Living and Dying Well

Keeping the law safe for sick and disabled people

Considering the Evidence

An analysis of the report of the 'Commission on Assisted Dying' and of its published evidence

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Living and Dying Well is a public policy research organisation established in 2010 to promote careful analysis of the issues involved in ‘assisted dying’ – the current euphemism for physician-assisted suicide. Living and Dying Well takes the view, based on all the evidence surrounding the subject, that legalisation of ‘assisted dying’ would pose serious risks to public safety and that debate needs to focus on rigorous analysis of evidence rather than on campaigning spin.

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Contents

EXECUTIVE SUMMARY

The Commission on Assisted Dying (CAD) published its report on 5 January 2012. The pages that follow present our analysis of the evidence presented to the CAD, as published on its website, and of the interpretation of that evidence in its report.

There are two fundamental questions at issue in the 'assisted dying' debate: is the present law on assisting suicide in need of change? and, if so, could a better law be put in its place?

The CAD states in its report that "*the current legal status of assisted dying…is inadequate, incoherent and should not continue*"[1]. Its report, however, is more concerned with *how* rather than *whether* the law should be changed. Although various arguments for and against changing the law are rehearsed in the report, the conclusion that the present law should not continue does not have the appearance of growing naturally out of the evidence that precedes it.

The specific proposals put forward by the CAD for licensing assisted suicide are little different from others presented to Parliament in recent years and rejected as unsafe. In some respects they are more stringent (for example, they would not allow qualifying applicants for assisted suicide simply to take lethal drugs home for use at will), while in other respects they are more lax - in particular, in defining a 12-months timeframe for terminal illness. Some of the wording used in the report is also worrying - for example, that people with significant physical impairments who are not terminally ill should not be eligible for assisted suicide "*at this point in time*" or that those seeking assisted suicide should not be "*unduly*" influenced by others or have "*significantly*" impaired decision-making.

More fundamentally, the report follows the pattern of previous unsuccessful 'assisted dying' proposals in seeking to place responsibility for implementing an assisted suicide regime with doctors and to embed it into the doctor-patient relationship. Such a system poses serious risks to the trust between doctors and patients and flies in the face of opposition to medically-assisted suicide from most British doctors, the Medical Royal Colleges and the British Medical Association.

While the CAD's report has made a contribution to the 'assisted dying' debate, it does not in our view provide a convincing case for changing the law.

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[1] CAD Report Page 299

INTRODUCTION

The Commission on Assisted Dying (CAD) published its report on 5 January 2012. We will not waste time commenting on the origins and composition of the 'commission': these received sufficient exposure when the report was published.

We have followed the progress of the CAD's inquiry as it progressed during 2011 via the evidence published on its website. This is not as extensive as the evidence gathered by a parliamentary select committee in 2004-05 in its consideration of Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill. Moreover, unlike the select committee, the CAD did not take oral evidence from some organisations, such as the British Medical Association and the Medical Royal Colleges, whose contribution to any consideration of 'assisted dying' is crucial.

Nonetheless, the evidence taken by the CAD and published on its website provides some insight into the issues as well as a yardstick against which to measure its findings. Our analysis of the CAD's conclusions is based on the evidence that has been published and on the report itself.

The CAD states its terms of reference as being to:

"*investigate the circumstances under which it should be possible for people to be assisted to die*
"*recommend what system, if any, should exist to allow people to be assisted to die*
"*identify who should be entitled to be assisted to die*
"*determine what safeguards should be put in place to ensure that vulnerable people are neither abused nor pressured to choose an assisted death*
"*recommend what changes in the law, if any, should be introduced*"[2].

It would appear from this that the CAD saw the question of *how* the law should be changed as taking precedence over that of *whether* the law should be changed. This perception is reinforced by the CAD's statement that it "*was set up to explore and provide an evidence-based answer to the question of what a framework for assisted dying might look like, if such a system was to be implemented in the UK*" and that its purpose was not "*to recommend whether such a system should pass into law in the UK, or within what timeframe it might be passed into law, as this decision must be made by Parliament on behalf of society as a whole*"[3]. Despite this disclaimer, the report states that "*we have reached a consensus that the current legal status of assisted dying...is inadequate, incoherent and should not continue*"[4]. Although various arguments for and against changing the law are

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[2] CAD Report Page 19
[3] CAD Report Page 321
[4] CAD Report Page 299

rehearsed in the report, the conclusion that the present law should not continue does not have the appearance of growing naturally out of the evidence that precedes it.

As regards the question of *how* the law might be changed, the report has not put forward, in its proposed framework for legalised assisted suicide, a regime of safeguards which has the necessary rigour and robustness to protect vulnerable people. The safeguards proposed are little different from - indeed, in certain respects they are less rigorous than - those that were proposed by Lord Joffe six years ago and rejected by Parliament as unsafe. A central feature of the system proposed by the CAD, as by Lord Joffe six years ago, is that any regime of licensed assisted suicide should be one of **physician**-assisted suicide and should be embedded in clinical practice. In a situation where most doctors are opposed to assisted suicide as part of medical practice and would be unwilling to participate in implementing it, the system proposed by the CAD is, to say the least, problematic.

In our analysis we consider:

- what the law on assisted suicide says and how it is applied;

- whether or not the law as it stands is working satisfactorily;

- the principal criticisms levelled at the law by the CAD;

- the main safeguards proposed by the CAD for incorporation in a law licensing assisted suicide;

- the extent to which such safeguards would be effective in protecting vulnerable people from harm;

- the implications for patient safety and clinical practice of embedding any regime of assisted suicide within health care.

CHAPTER ONE

IS THE LAW IN NEED OF CHANGE?

What the law says

1.1 The law is clear. Under Section 2(1) of the Suicide Act of 1961[5] a person who encourages or assists the suicide of another is guilty of a criminal offence and is liable, on conviction, to imprisonment for up to 14 years. This prohibition of assisted suicide reflects a widely held view in society that, while individuals who attempt to take their own lives should not be prosecuted, suicide itself is not something to be encouraged or assisted. The emergency responses to 999 calls, the strenuous efforts made to resuscitate those who have attempted to take their own lives and the 'suicide watches' that are maintained in establishments where individuals are considered to be at risk of self-harm provide ample testimony that society's view of suicide is essentially no different today from 50 years ago. Laws exist not simply to punish offenders: they also embody and state social values.

1.2 The terms of the 1961 Act may sound severe. But its provisions are tempered in two important respects. First, the sentence provided for in Section 2(1) is a **maximum** sentence, allowing lesser – including non-custodial – sentences to be imposed by the courts in appropriate cases. Second, Section 2(4) of the Act states that no prosecution may be undertaken without the consent of the Director of Public Prosecutions (DPP).

1.3 In both these respects the law recognises that acts of assisting suicide may cover a wide range of circumstances – from malicious, abusive or coercive acts designed to secure personal gain to compassionate assistance given reluctantly to someone who has persistently and earnestly requested it. It recognises also that, while robust penalties need to be held in reserve to deter and, where necessary, punish acts motivated by malice, the circumstances of others may warrant lesser penalties on conviction or even for no prosecution to be undertaken. Lord Joffe told the CAD that "*by specifically including the provision that the prosecutions would be subject to the public interest, it was clearly envisaged that in some instances assisting someone to die was not intended to be a punishable offence*"[6]. His statement is correct in spirit if not in law: assisting suicide was intended to be a punishable, but not invariably punished, offence.

How the law is applied

1.4 There is nothing unusual about the Suicide Act in the way it is applied. As DPP Keir Starmer QC told the CAD, "*there is a residual discretion for all offences*

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[5] As amended by Section 59 of the Coroners and Justice Act 2009

[6] Oral Evidence, Lord Joffe

whether to prosecute or not. This is a particular version of it. But it's not unique by any stretch of the imagination; it's the way our law operates"[7].

1.5 In July 2009 a ruling by the Law Lords (now the Supreme Court) required the DPP to publish a policy governing decisions on whether or not a prosecution should be undertaken in cases where there is evidence that a suicide has been encouraged or assisted. The policy, which was published in its final form in February 2010 following widespread public consultation, is available on the Crown Prosecution Service (CPS) website[8]. After describing how prosecution decisions in this area of the criminal law are reached, it lists sixteen aggravating and six mitigating factors which might influence a prosecution decision – for example, if there were evidence that the assister had pressured the deceased to commit suicide or that the deceased had not had a settled and voluntary wish to die (aggravating factors) or if it were clear that the assistance had been given for wholly compassionate reasons or that the assister had sought to dissuade the deceased (mitigating factors).

1.6 Despite this transparency and the clear distinction that is made between acts of differing criminality, the pressure group Dignity in Dying[9] (DiD) told the CAD that "*assisted suicide is a catch-all offence and it doesn't distinguish between compassionate actions to help end the life of a dying person at their request and malicious or irresponsible behaviour which should, evidence permitting, result in prosecution*"[10]. Similarly Baroness Warnock believed that the law was not sustainable "*because it lumps together two completely different things, which are people that broadcast and encourage unknown listeners to commit suicide, and a completely different set of people who have one particular patient, relative, friend, who is in deep distress and who wants to die and wants assistance with dying*"[11].

1.7 These views are difficult to comprehend. Though the Suicide Act itself does not differentiate between offences of differing criminality, it provides, like other criminal laws, for such distinctions to be made in the way it is applied by setting a maximum sentence on conviction and reserving prosecutorial discretion to the DPP in the light of the circumstances of each case. With, in addition, the publication of a prosecuting policy governing such cases, it is hard to think of a criminal law that distinguishes more clearly between different types of behaviour.

1.8 The CAD and some of those who gave evidence to it expressed various criticisms regarding the DPP's exercise of prosecutorial discretion and the terms of the CPS prosecuting policy. We address these below[12].

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[7] Oral Evidence, Keir Starmer QC

[8] http://cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

[9] Formerly known as the Voluntary Euthanasia Society

[10] Oral Evidence, DiD

[11] Oral Evidence, Baroness Warnock

[12] See Paragraphs 1.14 to 1.39

Is the law working as it should?

1.9 The DPP was clear that assisted suicide is a rare offence. He told the CAD:

"*In 2009-10 there were 19 cases where we received a file to make a decision. In 17 of those cases we decided there should be no further action. One of those cases is ongoing; one was withdrawn by the police. In the year 2010-11…there have been 14 so far. 11 are ongoing and we've decided no further action in 3*"[13].

He added that "*since the [prosecuting] policy has been in place, which is February 2010 (the final policy), there have been no prosecutions for assisted suicide*"[14].

1.10 The low incidence of the offence almost certainly results from the interaction of two forces – the public signal that the law sends that suicide is not something to be encouraged or assisted; and the deterrent effect of the penalties which the law holds in reserve to deal with malicious or manipulative assistance and which give reason to anyone contemplating such action to think very carefully about his or her motivation before proceeding. In these circumstances it is hardly surprising that the cases that cross the DPP's desk are few in number and generally of a nature that does not call for prosecution in the public interest.

1.11 The DPP was equally clear that the present law "*works well in practice*". He added:

"*That's not to say it's not difficult because these cases are all difficult. They are all very different; lots of difficult circumstances, they take quite a lot of investigation. But the difficulty is not, I think, in the law for us, it's that these are difficult cases. But it does work reasonably well in practice*"[15].

1.12 DiD did not agree. They told the CAD that "*the law is infrequently used and not respected by the public*"[16] and "*laws exist to protect the public but the law on assisted suicide fails currently to achieve this*"[17]. On DiD's view the effectiveness of a law is to be measured by the frequency with which it is invoked and offenders prosecuted. Others might argue that a better measure is the extent to which the law succeeds in preventing the offence that it prohibits. On this measure, given the rarity of cases of assisted suicide, the law might be said to be very effective and to offer a high level of protection to the public.

1.13 Robin Gill, Professor of Moral Theology at the University of Kent, took a pragmatic view:

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[13] Oral Evidence, Keir Starmer QC

[14] Oral Evidence Keir Starmer QC

[15] Oral Evidence, Keir Starmer QC

[16] Oral Evidence, DiD

[17] Oral Evidence, DiD

"*People have not been prosecuted if they have acted compassionately to help those who are over 18, have capacity and have reached a voluntary, clear and settled decision to be assisted to commit suicide. Those few cases that have come to the courts have always involved a major breach of one or more of these crucial features...It is possible that, after half a century of sustained thought and debate, we already have the right balance*"[18].

Professor Gill's conclusion was that, with the law's discretionary provisions and the publication of prosecution guidelines, "*I really can't see what else we could reasonably want*"[19].

So what is wrong with the law?

1.14 Against this background we examine below the principal criticisms that the CAD and some others have levelled at the law.

Prosecutorial Discretion

1.15 The CAD seemed to challenge the principle of prosecutorial discretion. It states in its report that "*the question of when cases of assisted suicide should be prosecuted is at the discretion of an individual official (the DPP) applying general guidelines rather than the letter of the law. If the DPP should change, the application of these guidelines could change*"[20]. In the CAD's view, "*the essence of the rule of law is that our society is 'ruled by laws not men*'" and, with the reservation of prosecutorial discretion to the DPP, "*this basic tenet of the law is broken*"[21].

1.16 As the DPP pointed out in his evidence to the CAD, prosecutorial discretion is a common feature of the criminal law as a whole. It is impossible to legislate in detail for every conceivable circumstance of human behaviour. Criminal laws are made in order to outlaw those actions - such as killing, stealing, injuring or cheating - which society regards as unacceptable, with individual breaches of the law being dealt with according to their degree of criminality.

1.17 The CAD's view that a change of DPP could result in a change in prosecuting policy rests on a misconception about the decision-making process. It seems to envisage the DPP arriving at such decisions in isolation and on a personal basis, whereas the reality is that a decision on whether or not charges should be brought in any specific case has to be taken in the light of precedent and against the possibility of challenge through judicial review.

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[18] Oral Evidence, Professor Robin Gill

[19] Oral Evidence, Professor Robin Gill

[20] CAD Report Page 23

[21] CAD Report Page 286

The Prosecuting Policy and Decriminalisation

1.18 The CAD writes that "*the guidelines*[22]*...amount to the DPP saying he will not prosecute in cases where the assistance is provided compassionately to a person who is capable of making a considered and autonomous decision*"[23], that "*there have been no prosecutions for the offence of assisting suicide since the DPP's prosecution policy was published in February 2010*" and that "*there is now a broad public perception that assisted suicides that meet the criteria stipulated in the DPP policy are effectively decriminalised*"[24]. The argument here appears to be that, as assistance with suicide given in certain circumstances is often not deemed to merit prosecution, the law should be changed to legalise in advance all cases where such circumstances are thought to be present.

1.19 The problem with this approach is that it sees the criminal law simply as a regulatory tool, as a set of rules for deciding whether an offence should be prosecuted. In reality, the criminal law is more than that: it is a statement of social values. As Baroness O'Neill observed in evidence to the CAD:

"*The law is far more than an enabler of prosecutions and convictions. The law is also a symbolic system, if you like, an indication that we are protecting people*"[25].

1.20 The law and its accompanying prosecuting policy are consistent with a widely-held view in society that suicide is not something to be encouraged or assisted, while recognising that there could be exceptional cases where such assistance does not need to be prosecuted in the public interest - ie in order to protect the public. Whether that view could be safely expressed in a law licensing such acts in advance and for prescribed categories of people is a matter for Parliament to judge. On two occasions in recent years when it has been asked that question Parliament has ruled against legalisation. While it is, of course, possible that Parliament might take a different view at a future date, the existence of a prosecuting policy that maintains the deterrent of the law while dealing sensitively with assistance with suicide in genuinely compassionate circumstances provides no justification of itself for changing the law.

The Prosecuting Policy and Legal Change

1.21 The CAD writes that "*the decision about whether the law should be changed...is not being made by the law-makers (Parliament) but by the DPP*" and that "*the effect of being forced to issue guidelines by the judgment of the House of Lords in the Purdy case means the DPP has to decide on the extent of the law and to whom it applies*". It concludes that "*the change is therefore piecemeal; it comes*

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[22] ie the prosecuting policy, which is often referred to colloquially as the prosecuting 'guidelines'

[23] CAD Report Page 285

[24] CAD Report Page 299

[25] Oral Evidence, Baroness O'Neill

after no coherent public debate and is driven by a response to individual cases rather than by a wider strategic consideration of the aims of the policy that society wishes to adopt"[26].

1.22 These statements ignore the wide consultation that the DPP undertook before finalising his prosecuting policy. They also see the publication of the policy, not as a clarification of how the law is applied, but as a stage on the road to legalisation. While this latter may have been the hope of some advocates of legal change, that is not its purpose. As the policy makes clear[27], it is not part of a "*decision about whether the law should be changed*", and the DPP is not "*deciding on the extent of the law and to whom it applies*". The law remains as it has been and the policy is simply a guide as to the sort of circumstances in which prosecution might and might not be appropriate. It is, therefore, misconceived to see the policy as part of a process of "*piecemeal change*". Moreover, the suggestion that there has been "*no coherent public debate*" is completely unfounded. Since the select committee on Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill reported in 2005, there have been many hours of carefully-argued debate in Parliament on the subject. On the two occasions when legalisation has been put to the vote, it has been decisively rejected. The issues have also been widely discussed in the media and in other public fora. The law remains intact, not because of an absence of public debate, but because those campaigning for legal change have failed to make their case.

The Law and Health Care Professionals

1.23 The prosecution policy published in February 2010 included, as one of the factors that might incline the DPP to prosecute, a situation where the assister of a suicide was "*acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care*"[28].

1.24 The CAD stated in its initial press release that "*current legal practice differentiates between amateur assistance to die by loved ones – which is likely, but not certain, to be forgiven by the criminal justice system – and assistance by healthcare professionals, which is likely to result in prosecution*"[29]. DiD similarly believed that "*the net result [of the published prosecution policy] is that we currently have a law that forgives amateur assistance to die but will punish compassionate assistance by doctors*"[30]. They thought that this "*could affect doctors' willingness to engage in discussions about a patient's…desire to end their*

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[26] CAD Report Page 285

[27] Crown Prosecution Service, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, 25 February 2010, Paragraphs 5 and 6

[28] Crown Prosecution Service, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, 25 February 2010, Paragraph 43

[29] CAD Press Release, 30 November 2010

[30] Oral Evidence, DiD

life" and that "*assistance in suicide will be carried out by inexperienced individuals*"[31].

1.25 The CAD's report endorses these views. It states that "*the particular prohibition on professional assistance, by implication, favours amateur assistance*"[32] and that this factor in the prosecution policy "*is causing considerable uncertainties for professional people involved in caring for dying people*"[33]*.* It refers to "*the anxiety that many health and social care professionals experience when patients wish to discuss the desire for a hastened death*"[34]. These perceptions, however, rest on a misunderstanding of the prosecution policy. They are also in conflict with evidence given by medical professionals to the CAD.

1.26 The prosecution policy does **not** say that it will 'punish' assistance with suicide by doctors and 'forgive' such assistance if provided by others. It states clearly that "*this policy does not in any way* '*decriminalise*' *the offence of encouraging or assisting suicide*"[35] and that "*prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment*"[36]. That assistance with suicide was provided by a health care professional is simply one factor among several to be considered by the DPP in coming to an overall assessment. In his evidence to the CAD Mr Starmer explained that "*we thought that…it was important to distinguish between, as it were, one-off acts of support or compassion and those that were engaged in the delivery of professional services*"[37].

1.27 The CAD's view that the prosecution policy is causing problems for doctors and their relationships with patients is surprising in view of evidence, given by witnesses from the General Medical Council (GMC), that only one query out of nearly a thousand received by the GMC from doctors in 2010 was concerned with the subject of 'assisted dying'. "*We don't get asked about this very often*", said the GMC's representatives[38]. Thy continued:

"*Most of the cases we see are about end of life issues in terms of doctors who are struggling with the difficult situation of people who are dying and deciding whether or not to withhold treatment or withhold hydration; that type of thing and whether or not it is a matter of enhancing the quality of life in the last few*

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[31] Written Evidence, DiD

[32] CAD Report Page 286

[33] CAD Report Page 23

[34] CAD Report Page 295

[35] Crown Prosecution Service, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, 25 February 2010, Paragraph 6

[36] Crown Prosecution Service, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, 25 February 2010, Paragraph 39

[37] Oral Evidence, Keir Starmer QC

[38] Oral Evidence, General Medical Council

hours or days of life, as opposed to making a decision to intentionally kill someone. That is fairly rare in my experience"[39].

1.28 Similarly, the Medical Protection Society told the CAD that "*it's a subject which actually is a small issue in terms of numbers for our members*"[40]. Asked whether any of his colleagues had voiced concerns on this score, Dr Martin Curtice, a Consultant in Old Age Psychiatry, told the CAD that he had "*not heard any colleagues mention it to me*"[41]. The medical director of an English hospice, who was interviewed anonymously by Demos on behalf of the CAD and who was asked whether the legal position on assisted suicide affected the conversations he could have with patients, replied: "*No, it's been quite clear that we can have discussions with patients. It's more that the act of doing something with intention of causing death that is illegal*"[42].

1.29 In fact, the inclusion of medical assistance as an aggravating factor of assisted suicide accords with professional advice from the Royal College of Physicians, who wrote to the DPP in December 2009, as part of the public consultation on his draft prosecution policy, that a doctor's duty of care for patients "*does not include being in any way part of their suicide*" and recommended that "*any clinician who has been part, in any way, of assisting a suicide death should be subject to prosecution*"[43]. The College's view was supported in written evidence to the CAD from Help the Hospices, who wrote that "*it is right that actions by a care professional are treated differently from actions by a friend or family member*", that "*doctors and other healthcare professionals have a unique role in providing and coordinating the best possible care for a person*" and that "*in our view the guidance for prosecutors provides a helpful framework to guide the decisions of healthcare professionals*"[44].

The Law and Discrimination

1.30 The CAD states in its report that "*discriminatory attitudes towards impairment have no place in the fair and inclusive society we are striving for, which values all dimensions of human experience equally*"[45]. Some of those who gave evidence to the group expressed the view that ensuring equality of access should apply also to assisted suicide. The report records the view of Pauline Smith, from NHS West Midlands, that the law was discriminatory because some people could afford to go to Switzerland for assisted suicide but others could not[46]. It also records the view of campaigner Debbie Purdy that "*the Disability*

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[39] Oral Evidence, General Medical Council
[40] Oral Evidence, Medical Protection Society
[41] Oral Evidence, Dr Martin Curtice
[42] Transcript of Interview with Medical Director (Anonymous) of an English Hospice
[43] Royal College of Physicians to Director of Public Prosecutions 14 December 2009
[44] Written Evidence, Help the Hospices
[45] CAD Report Page 284
[46] CAD Report Page 101

Discrimination Act…intends that I should not be discriminated against. That as able bodied people, you shouldn't be able to do something that is prevented by my disability…and to be honest, ending my life is one of those things"[47].

1.31 The law is not discriminatory. It applies equally to everyone irrespective of wealth, age, gender, race, religion - and state of health or disability. The question is: should there be positive discrimination in order to help offset inequalities in individual circumstances?

1.32 Debbie Purdy appeared to believe there should be. She told the CAD:

"*I think we shouldn't be distracted by disability when we are talking about somebody's right to end their lives. And if they require help to do that, I think we've got to consider, to make sure that they have all the possibilities in front of them, all of the different options, and that society is aware that they have different needs because of disabilities, but I don't think we can allow somebody's physical disabilities to limit their choices. I want the same choices as you all have*"[48].

1.33 The CAD adopted a more cautious attitude. Its report recommends legalisation of assisted suicide for people who are terminally ill but stops short of extending this facility to others with a physical impairment that prevents them taking their own lives. This is intended "*to establish a clear delineation*" between assisting the suicide of people who are terminally ill and of others who are not. "*This is something*", it says, "*that the DPP's policy currently fails to achieve*"[49]. The DPP's prosecution policy is, as it must be, non-discriminatory. However, in singling out terminally ill people as candidates for assisted suicide, the CAD is itself practising discrimination. It is, from one standpoint, offering a potential benefit to some but not to others or, from another, removing one group of people but not others from the protection of the law.

1.34 These legal aspects aside, there is another - some might say more important - aspect of this question to be considered. Legislation that has been introduced to combat discrimination has been conceived with the primary intention of offering protection to people considered to be the object of discriminating behaviour, such as racial abuse or unequal pay based on gender. It is questionable, however, whether positive discrimination in order to clear the way for suicide or assisted suicide falls into the same category.

The Threat of Prosecution

1.35 Those who assist a suicide are liable to investigation by the police in order to establish whether there is evidence that they have broken the law and, if so, what

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[47] CAD Report Page 100

[48] Oral Evidence, Debbie Purdy

[49] CAD Report Page 306

are the circumstances in which the law has been broken. Some of those giving evidence to the CAD considered this was unsatisfactory. Professors Brownsword, Lewis and Richardson, from King's College London, argued that, "*while some who assist the suicide of another will be prosecuted, others will not*" and that "*no one can be entirely confident about who will and who will not be prosecuted until the DPP has assessed the case file*"[50]. Referring to proposals from the above-named for a system of prospective legal immunity from prosecution, the CAD commented that "*this system would provide clarity for individuals on their legal position in advance, unlike the current situation in which clarity is only available after the act has been taken and the assister is at risk of being prosecuted*"[51].

1.36 The law and the prosecution policy set out clearly what is legal and illegal and the circumstances in which an act of assisting suicide is likely to be prosecuted. Those minded to assist a suicide can be in little doubt as to their legal position or the likelihood of prosecution if they should proceed. What they do not have, and what advocates of an assisted suicide law appear to want, is complete certainty. Such an approach would not, however, be advocated in the case of other criminal laws: it would, surely, not be suggested that, for example, there should be prospective legal immunity for acts of theft or assault provided that these were performed in prescribed circumstances.

1.37 According to the CAD, persons who are believed to have assisted a suicide are "*treated as criminal suspects*" and have "*the pain of being investigated*". "*It is unclear*", says the report, "*why our society treats as criminal suspects the same people whom we do not have the inclination to prosecute*"[52]. Such emotive statements rest on an uncritical assumption that acts of assisted suicide necessarily derive from altruistic and compassionate motives. It is not a matter of society 'not having the inclination to prosecute'. It is a matter of establishing whether, and if so in what circumstances, a criminal offence has been committed.

1.38 Until these facts have been established, it is impossible to say whether a case is one that calls for prosecution or not. It is undoubtedly true that such investigations have the potential to cause distress to people who have recently lost a much-loved relative or friend, and it goes without saying that there is a need for sensitive handling in such cases. All the available evidence points to sensitive investigative processes and a full process of consideration and review. However, the knowledge of post-event investigation serves to focus the mind of any potential assisters of suicide on their motivation and actions, and it is unsurprising if as a result the few cases that cross the DPP's desk are often those in which there is evidence of serious soul-searching and where prosecution is not appropriate.

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[50] Written Evidence, Brownsword, Lewis and Richardson

[51] CAD Report Page 246

[52] CAD Report Page 23

Safeguards

1.39 The CAD states that under the current law "*no prospective safeguards are in place to protect those who seek assistance*"[53] and it records that "*some of those who gave evidence argued that a system with upfront safeguards and prospective approval of individual cases would be preferable*"[54]. This argument ignores the fact that the law prohibiting assisted suicide is itself a safeguard in the same way as are the laws prohibiting other criminal acts. The essence of the CAD's argument appears to be that, if there were to be a law licensing assisted suicide for terminally-ill people and incorporating specific safeguards, that would provide greater protection than does the deterrent effect of the present law. Whether this argument can be sustained depends crucially on the nature and effectiveness of the safeguards envisaged. We address this question in detail in Chapter Two.

Conclusions

1.40 Legislating to license doctors to supply lethal drugs to terminally ill patients would represent a major change to the criminal law of this country. We are not talking about changes to tax law or planning law here: what is being proposed is the enactment of a law with (literally) life-or-death consequences. Such a change could only be contemplated responsibly if there were powerful evidence either that the law as it stands is not effective or that it is bearing harshly on society. The CAD's report has not provided convincing evidence that either of these situations obtains. The incidence of cases of assisted suicide is low and the few cases that cross the DPP's desk are generally of such a nature as not to call for prosecution in the public interest.

1.41 The law on assisted suicide cannot be viewed in isolation: it needs to be seen alongside other criminal laws. As Baroness Butler-Sloss, former Head of the Family Division of the High Court, has written:

"*There are exceptional circumstances where one might understand why someone has broken the law — a parent who disregarded the speed limit to get a desperately sick child to hospital, a mother who stole to feed her starving children. But no one would seriously suggest we should have laws licensing dangerous driving or theft. We expect those laws to be maintained to protect the public and we look to see exceptional cases treated exceptionally. And that is exactly what happens now in Britain, and in nearly every other country, with assisted suicide*"[55].

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[53] CAD Report Page 23

[54] CAD Report Page 286

[55] The Times, 5 January 2012

CHAPTER TWO

JUST HOW SAFE IS SAFE?

2.1 Asked whether she thought that compassion for the suffering of another could ever justify assisted suicide, Baroness O'Neill answered: "*Yes, I do; it's that I don't believe it's legislatable*"[56]. This really is the heart of the matter. The central question in this debate is whether assisted suicide could safely be licensed by law. Those who want to see an assisted suicide law enacted respond to this question in two ways. They tell us that the law as it stands now is not safe; and they argue that a law that licensed assisted suicide on the terms they propose would be safer.

Is the law safe as it stands?

2.2 The notion that the present law does not protect us appears to rest on two arguments – that doctors are already breaking the law by practising assisted suicide or euthanasia covertly; and that investigation of illegal activity after the event comes too late to protect the deceased.

2.3 DiD told the CAD that "*research by Clive Seale has demonstrated quite clearly that there is illegal voluntary euthanasia happening at the moment without regulation*"[57], that "*at present doctors' decisions are closed to scrutiny*" and that "*better regulation is needed to protect patients*"[58]. The evidence of Professor Seale, who has researched this subject in some depth, did not support these statements. Referring to two recent surveys, he stated:

"*Both surveys of UK doctors showed there were no cases at all reported of doctor-assisted suicide but that euthanasia occurred in a half a per cent of all deaths reported in both the surveys, which is actually lower than in other countries where the same survey has been done*"[59].

Commenting on his findings, Professor Seale said they revealed that:

"*in the UK doctors are particularly collegiate; they like to share their decisions, not just with patients and relatives, but also with each other and with nursing staff as well. There is a kind of joint quality to decision-making in the UK medical practice that is very marked compared to other countries. And with that situation decisions don't go unscrutinised*"[60].

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[56] Oral Evidence, Baroness O'Neill
[57] Oral Evidence, DiD
[58] Written Evidence, DiD
[59] Oral Evidence, Professor Clive Seale
[60] Oral Evidence. Professor Clive Seale

2.4 As to illegal activity by doctors, Professor Seale concluded that "*it does sometimes happen in UK medical practice but pretty rarely*"[61]. Indeed, the research referred to by him concluded that in the UK "*euthanasia, physician-assisted suicide and the ending of life without an explicit patient request ('involuntary' euthanasia) are rare or non-existent*"[62]. There would appear, therefore, to be little substance in claims that covert euthanasia is threatening patient safety.

2.5 We turn now to the suggestion that the present law is less able to protect vulnerable patients than would a law that licensed assisted suicide under certain conditions. DiD claimed it did not understand "*how safeguards against possible abuse via the threat of prosecution after someone has died is a more stringent approach than a law with upfront safeguards which demands a full consideration of someone's request to die when they are still alive*"[63]. Debbie Purdy suggested that "*we shouldn't be deciding after the fact whether or not we're going to prosecute…I don't think that decision should be made after somebody is dead because it is too late*"[64].

2.6 As we have observed in Chapter One, this argument leaves out of account the deterrent effect of the present law, both at a personal level (by making individuals think hard about whether they should assist a suicide) and at a societal level (by sending a clear message that encouraging or assisting others to take their own lives is not acceptable behaviour). As we have also observed in Chapter One, the incidence of assisted suicide in Britain under the present law is low, with around 20 cases a year in England and Wales crossing the DPP's desk. It is a matter for speculation how this figure would change if assisted suicide were to be licensed in advance with the 'upfront safeguards' to which DiD refers. But the situation in the US State of Oregon, which legalised physician-assisted suicide in 1997, may provide a pointer. In Oregon the number of deaths from physician-assisted suicide has quadrupled since the practice was legalised[65] and, if the death rate from this source (currently two deaths per thousand) were to be replicated in the much larger population of England and Wales, we would be looking at over 1,000 legalised assisted suicides a year. Under the CAD's definition of terminal illness, which is considerably wider than the definition employed in Oregon, the figure would be likely to be much higher.

2.7 Moreover, while post-event investigation of assisted suicide is not infallible, it does allow careful sifting of evidence to take place and a light to be shone on what has actually happened. Under the system of 'upfront safeguards' that is being proposed, assisted suicide would be licensed on the basis of subjective judgements

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[61] Oral Evidence, Professor Clive Seale

[62] End-of-life decisions in the UK involving medical practitioners, Palliative Medicine 2009; 00: 1-7

[63] Oral Evidence, DiD

[64] Oral Evidence, Debbie Purdy

[65] Based on the most recent official data available at the time of writing

around such things as the applicant's state of mind, freedom from coercion and the presumed intentions of third parties. There would be no scope for investigation of the actual circumstances surrounding the death – for example, whether coercion or subterfuge had actually been employed – as the act would have been officially licensed in advance. The CAD's proposal to establish a paper-based 'national monitoring commission' does not remove this fundamental problem.

2.8 As Baroness O'Neill told the CAD, "*it's right that it should remain a crime because only by its remaining a crime does it still remain possible to investigate it*"[66]. The threat of serious investigation after the event is almost certainly a major factor of the low incidence of assisted suicide in Britain and of the limitation of those cases that do occur to instances of genuinely compassionate assistance given with reluctance. Whether 'upfront safeguards' could result in similar or improved deterrence depends on the nature and effectiveness of the safeguards proposed. We turn now, therefore, to look at the specific safeguards that the CAD has proposed and examine them from a public safety standpoint.

How Safe are the Safeguards?

2.9 The safeguards that the CAD has proposed for an assisted suicide law are little different from those put forward by Lord Joffe a few years ago and rejected by Parliament. They also mirror, with some variations, the legislation which came into force in the US State of Oregon in 1997 and which licensed physician-assisted suicide for persons who are terminally ill and mentally capable.

2.10 The safeguards proposed may be said to fall into six main categories:

- **Terminal Illness** – a qualifying applicant for assisted suicide must have received a diagnosis of terminal illness, defined as "*an advanced, progressive, incurable condition that is likely to lead to the patient's death within the next 12 months*"[67];

- **Mental Capacity** – the applicant must have "*the mental capacity to make a voluntary and informed choice*" and his or her decision-making must not be "*significantly impaired as a result of mental health problems such as depression*"[68];

- **Freedom from Influence or Coercion –** an application for assisted suicide must originate from the applicant him/herself and must be "*free from coercion or pressure from others*"[69];

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[66] Oral Evidence, Baroness O'Neill
[67] CAD Report Pages 27 and 339
[68] CAD Page 340
[69] CAD Report Page 339

- **Informed Choice** – a request for assisted suicide must be based on an understanding by the applicant of his or her medical condition and of the alternative courses of action;

- **Settled Wish** – an application must reflect a settled wish and a period for reflection must be allowed before the suicide takes place;

- **Self-Administration** – the lethal drugs supplied to a qualifying applicant must be self-administered.

Terminal Illness

2.11 The campaigning group Healthcare Professionals for Assisted Dying (HPAD) accepted that with terminal illness "*it is very difficult to predict what is going to happen to people*"[70]. Professor Sir Mike Richards, National Clinical Director for Cancer and End-of-Life Care, told the CAD that prognosis of terminal illness was "*fraught with difficulty*"[71]. Dr Adrian Tookman, a Consultant in Palliative Medicine, told the group that "*that dying phase is more difficult to define than when I was looking after patients 20 years ago*"[72]. Professor Tim Maughan, a specialist in oncology, was more blunt about doctors' prognoses of terminal illness. "*I think we do it appallingly*", he said. "*Four per cent of people on the Liverpool Care Pathway*[73] *get better and recover, so even when you are really convinced that this patient is going to die in the next two days, still you're wrong*"[74]. DiD accepted that prognosis "*is not an exact science*" and that "*doctors are making probabilistic decisions all the time*"[75].

2.12 Doctors themselves are aware that terminally ill people who live longer, often much longer, than was predicted are far from being rare exceptions. In the US State of Oregon some of those who are given lethal drugs on the basis of a six-months-or-less prognosis live for much longer before either using the drugs to end their lives or dying of natural causes. In at least one case recorded in Oregon's official data lethal drugs were not ingested until three years after they had been supplied: it is a matter for speculation how long the person concerned might have lived if the drugs had not been swallowed. Nearer to home there is the case of the Libyan Abdelbaset al-Megrahi: released from prison in Scotland in 2009 and repatriated on the basis of a three-months prognosis he is alive at the time of writing two and a half years later. Phrases like 'three months to live' or 'six months to live' may sound authoritative to the layman, but in reality they are little more than best guesses.

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[70] Oral Evidence, HPAD

[71] Oral Evidence, Professor Sir Mike Richards

[72] Oral Evidence, Dr Adrian Tookman

[73] The Liverpool Care Pathway is a set of end-of-life care guidelines which recommends specific care regimes for patients considered to be in the last 48 hours of life

[74] Oral Evidence, Professor Tim Maughan

[75] Oral Evidence, DiD

2.13 Why does the fallibility of prognosis matter? It matters because the length of time remaining can be an important ingredient of a decision to 'end it all'. Doctors are all too familiar with the question asked by terminally ill patients 'How long do I have?'. The closer the patient is to death, the more accurate prognosis becomes. In 2004 the parliamentary select committee examining Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill heard from the Royal College of General Practitioners that "*it is possible to make reasonably accurate prognoses of death within minutes, hours or a few days. When this stretches to months, then the scope for error can extend into years*"[76]. A witness from the Royal College of Physicians described prognosis at a range of six to eight months as "*pretty desperately hopeless as an accurate factor*"[77]. The select committee recommended therefore that, "*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*"[78].

2.14 Yet in the face of all this evidence the CAD has chosen to define terminal illness, for the purposes of authorising assisted suicide, as an illness with a 12-months-or-less prognosis of life. This remarkable conclusion appears to rest on two pieces of questionable evidence. The CAD writes that, "*although there are inevitably challenges involved in defining what is meant by 'terminal illness', the General Medical Council's recent guidance for doctors on end of life care offers a practical approach to identifying when a person might be considered 'terminally ill' or otherwise potentially in need of end of life care*"[79]. It quotes the GMC as stating that "*for the purposes of this guidance, patients are 'approaching the end of life' when they are likely to die within the next 12 months*"[80]. The words "*for the purposes of this guidance*" are, however, important. The GMC's guidance for doctors is not saying that a terminal illness is an illness with a 12-months-or-less prognosis: indeed, the guidance makes clear that the twelve-months timeframe includes patients suffering from serious chronic conditions and general frailty. It is saying that a 12-months-or-less timeframe is a suitable rule of thumb for the purpose of providing care to patients who are nearing the end of life. This is a completely different matter from setting a timeframe for taking decisions for helping a patient to commit suicide. To conflate the two suggests a failure to recognise the differing gravity of the two situations.

2.15 The second argument that the CAD has used to justify its 12-months timeframe for terminal illness is that research has indicated that doctors' prognoses of life expectancy are in general over-optimistic and that terminally ill patients generally survive for less rather than more time than predicted. That may be so, but the fact remains that patients diagnosed as terminally ill who live

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[76] House of Lords Report (Session 2004-05) 86-I, Paragraph 118
[77] House of Lords Report (Session 2004-05) 86-I, Paragraph 118
[78] House of Lords Report 86 (Session 2004-05), Paragraph 269 (c)(iii)
[79] CAD Report Page 197
[80] CAD Report Page 197

longer, often much longer, than predicted are far from being rare exceptions: most doctors have had experience of such cases. A man with terminal cancer who was interviewed by Demos on behalf of the CAD said: " *When I was first diagnosed with cancer, I wanted to end it. Blow my brains out with a shotgun. But the doctor said to me: 'you've got a month to a year, but you won't make a year'. So you think: why bother? But that was 18 months ago*"[81].

2.16 It is also necessary to consider the impact of a 12-months timeframe on the number of assisted suicides that could be expected to result. The CAD has acknowledged in its report that Oregon's 2010 death rate from physician-assisted suicide, if replicated in Britain, would result in over 1,000 such deaths here every year. Oregon's death rate, however, reflects a six-months-or-less timeframe for terminal illness. It is a matter for speculation how a doubling of that period would affect the figures, but the number of assisted suicides would almost certainly be much greater. The question has to be asked: is assisted suicide on this scale something that society is prepared to contemplate?

Mental Capacity

2.17 DiD reminded the CAD that "*medical practice underpinned by the Mental Capacity Act is to assume competence from the outset in patients*"[82]. They questioned why this assumption should be reversed in the case of a patient seeking assisted suicide when patients asking for life-sustaining treatment to be withdrawn were not assumed to lack capacity. There is a simple answer to DiD's question. A suicide wish is normally regarded as grounds for psychological assessment. A patient refusing treatment is not, however, expressing a suicide wish but seeking to be rid of burdensome treatment, which may be doing more harm than good. The fact that he or she is prepared to let nature take its course as a consequence does not of itself imply a desire to die. It is the difference between accepting death and seeking death.

2.18 The CAD accepted that "*in the context of such a serious decision as requesting an assisted death…a formal assessment would be needed to ensure that the person concerned had capacity*"[83]. It observed that "*there are a number of factors that might affect an individual's mental capacity, including temporary factors caused by physical or mental illness, and more permanent impairments such as a learning disability*". It considered that "*it would be important that such factors were identified and that an assessment was conducted to explore whether the subject's decision-making capacity was significantly impaired*"[84].

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[81] Demos Interview with Hospice Service User
[82] Oral Evidence, DiD
[83] CAD Report Page 27
[84] CAD Report Pages 27-28

2.19 By whom and how would such capacity assessments be carried out? The CAD wrote that they had received evidence to the effect that "c*apacity assessments are part of every doctor's usual responsibilities*"[85] and they recommended that capacity assessment should be part of the role of the two doctors considering an application for assisted suicide. Such assessments should be carried out against a code of practice to be developed by the relevant professional bodies and should include a screening for depression "*using a validated screening tool in the context of an interview*"[86]. Depression, if identified, should be treated; and, if it did not respond to treatment, the patient should be referred for specialist assessment "*to assess whether the individual's depression was causing significant impairment of his or her decision-making capacity*"[87]. A specialist assessment should also be carried out where either of the two doctors assessing the patient's application for physician-assisted suicide "*suspected abnormal psychotic thinking or where a person has a history of psychosis*"[88].

2.20 Many of those who gave evidence to the CAD drew attention to difficulties involved in assessing mental capacity. Dr Martin Curtice, a Consultant in Old Age Psychiatry, referred to "*a big overlap between depression and terminal illness and chronic physical disorders*"[89]. The presence of such depression, he said, "*does not automatically mean you lack capacity, but it's highly likely to influence your decision-making*"[90]. Christine Kalus, a Macmillan Consultant Clinical Psychologist, said that "*it's incredibly difficult to assess people with a life-limiting disease for depression and anxiety*"[91].

2.21 Other witnesses with experience of assessing mental capacity also advised caution. Dr Matthew Hotopf, Professor of General Hospital Psychiatry at King's College London's Institute of Psychiatry, suggested that "*mental capacity, written down in law, looks simple. It looks like something objective*"[92], but he warned that in reality such assessments were complex. Capacity assessment, said Dr Annabel Price, a clinical researcher in palliative care psychiatry, was possible given sufficient time and experience of the patient[93]. Dr Andrew McCulloch, from the Mental Health Foundation, also emphasised the need for capacity assessment to be conducted over time "*because you couldn't just assume that what you heard on one day was actually representative of the person as a whole. So that would be a critical safeguard, gathering evidence at different points*"[94].

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[85] CAD Report Page 30
[86] CAD Report Page 340
[87] CAD Report Page 341
[88] CAD Report Page 341
[89] Oral Evidence, Dr Martin Curtice
[90] Oral Evidence, Dr Martin Curtice
[91] Oral Evidence, Chrsitine Kalus
[92] Oral Evidence, Dr Matthew Hotopf
[93] Oral Evidence, Dr Annabel Price
[94] Oral Evidence, Mental Health Foundation

2.22 Another question, to which we will return in Chapter Three, is whether the process of assessment could be separated from the personal values of the assessors. Dr Hotopf and Dr Price questioned "*whether the judgement of mental capacity in this context [ie a request for assisted suicide] can be made free of values*"[95]. They observed that "*the values and beliefs of the assessing clinician are likely to have a bearing on the assessment process*" and they drew attention to a survey of US forensic psychiatrists which found that "*the moral and ethical views of the respondents influenced their clinical-legal opinions about decision-making capacity*". This raised the prospect, they believed, of psychiatrists "*who oppose assisted suicide being more likely to remove themselves from the process and those who remain potentially being less stringent in their criteria for competence*"[96].

2.23 This problem applies not only to psychiatrists or psychologists whose specialist assessments of applicants for assisted suicide might be requested. It applies at least as much to GPs and other physicians who might be asked to lead the assessment process. While it is true that capacity assessment is part of a doctor's normal responsibilities, such assessments, when they take place, are carried out in order to protect patients. Assessing a patient's mental capacity as part of a process to clear the way for assisting his or her suicide is a different matter. As we will see in Chapter Three, it is likely that only a small proportion of doctors would be willing to become involved in such practices, and their self-selection could raise doubts as to the objectivity of the assessment process.

2.24 Oregon's physician-assisted suicide law requires that a doctor who has doubts as to an applicant's mental state must refer him or her to a psychiatrist or clinical psychologist for a professional evaluation. Evidence has emerged, however, that doctors in Oregon who assess patients for physician-assisted suicide are sometimes failing to identify mental problems. A study in 2008 of a sample of patients who had been supplied with lethal drugs with which to end their lives found that one in six of them had been suffering from undiagnosed clinical depression. They had not been referred for psychological evaluation and had been supplied by the assessing doctors with lethal drugs and had ended their lives via physician-assisted suicide. The report concluded that "*the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legalised aid in dying are needed*"[97].

2.25 There is also the question of whether a doctor considering an application for physician-assisted suicide would know the patient concerned sufficiently well to be able to make a reliable capacity assessment. Joyce Robins, of Patient Concern,

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[95] Written Evidence, Drs Hotopf and Price

[96] Written Evidence, Drs Hotopf and Price

[97] Prevalence of depression and anxiety in terminally ill patients pursuing aid in dying from physicians, BMJ 2008; 337:al682

did not see this as a problem. "*If you're ill and you have a GP*", she suggested, "*you will have seen that GP plenty of times, presumably regularly, so I would say they are ideally placed to say whether you have capacity or not*"[98]. However, in these days of geographical mobility the traditional 'family doctor' who has known his or her patients over many years is rapidly becoming a phenomenon of the past. In a busy multi-partner, urban practice patients are likely to find themselves being treated by a number of different doctors, especially if they require out-of-hours visits (not uncommon in seriously ill people) or admission to hospital. This problem of unfamiliarity would be exacerbated in the case of an applicant for assisted suicide whose regular doctor declined to participate and who was being assessed by another physician.

2.26 Our assessment of the evidence given to the CAD on this subject leads us to two main conclusions. One is that placing lead responsibility for capacity assessment with the patient's doctor poses serious risks to the assessment process. According to the CAD, one of the "*key elements*" in any regime for legalised assisted suicide is "*a doctor who, where possible, knows the patient well*"[99]. Its report also states that "*we envisage that the first doctor would be one with usual responsibility for the patient's care, who knows the patient well*"[100]. However, as we have observed, such close doctor-patient relationships often do not exist in clinical practice. Moreover, given the unwillingness of most doctors to participate in assisted suicide, those conducting the assessments - along with any other health care professionals who may agree to become involved - will be a self-selecting minority who may well act conscientiously but may not provide the level of challenge that is needed for a decision of such gravity. There is, therefore, a serious question mark over whether this 'key element' of the CAD's proposals could be realised.

2.27 A more fundamental conclusion is that the process of assessment for mental capacity needs to be made over time, not simply on one occasion. The CAD's report seems to have confused this question with another one - namely, whether psychiatric assessment should be made mandatory in all cases. Its report states:

"*Some studies have also suggested that for psychiatrists to make a successful assessment of a patient's competency, they would need to have an existing relationship with that patient. One study found that only 6 per cent of psychiatrists in Oregon thought they could accurately assess in a single meeting whether a patient's decision to have an assisted suicide was affected by psychiatric factors. This suggests that if people seeking an assisted death had to have a mandatory psychiatric assessment with a psychiatrist who was previously unknown to them, such an assessment might have limited value*"[101].

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[98] Oral Evidence, Joyce Robins

[99] CAD Report Page 301

[100] CAD Report Page 312

[101] CAD Report Page 233

2.28 We would agree that a single assessment by a psychiatrist could well fail to establish the presence or otherwise of a sufficient level of capacity for assisted suicide. But that argues, surely, in favour of such assessments being conducted over a period of time rather than against them being made mandatory. In his evidence to the CAD Professor Hotopf warned against a "*mechanistic safeguard which involves someone having a one-off assessment by a psychiatrist*"[102]. In his view "*the idea that you can have a sort of box in a flow chart which involves a psychiatrist somehow doing an assessment, somewhat out of the context of the clinical material, I think is a dangerous one and will not provide the safeguards which one might want*"[103]. Yet the assessment process described by the CAD amounts to just such a flow-chart of one-off assessments. As a hospice service user put it in an interview with Demos, "*anyone who's asking should be subject to a full psychological assessment, which should be done by a psychiatrist rather than a GP. Doctors are very variable in their ability to pick up on depression. And not a one-off visit; it should be a reasonable lengthy assessment*"[104].

2.29 The need for assessments to be conducted over a period of time is relevant not only to determining mental capacity but also to establishing whether or not there might be external influence or coercion underlying a request for assisted suicide and whether or not such a request represents a considered and settled wish to die.

Influence and Coercion

2.30 Many of those who gave evidence to the CAD expressed concerns about external influence on requests for assisted suicide. Gary Fitzgerald, from Action on Elder Abuse, referred to "*degrading relationships*", which he defined as "*the dynamics between one partner and another that dominates, that controls, that reduces the ability of somebody to actually make genuine, informed decisions in their life*". In such circumstances, he said, "*an older person can actually end up being placed in a situation where they appear to be making decisions in isolation, independently, but actually are heavily influenced by what's taking place within the family unit around them*"[105].

2.31 Dr Martin Curtice pointed to research showing the difficulty of establishing the presence or otherwise of coercion from a single consultation. "*Context and history and getting collateral history is important*", he said. He cited as an example the case of a patient "*who was being financially abused by his carer, who was his friend, and we just didn't know: we'd met with the carer loads of times*". "*If you want to be devious about it*", he told the CAD, "*you can be*"[106]. A palliative care nurse who took part in a focus group conducted by Demos said that "*we very*

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[102] Oral Evidence, Dr Matthew Hotopf
[103] Oral Evidence, Dr Matthew Hotopf
[104] Demos Interview with Hospice Service User
[105] Oral Evidence, Action on Elder Abuse
[106] Oral Evidence, Dr Martin Curtice

often question motives of why families are pushing for certain things and you really sometimes get the feeling that their motives aren't completely honourable"[107].

2.32 In addition to such external coercion, whether overtly or subtly applied, there is also the problem of internal pressure. The palliative care nurse referred to above said that "*a lot of our patients will talk about not wanting to be a burden on their family*"[108]. The Multiple Sclerosis Society stated that "*MS affects about three times as many women as men...The archetype would be a woman being looked after by her partner, typically her husband…and feeling that they are somehow a burden on that person*"[109]. Action on Elder Abuse commented that "*a family doesn't necessarily have to use threats and intimidation. We see scenarios where older people will make bad decisions…They will make bad decisions because they want to benefit their family…They are actually not making decisions based on what's best for them; they are making decisions on what they believe to be best for the wider and extended families*"[110].

2.33 The British Geriatrics Society wrote that "*the feeling of many older people that life is unbearable in its later stages is a direct result of the reaction of others to their frailty and the care and treatment they are afforded. Our concern then is that many older people, because of the care given to them by society in general and the NHS and social care system in particular, will perceive themselves as a burden and feel under pressure to end their lives*"[111].

2.34 The CAD recognised that it would be necessary to ensure that any decision to seek assisted suicide must be free from what it called 'undue influence'. The report states that "*it is essential that any future system should contain safeguards designed to ensure, as much as possible, that any decision to seek an assisted suicide is a genuinely voluntary and autonomous choice, not influenced by another person's wishes*"[112]. It would be necessary, the CAD believed, to ensure that someone seeking assisted suicide was "*not unduly influenced by others*". The group envisaged that any such safeguard "*would particularly rely on the skills of the first doctor, whom we envisage would have an established relationship with the person requesting this assistance and be familiar with their personal history and family context*"[113]. More specifically, "*each of the two doctors involved would be required to have in-depth discussions with the individual to explore his or her motivation for requesting an assisted death and to discover any indication that there might be another person influencing the individual's choice*"[114].

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[107] Transcript of Focus Group, Palliative Care Nurses
[108] Transcript of Focus Group, Palliative Care Nurses
[109] Oral Evidence, Multiple Sclerosis Society
[110] Oral Evidence, Action on Elder Abuse
[111] Written Evidence, British Geriatrics Society
[112] CAD Report Page 27
[113] CAD Report Page 315
[114] CAD Report Page 339

2.35 The report continues:

"*If either doctor had any suspicion that there may be an element of coercion at work and wished to seek an independent opinion, he or she could request an independent assessment of the patient. The person providing this assessment should be a professional (such as a community nurse, social worker or care worker) who is familiar with the patient and his or her personal circumstances. This independent professional should interview the patient alone and - where possible - also interview the patient's relatives to examine whether the individual may be experiencing any form of undue influence*"[115].

2.36 What protection could such arrangements be expected to provide to vulnerable people seeking assisted suicide? In our view very little. A crucial feature of this safeguard is that the first assessing doctor should be sufficiently familiar with the patient and his or her family circumstances to be able to form a reliable judgement of whether a request for assisted suicide is free from external or internal pressure. Yet, as we have observed in the preceding section, in many cases this prerequisite would not be fulfilled.

2.37 In-depth discussions with a patient seeking assisted suicide are certainly necessary. However, what is needed, if subtle external influence or hidden internal pressures are to be uncovered, is familiarity with the patient's personal situation and his or her family dynamics. The assessing doctor may not have this level of familiarity. All that is being proposed is that the doctor, if he or she should suspect coercion, *could* (not *should*) request an independent assessment and that the independent assessor should have a private interview with the applicant and '*where possible*' with the applicant's relatives. This is insufficient. It is hard to see how any reliable assessment of the presence or otherwise of coercion or other external influence could be made without an exploration of a request for assisted suicide with those who have the main potential for exercising such influence.

Informed Choice

2.38 The CAD believed that an applicant for assisted suicide should be "*fully informed of all other treatment and end of life care options that are available*"[116]. They also suggested that "*a patient should not be allowed to progress with seeking an assisted death in the immediate aftermath of an upsetting diagnosis, without a full understanding of that diagnosis and consideration of the many options for treatment and care that may be available*"[117].

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[115] CAD Report Page 340

[116] CAD Report Page 21

[117] CAD Report Page 313

2.39 Are these measures sufficient to ensure informed consent? In 2004 Help the Hospices wrote to the parliamentary select committee examining Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill that "*experience of pain control is radically different from the promise of pain control, and cessation is almost unimaginable if symptom control has been poor. On this view patients seeking assistance to die without having experienced good symptom control could not be deemed fully informed*"[118].

2.40 The CAD did not support such a 'palliative care filter'. Its report states:

" *While we recognise the essential role that end of life care can play in relieving patients' suffering and supporting their families to care for them, we also do not think a patient should feel compelled to accept treatment that he or she may find burdensome or unhelpful, in order to demonstrate that all options had been explored. For this reason, we recommend that people must be informed of all alternative options for treatment and care before they may proceed with assisted dying, but not that they should be required to experience this care*"[119].

2.41 We disagree. While it is fair to argue that a briefing provides a sufficient basis for informed consent in taking many decisions in life, a request for assisted suicide involves a decision of unusual gravity requiring a higher degree of assurance. This view is borne out by the experience of palliative care specialists, who sometimes have referred to them terminally ill patients with apparently intractable physiological or psychological suffering which has not been managed as well as it might have been in community or hospital medicine, who assert confidently that they simply want to 'end it all' but who, after experiencing what modern specialist palliative care has to offer, change their outlook completely. Most of them, however, would not have experienced such a change of heart simply on the basis of a briefing.

2.42 For consent to be valid it must be based on accurate information. There is a major difficulty in this respect with the CAD's definition of terminal illness. Even at shorter ranges than the 12 months proposed by the CAD prognosis of terminal illness is subject to a wide margin of error. A doctor may feel that a terminally-ill patient may well die in the next year, but such an opinion provides no firm basis for saying that death can be expected to occur in that timeframe. This problem cannot be resolved simply by pointing out to the patient that the prognosis is subject to error. The doctor's prognosis constitutes all the information the patient has to go on. At the range proposed by the CAD it is doubtful whether many patients considering hastening their deaths would have sufficiently reliable information to enable them to make an informed choice.

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[118] House of Lords Report 86-I (Session 2004-05), Paragraph 258

[119] CAD Report Page 314

Settled Wish

2.43 The CAD believed that a request for assisted suicide must reflect "*a settled view (as opposed to a fluctuating or weakly founded view)*"[120]. Once again, the burden of ensuring that this condition is fulfilled would fall on the assessing doctors. The CAD took the view that "*the first doctor would need to take time to explore the patient's request for an assisted death in an open and compassionate manner and where appropriate consult other health and social care professionals responsible for the patient's care*" and that "*the first doctor would be in a good position to identify whether the patient's request was a 'cry for help' expressing dissatisfaction with the patient's current care or anxieties about the dying process rather than a genuine request for assisted dying*"[121].

2.44 Here, once again, we come up against the problem that a doctor assessing a request for assisted suicide may well have no real knowledge of the applicant as a patient. The CAD recognised this problem. They wrote:

"*This would require more than one conversation over a period of time, including at least one conversation with the person on their own. These discussions would be particularly important if the doctor did not have a long-standing relationship with the patient, for example if their usual physician had a conscientious objection to assisted dying and the patient had had to seek a new physician who did not have a principled objection to considering their request. In these circumstances the physician might particularly wish to consult other professionals who know the patient well, such as their family doctor, community nurse or social worker, to explore whether any external factors or relationships might be influencing the person's request*"[122].

2.45 Such general statements are easy to make, but they do not come to grips with the fundamental problem - namely, that the judgement of whether a request for assisted suicide reflects a settled and carefully-considered wish may well be in the hands of a doctor who has not had a long-standing clinical relationship with the patient and who would have to make that judgement less from first-hand experience of the patient and more on the basis of what others think. Nor is this situation in any way improved by the availability of a second opinion from another doctor, who is envisaged by the CAD as being independent of the first doctor and who, says the report, "*should not have a pre-existing relationship with the patient or be in any way responsible for that patient's care*"[123]. As a result he or she is even less likely to have any real knowledge of the patient than the first assessing doctor.

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[120] CAD Report Page 27
[121] CAD Report Page 312
[122] CAD Report Page 315
[123] CAD Report Page 338

2.46 The CAD has also proposed that there should be a period for reflection in cases of assisted suicide. It envisages that "*a person would only initiate the process of requesting an assisted death after considerable discussion with their doctor*". The report continues:

" *We do not envisage that a formal process would be initiated until the person had made the decision that they would soon be in a position where they were ready to end their life. Given that the person concerned would need to have an advanced, progressive, incurable disease according to the proposed eligibility criteria, the Commission considers that it would be inappropriate to suggest safeguards that would require a very lengthy approval process at this point*"[124].

The report proposes, therefore, that "*a minimum time period of two weeks must elapse between the request being made by the subject and the assisted death occurring*"[125].

2.47 The CAD may well envisage that a formal request for assisted suicide would not be made until there had been extensive discussions with the assessing doctor. There can be no assurance, however, that this would be the case: there appears to be nothing in the proposals put forward to prevent a formal request being the first step in the process. Against this background a two-week period for reflection seems pitifully short. Given that the CAD envisages a searching assessment process, including "*more than one conversation over a period of time*"[126] and that the clock for the two-week 'cooling-off' period would begin to run from the moment when the application is made, it is likely in some cases that by the time the assessment is complete there will be no mandatory period for reflection remaining.

2.48 What is the objection, one might ask, to a longer period for reflection? Lord Joffe gave an interesting explanation when he gave evidence in 2004 to the parliamentary select committee examining his bill of that year. " *We are concerned*", he said, "*that, if there were so many steps, and we have already included a surprising number of safeguards, the patients will all have died before we get through them*"[127]. The CAD's approach has a similar irony about it. Its report says that "*where the patient's death was judged by the two doctors to be imminent (eg likely to occur within one month), they could in exceptional circumstances reduce the waiting period to six days as long as they were satisfied the patient had the requisite settled intention*"[128].

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[124] CAD Report Page 30

[125] CAD Report Page 30

[126] CAD Report Page 315

[127] House of Lords Report 86-II (Session 2004-05), Page 49

[128] CAD Report Page 342

2.49 These proposals are inadequate for a decision of such gravity. In practice, the CAD's proposals could provide no period for reflection at all.

Self-Administration

2.50 Here at least the CAD has proposed a safeguard that is an improvement on previous proposals. In October 2010 Living and Dying Well published a report[129], entitled 'What's Happening in Oregon', which analysed the outcome to date of that State's physician-assisted suicide law based on official reports from the Oregon Health Department. In their report the authors criticised the absence of any arrangements under Oregon's law for ensuring that lethal drugs supplied to patients for assisted suicide were used as intended - ie by a terminally ill and mentally competent person ingesting them knowingly and voluntarily.

2.51 The CAD appears to have recognised these shortcomings in Oregon's law. It proposes that "*the first doctor or a suitably qualified healthcare professional would need to deliver the medication to the patient in person and remain on the premises until the person had taken it or declined to take it. If it was declined, the doctor or other healthcare professional would be legally responsible for returning the lethal medication to the pharmacy for safe keeping*"[130].

2.52 While this improvement is to be welcomed, we feel it necessary to sound a note of caution. The CAD states that the doctor supplying the lethal drugs "*must be on hand (eg nearby although not necessarily in the same room) when the patient takes the medication*"[131]. However, unless the doctor actually witnessed ingestion of the drugs, he or she would not be in a position to confirm that they had been self-administered. This is a particular concern if, as the CAD envisages, arrangements were to be introduced to cater for persons for whom oral self-administration might pose problems as a result of illness or physical impairment.

Conclusions

2.53 No law can be 100 per cent safe. However, the degree of safety built into legislation has to match the gravity of the risk. Here there can be no doubt that the risk lies at the high end - some might say at the very top - of the spectrum. The debate here is about a law where errors cannot be retrieved. The nearest parallel is perhaps that of capital punishment, one of the main reasons for the abolition of which was that occasionally mistakes were made and a death was officially sanctioned which should not have taken place. If Parliament were ever to consider legislating for assisted suicide, therefore, the degree of safety built into such a law would have to be unusually high.

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[129] http://www.livinganddyingwell.org.uk/images/stories/pdfs/ldworegon.pdf

[130] CAD Report Page 343

[131] CAD Report Page 31

2.54 The safeguards proposed in the CAD's report do not measure up to these standards. Expert witnesses who gave evidence in 2004 to the select committee on Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill made clear that prognosis of terminal illness is unreliable at six months range. The CAD's extension of the range to twelve months ignores expert opinion on prognosis, and the arguments advanced to justify it are highly questionable.

2.55 Terminal illness itself is in any case permeable as a safeguard. Legalisation of assisted suicide is being commended to us as a means of relieving the suffering of people who are terminally ill. However, it is arguable - and indeed some do argue - that, if the relief of suffering is to be the touchstone, assisted suicide should be available also to others who have chronic but not terminal conditions, such as multiple sclerosis, Parkinson's, severe diabetes or heart disease, and whose suffering may be more long-lasting. Professor Robin Gill observed in his evidence to the CAD that, "*wherever you draw the line, there's always going to be something just over the line which looks very similar to the thing which is just this side of the line*"[132]. Andrew Copson, for the British Humanist Association, took the view that the principles that underpin terminal illness as a condition of assisted suicide "*might lead us to other categories where the same principles apply*"[133].

2.56 Baroness Butler-Sloss has written that:

"*Laws are like nation states. They are more secure when their boundaries rest on natural frontiers. The law we have rests on the principle that we do not involve ourselves in bringing about other people's deaths. Once exceptions are introduced, based on arbitrary criteria such as terminal illness or unbearable suffering, those frontiers get blurred. They become no more than lines in the sand, hard to define and easily crossed*"[134].

2.57 The procedures proposed by the CAD for establishing mental capacity and freedom from mental disorder are little different from arrangements in force in Oregon which have revealed worrying shortcomings. They ignore warnings from professionals that mental capacity cannot be established through a system of one-off assessments commissioned via a flow-chart approach. They are also heavily reliant, as are the proposed measures for establishing a settled wish to die that is free from influence or coercion, on the existence of a long-standing relationship between the patient seeking assisted suicide and the first assessing doctor. Such long-term 'family doctor' relationships are becoming the exception rather than the rule in community medicine in Britain today.

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[132] Oral Evidence, Professor Robin Gill
[133] Oral Evidence, Andrew Copson
[134] The Times 5 January 2012

2.58 The CAD's report refers[135] to research[136] carried out in Oregon which concluded that there was no evidence that vulnerable groups, including older people, women, racial minorities and persons of low educational attainment, were resorting to physician-assisted suicide more than others. It does not, however, point out that the methodology underlying the research has been called into question[137] and that official data actually show that the incidence of assisted suicide in Oregon is highest among persons who are aged 65 to 74.

2.59 Some of the wording used by the CAD in defining who should be eligible for assisted suicide suggests that the proposed eligibility criteria are less strict than might appear at first sight. Their report, for example, expresses concern "*that a person who has a terminal illness should not be required to be already* ***experiencing***[138] *unbearable suffering to request an assisted death; it could be the prospect of anticipated suffering that he or she does not wish to experience that gives rise to the request for assistance*"[139] . In other words, fear of future suffering, whether founded or unfounded, would suffice as a reason to proceed with assisted suicide.

2.60 The report also states that an applicant for assisted suicide must be "*not unduly influenced by others*" and that his or her decision-making capacity must not be "*significantly impaired as a result of mental health problems such as depression*"[140]. While we recognise that there are degrees of depression or other mental disorder and degrees of influence which would not preclude some decisions, the decision in question here - a decision to commit suicide - carries with it serious and irrevocable consequences. The question has therefore to be asked: are we as a society content to assist the suicides of others on the basis that we see no *undue* influence on their decision or no *significant* impairment of their thinking?

2.61 A similar issue arises with regard to whether assisted suicide should be extended to people who are not terminally ill but have significant physical impairment. The CAD states in its report that "*we were unable to reach a consensus*" on this question. The report continues:

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[135] CAD Report Page 185

[136] MP Battin et al; Legal physician-assisted dying in Oregon and The Netherlands: evidence concerning the impact on patients in 'vulnerable' groups, Journal of Medical Ethics 33, No 10, 2007, pp591-7

[137] IG Finlay and R George, 'Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups another perspective on Oregon's data', Journal of Medical Ethics 37, 2011, Pages 171-174

[138] The report places the word 'experiencing' in italics. As our reproduction of this extract from the report, as of other extracts, is in italics, we have indicated the emphasis that the CAD has given to the word 'experienced' by placing it in bold typeface

[139] CAD Report Page 305

[140] CAD Report Page 21

> "*We have taken on board the strong concerns expressed by many disabled people and do not consider that it would be acceptable to society at this point in time to recommend that a non-terminally ill person with significant physical impairments should be made eligible under any future legislation to request assistance in ending his or her life*"[141].

2.62 Phrases such as "*at this point in time*" fuel fears of a slippery slope in any assisted suicide law. Paralympic athlete Baroness Grey-Thompson has written that "*what the report seems to be telling me is that, while I am not seen as a potential candidate for assisted suicide right now, I am in the waiting room*"[142].

2.63 Anyone inclined to be sceptical on this score should read what some advocates of 'assisted dying' legislation told the CAD. Joyce Robins, of Patient Concern, had this to say on the subject:

> "*The only acceptable way to frame a law at this stage seems to us to limit it to those diagnosed as terminally ill. But if that works as it's supposed to, it's quite likely that down the line there will be pressure to extend it to those whose health problems lead to a life that they find unbearable, though death may be a way off. And I think anyone who insists that this would be the last word, that we could draw a line under it and say this far and no further, I think is either disingenuous or possibly even dishonest*"[143].

The sort of legislation needed, she suggested, was "*something that will get through*". She explained: "*Let's get it through first and then maybe we could tinker with it a bit, and you water the safeguards down a bit*"[144]. It is perhaps not surprising, therefore, that Professor Hotopf should have expressed concern to the CAD "*that some of the safeguards feel like they're papering over, that they are reassurance for a constituency who might feel a bit agnostic about it*"[145].

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[141] CAD Report Page 306
[142] The Parliamentary House Magazine 19 January 2012
[143] Oral Evidence, Joyce Robins
[144] Oral Evidence, Joyce Robins
[145] Oral Evidence, Professor Matthew Hotopf

CHAPTER THREE

ASSISTED SUICIDE WITHIN HEALTH CARE?

3.1 The CAD proposes that, if there is to be a law licensing assisted suicide, it should license **physician**-assisted suicide. It envisages, moreover, that such assistance should be provided within the context of the doctor-patient relationship.

3.2 If doctors were to become involved in assisting suicides, there are two areas of activity in which their professional knowledge or skills might be relevant – assessing applicants from a clinical standpoint (ie diagnosis and prognosis of terminal illness) and prescribing or supplying lethal drugs to those who met the criteria. However, if such services were to be provided as part of the doctor-patient relationship, doctors would be called on to do other things in addition to assessing applicants and prescribing drugs.

3.3 The arrangements suggested by the CAD would require doctors to "*assess those who request an assisted death to confirm their diagnosis, explore their reaction to and understanding of their health condition, the motivation for their request, the voluntariness of their choice and their decision-making capacity*"[146]. Though these responsibilities could be shared in some cases with other professionals, the CAD makes clear its view that the first of the two assessing doctors "*would have primary responsibility for overseeing the process of the request, the assessment and (if appropriate) prescribing lethal medication and supervising the assisted death*"[147].

Doctors and Assisted Suicide

3.4 A fundamental problem with legalising physician-assisted suicide is that the majority of doctors in Britain are opposed to it and would be unwilling to carry it out if it were to be made legal. Surveys of medical opinion regularly reveal opposition from at least two thirds of doctors[148] - the proportion rises to more than nine out of ten among those specialising in palliative medicine. Drawing on the surveys he had conducted, Professor Seale told the CAD that "*doctors are much less likely than members of the general public to support the legalisation of medically-assisted dying*", that "*at its highest only about a third of doctors support the idea of legalising assisted dying*" and that "*a lot of doctors who did support assisted dying actually said 'well, I only support it if doctors themselves are not involved in providing that assistance*'"[149].

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[146] CAD Report Page 29

[147] CAD Report Page 338

[148] See, for example, Legalisation of euthanasia or physician-assisted suicide: survey of doctors' attitudes, Clive Seale, Palliative Medicine 2009; 00: 1-8

[149] Oral Evidence, Professor Clive Seale

3.5 Healthcare Professionals for Assisted Dying (HPAD) did not see this as a problem. It suggested that "*there would be enough doctors who would feel that they are not having something imposed on them to be able to deliver the service if required*"[150]. DiD believed that "*the doctors' roles are central to the assisted dying process*"[151]. In their view the participation of doctors in assisted suicide "*enables individuals to approach a trusted doctor (for example, their family or long-term doctor)*" and "*a doctor with an established relationship with a patient may have a very good insight into the patient's motivations*"[152].

3.6 There are two difficulties here. The first is that fewer and fewer people in Britain today enjoy the traditional 'family doctor' relationship that their parents or, more realistically, their grandparents experienced. A physician who gave oral evidence to the parliamentary select committee examining Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill remarked that "*the bill puts forward this fantasy that somehow a doctor will come who will know you and your family, but this is becoming less and less likely given the pressures of general practice*". He continued: "*If you try and register with a general practitioner, you register with a practice; it is a team approach to care. If you call at night, you will get a different doctor, you will not get your own doctor coming to see you*"[153]. This assessment is borne out by most people's experience of primary care. DiD itself accepted that "*not all patients may have a doctor with whom they have this kind of relationship*"[154]. In reality, few of us do.

3.7 The second difficulty concerns HPAD's statement that "*there would be enough doctors…to be able to deliver the service*". Undoubtedly doctors could be found who would be prepared to engage in physician-assisted suicide, but their self-selection for the task raises some serious questions. Oregon's experience of physician-assisted suicide is relevant here. In Oregon patients seeking physician-assisted suicide sometimes have to shop around to find – or to be vectored onto – a small minority of doctors prepared to engage in the practice. The CAD quotes a representative of Compassion and Choices of Oregon that "*we are the ones that make sure that a prescribing doctor can be found and a consulting doctor, and if a psychiatrist is needed then we know from experience people who have filled those roles*"[155]. The report also quotes a volunteer worker for Compassion and Choices of Oregon that "*the difficulty that I have found in this last client was that their regular doctors and oncologist were not supportive of the process to appeal to this. So we had to find a prescribing physician, and the person, the client has to see this prescribing physician*"[156].

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[150] Oral Evidence, HPAD
[151] Written Evidence, DiD
[152] Written Evidence, DiD
[153] House of Lords Report 86-II (Session 2004-05), Pages 161-162
[154] Written Evidence, DiD
[155] CAD Report Page 151
[156] CAD Report Page 269

3.8 The annual official reports on the operation of Oregon's physician-assisted suicide law show that, in the 13 years of the law's existence from 1998 to 2010, the median length of the doctor-patient relationship for those who died by prescribed lethal drugs was just 10 weeks. We are not told how many cases were towards the top or the bottom of the range, but the fact that the median was as low as 10 weeks in a range of 0 to 1905 weeks suggests that there were many cases where the deceased patient's relationship with the prescribing doctor was a very short one indeed.

3.9 As we have seen in Chapter Two, evidence has emerged that doctors in Oregon who assess patients for physician-assisted suicide are sometimes failing to spot the presence of clinical depression. This prompts the question whether such failures of diagnosis could be connected with assessments of mental capacity being conducted by doctors who are approached because they are not uncomfortable with the State's physician-assisted suicide law and who may in consequence be inclined to see such applications as a rational and reasonable response to terminal illness. Given the opposition of most doctors in Britain to assisted suicide within health care, it is highly likely that the 'doctor shopping' that is a feature of the scene in Oregon would appear here too, with the risks this poses to the objectivity of capacity assessments and the safety of patients.

3.10 It can be seen, therefore, that there are real safety concerns involved in seeking to involve the medical profession in the implementation of a project which the majority of doctors consider to pose risks to their patients and in which they would be unwilling to engage. While it is fair to argue that laws cannot in general be enacted or rejected to accord with the views of the professionals who would be affected by them, in this case the situation is rather different. What is being proposed flies in the face of established medical ethics and, while there would obviously be provision for doctors to decline to provide physician-assisted suicide, the result of such opting out would be to place patients seeking such assistance in the hands of a minority of doctors who knew little of them beyond their case notes and whose judgements could be clouded by their personal views of the issue. The same argument could, of course, be made regarding assessments by doctors who are opposed to assisted suicide, but as they are unlikely to conduct assessments the point is academic.

Health Care and Assisted Suicide

3.11 As we have observed, it is not only physician involvement in assisted suicide that the CAD is proposing. It also wants to see the practice embedded within health care and provided as an integral part of the doctor-patient relationship. HPAD believed it was "*part of the therapeutic alliance with the patient, that you see the patient through and, if you can't, at least your partner in the practice could* *see it through*"[157]. They declared that "*assisted dying should be just one of the many options at the end of life*" and that "*it should complement other end of life care*"[158].

3.12 DiD believed that legalisation of physician-assisted suicide would improve doctor-patient relationships. They wrote that "*a study which examined patient/doctor relationships in Europe reported that patients in The Netherlands had the highest regard and trust for their doctor*"[159]; and HPAD suggested that "*far from patients losing faith in their doctors, I think that many patients will see this as improving trust*"[160].

3.13 Others were more sceptical. Oncologist Professor Maughan considered that it was the trust that patients, not only in Holland but everywhere, placed in their doctors that made physician-assisted suicide so dangerous. "*Patients have a huge amount of trust in their doctors*", he told the CAD. "*And, if doctors are engaged in this process, I think that can be a major distorting factor*"[161]. Professor Maughan referred to the conversations between doctors and terminally ill patients, where "*every word has weight and needs to be thought about, and even throw-away remarks can be picked up by patients*". He explained that "*there'll be some people who are very clear that they want assisted dying. There'll be other patients who are very clear that they don't want that; they have a principled objection to it. But I suspect that for many people in the middle it will be a grey area where they're not sure what they feel*"[162]. He added that "*it could also be very difficult for doctors but that's not my primary concern. My concern is for the patients*"[163].

3.14 People who are seriously ill often have a heightened awareness of verbal and non-verbal cues from their doctors. This makes them particularly vulnerable to subliminal messages from clinicians who may themselves be subject to a range of personal or professional pressures or may have an over-pessimistic view of the patient's condition.

3.15 The Royal College of Surgeons wrote to the CAD that physician-assisted suicide "*would fundamentally alter the role of the doctor and their relationship with their patient. Medical attendants should be present to preserve and improve life – if they are also involved in the taking of life this creates a conflict that is potentially very damaging*"[164].

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[157] Oral Evidence, HPAD
[158] Oral Evidence, HPAD
[159] Written Evidence, DiD
[160] Oral Evidence, HPAD
[161] Oral Evidence, Professor Tim Maughan
[162] Oral Evidence, Professor Tim Maughan
[163] Oral Evidence, Professor Tim Maughan
[164] Written Evidence, Royal College of Surgeons

3.16 The CAD proposes that the second of the two doctors who are asked to assess requests for assisted suicide "*should be someone experienced in providing end of life care, so he or she can provide their expertise and support*"[165]. This proposal may perhaps be based on a statement by an anonymous medical director of an English hospice. Asked whether "*a consultant in palliative medicine would have more of the skills that are needed for being involved in assisted dying than, for example, a GP*", he replied:

"*I think so because helping patients to make informed decisions is very much part of our raison d'être and also discussing difficult choices and not shirking away from those difficult subjects. The average GP I believe has 10 deaths a year, of which half of those will die in hospital so it's a very small number. I have about 250 deaths per year*"[166].

3.17 However, while palliative care specialists may have the skills needed to understand and manage the physiological and psychological issues involved in end of life care, they are near-unanimous in their rejection of assisted suicide, which they do not consider to be compatible with their role. Suzie Croft, a senior social worker at St John's Hospice, expressed similar concerns when she spoke about the impact of an assisted suicide law on the hospice movement. There were, she told the CAD, people who resisted going into hospices because they associated hospices with dying and, in consequence but wrongly, some of them believed that hospices hastened patients' deaths: placing assisted suicide within hospice care "*could have a profound impact…It would have to be completely separated out from hospice and palliative care services*"[167].

3.18 It is sometimes argued that in Oregon over 90 per cent of those who resort to legal assisted suicide are enrolled in hospice programmes and that this shows the practice is compatible with good end-of-life care. But the situation in Oregon is very different from that which we see in the UK. In Oregon access to Medicare benefits requires enrolment in a hospice programme – a term which should not be confused with being treated in a hospice; and enrolment in an Oregon hospice programme requires the patient to have a prognosis of six months or less. It is unsurprising, therefore, that most of those who end their lives through legalised assisted suicide are enrolled in hospice programmes. Moreover, as the select committee was told when it visited Oregon in 2004, entering a hospice there requires the patient to waive the right to curative treatment – public funds pay for comfort care only[168]. The situation in Britain is radically different. Palliative care in the UK is free to all and is guided by specialists who have undergone rigorous training in whole-person end-of-life care and who provide support and education

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[165] CAD Report Page 313

[166] Transcript of Interview with Medical Director (Anonymous) of an English Hospice

[167] Oral Evidence, Suzie Croft

[168] See House of Lords Report 86-II (Session 2004-05), Page 270

to GPs and general secondary care services. The terms ‘hospice care’ and ‘palliative care’ do not mean the same thing here as they do in Oregon.

Conclusions

3.19 So why in the face of these difficulties does the CAD wish to place responsibility for assisted suicide with the medical profession and to embed the practice within health care? There are three main reasons. One is a perception that, unless assistance with suicide is provided by medically qualified people, it will be an ‘amateur’ activity with the risk of ‘botched’ suicides. Another is the belief that a doctor is better placed than anyone else to assess a request for assistance with suicide. A third is that assisted suicide is seen as a therapeutic option for people who are terminally ill and, as such, something to be embedded in the practice of health care.

3.20 The CAD considered that the DPP’s prosecution policy meant that, “*if doctors and other healthcare professionals are specifically prohibited from providing assistance, this puts an onus on friends and family members*” and that “*the particular prohibition on professional assistance, by implication, favours amateur assistance*”[169]. As we have observed in Chapter One, the prosecution policy does not ‘specifically prohibit’ doctors or other healthcare professionals from assisting suicide. That aside, the ‘botched suicide’ argument contains a half-truth. If assisted suicide were ever to be legalised and if any such law were to prescribe an implementation process[170], it may well be considered desirable to place the supply of the means of suicide in the hands of persons with appropriate pharmacological knowledge.

3.21 However, that does not of itself imply physician-assisted suicide, which involves responsibilities other than the supply of lethal drugs – for example, diagnosis and prognosis of terminal illness, assessment of mental capacity, confirmation of informed decision-making and so on. The distinction is important. As the DPP’s prosecution policy makes clear, an assisted suicide will be regarded as aggravated if committed by a doctor or healthcare professional and the person assisted “*was in his or her care*”. It is the implication for the doctor-patient relationship rather than the profession of the assister that is the issue.

3.22 The second argument – that a doctor is better placed to assess a request for assisted suicide – is at best tenuous. While it is fair to ask a doctor to diagnose terminal illness and to offer a prognosis, to expect him or her also to confirm that a

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[169] CAD Report Page 286

[170] It is conceivable that such a law might simply decriminalise assistance with suicide without prescribing a procedure to be followed by those seeking assistance. For present purposes, however, we are assuming that any such law would be along the lines envisaged by the CAD – ie it would make assistance with suicide lawful under certain circumstances and subject to the satisfactory completion of specific actions.

patient seeking assistance with suicide is mentally capable, free from depression or other mental disorder, making an informed decision and acting without any coercion or undue influence is to misunderstand the nature of modern-day doctor-patient relations. As we have observed, some patients may enjoy a close and long-term 'family doctor' relationship with their physicians, but nowadays most of us do not. Indeed, a commonly-voiced criticism of health care today is lack of continuity.

3.23 It is also important to recognise that most doctors have heavy workloads. With upwards of 2,000 patients on his or her list, with the best will and skills in the world the average GP simply does not have the resources to conduct the time-consuming discussions that the CAD seems to envisage taking place with patients seeking assisted suicide. This concern was raised with the CAD by Christine Kalus, a Macmillan Consultant Clinical Psychologist:

"*I don't think there are enough resources around, and we know that we're in the face of significant changes and downsizing within the health system broadly and community services have been hit by that, so I think that that's quite difficult. How can you, if you're a pressured district nurse or GP or whoever, with a lot of people on your books to see that day, how can you find the time to have that conversation?*"[171].

3.24 It is, however, the third argument – that physician-assisted suicide should be seen as an extension of health care – that is the most problematic. It implies that assisted suicide is a treatment – or, to use the words of HPAD, "*part of the therapeutic alliance with the patient*". That 'alliance', however, is for most of us an asymmetric one, with the patient heavily reliant on advice and judgement, as well as subliminal messages (real or imagined), from a doctor who has a near monopoly of information and experience. Such a relationship cannot operate without trust. It is all very well to say that patients trust their doctors where assisted suicide or euthanasia have been legalised. Of course they do: patients of necessity trust the doctors they have wherever they live in the world. In much the same way passengers must place their trust in the airlines who operate in the countries where they live, whatever their safety standards happen to be. Trust is an essential condition of clinical treatment as much as it is of air travel. But trust, however necessary, also involves vulnerability.

3.25 It is not uncommon for seriously ill patients to talk to their doctors about wanting to 'end it all'. Rarely do these discussions signal a serious wish for suicide: they are usually a means to open discussion about dying and about the causes of the patient's distress. The hospice medical director who gave evidence anonymously to the CAD put it this way:

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[171] Oral Evidence, Christine Kalus

"*With some people it's definitely a cry for help. I think - if you've got a physical symptom, it's ok to say 'I've got pain, I'm feeling sick'. I think especially in our modern society, we're not really on top of our spiritual side. People don't have the language to say 'I'm scared of the afterlife, I'm scared of what's going to happen'. So, instead of saying 'I'm scared,' or 'I'm hurting', they'll say 'I want to die', and that allows the conversation to go that way*"[172].

3.26 Under the law as it stands patients can voice their fears safely in the knowledge that what they say will not be taken at face value and acted on. A good doctor recognises such a situation for what it is - a cry for help, or perhaps an expression of despair, from a patient who is looking for better symptom control, for psychological support, for reassurance that the future is not as bad as it may seem, for re-affirmation of his or her personal worth or simply for an empathetic ear. In an email interview conducted by Demos on behalf of the CAD a woman with motor neurone disease wrote that "*there were times during those early years when I would have chosen assisted suicide, if it were legal. I was clinically depressed and didn't care about anything anymore. But, with the help of my hospice doctor, I managed to overcome my depression…Although I'm now severely disabled, I have a good, enjoyable, full life*"[173].

3.27 As we have observed, patients in this situation are highly susceptible to subliminal messaging and to picking up a myriad of nuances in the responses that a doctor makes to them. A doctor who responded to such a situation by agreeing to take forward a request for legalised assisted suicide could easily send the message to the patient, however unintentionally, that the patient's condition was every bit as bad as he or she feared and that suicide was in the doctor's view the most appropriate response. It is important not to blind ourselves to these risks through focusing attention on a small number of highly resolute people who are completely set on wanting to end their lives but to fail to see that there are larger numbers of terminally ill people who wonder half-seriously about being 'better off dead' and who are susceptible to the responses of the doctors, nurses and other carers in whom they place their trust.

3.28 Embedding assisted suicide within the doctor-patient relationship would be highly dangerous. We would do well to remember the words of the Royal College of Physicians - "*we believe that our duty of care is to work with patients to mitigate and overcome their clinical conditions and suffering*" and that "*it is clear to us that this does not include being in any way part of their suicide*"[174].

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[172] Transcript of Interview with Medical Director (Anonymous) of an English Hospice

[173] Email Interview with Demos

[174] Letter from Royal College of Physicians to Director of Public Prosecutions 14 December 2009

CHAPTER FOUR

CONCLUSIONS

4.1 The question before us is not whether assisting suicide is moral or immoral, compassionate or cruel. It is whether assisting suicide should be made lawful. To answer this question it is necessary to establish whether the law that we have is working as it should; and, if not, whether a different law would improve the situation - and, above all, would provide effective protection for vulnerable people.

4.2 In both these respects the CAD has failed to make a case for changing the law. Its report focuses predominantly on *how* rather than *whether* the law should be changed. It is critical of the present law, but it has not demonstrated that the law is not working properly or that it is bearing harshly on society. The reality is that cases of assisted suicide in Britain are rare and, when they do occur, there is often evidence that the assistance given has been motivated by compassion and has followed genuine soul-searching. The law allows the DPP the discretion not to press charges in such cases, and this discretion is fully exercised in practice. On the other hand, the penalties that the law holds in reserve to deal with other situations - for example, where assistance with suicide might have been given for malicious or abusive reasons - provides a powerful deterrent to anyone minded to engage in such activities for exploitative reasons. In the words of the DPP, the law "*works well in practice*"[175].

4.3 The law on assisted suicide operates like other criminal laws dealing with, for example, murder, assault, theft or fraud - in that it outlaws an action which society regards as unacceptable and deals with individual breaches of the law on their merits. It is unrealistic to suppose that we can design criminal laws around every conceivable circumstance of human behaviour. We would not, for example, consider enacting a law to legalise theft in prescribed circumstances, even if we felt that the circumstances in question were such that we would not wish to see a prosecution brought.

4.4 Moreover, the suggestion that assistance with suicide should be legalised for certain groups of people, such as those with a terminal illness, has about it an air of discrimination that does not sit well with the law's underlying principle that it should be applied equally to all irrespective of age, gender, race, belief - or state of health. Though on one view of the matter such discrimination might be seen as conferring a benefit on people who are terminally ill, on another it can be seen as withdrawing from them, but not from others, the protection that the law now gives them.

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[175] Oral Evidence, Keir Starmer QC

4.5 Not only has the CAD failed to make a convincing case for changing the law; it has also failed to provide any serious assurance that, if the law were to be changed, vulnerable people would not be put at risk. The safeguards it has proposed are inadequate for the purpose. Its proposal of a twelve-months-or-less timeframe for terminal illness rests on a definition of the end of life which exists for quite different purposes and it flies in the face of expert evidence given to a parliamentary select committee that even a six-months-or-less timeframe provides no sound basis for prognosis of terminal illness.

4.6 Its proposals for assessment of mental capacity ignore the evidence of professionals that such assessments need to be conducted over time and cannot rest on one-off assessments following a flow-chart approach; and they also place primary responsibility on the doctor leading the overall assessment process to pick up signs of mental disorder and make the necessary referrals - a system that has revealed serious weaknesses in Oregon.

4.7 Even more problematic is the placing of the assessment process in the hands of the applicant's doctor or of another doctor selected by the applicant. To ask doctors to provide a diagnosis and prognosis of terminal illness is fair enough, but the CAD envisages a much wider role for them, including the responsibility to "*explore their reaction to and understanding of their health condition, the motivation for their request, the voluntariness of their choice and their decision-making capacity*"[176]. The report states that "*these are all skills that many health and social care professionals, and particularly doctors, use daily*"[177]. Indeed they are, but they are skills that exist to support and complement a doctor's clinical care of a patient and, where necessary, to protect the patient from harm. That is quite a different matter from asking a doctor to use those skills with a view to clearing the way for assisting a patient's suicide. Given the gravity of the decision and the consequences of error, such an assessment would require the doctor to have considerable, and preferably long-standing, knowledge of the patient and his or her personal and family circumstances. In today's world of the busy, multi-partner clinical practice such knowledge is the exception rather than the rule.

4.8 However, the situation is even more problematic than this. As we have observed, most doctors are opposed to assisted suicide being introduced into health care and would be unwilling to participate in any procedures designed to hasten the deaths of their patients. Anyone seeking assisted suicide under the CAD's proposals, therefore, would have to find a compliant doctor, with the result that many, if not most, applicants would find themselves being assessed by a small minority of doctors who had little, if any, knowledge of them as patients. The data from Oregon, showing extremely short doctor-patient relationships for those who have died by physician-assisted suicide, should serve as a warning.

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[176] CAD Report Page 29

[177] CAD Report Page 29

4.9 The onus of proof rests on those who wish to change the law to demonstrate that the law we have is not fit for purpose and, if so, that it could be changed without putting the public, and especially its more vulnerable members, at risk of harm. We do not consider that the CAD has put forward a convincing case on either count.