
Assisted Dying Bill: unsatisfactory

21 JULY 2014 PLEASE LEAVE A COMMENT BELOW



By [Khawar Qureshi](#) and Catriona Nicol

Introduction

On 18 July 2014, the House of Lords debated the Assisted Dying Bill which is described as “*A Bill to enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life; and for connected purposes.*”

The draft Bill legalises physician-assisted dying – provided that certain conditions are met, terminally ill individuals can obtain a prescription from a doctor which they can then administer themselves to bring about their own death.^[1] However, the proposed change in the law has been met with criticism by many, both as a matter of principle and practice.

This article considers the history and provisions of the Assisted Dying Bill, opposition to the Bill, and domestic and European jurisprudence.

Assisted Dying Bill

Background

The Assisted Dying Bill is the fifth bill dealing with assisted dying to come before Parliament in ten years.^[2] Previous bills (three introduced by Lord Joffe between 2004 and 2006) and one introduced by Lord Falconer in 2013. In 2006, Lord Joffe’s Assisted Dying for the Terminally Ill Bill was defeated following debate (by 148 votes to 100).^[3]

Commission on Assisted Dying and a new draft Bill

On 5 January 2012, the Commission on Assisted Dying (the “Commission”) published its Final Report. The Commission, launched in 2010, was set up to consider whether the current legal and policy approach to assisted dying in England and Wales was fit for purpose, and a potential framework for England and Wales. In the Final Report, the Commission concluded that the current legal status of assisted suicide was inadequate and incoherent, and set out a proposed legal framework (including eligibility criteria and potential safeguards).

Subsequently, in 2012, the All Party Parliamentary Group on Choice at the End of Life (of which Lord Falconer was not a member) prepared a draft Assisted Dying Bill based on the Commission’s Report.

In 2013, Lord Falconer submitted a Private Member’s Bill in the House of Lords which was in substantially similar terms. After the Assisted Dying Bill ran out of time in the Parliamentary session in 2013, Lord Falconer reintroduced the Bill in identical terms in 2014, with it receiving its first reading in the House of Lords on 5 June 2014 (three weeks before the Supreme Court released its decision in [R \(Nicklinson\) v Ministry of Justice](#), discussed further below).

Summary of the Bill

The Assisted Dying Bill 2014 consists of 13 sections and one schedule.[4]

Section 1 provides that “a person who is terminally ill may request and lawfully be provided with assistance to end his or her own life only if the person—

(a) has a clear and settled intention to end his or her own life;

(b) has made a declaration to that effect in accordance with section 3; and

(c) on the day the declaration is made—

(i) is aged 18 or over; and

(ii) has been ordinarily resident in England and Wales for not less than one year.”[5]

The request must be made by the individual – no other person, including the patient’s doctor or relative, would be able to initiate the process of requesting an assisted death.[6]

Taking each of those points in turn:

- A person will be said to be “*terminally ill*” where that person has been diagnosed by a registered medical practitioner as having an inevitably progressive condition which cannot be reversed by treatment; and as a consequence of that terminal illness, is reasonably expected to die within six months.[7] Accordingly, the Bill in its current form would not apply to persons suffering from degenerative or progressive conditions (such as motor neuron disease); “locked-in syndrome”; or those who have been paralysed unless life expectancy is less than six months.[8]
- The declaration must be made in the form set out in the Schedule to the Bill. That declaration must be signed by a witness (who must not be a relative or directly involved in the person’s care or treatment).[9]
- The declaration must also be signed by two medical practitioners (who must not be related or working in the same practice) who must conclude, working independently, that the individual is terminally ill and that the diagnosis and prognosis is correct; has the capacity to make the decision to end their own life; and has a clear and settled intention to do so, which has been reached on an informed basis, without coercion or duress, and having been informed of the palliative, hospice and other care which is available.[10]
- Assisted dying would not be available to those under 18. In addition, it would only be available for those who have been residing in England and Wales for over a year (to prevent individuals travelling to England solely to make use of the legislation).[11]

If the conditions are satisfied, the attending doctor may write a prescription for the necessary medication but it would only be delivered after a 14-day “cooling off” period (or six days if both doctors agreed that the person is likely to die within one month). The attending doctor or another doctor or nurse authorised by the attending doctor would deliver the medicine at the patient’s request, check that the person had not revoked or did not wish to revoke their declaration, and remain with the person until the medicine had been taken and the person had died or the person had declined to take the medicine. While the doctor could help with the preparation of the medication, the individual must self-administer. It is explicitly stated that the Bill does not authorise an assisting health professional to administer medication to another person with the intention of causing that person’s death.

A doctor or other person has no duty to participate in anything to which they have a conscientious objection.[12]

Under the Bill, codes of practice may be promulgated by the Secretary of State, particularly in relation to the assessment of whether a person has a clear and settled intention to end their own life (including (i) assessing whether the person has capacity to make such a decision; (ii) recognising and taking account of the effects of depression or other psychological disorders that may impair a person’s decision-making; and (iii) the information

which is made available on treatment and end of life care options available to them and of the consequences of deciding to end their own life).[13]

The Bill creates three offences:

- making or knowingly using a false declaration under the Bill;
- wilfully concealing or destroying a declaration made under the Bill; and
- knowingly or recklessly provides a medical or other professional opinion which is false or misleading in a material particular.[14]

Monitoring is to be carried out by the Chief Medical Officers, who will submit an annual report on the operation of the Act[15] which must be published publically.[16]

Criticism and Opposition to the Assisted Dying Bill

Support for the Bill has been publically expressed by a number of organisations and individuals, including Dying In Dignity; the British Humanist Association; the former Archbishop of Canterbury, George Carey; Desmond Tutu; and Boris Johnson, Mayor of London. Surveys of public opinion indicate that 70-80% of the British public support a change in the law.[17]

However, there is also significant criticism and opposition to the Bill, particularly amongst medical professionals with the British Medical Association, the Royal College of Physicians, the Royal College of General Practitioners, the Royal College of Surgeons, Living and Dying Well, and the leaders of major faiths in the UK all speaking out against any change in the law.

The opposition can generally be categorised under two headings:

- Principle – relating to matters such as the sanctity of life (including concerns that an individual's right to commit suicide, whilst understood, should not be encouraged or normalised); and the alternatives to choosing to die. Supporters of a change in the law typically cite the concept of personal autonomy in response.
- Practice – the extent of application of the Bill, and availability and operation of safeguards.

This article focuses only on the practical and legal aspects, rather than a wider consideration of the ethical, moral and philosophical issues.

Specific issues relating to the Assisted Dying Bill

The main criticisms of the Bill are as follows:

- Eligibility;
- Assessing capacity, and the role of undue influence;
- Role of doctors;
- Monitoring the law.

Eligibility

The Bill is limited to those suffering from terminal illnesses with a prognosis of less than six months. However, doctors have emphasised how difficult it is to accurately make such a prognosis. Evidence given to the House of Lords Select Committee stated that while it was possible to make reasonably accurate prognoses of death within minutes, hours or a few days, the scope for error could extend into years when considering prognosis as a matter of months.[18]

In addition, any change in the law (under current proposals) would not apply to those suffering from progressive conditions such as motor neurone disease, severe paralysis or “locked in” syndrome. However, it is precisely those conditions which have given rise to the “right to die” cases considered by the UK Supreme Court and the European Court of Human Rights (as discussed further below). This raises two issues – firstly, the Bill doesn’t cover those conditions which have given rise to the most difficult and controversial cases so far; and may also be used as a springboard to extend it to those conditions (and others) at a later date.

Assessing capacity, and the role of undue influence;

Certifying doctors must satisfy themselves that the individual “*has the capacity to make the decision to end their own life; and has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress.*”

However, while capacity is defined by reference to the Mental Capacity Act 2005, no guidance is given as to how doctors should conduct such an assessment. This is problematic for a number of reasons:

- In contrast to the previous Bills put forward by Lord Joffe, there is no requirement to refer patients for psychiatric evaluation in cases of doubt.^[19] Further, the Bill makes no provision in respect of individuals who may be suffering from depression, and therefore whose decision making is impacted.
- Doctors are unlikely to be best placed for assessing capacity of patients and particularly any undue pressure that is being brought to bear, especially without guidance.
- Matters of mental capacity, coercion or undue influence are so significant to the issue of safeguards that they should not be consigned to codes of conduct to be promulgated by the Secretary of State following the but should be scrutinised as part of the overall package of legislation to be considered by Parliament.

Role of doctors

The Bill will rely on doctors in order for its operation and effect, and therefore the opposition of doctors and medical organisations should not be overlooked. There are concerns that a majority of doctors (who, according to the BMA in an interview on 15 July 2014, see their role as alleviating suffering and looking after people, rather than helping people to end their life) would decline to assist and therefore individuals would have to approach the minority of doctors who would be willing to assist but would have no familiarity with the patient or their history (and therefore would be worse placed to assess capacity issues).

It has previously been suggested that involvement from legal professionals would be more appropriate. Lord Joffe’s original Bill required that the declaration be witnessed by a solicitor or public notary who had to certify that the patient was personally known to, or had proved his identity to, him; it appeared to him that the patient was of sound mind and had made the declaration voluntarily; and he was satisfied that the patient understands the effect of the declaration.

Alternatively, a number of organisations have suggested that the role of certifying or approving the individuals decision should instead be undertaken by the courts who are used to dealing with such difficult decisions, particularly in the Family Courts.^[20] Indeed, in the Supreme Court decision in *R v Nicklinson*, Lord Neuberger suggested that risks to vulnerable and elderly people “if no assistance could be given to a person who wishes to die unless and until a Judge of the High Court has been satisfied that his wish to do so was voluntary, clear, settled and informed.”^[21]

Monitoring the law

In addition, the monitoring provisions in the Bill are very limited.

No equivalent provision exists in the Bill to Lord Joffe's requirement that a doctor who prescribed medication to an individual had to report his actions to a monitoring, and send copies of documentation including evidence that the qualifying conditions had been met; the declaration; and a note by the assisting physician stating that he was satisfied, at the date and time of his having assisted the patient to die, that all requirements had been met and indicating the steps taken to end the patient's life including the description and quantity of the medication and any means of self-administration prescribed or provided.

While the approach in Lord Falconer's Bill may be that these are matters to be dealt with in regulations or codes of practice, it is suggested that these are matters too significant to be left until after the legislation has been passed.

Jurisprudence

The existence of a "right to die" has been considered in detail by both the UK Supreme Court and the European Court of Human Rights.

In *Airedale NHS Trust v Bland*, the House of Lords held that it was lawful for doctors to discontinue treatment of a person who was in what was then called a persistent vegetative state; however, Lord Browne-Wilkinson noted that "*the doing of a positive act with the intention of ending life is and remains murder*".[22]

In *R (Pretty) v Director of Public Prosecutions*, Mrs Pretty (who suffered from the progressive condition of motor neurone disease) challenged that assertion by Lord Browne-Wilkinson, and argued that (i) the refusal of the DPP to grant her husband proleptic immunity from prosecution if he assisted her in killing herself (which she wished to do when her disease became intolerable), and/or (ii) the prohibition on assisting suicide in s 2, violated her rights under arts 2, 3, 8, 9 and 14 of the European Convention on Human Rights (the "Convention"). The House of Lords held that Mrs Pretty's desire to end her life prematurely did not engage her rights under any of those articles.

Mrs Pretty then appealed to the European Court of Human Rights, who found that while her Convention rights had not been violated, her art 8 right to respect for a private and family life had been interfered with.[23] However, this interference was justified as the restriction was in pursuit of the legitimate aim of safeguarding life and thereby protecting the rights of others. In particular, the ECHR noted that:

"The Court does not consider therefore that the blanket nature of the ban on assisted suicide is disproportionate. The Government has stated that flexibility is provided for in individual cases by the fact that consent is needed from the DPP to bring a prosecution and by the fact that a maximum sentence is provided... It does not appear arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and 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 fair and proper requirements of retribution and deterrence."[24]

In the later ECHR case of *Haas v Switzerland*, the Court noted "*the vast majority of member states seem to attach more weight to the protection of the individual's life than to his or her right to terminate it... the states enjoy a considerable margin of appreciation in this area.*"[25]

Of particular relevance to the draft Bill presently under consideration, the Court in Haas also noted that "*the right to life guaranteed by article 2... obliges states to establish a procedure capable of ensuring that a decision to end one's life does indeed correspond to the free wish of the individual concerned*".[26]

In *R (Purdy) v Director of Public Prosecutions* (a case on assisted suicide), the House of Lords (following the ECHR decision in *Pretty v United Kingdom* and declining to follow its own decision in *R v Pretty*) found that the refusal of the Director of Public Prosecution to confirm to Mrs Purdy its likely approach if her husband assisted her in committing suicide violated her art 8 rights. Accordingly, Lord Hope said at para 56, the DPP should be required to “promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy’s case exemplifies, whether or not to consent to a prosecution.”

Following that decision (and consultation), the Director of Public Prosecution published the “*Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*”, which listed public interest factors, in favour of and against prosecution, with a particular focus on the motivations and actions of the suspect in cases of assisted suicide, rather than the characteristics of the victim.

That policy was considered in *R (Nicklinson) v Ministry of Justice* in a judgment handed down by a nine-member Supreme Court. The Supreme Court considered whether the present state of the law of England and Wales relating to assisting suicide infringed the Convention, and whether the DPP Policy on assisted suicide was lawful. The Supreme Court held that whether the current law on assisted suicide was incompatible with art 8 lay within the UK’s margin of appreciation, and was therefore a question for the UK to decide. While five Justices held that the Supreme Court had the constitutional authority to make a declaration that the general prohibition on assisted suicide in s 2 was incompatible with art 8, only two Justices (Lady Hale and Lord Kerr) would have done so. The other four Justices concluded that the question whether the current law on assisting suicide was compatible with art 8 involves a consideration of issues which Parliament was inherently better qualified than the courts to assess, and that under present circumstances the courts should respect Parliament’s assessment.

The Supreme Court’s decision also contained an extensive discussion on assisted dying. In concluding whether the present legislative regime infringed art 2 of the Convention, Lord Neuberger stated: “*Parliament now has the opportunity to address the issue of whether section 2 should be relaxed or modified, and if so how, in the knowledge that, if it is not satisfactorily addressed, there is a real prospect that a further, and successful, application for a declaration of incompatibility may be made... However, bearing in mind... the attention the matter has been given inside and outside Parliament over the past twelve years, one would expect to see the issue whether there should be any and if so what legislation covering those in the situation of Applicants explicitly debated in the near future, either along with, or in addition to, the question whether there should be legislation along the lines of Lord Falconer’s proposals.*”^[27]

Concluding observations

The authors express no opinion on the moral, ethical or philosophical implications of a “right to die” or assisted dying.

However, regardless of whether the reader supports or opposes the general principle, the Assisted Dying Bill as currently drafted is unsatisfactory. Significant amendments are required in order to ensure the protection of vulnerable or elderly individuals, both by strengthening the eligibility criteria (particularly in relation to the assessment of capacity and “clear and settled intention”) and ensuring the appropriate monitoring systems are in place. Such matters are far too important to be left to “codes of practice” developed after the passing of legislation. Serious consideration should also be given to whether such responsibility should be placed on the shoulders of a medical profession unwilling to bear it, or passed to the judicial system which is accustomed to considering difficult decisions and making the appropriate enquiries.

[1] In such a debate, a number of terms are utilised. Assisted dying typically refers to the practice of allowing terminally ill, mentally competent adults with choice and control over the timing and manner of their death by self-administering medication. Assisted suicide is a wider practice than assisted dying, and may allow chronically ill and disabled people help to end their lives. Voluntary euthanasia allows a doctor to directly administer life-ending medication to a patient at their request.

[2] Assisted Dying has also been debated on a number of occasions, both in connection with draft bills and separately – see, for example, 10 October 2005 (debating Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill (published on 4 April 2005)); 13 February 2012 (application of the policy published by the Director of Public Prosecutions relating to cases of encouraging or assisting suicide); 5 December 2013 (debate on assisted dying legislation for terminally ill patients); 12 December 2013 (debate on proposals to legalise physician-assisted suicide); 5 March 2014 (debate relating to the application of the policy published by the Director of Public Prosecutions relating to cases of encouraging or assisting suicide).

[3] Further, in 2009, Lord Falconer also proposed an amendment to the Coroners and Justice Bill (now the Coroners and Justice Act 2010) which would have decriminalised the provision of assistance to terminally ill persons intending to travel abroad to commit suicide, provided the terminally ill individual had been certified by two medical practitioners. That amendment was defeated by 194 votes to 141.

[4] Unless otherwise stated, all references are to the relevant provisions of the Assisted Dying Bill (HL Bill 6).

[5] Section 1.

[6] Explanatory Notes, para 3.

[7] Section 2.

[8] This is in contrast to the widely-drawn Assisted Suicide (Scotland) Bill currently under consideration by the Scottish Parliament, which applies to persons suffering from “an illness that is, for the person, either terminal or life-shortening, or (b) a condition that is, for the person, progressive and either terminal or life-shortening.” (s 8(5))

[9] Section 3(1).

[10] Sections 3(3), 3(4); Schedule.

[11] Explanatory Notes, para 5.

[12] Section 5.

[13] Section 8(1).

[14] Section 10.

[15] Section 9(1).

[16] Section 9(3).

[17] The validity of results of such surveys is disputed by Care Not Killing, which states “... *most polls of this nature are based on answers to Yes/No or Either/Or questions without any explanatory context and without other options – eg good quality palliative care – being offered... Most people have little understanding of the complexities and dangers in changing the law in this way and opinion research consists therefore to a large extent of knee-jerk answers to emotive – and often leading – questions.*”

[18] House of Lords Select Committee Report on the Assisted Dying for the Terminally Ill Bill (4 April 2005), per Royal College of Physicians at p44, para 118

[19] Similar provisions also exist in assisted dying laws in Oregon (on which Lord Falconer’s bill purports to be based) and The Netherlands

[20] See, for example, interview with Lord Coleridge on 15 July 2014; *R v Nicklinson* [2014] UKSC 38 per Lady Hale at para. 314

[21] *R v Nicklinson* [2014] UKSC 38 per Lord Neuberger at para 123

[22] *Airedale NHS Trust v Bland* [1993] AC 789 per Lord Browne Wilkinson at p885.

[23] In three subsequent decisions, the ECHR has stated that art 8.1 encompasses the right to decide how and when to die, and in particular the right to avoid a distressing and undignified end to life (provided that the decision is made freely) – see *Haas v Switzerland* (2011) 53 EHRR 33, para 51; *Koch v Germany* (2013) 56 EHRR 6, paras 46 and 51; and *Gross v Switzerland* (2014) 58 EHRR 7, para 60.

[24] *Pretty v United Kingdom* (2002) 35 EHRR 1 at para 76.

[25] *Haas v Switzerland* (2011) 53 EHRR 33, para 55.

[26] *Haas v Switzerland* (2011) 53 EHRR 33, para. 58.

[27] *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38 at para. 118