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The situation in the United Kingdom
The Assisted Dying for the Terminally Ill Bill:

Scope / content of the Bill

The Assisted Dying for the Terminally Ill Bill 2005[1] which was defeated, at its second reading in the House of Lords on 12 May 2006, is a reconstituted version of a previous Bill introduced to Parliament in 2004 but which ran out of time before the 2005 general election. It was introduced as a Private Members Bill on the 9th of November 2005 by Lord Joffe - a crossbench peer and former human rights lawyer. It is heavily influenced by the Death with Dignity Act passed in the US state of Oregon.

The underlying premise of the Bill [2] remains unchanged from the previous version however the revised edition is slightly more tempered. It does not (in contrast to the 2004 Bill) allow for voluntary euthanasia whereby the doctor directly administers the fatal medication to the patient, but focuses instead on physician assisted suicide (PAS) whereby the doctor is able to prescribe the medication but it is the patient who takes responsibility for administering it.[3]Where the patient is suffering from a condition ‘which makes it inappropriate or impossible orally to ingest [the] medication the bill permits the physician to provide a means of self-administration’.[4] It will remain a criminal offence for someone to actually administer the medication. Where however the provisions of the

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[1] HL Bill 36
[2] (to 'enable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request)
[3] Assisted Dying for the Terminally Ill Bill 2005, S.1(a)
[4] Ibid

Bill are followed a doctor who assists in the patient's suicide will not face criminal prosecution the Suicide Act 1961 would be amended to reflect this situation.

The application of these provisions is limited according to section 2(1) by the provisions contained in sections 2(2), 2(3), 4 and 5(3). Section 2(2) requires the attending physician to have:

(a) been informed by the patient in a written request signed by the patient that the patient wishes to be assisted to die;

(b) examined the patient and the patient's medical records and satisfied himself that the patient does not lack capacity;

(c) determined that the patient has a terminal illness;

(d) concluded that the patient is suffering unbearably as a result of that terminal illness;

(e) informed the patient of –

 (i) his medical diagnosis;

 (ii) his prognosis;

 (iii) the process of being assisted to die; and

 (iv) the alternatives to assisted dying…

(f) ensured that a specialist in palliative care, who shall be a physician or a nurse, has attended the patient to inform the patient of the benefits of e various forms of palliative care,

(g) recommended to the patient that the patient notifies his next of kin of his request for assistance to die,

(h) if the patient persists with his request to be assisted to die, satisfied himself that the request is made voluntarily and that the patient has made an informed decision; and

(i) referred the patient to a consulting physician.

Section 2(3)' imposes a similar list of obligations upon the consulting physician adding only that he must confirm the diagnosis and prognosis made by the attending physician[5] and that he must advise the patient that prior to being assisted to die the patient will be required to complete a declaration which the patient can revoke'.[6]

Section 4 requires the patient to make a 'declaration of his wish to die in the form prescribed by regulations made by the Secretary of State'[7]. This declaration 'must be witnessed by two individuals one of whom shall be either a solicitor who holds a current practising certificate or a public notary'[8] and the signing and witnessing of the declaration shall be done ''at the same time and each in the presence of the others'.[9] Moreover, the solicitor or public notary can only witness the declaration if 'the patient is personally known to him or has proved his identity to him; it appears to him that the patient was of sound mind and had made the declaration voluntarily; and he is satisfied that the patient understands the effect of the declaration.'[10]The term 'sound mind is not given any further definition and so it is unclear whether it has the same meaning as 'capacity'.

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[5] Ibid. S.2(3)(c)

[6] Ibid. S.2(3)(g)

[7] Ibid. S.4(1)

[8] Ibid. S.4(2)

[9] Ibid. S.4(4)

[10] Ibid. S.4(3)

Sections 4(5) and 4(6) outline a list of people who are specifically excluded from witnessing the declaration. These include relatives or partners of the patient, [11] members of the health care team[12] or anybody who 'owns, operates or is employed at a health care establishment where the patient is a resident or is receiving medical treatment.'[13]

Section 5(3) provides that prior to assisting in the patient's suicide 'the existing physician shall have—(a) informed the patient of his right to revoke the declaration, and (b) asked the patient to confirm that the declaration has not been revoked, and received such confirmation.' Section 5 also provides for a 'cooling-off' period whereby the physician cannot provide assistance in suicide until after the expiration of 14 days from the patient's initial request.[14]

A further safeguard is contained in section 11(2) which requires the physician to forward a copy of the relevant documents to the monitoring commission for the region concerned within seven days of the qualifying patient having been assisted to die or of an attempt so to assist having been made.[15]The monitoring commission (the precise number of monitoring commissions will be determined by the Secretary of State[16]) are charged with the responsibility of reviewing the operation of the Act and' to hold and monitor records pursuant to it.'[17]'The Secretary of State would have a duty to publish an annual statistical report of the information collected by the monitoring commissions. '[18]

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[11] Ibid. S.4(5)
[12] Ibid
[13] Ibid. S.4(6)
[14] Ibid. S.5(2)
[15] Ibid. S.11(2)
[16] Ibid. S.12(1)
[17] Ibid
[18] Ibid. S.12(5)

‘The monitoring commissions would be comprised of three members (a medical practitioner, a lawyer and a lay person with first hand experience in caring for a person with a terminal illness’) appointed by the Secretary of State.[19]Should two of its members consider (in the light of the information forwarded to the commission by the physician) that a particular PAS did not comply with the Act in some way then they must refer the matter to the district coroner.[20]

The ability of the monitoring commissions to serve as an effective safeguard is severely compromised by their rather circumscribed remit. The commissions would be altogether more useful if they had the authority to review and veto cases prior to the PAS taking place, rather than simply looking at the legitimacy of individual cases retrospectively. One major criticism of the Bill is that it failed to adopt many of the sensible recommendations made by the Select Committee of the House of Lords in 2005 whilst scrutinising the 2004 Bill. Whilst the Select Committee failed to reach a conclusion on the legitimacy of assisted dying as a principle, it did manage to identify several practical concerns, many of which were ignored in the drafting of the 2005 bill.

Firstly, it recommended that any applicant for PAS should be given a mandatory psychiatric assessment in order to determine that the request was founded on a reasoned decision free from undue influence and that the applicant was not impaired by a psychological or psychiatric disorder[21]. The 2005 Bill contains no such mandatory requirement. Instead it provides that a consultant psychiatrist or psychologist should be

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[19] Ibid S.12(2)

[20] Ibid. S.12(3)

[21] Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill. H.L. Paper 86-I, 2005, para 254. Available at http:/ /www.publications.parliament.uk/pa/ld/ldasdy.htm.

consulted only if either the attending or consulting physician believes that the patient may lack capacity[22]. Where such a referral is made the Bill provides that '[n]o assistance to end the patient's life may be given unless the consultant psychiatrist or the psychologist has determined that the patient does not lack capacity.'[23]

The absence of a mandatory psychiatric or psychological assessment was subject to comment by the Royal College of Psychiatrists who expressed concern that few doctors were knowledgeable about assessing capacity.[24] They were also concerned about the adverse influence that depression had on those who would qualify for PAS under the Bill, particularly as depression is very common in persons suffering with painful/disabling terminal illnesses and that many doctors fail to recognise depression or understand how to ascertain its presence in the terminally ill.

They drew attention to research **(**using systematic assessments in terminally ill patients**)** which revealed that depression is strongly associated with the desire for a hastened death, including the wish for PAS or euthanasia and that once a person's depression is treated effectively most (98-99%) will no longer wish to die. They concluded that a request for PAS should automatically trigger a treatment programme for depression and its causes rather than PAS. Such treatment may involve drug therapy, in particular the use of antidepressants, anxiolytics, psychostimulants as well as electroconvulsive therapy and psychotherapy.

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[22] Assisted Dying for the Terminally Ill Bill 2005, S.3(1)

[23] Ibid. S.3(2)

[24] Royal College of Psychiatrists, 'Assisted Dying for the Terminally Ill Bill - Statement from the Royal College of Psychiatrists on Physician Assisted Suicide' (2006). Available at http://www.rcpsych.ac.uk/pressparliament/collegeresponses/physicianassistedsuicide.aspx

The Select Committee also recommended greater use of palliative care.[25] In particular they recommended that the Bill should require the patient to have experienced some form of palliative care before a request for PAS could be considered.[26] The 2005 Bill does not contain such a pre-requisite but instead contains a rather tepid requirement for a consultation with a palliative care expert. As John Keown has observed: '[b]y requiring only a simple consultation, the Bill failed to ensure that patients would be making fully informed choices or that PAS would be complementary to, rather than an alternative to, palliative care'.[27]

There is however a more fundamental problem in this context, which would need to be addressed prior to the introduction of legislation. According to the House of Commons' 2004 Health Committee Report on palliative care, current demand for palliative care in the UK far outstrips supply and it is not equally accessible across the country. This is a result of persistent under funding within the NHS and over reliance on the goodwill and charitable funding of the hospice movement. It is crucial therefore that the general provision of palliative care is substantially improved before legislation permitting assisted suicide is even considered.

A final recommendation of the Select Committee that has not subsequently been incorporated by Lord Joffe was that the Bill should measure suffering in a less subjective manner.[28] It recommended the use of 'unrelievable' or 'intractable' suffering rather than

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[25] The World Health Organisation defines palliative care as: an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Available at: http://www.who.int/cancer/palliative/definition/en/

[26] Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill. H.L. Paper 86-I, 2005, para 258. Available at http:/ /www.publications.parliament.uk/pa/ld/ldasdy.htm.

[27] Keown J, 'Physician-Assisted Suicide: Lord Joffe's Slippery Bill' Med Law Rev 2007 15 (126)

[28] Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill. H.L. Paper 86-I, 2005,

‘unbearable suffering’ – defined in section 13(1) of the 2005 Bill as ‘suffering, whether by reason of pain, distress or otherwise which the patient finds so severe as to be unacceptable’.

The Bill has several significant flaws that make its inception impractical as well as morally wrong. The Bill places an extremely heavy and unfair burden on health care professionals. They will be given the unenviable task of prescribing the medication, providing the patient with the means to administer the prescription and ensuring that all the legal documents and requirements have been completed. Should they fail to follow the procedures of the Bill in any way they would face the prospect of criminal prosecution. The monitoring commissions could alleviate this burden somewhat by reviewing all proposed instances of PAS prior to the event thus providing reassurance that the action is legally sound and that no criminal prosecution would ensue. As Stephen Evans and David Hewitt have pointed out: ‘where serious criminal charges may be in prospect, don’t health care professionals deserve early-preferably anticipatory reassurance?’[29] Instead the Bill provides only for retrospective revision. This could create an unhealthy tension between the monitoring commissions and the doctors with the latter living in fear that the former will interpret their actions to be in breach of the Bill even though they were performed in good faith and with due diligence.

Whilst it is true that the Bill does not create an obligation for doctors to assist a patient to die or indeed to help him/her find someone who will perform the task, in practice it is likely that doctors will face internal pressures to do so. For instance, they may feel

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Para 269(c)(v). Available at http:/ /www.publications.parliament.uk/pa/ld/ldasdy.htm.

[29] Evans S and Hewitt D, *A Question of Choice*, 156 NLJ 44, 13 Jan 2006

obliged to carry out the procedure (even though they feel uneasy about doing so) in order to avoid being overlooked for promotion. In addition, the safeguards embodied in the Bill are rather cursory and inadequate. In particular the process by which the patient's mental capacity is determined is extremely lax as is the absence of a mandatory requirement for the patient to have fully explored the benefits of palliative care before a request for PAS can be processed.

It is clear that Lord Joffe will pursue his aim of trying to introduce legislation to assist dying for the terminally ill. Commenting after the defeat of the Bill Mark Slattery of Dignity in Dying (formerly the Voluntary Euthanasia Society) commented,' *"The bill has faced the an onslaught from the biggest political campaign in church history, but public support for it has held firm. The bill will be back and the campaign has not stopped* '[30] It may be that the proposals will be 'watered down' in order to make them more acceptable to a greater number of legislators. However the thrust of putting such proposals on to the statute book will continue.

Lord Joffe's attempts so far have been littered with practical inadequacies that have only served to compound the moral difficulties that surround physician assisted suicide as a principle. In particular the 2005 Bill places excessive pressure on healthcare professionals, They have the burden of prescribing the medication, providing the patient with the means to administer the prescription and ensuring that all the legal documents and requirements have been completed. All of this they must do with the sword of Damocles dangling precariously above them in the form of the monitoring commissions who would have the power to refer a case to the district coroner if the proper procedure

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[30] 'BBC Health News' on line 12 May 2006 www.bbc.co.uk/health

was not followed, even if the healthcare professional in question acted in good faith. There is little protection available for healthcare professionals and similarly the safeguards for the patients are superficial at best.

The primary arguments used to support the introduction of PAS are extremely unconvincing. The availability of PAS in the Dignitas clinic and the increasing number of Britons who are making use of this service is extremely alarming. For whatever reason Switzerland has decided that this is a route it wishes to take (as it is perfectly entitled to do as a sovereign nation state). The UK cannot meddle with Swiss law however it can refuse to be led by it. There may be no practical way of stopping British Citizens making the journey to the Dignitas clinic and it is undoubtedly true that the process of committing suicide would be much safer for such people if PAS were legalised in the UK, nevertheless it is imperative that the UK takes a moral stance. The Christian Churches are much opposed to the introduced of PAS for both moral and practical reasons, yet if it were introduced it would at least be more palatable if it was the result of a strong Parliamentary conviction that this was the morally acceptable approach. The situation would be even more distressing if the decision was influenced by the existence of Dignitas.

It does not follow that if we cannot achieve a worldwide ban on PAS then we might as well have no ban at all.

We must also highlight the fallibility of strong public support as a rationale for the introduction of PAS. Measuring collective public opinion will with accuracy is difficult, and even where it can be said that the groundswell of opinion lies in a particular direction it must be approached with caution. Public opinion is inherently capricious and doesn't always take into account the full effect of a particular measure.

We have also noted that personal autonomy is not an absolute right and it is correct that it should be constrained where wider social interests are at stake. Accordingly it can only real work as a justification for PAS when its meaning is grossly distorted to the point where it would jettison the very notion of a society.

Finally, we have dismissed the notion that it is somehow inhumane or cruel to prevent individuals suffering from a terminal illness that subjects them to unbearable pain from obtaining help to die peacefully. Preventing such action should instead be viewed as a sacred duty in order to uphold the inherent sanctity and value of life. The only limit to the obligation to preserve life should be where the means by which the preservation is achieved could be described as 'extraordinary' in the sense that it would impose an undue burden on the patient, such as that imposed on Tony Bland (discussed in Chapter 1). Mr. Bland was being kept alive by artificial means with no prospect of recovery. He had entered a persistent vegetative state and whilst his life was not without meaning, the situation is morally distinguishable from the person seeking physician assisted suicide. It is not inconsistent to say that it is morally acceptable for treatment to be withdrawn where that treatment is the only thing keeping the patient alive and there is no hope of recovery and at the same time refuse those wishing medication to end their lives.

Leaving aside the provisions in the Mental Capacity Act 2005, the current law deals with the question of assisted dying and euthanasia in perhaps the best possible way. It may not be perfect however a perfect solution is unattainable. Leaving open the possibility of criminal conviction for those who assist in another’s suicide, even if their motives are completely altruistic, may seem draconian. However removing the possibility would have a far more detrimental effect on society as a whole. Moreover, whilst it is not set in stone, in practice the courts tend to show appropriate compassion to such people through lenient sentencing.

The clear starting point for the believer is a belief that every human life is a gift from God and made in His image. However it is also clear that medical technique and technology has and will continue to advance, so that issues which might never have been considered in the past, now cause confusion when the reality of suffering is faced. If it is possible for the Church to clarify teaching and assist decision making for the faithful, then it is also possible to make creative end of life decisions (recognizing the obligation to preserve life and the responsible limits of that obligation) and so continue to oppose the arguments put forward by Lord Joffe and his acolytes.