

Citation for published version:

Claudia Carr, 'The Assisted Dying (No2) Bill 2015, a missed opportunity?', *Student Law Review*, Vol. 77, pp. 54-56, February 2016.

DOI:

Not available.

Document Version:

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The Rise and fall of the Assisted Dying (No2) Bill 2015 – a missed opportunity?

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Introduction

Although the offence of suicide was decriminalised by section 1 of the Suicide Act 1961, assisting a suicide remains a criminal offence punishable by a maximum sentence of 14 years imprisonment. Section 2(1) states that a person commits an offence if he *'does an act capable of encouraging or assisting the suicide or attempted suicide of another person'* and his *'act was intended to encourage or assist suicide or an attempt at suicide'*ⁱⁱ.

One of the high profile cases that helped garner significant public support to legalise assisted suicide is that of Debbie Purdyⁱⁱⁱ. She suffered from multiple sclerosis and sought an assurance from the DPP that her husband would not be prosecuted if he assisted her to end her life. The House of Lords held that the Code in force at the time provided insufficient guidance as to the factors that could lead to prosecution, and the House ordered the DPP to produce a policy which clearly set out the factors likely to lead (or not to lead) to a prosecution. As a result, new DPP Guidelines were introduced,^{iv} the effect of which is that where the 'suspect' is motivated entirely by compassion and the 'victim' has expressed a clear and settled wish to end their life, a prosecution is now unlikely. Whilst the DPP Guidelines were broadly welcomed and signalled that those who assist someone to die through wholly compassionate motives should not be prosecuted, the Guidelines have been criticised as being ambiguous, use the terms 'victim' and 'suspect' and are used retrospectively. What they do not do, is to provide a person with the right to die at a time and manner of their choosing which the Assisted Dying Bill sought to do. As a nation, we appear to be exporting assisted death tourism to Switzerland, rather than allowing people the right to die at home in their home country surrounded by those who they love.

The Assisted Dying (No2) Bill

The Assisted Dying Bill was introduced in 2013 and was the fifth such Bill to come before Parliament in the past 10 years, but it differed from those previously introduced due to a background of significant public support and high profile cases that had come before the Courts^v. A 2015 Populus poll^{vi} of 5,000 participants carried out by the national campaign organization, Dignity in Dying, showed that 82% of the public supported the Assisted Dying Bill and that there was clear popular appetite for legalisation of assisted suicide, a sentiment not reflected by those in Parliament. Supported by a number of high-profile personalities, including Professor Stephen Hawking, there was a groundswell of public opinion to support and permit a competent adult suffering from a terminal condition with less than 6 months to live, the right to determine for themselves the manner and time of their death.

The Assisted Dying (No2) Bill was introduced into the current Parliamentary session by backbencher MP Rob Marris, when the Bill's predecessor, the Assisted Dying Bill introduced by Lord Falconer in the House of Lords, ran out of Parliamentary time. The Assisted Dying (No2) Bill would have permitted, with the High Court's consent, a terminally ill person to request and be lawfully provided with assistance to end his or her life.^{vii} Section 1 would only have applied if the High Court confirmed that the person had made a voluntary, clear, settled and informed wish to end his or her life^{viii}, had

made a declaration to that effect^{ix} and on the day that the declaration was made, was aged 18 or over, had the capacity to make the decision to end his or her life and had ordinarily been resident in England and Wales for not less than one year.^x One of the key points to note is that, whilst a doctor may have prescribed medicine under the Act to enable that person to end their life^{xi} and an assisting health professional could have assisted the person with self-administration^{xii}, the final act of self-administration remained with the patient^{xiii}.

However, on September 11th 2015, the House of Commons voted by a resounding majority against further progress of the Assisted Dying (No2) Bill, so as to prevent its progress to Committee Stage and stifle further debate. Even before we look at the arguments that defined the demise of the Bill, it is disappointing to note that the Bill was not afforded the opportunity for greater debate, particularly since the deeply emotive and sensitive issue of assisted suicide had not been debated in depth in Parliament within the past 18 years.

Lord Faulks commented on an earlier reading of the first Assisted Dying Bill saying that *'any change in the law in this emotive area is an issue of individual conscience. In our view, it is rightly a matter for Parliament to decide rather than government policy'*^{xiv} Indeed, Lord Mackay of Clashfern added that even though he was personally opposed to the Bill, he was *'strongly in favour of it being afforded a Second Reading so that we may have the opportunity to discuss the many vitally important issues that it raises'*.^{xv}

Many argue there is an unhappy relationship in the law which distinguishes between *'killing'* and *'letting die'*. The law respects the prevailing principle of autonomy in bioethics which enables a competent patient to refuse treatment even where it will lead to their death^{xvi}, but the person who suffers from a terminal condition and wishes to end their life, is legally unable to unless they are dependent on life sustaining treatment, which they would then be able to refuse.

The following paragraphs outline some of the issues regarded by opponents of the Bill as fundamental flaws but the reader should appreciate these are simply snapshots of the issues and do not do justice to some of the lengthy and complex arguments.

Safeguards

The Bill would have allowed those patients with terminal conditions (admittedly few in number) to decide for themselves when to end their life. Opponents of the Bill argued that if assisted suicide were to be legal, the elderly or disabled would be vulnerable to undue influence or coercion and, would regard the option to end their life through assisted dying as an obligation to end their life, for fear of being an emotional or financial burden on their loved ones. Opponents argued that the noisy few who advocate assisted dying would outweigh the silence of the vulnerable majority. It was, for this reason, that judicial oversight was introduced in the House of Lords debates in November 2014, in order that each case would go before the court and so that the court could examine whether the person wishing to end their life has been coerced or subjected to undue influence. Arguably the judiciary are well equipped and sufficiently experienced to investigate and adjudicate on complex bioethics issues. One need only consider seminal cases such as those concerning withdrawing and withholding medical treatment from patients in vegetative or minimally conscious state^{xvii} to be reassured that cases concerning assisted suicide would comfortably fall within the judiciary's remit.

Undoubtedly, protection of the vulnerable must be one of society's primary concerns but the evidence from Oregon's Death with Dignity Act 1997, upon which the Assisted Dying Bill is based, shows no abuse of the vulnerable. Statistics from Oregon's DWDA 2014 annual report shows that of the 105 deaths under the Act (representing a tiny percentage of nearly 4 million), 68% were aged 65 years of older, 72.95% were white and well educated.

Life expectancy

Section 2 (1) (b) of the Assisted Dying Bill stated that the terminally ill person is reasonably expected to die within six months. Herein lays one of several reasons why the Bill failed to proceed. It is well known that it is challenging in the extreme to predict with any degree of certainty a patient's prognosis. The Royal College of Physicians explained to a select committee which examined an earlier assisted dying Bill introduced by Lord Joffe, that *'prognosticating may be better when somebody is within the last two or three weeks of their life...when they are six or months away from it, it is actually pretty desperately hopeless as an accurate factor'*^{xviii}. The select committee recommended *'if a future bill should include terminal illness as a qualifying condition, this should be defined in such a way as to reflect the realities of clinical practice as regards accurate prognosis.'*^{xix}.

Whilst the Assisted Dying (No2) Bill failed to pay heed to the advice of the select committee, there has been little suggestion as to how this issue of life expectancy could be better expressed. It is, by its own definition, fraught with difficulties. There may be many readers of this article who have first-hand experience or have heard of a friend or relative who was given months to live and are still living several years later. However, what the Bill sought to achieve was a time frame within which a person could decide for themselves whether they wish to risk the debilitating and devastating progression of their condition over the ensuing months or determine for themselves the nature and time of their death. Indeed, this was precisely the circumstances of Jeffrey Spector^{xx}. Diagnosed with an inoperable tumour on the spine, which would eventually lead to paralysis, Mr Spector travelled to Dignitas in Switzerland in order to end his life at a time when he could still travel, albeit at a time earlier than he would have, if assisted suicide were legal in England and Wales. Being forced to travel to Dignitas in Switzerland as the only legal option to end one's life is unsatisfactory and does not reflect the values of a compassionate society^{xxi}. Moreover, it prejudices both those who cannot afford the expensive trip and those who are too disabled to make the trip. Effectively, it only serves the 'healthy unhealthy' who may, more often than not, travel to end their life at time earlier than they otherwise would.

Doctor-patient relationship

Whilst empirical evidence does not support the fear that the vulnerable, infirmed or disabled will be unduly influenced to end their life, the additional fear is that the potential of assisted dying legislation would damage the doctor-patient relationship and the basic tenet for the medical professional; 'above all do no harm.' Whilst this principle is historic and engrained in the medical profession, one might argue whether the greater harm would be caused to the terminally ill patient who is unable to end their life when they are desperate to do so. In any event, the fear is that the unscrupulous doctor will call 'time' on his elderly patient. However, the Bill only applied to a patient with a 'terminal illness' and not the healthy elderly patient or the disabled, and evidence from Oregon suggests that the DWDA 1997 has improved doctor's understanding and communication with the terminally ill patient^{xxii} and the Oregon Hospice Association found 'no evidence that assisted

dying has undermined Oregon's end of life care or harmed the interests of vulnerable people^{xxiii}. Whilst the majority of doctors (and by far the majority of palliative care doctors) in the UK are opposed to assisted dying, 64% of doctors agreed that where a person suffers from a painful and incurable terminal condition, they should be allowed to end their own life^{xxiv}. Nevertheless, it was argued that people wishing to end their life would have to 'shop' around for sympathetic doctors, who would have no previous personal knowledge and understanding of the patient and whose professional reputation would then become synonymous with those who chose to end their lives. Perhaps the clarity that legislation brings in Oregon also creates a more honest and transparent relationship between doctor and patient, removing the elephant from the room.

Palliative care

Opponents argued that introduction of an Assisted Dying Bill would stifle the growth and funding of palliative care although there is clear evidence from the Oregon DWDA that this is not the case in Oregon. The British Medical Association states that *'for most patients, effective and high quality palliative care can effectively alleviate distressing symptoms associated with the dying process and allay patients' fears'*^{xxv}. Yet *'distressing symptoms'* do not appear in the most common end of life concerns from Oregon. This suggests that the overriding reasons why those who want control over the time to end their life is not necessarily related to pain management, but to other factors concerning quality of life. Oregon's DWDA 2014 Report confirms this very point, as issues of loss of autonomy accounted for 91.4% of the reasons behind choosing an assisted death, being unable to enjoy activities they were previously able to (86.7%) and a loss of dignity (71.4%). In fact, only 33% of those patients were concerned about inadequate pain control. Furthermore, given that 93% of all patients opting for an assisted death were enrolled in hospice care at the end of life, the option of an assisted death and the knowledge that a fatal prescription can be made available, may provide some level of comfort for the patient on a day to day basis.

Sanctity of life

The prevailing Conservative religious argument is that, since God gave life, it is only for God to take away. Life is a gift from God and not for us to dispose of as we wish. Suffering and pain is seen as part of life and assisted suicide exists contrary to religious teaching. Equally, there is also a secular view that human life is sacred. Lord Carey, the former Archbishop of Canterbury is recently reported as saying *'There is nothing sacred about suffering, nothing holy about agony, and individuals should not be obliged to endure it'*. Whilst his view has been criticised by the Church, it does represent a more compassionate view, which is also reflected in more Conservative (Reform) Judaism. To what extent should religious views be imposed upon a largely secular society where over 80% of those questioned, supported assisted suicide? Whilst many respect religious doctrine and would not contemplate an assisted death, it is difficult to maintain an argument that assisted suicide should not be introduced based solely on religious reasons.

Slippery slope

It was not necessarily the current provisions of the Assisted Dying (No2) Bill that led to its demise, rather the unresolvable concern that once doctors are permitted to provide patients with lethal drugs to self-administer and end their life, the limits to ending life will be removed. Perhaps there is some evidence to support the argument that permitting physician assisted suicide has indeed led to

a more permissive approach in the Netherlands but slopes can be ‘sticky’ rather than inherently slippery. With tightly drafted legislation and appropriate safeguards, there is no reason to suspect that legislation which today, may allow assisted suicide for a person with a terminal condition will tomorrow permit assisted suicide to a patient with depression. The fear of a slippery slope, whether justified or not, is no reason not to legislate in favour of assisted suicide. The key is to legislate with ultimately acceptable safeguards.

Conclusion

The debates and argument that arise in this controversial, yet crucially important question for society of assisted suicide are too lengthy for an article of this length to do justice to. Arguably, permitting assisted suicide will redefine society’s relationship with the dying, introducing a prevailing attitude that the elderly, ill or vulnerable have a moral duty to remove themselves from society, permitting the survival of only the healthy and able. However, death is inevitable; we all hope for a ‘good’ death however that might be variously defined, but a good death is surely one with dignity. The Assisted Dying (No2) Bill would have, with the tightest of safeguards only applied to the very few people who, expressing their autonomy, wished to end their life.

The defeat of the Assisted Dying (No2) Bill is a defeat for the concept of a good death. For those ‘privileged’ enough to be able to travel to Switzerland, they can end their life largely alone in anonymity –this is not a good death, just the only available option, save for self-starvation. For those patients such as Tony Nicklinson and Debbie Purdy, who were unable (or unwilling) to travel, the only option to risking potential (albeit unlikely) criminal prosecution for their loved ones was to starve themselves to death. Lady Hale observed in her compelling dissenting judgment in the *Nicklinson* appeals that it is cruel to force the competent adult with conditions such as those suffered by Nicklinson, Purdy, Lamb and ‘Martin’ to remain alive for the sake of unknown, unidentified others who may or may not be at risk. Lady Hale added ‘*it would not be beyond the wit of a legal system to devise a process for identifying those people, those few people, who should be allowed help to end their own lives*^{xxvi}’ With the demise of the Bill, there is unlikely to be a further opportunity during the life of this Parliament.

ⁱ Section 2 (1) (a) Suicide Act 1961 as amended

ⁱⁱ Section 2 (1) (b) Suicide Act 1961 as amended

ⁱⁱⁱ R (on the application of Purdy) v DPP 2009 UKHL 45

^{iv} DPP Policy for Prosecutors in Respect of Cases of Encouraging or Assisting a Suicide
https://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

^v See R (on the application of Pretty) v DPP 2001 UKHL 61, R (on the application of Purdy) v DPP 2009 UKHL 45 and R (on the application of Nicklinson and other) v Ministry of Justice 2014 UKSC 38

^{vi} <http://www.dignityindying.org.uk/press-release/poll-assisted-dying/>

^{vii} Section 1(1)

^{viii} Section 2(a)

^{ix} Section 2 (b)

^x Section 2(c) (i-iii)

^{xi} Section 4(1)

^{xii} Section 4 (5)

^{xiii} Section 4 (5) (c)

^{xiv} Official Report, House of Lords, 18th July 2104; vol.755, c.919

^{xv} Official report, House of Lords, 18th July 2014, vol. 755, c.788

^{xvi} Re B (Consent to treatment – capacity) 2002 1 FLR 1090

^{xvii} See for example, *Airedale NHS Trust v Bland* 1993 AC 789 and *W v M (An adult patient)* 20111 EWHC 1197

^{xviii} House of Lords Report (Session 2004-05) 86-I, Paragraph 118

^{xix} House of Lords Report (Session 2004-05) 86-I, Paragraph 269

^{xx} <http://www.theguardian.com/society/2015/may/26/jeffrey-spector-assisted-dying-dignitas-tumour-paralysis-explains-decision>

^{xxi} No proceedings can be brought without the consent of the Director of Public Prosecutions and the exercise of the DPP's discretion has been particularly pertinent where family members or friends have travelled with those wishing to end their life at Dignitas in Switzerland.

^{xxii} Dobscha, SK, Heintz RT, Press, N and Ganzini, L 'Oregon physicians' responses to requests for assisted suicide: a qualitative study' *Journal of palliative Medicine* 2004; 7 (3): 451-461

^{xxiii} Jackson A, Oregon Hospice Association, The reality of assisted dying in Oregon. All Party Parliamentary group on Compassion in Dying. House of Lords, 2006

^{xxiv} Seale C, Legalisation of euthanasia or physician assisted suicide: survey of doctor's attitudes *Palliative Medicine* 23;205-12

^{xxv} <http://bma.org.uk/practical-support-at-work/ethics/bma-policy-assisted-dying>

^{xxvi} *R (on the application of Nicklinson) and Lamb v Ministry of Justice and DPP and others; R (on the application of AM) v DPP and another* 214 UKSC 38 at para 314