life decision making - it "[permits] people the opportunity to decide the timing and circumstances of their own demise if that is what they wish."[11] Granting patients the right to assisted dying allows them to reclaim that autonomy, enabling them to retain a shred of control over their own lives where their illnesses have deprived them of all other choices, giving them the ability to direct the course of their own lives. This line of argument rests on the idea of 'negative liberty'. Autonomy also safeguards patients from the phenomenon of ''medical paternalism and therapeutic insistency',[12] because to force a person to continue with his or her life constitutes a lack of respect for that person's dignity and a violation of his or her conscience.

iii. A technical point of view

The appeal to patient autonomy in relation to the right to die can be traced to the rise of the doctrine of *informed consent*.[13] The doctrine acknowledges a patient's right to refuse medical treatment on the condition that he is: i) fully informed of the nature, benefits and risk of each procedure, and ii) her consent or refusal is freely chosen (Declaration of Helsinki 2008). Like any other medical procedure, the decision to use medical technology to prolong a patient's life should require the patient's informed consent. In this sense, patient autonomy protects: "...the [patient's] right to decide how one is to live one's life, in particular how to make critical life decisions".[14] Furthermore, assisted dying can be seen as a "natural" extension of the constitutionally protected "right to privacy," and as a mere specification of the moral right to self-determination.[15]

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[11] H Biggs, *Euthanasia, death with dignity, and the law* (Hart Publishing 2001).

[12] M A M Pijnenburg, 'Catholic Healthcare and the Dutch National Character', in D C Thomasma et al (eds), *Asking to Die. Inside the Dutch Debate About Euthanasia* (Kluwer Academic Publishers 1998) 252.

[13] T L Beauchamp, 'The right to die as the triumph of autonomy' 2006 Journal of Medicine and Philosophy 643–654.

[14] J Feinberg, *Harm to self: The moral limits of the criminal law* (OUP 1986).

[15] T Salem, 'Physician-Assisted Suicide: Promoting Autonomy—Or Medicalizing Suicide?' 1999 Hastings Center Report, 29, 30–36.

III.IV. Common objections of the autonomy argument

i. The intention to promote patient autonomy is counterintuitive:

Salem argues that far from honouring self-determination, measures assisting dying in fact return ultimate authority over this "private and deeply personal" decision to medicine and society[16]. This is because assisted dying represents an extension of medical power over the life and death of the patient. Far from empowering patients, the decision to die by suicide is treated precisely as if it were a set of clinical problems to be solved medically - the "private," "intimate," "self-determining" decision to commit suicide is translated into a clinical event.[17] Such an argument is however misleading, for whilst the regulation of assisted dying is indeed now taken over by external parties, the ability to set the chain of events in motion is still with the patient himself.

ii. The over-importance attached to autonomy:

Salem also contests the pre-eminence conferred on autonomy vis-a-vis other social values and interests. The sanctity of life, the protection of those who are vulnerable to medical or family abuses and the ethical integrity of the medical professional (that is, the preservation of its ancient vow never intentionally to kill) are variously seen as competing values that in fact outweigh individual autonomy. Nevertheless, such concerns can be refuted in two ways: first, the seeming conflict between ‘autonomy’ and ‘the sanctity of life’ can in fact be reconciled. This will be discussed in the next section. Secondly, values like the prevention of abuse of assisted dying and the preservation of the medical profession’s ethical integrity are not necessarily in competitive terms with the value of autonomy, for all three values can be maintained as long as proper procedural safeguards are being enacted.

III.V. Dignity and Value Theory

i. Violation of human dignity by assisted dying

The argument underpinning the concept of the inviolability of human life is based on the belief that all human life has worth and, accordingly, it is wrong to end a person's life, directly or indirectly, no matter what the ‘quality’ of that life.[18] When a person kills another, he makes the

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[16] ibid.

[17] ibid.

[18] C Mackellar, ‘Human Dignity and Assisted Dying’ 2007 Islam and Christian–Muslim Relations 18:3 355-366.

conscious and deliberate decision that the life that is being ended no longer has any worth or value. In the context of assisted dying, although the person assisting the killing might maintain that he is bestowing human dignity to the patient, he cannot be said to simultaneously kill yet fully and genuinely respect the patient's human dignity for both ideas are contradictory. As Mackellar points out, the "prima facie implication of the dual grounding values—inherent inviolability and intrinsic dignity—means that a person cannot respect the life of another whilst at the same time believing that it would be preferable that such life be terminated and not left to continue its existence."[19] Indeed, Mackellar goes on to point out that the fact that a person is suffering (from the pain of a terminal illness) does not take away his dignity, and thus does not warrant a termination of his life. Viewed in such terms, it appears that the dignity argument is in direct confrontation with the autonomy argument - it seems to convey the message that although assisted suicide might have given the patient a degree of control over his own life, that power merely bestows upon himself the ability to affront his own dignity.

ii. Intrinsic dignity

To put it simply, if dignity is intrinsic in nature, then no matter whether this value is recognised by external valuers, no matter whether there are any external valuers, things with intrinsic value have value.[20] Kant declared that "humanity itself is a dignity"[21] and insisted that human beings be treated as ends in themselves and never purely instrumentally. In other words, intrinsic dignity is the kind of dignity that one has simply because one is a member of the human natural kind – a member of the human family.

iii. Attributed dignity

On the other hand, attributed dignity exists by virtue of dignity being capable of attributing value to an individual object, natural kind, state of affairs, concept, or some other sort of thing.[22] There are two kinds of attributed dignity: i) dignity which is instrumental in nature i.e. that which refers

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[19] ibid.

[20] DP Sulmasy, 'Death, Dignity, and the Theory of Value' (2002) Ethical Perspectives 9(2) 103-130.

[21] I Kant, *The Metaphysics of Morals, Part II: The Metaphysical Principles of Virtue* (J W Ellington tr, Hackett 1983) 127.

[22] ibid.

to the usefulness of a human being to oneself or to another, and ii) dignity which is attributed but non-instrumental, such as aesthetic value.

iv. Reconciliation

The usual assault against assisted dying is made exclusively on the basis of intrinsic dignity, i.e. that assisting dying treats the patient instrumentally - the patient is being 'utilised' to achieve a state of painlessness. Even if one accepts this line of argument (which is not necessarily sound and will be contested below), assisted dying does not violate one's attributed dignity, for attributed dignity: a) condones the instrumentality of dignity and b) is seen by reference to a third-party variable (say meaningfulness of life). Where b) is concerned, as Sulmasy points out, illness certainly attacks the attributed dignities of patients, for when the physical appearance of patients, their degree of independence, their social worth and their ability to make rational choices are diminished, the attributed dignity of the patient is also diminished.[23] If the patient's dignity is diminished, perhaps even nearly to the point of non-existence, it can hardly be said that his dignity would be violated when his life is being ended for there would be barely anything to violate. It is important to note, nevertheless, that as long as intrinsic dignity as a value still exists, the aforesaid argument cannot properly hold. This brings us to the issue of where *intrinsic* dignity really exists for those terminally ill. It is possible to argue that not all human beings have intrinsic dignity, and that intrinsic dignity is only a feature of a class within the human natural kind, the class of persons. It is thus morally permissible to assist the death of human beings who have lost (or are about to lose) their personhood.[24]

v. Behavioural Economics

The paradox is the finding that when terminal patients in Oregon receive lethal medication (under Oregon's Death with Dignity Act), they often feel a sense of greater well-being and a desire to live longer. In 2010, of 96 patients requested lethal medication, only 61 took it. Even more interesting are the many anecdotal accounts of terminal patients, upon receiving lethal

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[23] See n 16.

[24] ibid.

medication, that feel a surge of wellbeing and a desire to persevere through their illness.[25] This is so because from an expected-utility perspective, when patients are given the option to terminate their own life, they will decide how long they want to live by comparing the value they expect to gain from the rest of their lives to the expected intensity of their suffering. At the point where future utility is expected to be negative – that is, when the patient's condition becomes so intolerable that living any longer is not worth the cost – the patient would choose to end life if the option were available.[26] When terminally ill patients are being given the option to determine the time and circumstance of their death, that can transform patients from powerless victims of their illness to willing survivors of it, thereby strengthening patient autonomy.

IV. THE CURRENT POSITION

IV.I. The Basic Position

The general legal position on complicity in the suicide of another can be found in the 1961 Suicide Act.

Section 2(1) reads as follows:

A person ("D") commits an offence if—

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person,

and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide.

It is worth noting two things about the scope of this section, the first of which relates to the *actus reus* of the offence. Section 2(1)(a), supported by s(2)(1)(b) makes it clear that it is not necessary for D's act to actually have encouraged or assisted the suicide of another, or indeed for any suicide to have actually taken place. The statute, therefore, takes the view that such an act by itself is sufficiently grave to warrant criminal punishment. The Suicide Act is not alone in taking this

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[25] D Arieley, 'Physician Assisted Suicide and Behavioral Economics' (*Dan Arieley*, 5 May 2011) <http://danariely.com/2011/05/05/physician-assisted-suicide-and-behavioral-economics/> accessed September 2017.

[26] ibid.

approach; the general law on encouraging or assisting offences contained in ss 44-6 Serious Crime Act 2007 (SCA 2007) also has no requirement that D's act actually encouraged or assisted an offence. In relation to the SCA 2007, the wide approach is usually justified on the basis that even though harm need not have occurred, D is still morally culpable.[27] Yet we must question whether such culpability exists in equal measure in respect of assisted suicide. The offence in section 2 is somewhat unique as section 1 of the Act decriminalises suicide itself, meaning that D cannot be said to be culpable, as a defendant under the SCA would be, for his attempt to bring about a crime. We are therefore in the position of having an 'assisting or encouraging' offence which condemns D as culpable for reasons other than involvement in a primary offence. Given the heated ethical debate explored in the previous section, this seems a very difficult position to maintain.

This culpability issue could have been dealt with through the *mens rea* of the offence. However, we can see in s2(1)(b) that this approach has not been taken. We instead see a focus on the sanctity of life above all else, ignoring the complexities of the debate in the previous section. As a consequence, the courts have been faced with a number of difficult cases in which the best interests and wishes of the individual who seeks to end their life cannot be given effect. This issue will be explored more fully in later sections. However, it should be said here that this failure to at least acknowledge the ethical debate is a serious failure in the law.

The statute appears to set out a clear position. However, this is far from the whole picture. The effectiveness of the Suicide Act has been undermined in two principal ways, both of which will be explored below.

IV.II. CPS Guidelines

Despite the apparent simplicity of s 2(1), the actual effect of the law is made somewhat more complicated by s 2(4) which states that the consent of the Director of Public Prosecutions is needed before any proceedings can be instituted. This section was the subject of the House of Lords case of *R (Purdy) v DPP.*[28] The case concerned an appellant with a debilitating illness who wished to know whether her husband would be prosecuted if he helped her to travel to a country where assisted suicide was lawful. It was highly likely that he would be guilty of the offence,

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[27] See, for example, Law Com No 300, 2006.
[28] [2010] 1 AC 345.

however, it was difficult to predict how the DPP would exercise their discretion under s 2(4). The House of Lords held that despite the existence of a general prosecutorial code, the European Convention on Human Rights Article 8(2) requirements of accessibility and foreseeability were not satisfied. Lord Hope explained, with reference to the 'Daniel James' case, that a number of the factors in the general code were not relevant in assisted suicide cases, and, further that the decision of whether to prosecute offences under the Suicide Act could only be taken with reference to factors not contained in the general code.

For present purposes, *Purdy* is most notable for the fact that it resulted in the publication of prosecutorial guidelines specific to assisted suicide cases. These guidelines reveal that prosecutors are obliged to take into a range of factors such as the 'victim's' communicated wishes, the suspect's motivation and the nature of the pre-existing relationship between the suspect and the victim.[29] Many of these factors have similar counterparts in the policies found in countries where assisted suicide is legal, as will be discussed further later. Moreover, out of 136 cases referred to the CPS between 2009 and 2017, 113 were not taken further.[30] Hence, although the Suicide Act does not seem to take into account the ethical debate around assisted suicide, such factors do appear to affect the operation of the law in practice.

IV.III. The European Convention on Human Rights

The European Convention on Human Rights (ECHR) sets out 'fundamental freedoms', the United Kingdom signed the Convention in 1950 and gave 'further effect' to such rights by implementing the Human Rights Act 1998. The Convention does not contain an article or protocol by which assisted dying can be said to be unequivocally guaranteed as a right, though it has often been the foundation of disputes surrounding the issue.

The articles most frequently engaged within such disputes are as follows: Article 2: Right to life, Article 3: Prohibition of torture, Article 9: Freedom of conscience, Article 8: Right to respect for private and family life, Article 14: Prohibition of discrimination.

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[29] Crown Prosecution Service, 'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (*CPS Guidelines*, Oct 2014) <www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed December 2018.

[30] ibid.

There are several cases which have used the ECHR, arguing that the 1961 Act in its blanket ban of assisted dying conflicts with their rights in it. The most notable of these disputes includes *Pretty* and *Nicklinson.*

IV.IV. *Pretty*

Diane Pretty had motor neurone disease, resulting in her being unable to move and communicate with ease, meanwhile her mental faculties remained unchanged. Due to her limited capacity, she was unable to commit suicide and wanted her husband to assist her in ending her life.

Worried about the possibility of criminal proceedings against her husband taking place after her death, she sought an undertaking from the Director of Public Prosecutions (DPP) that he would not give his consent to her husband's prosecution, pursuant to s 2(4) of the 1961 Act which provides that no proceedings for an offence in relation to assisted suicide will be initiated without the consent of the DPP.

The DPP responded to her, explaining that he was unable to give such an undertaking, contending that what Pretty was asking him to do in fact amounted to asking him to pardon the offence before it had taken place.

Pretty applied for judicial review, arguing that articles 2, 3, 8 and 9 of the ECHR required the DPP to give the undertaking, and if he was not able to do so then section 2(1) of the Act was incompatible with her Convention rights.

The case made its way from the Divisional Court to the House of Lords and finally to the European Court of Human Rights. Pretty's arguments were ultimately rejected by each court.

In summary, the House of Lords rejected that any of Pretty's rights had been violated. They explained that articles 2 and 3 were complementary to each other, that the language of the former reflected the sanctity of life and could not be interpreted as conferring a right to the self-determination of death. Secondly, that the latter imposed a positive obligation on the state to safeguard the lives of those within its jurisdiction but entailed no positive duty on the state to recognise the right to assisted suicide.

Additionally, the Lords held that Article 8 should be interpreted as the protection of personal autonomy whilst the individual was alive, and did not encompass a right to decide when or how to die. Article 9 should be interpreted as protecting a person's freedom of conscience. Article 9 protected freedom of conscience but could not found a requirement that the manifestation of the claimant's belief in assisted suicide should absolve her husband from the consequences of conduct proscribed by the criminal law.

Article 14 only has effect where other Convention rights are engaged, and according to their Lordships none were engaged, hence the article did not apply. However, had another right been engaged, the Lords explained that Pretty would not have succeeded in demonstrating that this article had been violated. This was because no discrimination took place as the criminal law in relation to assisted suicide applied offence-creating provisions to all and had weight to personal circumstances when prosecution was considered, pursuant to s2(4) whereby the DPP had to give consent to proceedings.

The court in Strasbourg agreed with much of the judgment set out by the House of Lords, and ultimately concluded that the UK had not breached the ECHR. Where the court did differ though, concerned Article 8, the right to private and family life.

The Lords decided that this article had not been engaged at all, but the judges in Strasbourg said that it had. They therefore went on to assess the proportionality of the blanket ban on assisted suicide.

The Court went on to explain that it was for individual States to weigh up the benefits of personal autonomy and protection of the vulnerable within their margin of appreciation, and that the blanket ban was not disproportionate to the legitimate aim of the 1961 Act, with the court remarking: "It does not appear arbitrary for the law to reflect the importance of the right to life by prohibiting assisted suicide while providing for a system of enforcement adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the requirements of retribution and deterrence."[31]

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[31] See [76] - [77].

IV.V. *Nicklinson*

The case involved three individuals – Tony Nicklinson, Paul Lamb and Martin. They all suffered a disability rendering them immobile, whilst being of sound mind. Martin sought further clarification of the DPP's prosecution policy. Nicklinson and Lamb sought judicial review for a declaration that whoever assisted their deaths would not be subject to criminal proceedings. In the event this declaration would not be handed down, they alternatively sought a judgment that s 2(1) of the Suicide Act 1961 was incompatible with Article 8 of the ECHR.

Having both decisions denied, they appealed to the Supreme Court seeking a declaration of incompatibility, and Martin seeking further clarification of the DPP's policy.

The case made its way to the Supreme Court on appeal. The appeals were ultimately dismissed by the Supreme Court. On appeal to the European Court of Human Rights, the court rendered the case inadmissible.

However, the case is significant despite its lack of success for it was the first time that the UK courts conceded that s 2(1) of the 1961 Act conflicts with Article 8 of the ECHR, and that in principle the Supreme Court judges were open to making a declaration of incompatibility – only practicalities stopped the majority from doing so.

The judgment of the Supreme Court was significant in its departure from previous House of Lords decisions in that it recognised, for the first time, that s 2(1) of the 1961 Act conflicts with Article 8 of the ECHR – which had been recognised by Strasbourg in *Pretty*.

With this conflict, the judges were compelled to consider the possibility of making a declaration of incompatibility with their s 4 HRA 1998 powers which would have no legal impact on the statute, nor would the parties in the dispute receive any resolution. The political effect, however, of such a declaration is undeniable – it acts as a 'flagging' up to Parliament that the law is in violation of international human rights.

In spite of this opportunity, the majority of the judges did not make the declaration of incompatibility, with Lady Hale and Lord Kerr dissenting.

The arguments for the majority were best put by Lord Brown, who conceded that the interference with the claimant's Article 8 rights was "grave"[32], and the arguments in favour of the current law were "by no means overwhelming"[33], but that the judiciary was not the appropriate chamber at that time to influence the change of the law in such a manner.

Reasons for his belief that it was inappropriate for the judiciary to take such a step at the time included the fact that it was a "difficult, controversial and sensitive issue".[34] Also, that the subsequent steps to rectify the law with the ECHR were not simple and faced logistical planning. Lord Brown also noted that Parliament were actively considering the matter in debates.

V. PUBLIC OPINION

The DEMOS report outlines that public opinion towards assisted dying has been consistent in favour of change by the majority since the 1970s, with a slight increase for the legalization of assisted dying, which is indicated by information collected by the Voluntary Euthanasia Society.[35]

V.I. Attitudes in the 1970s and 80s

The DEMOS report notes that the earliest poll regarding attitudes towards assisted dying was conducted by the National Opinion Poll (NOP) in 1976 which found that 69% of those surveyed supported the statement that the law should allow adults to receive medical help to an "immediate peaceful death" if they are suffering from an incurable illness that is "intolerable to them" if they request such help in writing. The same survey was repeated in 1985 and 1989, with increased majorities of 72% and 75% agreeing respectively.[36]

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[32] At [111].
[33] ibid.
[34] At [116].
[35] 'Commission on Assisted Dying Report' (*DEMOS*, 2012) <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363> accessed August 2017.
[36] ibid.

V.II. Attitudes in the 1990s

The Demos report suggests that surveys in the 1990s show a trend of "a large and incrementally increasing majority in favour of the legalization of some form of assisted dying"[37], with an increased majority of 79% favouring legislation of some form in 1993, compared to 75% in 1989 as discussed above.

The British Social Attitudes published a more specific report in 1995A report published in 1995 which outlined that the highest support, 86%, was for a form of involuntary euthanasia for individuals on life support not expected to recover, with the consent of relatives. 80% also supported the legalization of euthanasia for those suffering from a painful and incurable terminal illness. However, a sharp decrease of support was noted as 42% of those surveys believed that assisted dying should be an option for those with a painful but non-terminal illness.

V.III. Contemporary attitudes

A 2005 survey by the BSA noted that 80% of those surveyed believed that those suffering from terminal illnesses should have the option of assisted dying available to them, compared to only 45% of those surveyed who thought that the option of assisted dying should be available to people suffering from incurable but non-terminal illnesses. Additionally, only 44% of people thought that relatives should be the ones undertaking this, compared to 80% of people who thought that doctors should be the ones doing it.

The most recent data regarding public attitudes towards assisted dying from YouGov indicate that 69% of people think that the law should be changed to allow someone to assist in the suicide of someone "suffering from a terminal illness".[38] Additionally, 56% of people stated that they would 'probably' consider assisted dying if they were suffering from a painful and incurable illness if assisted dying was legal – hence the majority of the country believe that the option should be available for them in law.

The campaign group, Dying in Dignity outline categories of groups who support law reform. For example, they state that 54% of GPs are either supportive or neutral to law change on assisted

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[37] ibid 61.

[38] W Jordan, 'Majority of Public "Would Probably Consider" Assisted Dying' (*YouGov*, 6 June 2014) <https://yougov.co.uk/news/2014/07/06/majority-public-would-consider-assisted-dying-some/> accessed August 2017.

dying, and that 86% of people with a disability support a change to the law.[39] More ambiguous is their suggestion that 79% of religious people "support an assisted dying law", with no source for their data and no elaboration as to what an "assisted dying law means", for example this could reasonably be interpreted to mean a law prohibiting it.

With that said, public opinion is weaker with regards to non-terminal illnesses which are nonetheless painful and incurable, with only 42% believing that the law should be changed to allow someone to assist in the suicide of someone in these circumstances.[40] This implies that the majority of the public believe that assisted suicide is only just in circumstances where the life of the individual is inevitably premature because of their illness, not merely painful and incurable.

It is clear from the data that there is a consistent majority in favour of some kind of assisted dying law over the past four decades, though what is also consistent is that there is a substantial decrease in support for assisted dying for those suffering from illnesses which are not terminal despite them being both incurable and painful.

VI. LEGAL REASONS FOR REFORM

VI.I. Constitutional Reasons

Beaton, who renders the law "less principled than ever",[41] argues that it is imperative that Parliament reform the law on assisted dying in order to avoid the constitutional dilemma the law currently poses.

As discussed already, the DPP sets out guidelines as to when a person might be prosecuted for assisting when a death has taken place. The DPP's prosecution policy guidelines begin by noting that nothing in the policy amounts to a guaranteed assurance that a person will avoid prosecution. The DPP told the Falconer Commission on Assisted Dying that the policy guidelines must be carefully constructed and cannot be a guarantee against prosecution because to be a guarantee

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[39] 'Public Opinion' (*Dignity in Dying*) <www.dignityindying.org.uk/assisted-dying/public-opinion/> accessed August 2017.

[40] ibid.

[41] Ross Beaton, 'Assisted Dying – a legal problem and a proposal for reform' (*Bar Council*, 2013) <www.barcouncil.org.uk/media/241800/_25__ross_beaton.pdf> accessed August 2017.

would undermine Parliament's intention that assisted dying be an offence, as clearly set out in the 1961 Act.[42]

Whilst the DPP's policy does note that there is no guarantee against prosecution in order to undermine Parliamentary supremacy, Beaton argues that the material effect of the DPP's policy is that no prosecution takes place in relation to family members, in effect decriminalising the offence to this class of people:

"Even though the Director has said, quite properly, that it cannot be for him to suspend or dispense with the offence, the fact that not a single case has been prosecuted since Purdy suggests that he has, in reality, done so with regard to family members."[43]

It is Beaton's view, therefore, that the DPP's policy amounts to de facto law in relation to how the criminal law operates on family members in relation to assisted dying, hence conflicting with the constitutional doctrine of Parliamentary sovereignty.

VI.II. Inconsistency between the treatment of acts and omissions

Today, individuals of sound mind who desire to seek assisted dying are within the purview of the blanked ban in s 2 Suicide Act. However, no offence is committed if a doctor refuses or withdraws treatment from an adult (even without the patient's express wish to this effect)[44]. This distinction has been repeatedly relied upon by courts to justify the assertion that there already is enough attention on the part of the law to the autonomy of patients seeking to end their lives[45]. Palmer argues this distinction between acts and omissions is unwarranted and artificial. The opposite argument remains, however, open: such a differentiation may be supported in light of the law's generally lenient treatment of omissions in both criminal law and tort.

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[42] 'Commission on Assisted Dying Report' (DEMOS, 2012) <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363> accessed August 2017.

[43] ibid 6.

[44] *Re B (Consent to Treatment) Capacity)* [2002] EWHC 429 and Palmer, 'The Choice is Cruel: Assisted Suicide and Charter Rights in Canada' [2015] CLJ 191, 194.

[45] *R (Conway) v Secretary of State for Justice* [2018] 3 WLR 925 [54]: *[...] if Mr Conway wished to die, he could lawfully act upon that wish by communicating his desire for his NIV equipment to be removed.* The argument Conway made that the result would be a painful, undignified death did not find favour with the court.

VI.III. The Human Rights Act 1998

The Human Rights Act provides the courts with the power to make a declaration of incompatibility with a provision of any primary legislation it deems to be in conflict with the ECHR. This is set out in section 4 of the 1998 Act, which also notes that the declaration has no legal effect on the continuing operation of the said provision and also has no effect on the parties to the dispute before the court.

Despite the section 4 power being legally insignificant, its political weight should not be underestimated – it provides a signal to Parliament and wider society that the UK is in breach of international human rights.

The Supreme Court was given the opportunity to use their section 4 powers in the case which has already been discussed, *Nicklinson.* And whilst the majority of the judges did not make the declaration, two dissenting judges, Lady Hale and Lord Kerr, would have made the declaration of incompatibility as it was their view that the s 2(1) of the Suicide Act 1961 breached the ECHR.

Whilst the court is not compelled to use their section 4 powers even in cases where they have the authority to, Lord Kerr spoke of it being their "duty" under the Human Rights Act when dissenting in Nicklinson.[46]

Lord Neuberger, who would not make the declaration, commented that the court in *Pretty,* 13 years prior to Nicklinson, held it was inappropriate to make a declaration of incompatibility, and that therefore "a declaration of incompatibility on this appeal would represent an unheralded volte-face."[47] The majority judges were open about the fact that they had the constitutional authority to declare s 2(1) of the 1961 Act incompatible with Article 8 of the ECHR, just that they were not the appropriate institution to meddle with this area of the law.

VI.IV. Jurisprudence of the European Court of Human Rights: Engagement of Article 8

Everyone has the right to respect for his private and family life, his home and his correspondence.

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[46] [2015] AC 657 [347].

[47] ibid [347].

Claimants in disputes surrounding assisted dying have often relied on Article 8 of the ECHR, contending that the state's blanket ban on assisted dying conflicts with their right to private life as it constitutes an improper interference. The House of Lords decided in Pretty that this right was not engaged at all, and that it should be interpreted as protecting the individual's personal autonomy whilst they were alive and did not entail the right to die.

However, the ECtHR decided otherwise on appeal, suggesting that the right had been engaged. Additionally, in *Haas v Switzerland*, *Koch v Germany* and *Gross v Switzerland* the court stated that Article 8(1) encompasses the right to decide how and when to die, particularly the right to avoid a distressing and undignified end to life:

i. *Pretty v United Kingdom*

"The applicant is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1)".[48]

ii. *Haas v Switzerland*

"The Court considers that the right of an individual to decide how and when to end his life, provided that said individual is in a position to make up his own mind in that respect and to take the appropriate action, is one aspect of the right to respect for private life within the meaning of art. 8 of the Convention".[49]

The fact that Strasbourg has clearly and consistently ruled that Article 8 encompasses the right to decide when and how to end one's life in their judgement, illustrates a clear disengagement with English law. However, Lord Bingham suggested in *Pretty* that it is not enough to demonstrate that the ECHR does not prohibit assisted suicide, it must be shown that the UK is in breach of the ECHR in not permitting it, a view he rendered "untenable".[50]

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[48] *Pretty v United Kingdom* (2002) 35 EHRR 1 [67].

[49] *Haas v Switzerland* (2011) 53 EHRR 33 [51].

[50] *Pretty v DPP* [2002] 1 AC 800 [9].

VI.V. The Right to an Effective Remedy

Article 13 of the ECHR sets out that everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.[51]

The European Court of Human Rights' case law concerning Article 13 is developed and consistent in its view that the right to an effective remedy entails that rights are real, not merely exist in law and that people must have effective access to them.

In *Tysiqc v Poland,* the court stated that:

"[The Convention] is intended to guarantee not rights that are theoretical or illusory rights but rights that are practical and effective."[52]

Elizabeth Wicks argues that the Human Rights Act is a mechanism empowering the domestic courts to determine the compatibility of Convention rights and that the court's evasion of this responsibility in not making a declaration of incompatibility in *Nicklinson*, as a 'national authority' under the Article, could potentially conflict with Article 13.

"…if the legalisation of assisted dying or abortion requires that those rights be practical and effective and not merely illusory, would not the incorporation of the Convention rights into domestic law in the HRA similarly require real and not theoretical enforcement of the rights?"[53]

Whilst Wicks' argument is somewhat convincing coupled with the dissenting judges' speeches concerning the responsibility of the judges, ultimately the Supreme Court are not compelled to use the power to make a declaration of incompatibility as section 4(4) states that the court "*may* make a declaration of that incompatibility"[54] should one be found.

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[51] European Convention on Human Rights, Article 13.
[52] *Tysiqc v Poland* (2007) 45 EHRR 42 [113].
[53] (2016) Medical Law Review 24 (4): 633 3.
[54] Human Rights Act 1998, s 4(4) (emphasis added).

VII. GRAVITATING OUT OF EUROPE: BREXIT AND LEAVING THE ECHR

With Brexit on the horizon, the apparent disengagement with British law and European law in relation to assisted dying may have very little significance should the UK decide to do away with European law altogether, hence any legal arguments based on the Human Rights Act, the ECHR or Strasbourg jurisprudence may soon be ineffective.

Whilst the UK will remain a member of the Council of Europe in spite of its lack of EU membership, and will also still be a state party of the ECHR and thus remain subject to the European Court of Human Rights, there is a fear that Brexit may be the perfect opportunity for the government to cleanly break free from European law in one go by scrapping the Human Rights Act and leaving the ECHR.

Repeal of the HRA and replacing it with a British Bill of Rights was promised in the 2015 Conservative manifesto[55] but was never delivered and was not included in the 2017 manifesto, it seems likely that the policy has slipped off the government's agenda – it being busy with Brexit. However, some think otherwise with Theresa May leading the Brexit negotiations as Prime Minister, who advocated the policy of scrapping the Human Rights Act and leaving the ECHR altogether within her former role as Home Secretary.

Connor Gearty writes that critics of the HRA advocated similar rhetoric to that of the campaigners of Brexit and that now "that the larger European entanglement has been successfully seen off, the time has come for finishing the unfinished business of human rights destruction."[56]

Further, there has been adversity against the Human Rights Act in recent years, Gearty suggesting that the anti-HRA-pro-common-law view of the law is coming "back into fashion". During the debate following the passing of the Queen's speech in May 2015, the then Lord Chancellor Michael Gove reminded the House that human rights existed via the common law prior to 1998, and that to do away with the HRA would not be a terrible sin.[57] Other adversity to the HRA is based on concerns that the UK's Supreme Court Judges have too much power in relation to their

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[55] 'Conservative Manifesto' 58 (*Conservative and Unionist Party*, 2015) <www.bond.org.uk/data/files/Blog/ConservativeManifesto2015.pdf> accessed October 2017.
[56] C Gearty, *On Fantasy Island* (OUP 2016), xiii.
[57] HC Deb 28 May 2015, col 291.

power to make declarations of incompatibility by virtue of s 4 of the Act. Charles Moore writes of the Supreme Court "undermining the rights of our politicians".[58]

It is clear that a clean break from European rights is desired by some, not least the incumbent Prime Minister. While it is dubious to what extent the law of the ECHR has been incorporated into English common law, if the UK did decide to withdraw from the Convention, arguments outlined above may be invalid. This would have a significant impact on those seeking to challenge assisted dying law in this country since it was only with the passing of the Human Rights Act that individuals acquired a way of challenging the law.

VIII. SOCIAL REASONS FOR REFORM

VIII.I. Psychological effect on patients and doctors

The social perspectives driving change in the end-of-life care area and assisted dying originate from two broad standpoints.

The first is that of the patients. Most calls for reforming existing law ground themselves in the idea of 'dying with dignity' in circumstances where normal treatments and palliative care would fail. They also invoke the concept of full individual autonomy whereby assisted dying may function both as a physical alleviation of extreme bodily and psychological suffering and as a form of comfort in knowing this option exists. There is ample evidence for this attitude in that a significant number of those who demand lethal medicines to be prescribed in jurisdictions where this is legally allowed end up not using them. In 2015, Oregon saw 218 prescriptions issued, whilst only 132 deaths actually occurred.[59]

Apart from the feeling of exerting some level of control over one's own destiny, some consultations suggest legalisation may improve the patients' trust in their attending doctors: "It would increase trust in your doctor. It's a matter of control, and if it was legal you would know the doctor could give whatever care you want, it would be more comforting knowing that you're

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[58] C Moore, 'Our top judges have become too powerful' *The Telegraph* (London, 23 Oct 2015) <www.telegraph.co.uk/news/politics/11951936/Our-top-judges-have-become-too-powerful-we-need-to-rein-them-in.html> accessed October 2017.
[59] *End of Life Care and Physician Assisted Dying Report* (vol 3, British Medical Association 2016) 67.

completely in control."[60] Most surveys are, however, affected by a lack of information within the public with regards to the type of procedures that would be used and to their lack of success (it appears, for instance, that there is no clear understanding of the difference between assisted dying and euthanasia; in addition, a large section of the public simply assumes that almost all assisted dying attempts are smooth and successful).[61]These irregularities have the potential of explaining why polls and consultations within the general public consistently show a larger support of reform than those within the medical profession.

The second perspective belongs to doctors. This professional group has a highly relevant perception on the matter, as they are likely to either be specifically designated as responsible to carry out assisted dying procedures or, even if not mentioned in legislation (e.g. the Swiss model), de facto perform the same role in their capacity as experts. Apart from the instrumental reason, medical professionals also tend to be the first port of call for patients who are concerned about end-of-life issues and frequently need to offer advice and care. These two latter roles are fundamentally interlinked with the doctor's necessity to be in a relationship of trust with the patient which would ensure the treatment received by the patient is accepted and efficient.

In the UK, despite some views to the contrary amongst the public, most doctors believe these bridges of trust would be threatened by any procedure perceived to go against the life of the patient.[62] Thus, among other organisations, the British Medical Association has twice published policies advising against decriminalisation.[63] The different views uncover a deep division of values. When prompted on how reform would affect the doctor-patient relationship, the following improvements emerged:[64](1) doctors would be more able to provide a good death (by relieving pain and suffering, control and dignity, better quality of life), (2) doctors would be able to provide more service to patients (on this view, assisted dying is just another service that would be available to satisfy some people's wishes), (3) communication of people's fears and wishes would be improved. Conversely, doctors also feared of downsides:[65] (1) increased fear of doctors, hospices and palliative care, which might be associated with death, (2) decrease in the quality of

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[60] ibid 68.
[61] ibid 66.
[62] ibid 69.
[63] P Yeung, 'BMA Doctors to Consider Allowing Assisted Suicide in the UK' *The Independent* (London, 16 June 2016) <www.independent.co.uk/news/uk/home-news/assisted-suicide-uk-bma-euthanasia-end-of-life-care-dignitas-a7090541.html> accessed September 2017.
[64] *End of Life Care and Physician Assisted Dying Report* (vol 3, British Medical Association 2016) 69.
[65] ibid.

information patients share with doctors, (3) doctor's reputation would be undermined by: refusals to assent to the procedure, opt-outs, negative rumours in small communities, accusations of coercion, disagreement with the patient's relatives, (4) changes of the fundamental role of a doctor (especially if a different specialism is created, which would be colloquially known as death doctor), too much control over the patient's life, (5) concerns that assisted dying would gradually be seen as an ordinary treatment option rather than an exception. It is still uncertain whether the objections can simply be reduced to an underlying opinion against reform.

It is known some of these difficulties can be mitigated by procedural controls. One of the most effective in psychological terms is the division of responsibility for the assisted dying process between multiple actors (the patient himself, an attending physician, an independent physician, and a legal professional – in the most recent proposals a judge of the High Court's Family Division). Attending physicians have always been appreciated to be inherently involved and able to conduct all procedures as a first step. However, it has been recognised this responsibility puts enormous emotional pressure on the doctor.

One way to reduce this pressure would be the introduction of an independent doctor, who would not have a personal relationship with the family.[66] A disadvantage of the consultant (and any further number of consultants) may still be that a dissatisfied patient could seek the advice of a different doctor. A second way to relieve doctors of excessive responsibility is the involvement of judges. In consultations, doctors were unsurprisingly far more likely to recommend the addition of judicial oversight. While recognising their ability to adjudicate independently and recognise circumstances of coercion, members of the public are generally less inclined to support the participation of a judge. Amongst the arguments cited are increased costs, bureaucracy, added stress to the patient, the association of judges with crimes and wrongdoing.[67]

We regard the considerable responsibility placed on doctors to be an essential issue, and we recommend that if legislation is proposed, a form of court or tribunal oversight should be part of the mechanism.

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[66] ibid 71.
[67] ibid.

VIII.II. Vulnerable categories

Perhaps the strongest arguments against changing current criminalisation as outlined in the Suicide Act 1961 are entertained by groups representing disabled persons. They contend that the compassionate action some members of the public undertake towards terminally ill and disabled people runs contrary to the attempt to institute equality for these categories. Informal pressure from relatives, friends, or even public bodies (e.g. the NHS) who would be relieved of expenses in case the cheaper assisted death option is pursued, as well as the belief that a disabled or illness affected life is not worth or less worth living have been shown to weigh considerably against assisted death laws of any form.[68] This view is supported by showing that foreign jurisdictions like Oregon or the Netherlands often register the wish not to be a burden on others among the reasons for requesting lethal drug prescriptions.[69] There are also questions regarding the capacity of doctors to accurately assess how much a patient is going to live (such assessments are greatly approximative and patients frequently outlive expectations).[70] In addition, there is the risk, these organisations argue, that assisted dying becomes the normal or expected route in terminal illness situations, and legislators and courts come under pressure to extend both eligibility for (to include the disabled, those with progressing diseases or finally any willing person) and breadth of procedures (to include euthanasia, for instance).

Whilst these arguments are widespread and partly backed by evidence, they cannot be described as conclusive. Most of the feared measures have not been proposed in England and Wales and, in jurisdictions which have similar legislation to the Falconer bills (Oregon, Washington), the number of persons electing to use the procedure has been significantly lower than in others which have more far-reaching versions (Belgium, the Netherlands). Moreover, polling shows that a majority of the public might back reforms even knowing the extent of this phenomenon.[71]

In addressing these legitimate concerns, we recommend that an improvement of current care facilities should be considered prior to any legislation for assisted dying. We further suggest that in the event legislation is considered, the safeguards discussed in older bills should be enhanced by: (1) strictly limiting the number of qualifying persons using the most objective criteria available, (2) ensuring the process does not affect efforts against discrimination of the disabled, (3) ensuring

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[68] 'About Care not Killing' (*Care not Killing*, 2018) <www.carenotkilling.org.uk/about/> accessed September 2018
[69] 'Why Scope is against legalising assisted suicide' (*SCOPE*, 2018) <www.scope.org.uk/media/scope-against-legalising-assisted-suicide> accessed September 2018.
[70] ibid.
[71] *End of Life Care and Physician Assisted Dying Report* (vol 1, British Medical Association 2016) 90.

external influence (from relatives, activist groups, medical institutions with a specific agenda) is excluded from the patient's decision, (4) setting up a lengthier waiting period between the various moments of the process, so as to address the fact that life expectation advice is often inconclusive.

In summary, there are many desirable reasons for law reform on the issue of assisted dying. Reform of the law could solve the constitutional dilemma that currently exists in the DPP's prosecution policy amounting to de facto law. Additionally, Parliament has had ample time to respond in some way to the judgment in *Nicklinson*, given almost three years ago in June 2014, whereby the judges acknowledged that there was an incompatibility in the law but didn't use their section 4 powers. Should Parliament not make their intentions clear as to how they will proceed on the issue, the Supreme Court justices might not be so tentative in using their section 4 powers in the future. Having established that Convention rights are engaged in cases of assisted dying, law reform should follow despite the margin of appreciation allowed to states for the various reasons discussed above about the psychological impact and the vulnerability of patients.

IX. REFORM PROPOSALS IN ENGLAND AND WALES

IX.I. The Assisted Dying for the Terminally Ill Bill, 2004 (Lord Joffe)

The Assisted Dying for the Terminally Ill Bill (the Bill) was introduced in the House of Lords by Lord Joffe in 2004, and was the first in a series of bills he promoted. The Bill allows a physician to assist a qualifying patient who has made the requisite declaration to die. By defining the notion of assisted dying as 'the attending physician, at the patient's request, either providing the patient with the means to end the patient's life or if the patient is physically unable to do so ending the patient's life',[72] this proposal included de facto euthanasia in its ambit. However, in subsequent versions of the Bill, this provision was qualified, so as not to authorise a fully third-party intervention towards the end of life, as the initiator explained during parliamentary debates[73].

To qualify, a patient must have been resident in the United Kingdom for twelve months before the declaration and must have reached the age of majority. Once these preliminary hurdles are overcome, the first (attending) physician would have to ascertain himself of the following: (1) the patient has formulated the request to be assisted to die, (2) after checking the records, the patient

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[72] Assisted Dying for the Terminally Ill HL Bill (2003-2004) 17, cls 1(1) – 1(2).
[73] HL Deb 12 May 2006, vol 60512, col 1189.

is competent (capable of making an informed decision), (3) the patient suffers from a terminal illness, (4) the patient is suffering unbearably as a result of that specific illness, (5) the patient has been informed of his diagnosis, prognosis, procedure of assisted dying, alternative care, (6) the patient is referred to a consultant (independent physician).[74] Terminal illnesses are defined unclearly as leading to death within 'a few months', without a definite prognosis indicator.

The consulting physician would investigate and confirm the accuracy of the attending physician's findings according to the legally prescribed steps already outlined. They would also inform the patient that to effect the assisted dying procedure, the patient must complete a declaration which is revocable at any time.[75] At this point, the attending physician would have to ensure the patient has received the visit of a specialist in palliative care, with whom this option was discussed.[76] If any of the doctors have uncertainties regarding the patient's capacity, they must refer the patient to a psychiatrist for an authorised opinion. No assisted death may be carried out against such psychiatric advice.[77] This declaration, benefiting from a set form attached to the schedule, must be countersigned by two witnesses. One of them must be a solicitor with a current practising certificate, who must fulfil a list of conditions: (1) the solicitor must verify the identity of the patient or be personally known to the latter, (2) the solicitor must ascertain the soundness of the patient's mind and his ability to understand the effects of the declaration. The second witness may be any person aware of the patient's identity, except: (1) the assistant or consultant physicians, (2) psychiatrists or members of the care team, (3) relatives or partners of the patient, (4) owners, operators, or employees of the care establishment where the patient is resident. Such a declaration expires after six months.[78]

The attending physician cannot perform any step towards assisted dying without first confirming with the patient that the declaration has not been revoked. Revocation may be made orally or otherwise, and upon notification, the declaration must be erased from the patient's medical file.[79] The medical practitioners are also protected, in that conscientious objectors may refuse to take part in the procedure. They are, nevertheless, directed to refer the patient to a different

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[74] Assisted Dying for the Terminally Ill HL Bill (2003-2004) 17, cl 2(2).
[75] ibid cl 2(3).
[76] ibid cl 3(1).
[77] ibid cl 8(1).
[78] ibid cls 4(2) – 4(8), 5.
[79] ibid cl 6.

practitioner without objections.[80] The Bill specifies that a physician acting in good faith in accordance with its provisions would not be guilty of any offence.[81] The decriminalisation covers members of the medical care team.[82] Arguably, this clause would impliedly amend the Suicide Act 1961 (SA), but no explicit changes are discussed, leaving the aspect to be clarified judicially.

Furthermore, another safeguard on decriminalisation states that 'No physician, psychiatrist or member of a medical care team may take any part whatsoever in assisting a qualifying patient to die, or in giving an opinion in respect of such a patient, nor may any person act as a witness, if he has grounds for believing that he will benefit financially or in any other way as the result of the death of that patient.'[83] Hence, the exception to s 2 SA explained above would receive a vested interest qualification. This borrows from Oregon legislation, but a simpler version is the one expressed in the Swiss Criminal Code ('selfish motives').[84] An array of new offences would additionally be created:[85] (1) forging a declaration with the intent of causing the patient's death (it is questionable whether this does not already amount to murder – if completed – or attempted murder), (2) putting one's name in a declaration known to be false, (3) concealing or destroying a declaration, (4) taking part in an assisted dying process, including by giving opinions or as a witness, whilst having grounds to believe that a financial or other benefit would ensue from the death of a patient (this seems to already be a part of the SA). The Bill seeks to duplicate the sanctions by letting other overlapping offences in force, which constitutes an example of legal inconsistency.

Finally, all relevant elements must be kept as documentation in the medical records of the patient,[86] and the whole application of the law would be reviewed by a monitoring commission.[87] Subsequent normative adjustments would be made by a statutory instrument approved in by both Houses of Parliament.[88]

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[80] ibid cl 7.
[81] ibid cl 10(1).
[82] ibid cl 10(2).
[83] ibid cl 10(4).
[84] Swiss Criminal Code 1937, Art. 115.
[85] Assisted Dying for the Terminally Ill HL Bill (2003-2004) 17, cl 11.
[86] ibid cl 13.
[87] ibid cl 14.
[88] ibid cl 16.

IX.II. The Falconer Commission Report

Considering the international developments regarding assisted dying and euthanasia, as well as of the changing attitudes of the British public and judicial decisions (leading to the 2010 CPS Policy on Assisted Suicide Prosecutions), a Commission on Assisted Dying (the Commission) was set up in 2010 by DEMOS under the chairmanship of Lord Falconer of Thoroton to explore the issue. In its report published two years later (the Report), the Commission draws upon significant consultation within the medical sphere, legal professionals, affected patients and civil society. It also evaluates the technical difficulties encountered and results obtained in the various jurisdictions accepting a form of assisted dying at that point. The outcome is a set of principles and proposals underlying a future Assisted Dying Bill (the Bill).

The Commission retains as a first principle the genuinely autonomous character of the concerned individual's choice.[89] This autonomy must be underpinned by two factors: (1) the absence of external influence factors, such as abusive pressure from other interested persons, and (2) ensuring that the concerned individual is of sound mind and not affected by impairments caused by depressions or other undiagnosed or untreated mental health conditions. As a result, the report emphasises the adequate safeguards that must be put in place.

Subsequently, the Report proceeds to lay down a list of key elements on which the Bill should be based: (1) a good level of health-care services with properly trained staff, (2) clearly defined eligibility criteria, the concerned person must have capacity and make the request on their own behalf, (3) the participation of a doctor who is known to the patient and is able to support them and their family, (4) an assessment as to whether the eligibility criteria are met to be done by an independent doctor in addition to the first one, (5) full information of the patient about alternative treatments available, (6) detailed guidance and regulations on the prescription, storage and use of lethal medicines, (7) the patient must take the final action to end their own life, (8) the death is reported explicitly as an assisted one in the death certificate, (9) the creation of a national monitoring commission to keep track of assisted deaths and inquire into their conformity with the law.[90] Noteworthily, therefore, the Commission did not include a requirement for a court order to be issued (or a different form of legal approval, e.g. that of a solicitor) nor did they

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[89] Commission on Assisted Dying Report' 300 (DEMOS, 2012) <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363> accessed August 2017
[90] ibid 301.

provide for 'unbearable suffering' to be felt by the patient as an eligibility requirement. In addition, no euthanasia is permitted, contrary to Oregon legislation and the older bill introduced by Lord Joffe.[91]

The eligibility criteria are as follows: the person must be at least 18 years old, have a diagnosis of a terminal illness, be making a voluntary, not extraneously informed choice, and have the mental capacity to make that choice. Hence, some highly debated categories are excluded: (1) child patients, (2) patients with degenerative diseases who would like to specify in a document while they have mental capacity that assisted dying would be performed once they lost that capacity (e.g. Tony Nicklinson), (3) patients who are not terminally ill. The permitted type of assisted dying, as shown above, is also limited. A qualifying patient would be allowed to take a dose of medication that would end their life.[92] This means that it is only the patient themselves that could perform the act constituting the cause of their death, as an expression of voluntariness. The policy aims to give the patient full control over the process and an ability to change their mind at any point. The limitations are justified by an assessment of public opinion through polling. In British Social Attitudes surveys published in 2007 and 2010, more than 80% of the public supported assisted dying for people with incurable illnesses, whereas only 45% supported the same procedure for patients suffering from non-terminal illnesses.[93] Still, the commission recommends that in non-terminally illness cases, the CPS charging guidelines currently applied should continue to be referred to.

A particular difficulty recognised by the Report is the attempt of defining the notion of approaching the end of one's life. Although approaches differ between jurisdictions (with Oregon specifying a prognosis of 6 months), the Commissioners evaluate the UK General Medical Council guidelines, which stipulate a broader range of circumstances: patients whose death is imminent (likely to die within days), patients who due to existing conditions are likely to die within the next 12 months, patients who due to their existing conditions are likely to die in a future sudden/acute crisis, life-threatening acute conditions caused by sudden, catastrophic events. They rightly observe the latter four instances pose too much uncertainty to be included in an assisted dying requirement, and therefore establish the requirement of a progressive,

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[91] Assisted Dying for the Terminally Ill HL Bill (2003-2004) 17, cl 1(2).

[92]Commission on Assisted Dying Report' 302 (DEMOS, 2012). <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363> accessed August 2017.

[93] ibid 304.

incurable condition likely to lead to death in the next 12 months. It is unclear, nevertheless, to which extent this time length is effective, and its reception varies: the unsuccessful UK Assisted Dying Bill 2014, based on this report, has included a more cautious option of 6 months,[94] while the 2017 Ministerial Advisory Panel on Voluntary Assisted Dying Final Report (Victoria) went ahead with the 12 months proposal.[95]

As shown in the introduction, the Commission did not recommend the acceptance of a criterion of unbearable or unrelievable suffering. In their view, this criterion is too unclear and subjective for doctors to assess. The Euthanasia Act (Belgium) 2002 provides that the assistant physician must satisfy themselves the patient is under unbearable and constant physical or psychiatric suffering.[96] Similarly, in the Victorian 2017 report, the patient must have a disease which 'is causing suffering that cannot be relieved in a manner the person deems tolerable'.[97] We find the argument of the Report, which based on UK research determines the criterion is not effective in limiting instances of assisted suicide, compelling, particularly given the differences that might appear between the patient's opinion as to the issue and the doctor's. This leads to the Victorian report using a de facto inoperable provision.

The capacity criterion mirrors the definition provided for in the Mental Capacity Act 2005: 'A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain... It does not matter whether the impairment or disturbance is permanent or temporary.', 'A person is unable to make a decision for himself if he is unable: a) to understand the information relevant to a decision, b) to retain that information, c) to use or weigh that information as part of the process of making the decision, or d) to communicate his decision.'[98] A significant change to this model is, in the Commission's view, that the existence of mental capacity should, for the purpose of assisted dying declarations, not be presumed.[99]

To alleviate concerns about the reluctance of medical practitioners to engage in assisted dying, the Report advises that new legislation should protect doctors and other health and social care

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[94] Assisted Dying HL Bill (2016-2017) 42, cl 2(1)(b).
[95] Government of Victoria, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 2017) 13.
[96] Euthanasia Law (Belgium) 2002, Art. 3.
[97] Government of Victoria, *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 2017) 13.
[98] Mental Capacity Act 2005, ss 2(1) – 3(1).
[99] Commission on Assisted Dying Report' 308 (DEMOS, 2012) <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363> accessed August 2017.

professionals wishing an opt-out for ethical reasons. However, a doctor making use of such an opt-out opportunity would be required to refer the patient to a different doctor who is ready to perform the requisite acts.[100] Further, the procedure would involve two doctors. The first doctor would be a person who has a long-standing involvement in the treatment of the patient (either a specialist or a GP), and who knows the patient and his family well. His responsibility would include a first assessment of motivation and certainty in the patient's decision, voluntariness, and capacity. A supplementary competence of the first doctor is arranging support for the family. This framework constitutes an extended list of competences from those demanded in Oregon and Switzerland. The second doctor[101] would be (1) professionally independent of the first doctor, and of the patient and their family, (2) possessing expertise in end-of-life care. His role would be to provide a second opinion and, where necessary, challenge the assessment made by the first doctor. Both doctors would have to inform the patient of all available alternative treatments and would have to certify, independently of one another, that the safeguard measures described above have been met (terminal nature of the illness, lack of external influence, mental capacity). With regards to the level of settlement of the intention to die, the Report acknowledges the fears that the process must not be overwhelmingly lengthy but suggests some built-in delays must apply, coupled with the ability to reverse the decision at any time.[102] The prescribing doctor would be required to deliver the medicines, ensure they are not misused and dispose of them in case they were not utilised. The same medical professionals would have to ensure proper reporting.[103]

For the implementation of the assisted dying framework developed under the principles they propose, the Commission advised a sequence of practical steps to be taken: (1) continuing investment from the Government in end-of-life care, (2) drafting a bill to de-criminalise physician-assisted suicide for the terminally ill, (3) continuing the current CPS policies for non-terminal cases, (4) drawing up codes of practice for all professionals involved, (5) implementing support and training for doctors, (6) clear procedures for reporting the effect of the legislation, (7) a national monitoring commission with investigative powers.[104]

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[100] ibid 311-312.
[101] ibid 313.
[102] ibid 317.
[103] ibid 319.
[104] ibid 321-325.

IX.III. The Assisted Dying Bill, 2014 (Lord Falconer)

Based on the Assisted Dying Commission's Report (2012), Lord Falconer introduced several bills, out of which the Assisted Dying Bill, 2014 reached committee stage, but without receiving a report.

The qualifying criteria for a terminally ill person are:[105] (1) clear and settled intention to end his or her own life, (2) has made a declaration to that effect, (3) is aged 18 or over and has been resident in England and Wales for no less than one year. Terminal illness is defined as an inevitably progressive condition which cannot be reversed by treatment and which is reasonably expected to lead to death within six months.[106] The bill, therefore, departs from the suggestion made in the Report but brings a welcome clarification to the formulation supported by Lord Joffe. It also accounts for the difficulty doctors face in establishing an accurate prognosis, which is still far from overcome; this account is only partial: there is no sufficient evidence so far that a better evaluation is made closer to death and there are often significant differences between the evaluations and the actual evolution of the patient.

The declaration must be: (1) signed in the presence of a witness, which may be any person except a) relatives and b) persons involved in the care of the patient, (2) countersigned by a) the attending doctor – the doctor from whom the end-of-life assistance had been requested, and b) the independent doctor – who is not a relative, partner, or colleague of the attending doctor.[107] Neither of the doctors may also serve as a witness. Before countersigning, both doctors must examine the patient independently and in the same way ascertain: (1) the terminal illness, (2) capacity, (3) the intention to die is clear, settled, informed, not generated by coercion or duress. The person must be fully informed of hospice, palliative and other forms of care available. A person who has made such a declaration may withdraw it at any time, not necessarily in writing.[108] Compared to previous bills, this proposal lowers the number of witnesses required and leaves a considerable number of other aspects to be determined in secondary legislation. Although the said legislation is scrutinised by Parliament, we appreciate the level of scrutiny is lower than that deployed for bills, and therefore this methodology should be avoided.

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[105] Assisted Dying HL Bill (2014-2015) 6, cl 1.
[106] ibid cl 2(1).
[107] ibid cl 3(1,2).
[108] ibid cl 3(6).

Medicines may be prescribed for assisted dying, subject to limits. They may not be administered by doctors without the physical participation of the patient, self-administration (albeit potentially aided) being essential. An assisting health professional is explicitly prohibited from administering a medicine to another person with the intention of causing the other person's death.[109] The prescribing doctor must permanently keep track of these medicines and, in the event they are not administered, the doctor must return them to the pharmacy.[110]

The medical professionals involved benefit from the protection afforded to conscientious objectors.[111] They are also explicitly, not only implicitly (as in the Joffe bill), protected from criminal liability by an amendment to s2 of the Suicide Act 1961, which specifically excludes lawful assisted dying procedures from the ambit of that act.[112] Assisted dying cases are also removed from the list of suspicious deaths which necessitate an inquest, according to the Coroners Act 1988. Codes of practice have to be established by legislation.[113] Monitoring pertains to Chief Medical Officers, who must report annually to the relevant authorities. In turn, the Secretary of State and the Welsh ministers must submit them to legislative scrutiny. [114]

New offences can be found in this bill,[115] mirroring previous versions: (1) making or knowingly using a false declaration, (2) wilfully concealing or destroying a declaration made by another, (3) knowingly or recklessly providing a professional opinion which is false or misleading to another who wishes to make or has made a declaration. The first offence, if committed with the intention of causing death to another, carries a life imprisonment sentence, with the alternative of a fine. This set of offences is markedly more limited than that in the Joffe bill. Without eliminating the overlapping offences, this does not clarify the criminalisation of partaking in what is (or there are reasonable grounds to believe is) an assisted dying procedure motivated by interests pertaining to another person than the patient.

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[109] ibid cl 4(5).
[110] ibid cl 4(8)(b).
[111] ibid cl 5.
[112] ibid cl 6.
[113] ibid cls 7(1) and 8(1).
[114] ibid cl 9.
[115] ibid cls 10(1) – 10(4).

IX.IV. The Assisted Dying Bill, 2015 (Robert Marris)

This bill was introduced by Robert Marris MP, heavily relying on Lord Falconer's previous bills. The innovation of this attempt (though first envisaged by an amendment to Lord Falconer's bill tabled by Lord Pannick) resided in providing for a supplementary safeguard in the shape of a court order, to be granted within 14 days or as soon as reasonably practicable by the High Court (Family Division).[116] The order would be made if the judge was satisfied that the person soliciting it: (1) has a clear, settled, and informed wish to end their own life, (2) has made a declaration as designated in the Bill, (3) on the day of the declaration is aged 18, has capacity and has been resident in the United Kingdom for at least one year.[117] One uncertainty as to this order would be if the criteria to be considered by the court exclude other considerations the judges might make. The House of Commons rejected the bill by 330 to 118 later that session.[118] In the House of Lords, a virtually identical bill was introduced in 2016 by Lord Hayward, only to be discontinued by not being scheduled for a second reading. Currently, there seems to be a lack of political will to proceed even with the most conservative options of assisted dying, associated with unsettled views in the medical world.[119]

X. REFORM BY STATUTE? REFORM BY JUDICIAL DECISIONS?

All bills considered were attempts to bring about changes in statutory form. Albeit this is certainly the most democratically legitimate way of reforming the law, it is by no means the only one.

In *Carter v Canada*[120], the Canadian Supreme Court found the Canadian assisted suicide Criminal Code provisions contravened s 7 (private rights) and 15(1) (equality) of the Canadian Charter of Rights and Freedoms, despite its own previous case-law pointing to the contrary (cf. *Rodriguez v British Columbia*[121]). A blanket ban was found disproportionate considering the existence of safeguards and other procedures presupposing end-of-life decisions. The court did not

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[116] Assisted Dying HC Bill (2015-2016) 7, cls 1(1) and 1(3).

[117] ibid cl 1(2).

[118] R Mason, 'Assisted Dying Bill Overwhelmingly Rejected by MPs' *The Guardian* (London, 12 Sept 2015) <www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill> accessed September 2017.

[119] 'End-of-life care and physician-assisted dying' (*British Medical Association* 2016) <www.bma.org.uk/collective-voice/policy-and-research/ethics/end-of-life-care> accessed September 2017.

[120] [2015] SCC 5, noted Palmer, 'The Choice is Cruel: Assisted Suicide and Charter Rights in Canada' [2015] CLJ 191. Palmer's optimism as to the likelihood of reform was not mirrored by UK case-law or parliamentary action.

[121] [1993] 3 SCR 519.

immediately strike down the legislation but offered Parliament an opportunity to make the changes through statute within 12 months.

In the United Kingdom, the Supreme Court established in *Nicklinson* (see previous sections) that s 2(1) of the Suicide Act 1961 breached the European Convention on Human Rights. S 4 of the Human Rights Act 1998, under which the action was brought, authorised the court to make a declaration of incompatibility, which the Court decided not to make, reasons differing between the justices (some, like Lord Sumption, argued the matter entirely belonged to Parliament; a second view was that it should be deferred to Parliament for the time being to enact a reform, and the court could revisit the matter at a later date; a third view, per Baroness Hale, was that a declaration was appropriate, but this did not meet the majority; finally, there even was the perspective that no breach of the ECHR had taken place).

All this uncertainty is reflective of the United Kingdom's constitutional structure, where the Supreme Court, unlike its Canadian counterpart, was unable to strike down the criminal law statutory provisions. In Canada, the Charter, much like the Constitution, represents higher order law which trumps lower-order statutes. This is not the case in the parliamentary-sovereignty-based United Kingdom, thus rendering any judicial reform improbable.[122] Ostensibly, the Supreme Court has the option of a daring interpretation of the SA under s 3 HRA, but it would be resplendent of such intrusive judicial activism in an extremely politically contentious issue that one rightly expects caution to be exercised.

XI. A SURVEY OF INTERNATIONAL ATTITUDES

XI.I. Switzerland (approved in 1940)

Although Article 114 of the Swiss Criminal Code prohibits euthanasia, Article 115 considers assisted suicide a crime only if the motive is selfish. A selfish motivation would include, for example, assisting a patient upon whose death the assister would benefit financially. The emphasis on motive is a concept that is foreign to the English common law jurisprudence, which discounts the defendant's motives, taking into account only his intention to kill. Unlike in the

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[122] This assessment of the authors has been confirmed by the Court of Appeal in *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 143 (a case arising on a very similar fact-pattern to *Carter*, namely a patient suffering from motor neurone disease). The Supreme Court has on 27 November 2018 refused permission to appeal.

Netherlands, Belgium and Oregon, the involvement of a physician, usually a necessary safeguard, is not required by Article 115. On the contrary, the act of assisting death is carried out by non-physician volunteers from non-profit organisations (NGOs); the physicians' role is limited to prescribing the lethal drug and assessing the patient's decisional capacity.[123] There is also no requirement that the patient be terminally ill, unlike the Netherlands and Belgium, as long as the patient has decisional capacity (having which the act can only be considered 'suicide').[124] The case of *Haas v Switzerland*[125] confirmed that patients attempting assisted suicide are required to obtain medical prescriptions of lethal substances, for the Court insisted on the importance of reducing the chances of abuse of an over liberal procedure.

XI.II. Oregon (approved in 1994)

In Oregon, the assisted suicide regime is governed by the Death with Dignity Act (DWDA). Like Switzerland, Oregon also specifically prohibits euthanasia. The DWDA allows terminally ill Oregon residents to obtain and use prescriptions from their physicians for self-administered lethal medications.[126] Unlike the Swiss Criminal Code, however, the DWDA clearly lays down the requirements that have to be met in order for the assisted suicide to be legally recognised: the patient has to be an adult (i.e. 18 years or older), a resident of Oregon and capable of making and communicating and be diagnosed with a terminal illness that will lead to death within six months.[127] To receive a prescription for lethal medication from a licensed Oregon physician, the patients must i) meet the above requirements, ii) make two oral requests to his or her physician, separated by at least 15 days, iii) provide a written request to the physician, signed in the presence of two witnesses.[128] That physician and a consulting physician must confirm the diagnoses and prognosis, as well as that the patient has decisional competence- hence a patient who is believed to suffer from psychological disorders, he or she must be referred for psychological examination.

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[123] R Andorno, 'Nonphysician-Assisted Suicide in Switzerland' 2013 Cambridge Quarterly of Healthcare Ethics 22(3) 246-253.

[124] ibid.

[125] *Haas v Switzerland* [2011] ECHR 2422.

[126] Oregon Health Authority, *Death with Dignity Act Requirements* <www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/requirements.pdf> accessed December 2017.

[127] ibid.

[128] ibid.

To avoid abuse of the DWDA, the physician must prescribe feasible alternatives to the patient, e.g. hospice care, pain control etc. Physicians must report to the Oregon Health Authority (OHA) all prescriptions for lethal medications. Those physicians and patients who adhere to the requirements of the DWDA are protected from criminal prosecution.

XI.III. Netherlands (approved in 2002)

Before the legalisation of physician-assisted suicide (PAS) in 2002, Article 293 of the Dutch criminal code prohibited the killing of a person at his or her request.[129] Interestingly, even though PAS was legally presumed guilty until presumed innocent, it has nevertheless achieved the status of de facto legality owing to public approval and consensus.[130] Post-2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, PAS is allowed on certain conditions, namely that the physician must: a) be convinced that the patient's request was voluntary and well-considered, and that his suffering is lasting and unbearable, b) inform the patient about his prospects, and c) exercise due care when ending life.[131] On the other hand, the patient must i) be convinced that there was no other reasonable solution, ii) have consulted at least one other independent physician who has seen him and who has given his written opinion on the aforementioned a), b) and c).[132] Overseeing the physicians would be the regional review committee whose powers are laid down under Articles 3–19 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. The committee has the task of assessing "whether the physician who has terminated a life on request or assisted in a suicide has acted in accordance with the requirements of due care, referred to in Article 2."[133] Notably, PAS is treated in the same way as cases involving the cessation of or withholding of treatment that serves no medical purpose- all are considered normal medical practices that do not fall within the scope of the criminal law; the latter is only invoked when the physician has failed to act with due care.[134]

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[129] G Lewy, *Assisted Death in Europe and America: Four Regimes and Their Lessons* (OUP, 2011).

[130] ibid.

[131] Termination of Life on Request and Assisted Suicide (Review Procedures) Act (TLRA) 2002, s 2

[132] ibid.

[133] ibid Article 8.

[134] ibid Articles 9-10.

The notion of "due care" is defined as such: the consultant physician must be "independent", i.e. he is not connected with the original doctor nor involved in the treatment of the patient.[135]

XI.IV. Belgium (approved in 2002)

The Belgian Euthanasia Act 2002 legally allowed doctors to help patients to end their lives when they freely express a wish to die because they are suffering intractable and unbearable pain.[136] However, because euthanasia is legalised by the Euthanasia Act, the Act does not mention "assisted suicide" specifically, perceiving the difference between both as a matter of "semantics".[137]

XI.V. France (approved in 2016)

In 2016, the French government enacted the Claeys-Leonetti (CL) Law introducing the right to deep and continuous sedation,[138] but which stops short of euthanasia and assisted suicide.[139] Coined the "deep-sleep" law[140], it allows doctors to sedate terminally-ill patients with until they die from illness or starvation. The aim of sedation is to prevent the suffering possibly caused by discontinuing treatment for maintaining the patient artificially alive. However, such a right may only be exercised by the patient in two situations: i) when he is a victim of refractory symptoms and ii) when he decides to discontinue vital treatment.[141] Unlike euthanasia, which is defined as 'the intentional taking of someone's life by another, at his request', the heart of the CL legislation is a reluctance to legally approve an intention to kill or cause death.[142] Nevertheless, if there is an

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[135] ibid Article 2(e).

[136] 'Euthanasia and Assisted Suicide Laws Around the World' *The Guardian* (London, 17 Jul 2014) <www.theguardian.com/society/2014/jul/17/euthanasia-assisted-suicide-laws-world> accessed December 2017.

[137] ibid.

[138] A de Noneville, 'End-of-Life Practices in France under the Claeys-Leonetti Law: Report of Three Cases in the Oncology Unit' 2016 Case Reports in Oncology 9.3 650–654.

[139] J Smits, 'France Takes a Big Step towards Euthanasia with New "Terminal Sedation" Law' (*Life Site*, 29 Jan 2016) <www.lifesitenews.com/opinion/frances-new-end-of-life-law-more-extreme-than-belgiums> accessed December 2017.

[140] D Chazan, 'France Passes New End-of-Life Legislation to Alleviate Suffering' The Telegraph (London, 17 Mar 2015) <www.telegraph.co.uk/news/worldnews/europe/france/11478999/France-passes-new-end-of-life-legislation-to-alleviate-suffering.html> accessed December 2017.

[141] ibid.

[142] ibid.

intention to starve the patient or to allow the patient to suffer from illness, from both of which death is virtually certain to occur, is the line between euthanasia and the CL Law really distinct? After all, critics of the CL have likened it to, *inter alia*, a "disguised and socially acceptable".

XI.VI Victoria, Australia[143] (approved in 2017, entry into force in 2019)

Victorians who suffer from an advanced and incurable illness, disease or medical condition would be able to seek a medically assisted death starting from 2019, under a model proposed by the Victorian Ministerial Advisory Panel on Voluntary Assisted Dying and enacted by the local legislature. Under this model, several criteria are required to be fulfilled before one is eligible for assisted suicide: the person must be (i) at the end of life (final weeks or months of life), (ii) an adult, 18 years and over, (iii) ordinarily resident in Victoria and an Australian citizen or permanent resident, (iv) have decision-making capacity about their own medical treatment, (v) suffering from a serious and incurable condition that is causing enduring and unbearable suffering that cannot be relieved in a manner the person deems tolerable. Unlike in Belgium, it was recommended in the Victorian model that suffering as a result of mental illness only does not satisfy the eligibility criteria for voluntary assisted dying.

XII. CONCLUSION

In this paper, we have seen how the issue of assisted suicide remains one of the most contentious ethical issues, and there is no sign of this changing. This is in part due to the complexity of current law, which has left people largely in the dark as to what the effective legal position is. Arguably the law, as enforced, is much more reflective of the ethical debate than many think.

However, this is of limited comfort when for many the law on this issue is shrouded in mystery. There are consequently significant constitutional and rule of law arguments that stand alongside the ethical arguments in militating for review and reform of the current position. In drawing the conclusions, we have taken the aspects of international positions and various Parliamentary and non-Parliamentary projects which we believe best encapsulate the underlying ethical and constitutional issues.

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[143] Government of Victoria, *Victoria Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, 2017).

We have also sought to consider the very real concerns around safeguarding of both patients and medical professionals. The result is a balanced proposal which we believe could provide a strong framework for reform. One must remain mindful of the risk that any proposal presenting itself as a compromise may end up, like the EU Withdrawal Agreement negotiated by HM Government in 2018, unpalatable for any of the hardliners. The consultation and debate on the present paper have been a reminder of this danger. The way forward is a matter of values for society to settle.

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