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Clear thinking on the end-of-life debate

Should Parliament License Assistance with Suicide?

An analysis of proposals currently before Parliament

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EXECUTIVE SUMMARY

There are two bills before Parliament proposing legalisation of assisted suicide - Lord Falconer's Assisted Dying Bill in the House of Lords and Rob Marris MP's Assisted Dying No.2 Bill in the House of Commons. The text of Mr Marris's bill has not, at the time of writing, been published but its long title suggests that its terms will be similar to those of Lord Falconer's. Given that there is only a handful of parliamentary days remaining before the date scheduled for the Second Reading of Mr Marris's bill (11 September), this report is issued on the assumption that the two bills are similar. If, when Mr Marris's bill is published, it should reveal material differences, we will publish a supplementary report.

What is being proposed is that doctors should be licensed to supply lethal drugs to terminally ill people to enable them to end their own lives if they are thought to meet certain conditions. That would represent a major change both to the criminal law and to the fundamental 'do no harm' principle that underpins medical practice.

Before legislation of such gravity can be responsibly enacted, serious evidence is needed, first, that the law as it stands is not fit for purpose; and, second, that what would be put in its place would be better. On neither count has any convincing evidence been presented.

The law that we have is not perfect but it does what it is designed to do. It holds penalties in reserve to deter malicious assistance with suicide and it allows for discretion not to prosecute where that is appropriate. The law also reflects social attitudes to suicide - that, while people who attempt to end their lives should be treated with understanding and compassion, suicide itself is not something to be encouraged, much less assisted.

The legislative proposals that have been put forward fail the public safety test. Safeguards to protect vulnerable people are either non-existent or, where they exist, inadequate. They also seek to involve doctors in practices in which most of them are unwilling to participate and to involve the courts in a way which blurs responsibilities for decision-making and undermines accountability.

Living and Dying Well is a public policy research organisation established in 2010 to promote clear thinking on the end-of-life debate and to explore the complexities surrounding 'assisted dying' and other end-of-life issues.

Introduction

1. Two Private Member bills to legalise assisted suicide are currently before Parliament. Lord Falconer's Assisted Dying Bill had its First Reading in the House of Lords on 4 June and Rob Marris MP's Assisted Dying No.2 Bill had its First Reading in the House of Commons on 24 June. Mr Marris's bill will have its Second Reading debate on 11 September.

2. The precise terms of Mr Marris's bill are not known at the time of going to press - as the MP has not released the text - but its long title suggests that they will be similar to those in Lord Falconer's bill. Bearing in mind that there are very few parliamentary days remaining before Second Reading we are issuing this report now on the assumption that the provisions of the two bills are similar. If, when Mr Marris's bill appears, it should be materially different from Lord Falconer's, we will issue a supplementary report.

The Proposals

3. It is being proposed that people who are terminally ill should be able to apply to the Family Division of the High Court for lawful assistance with suicide if two doctors are satisfied that:

- they are terminally ill and are expected to die within six months;
- they have the capacity to make the decision to end their lives;
- they are deciding to do so as the result of a clear and settled intent, on an informed basis and without coercion or duress.

If two doctors are satisfied that these criteria have been met, the application may be passed to the Court for confirmation. If the Court is content, the applicant would be supplied with lethal drugs for suicide.

4. These proposals would involve a major change both to the criminal law and to the principles that underpin medical practice. Before examining them, therefore, we need to look at what the law says and how it works and at how it would impact on the practice of medicine.

The Law

5. It is not against the law to commit suicide but it is illegal to encourage or assist the suicide of another person. In this respect the law reflects society's perception of suicide - that, while people who attempt to take their own lives should be treated with understanding and compassion, suicide itself is not

something to be encouraged or assisted. These social attitudes lie behind the suicide watches that are put in place where individuals are thought to be at risk of self-harm and the suicide prevention strategies that successive governments have introduced.

6. However, the law recognises that assisting another person to end his or her life could cover a wide spectrum of criminality - from (at one end) compassionate assistance given with great reluctance and after much soul-searching to (at the other) malicious or manipulative assistance given for personal gain and accompanied by pressure. The law therefore gives the Director of Public Prosecutions (DPP) discretion to decide, in the light of all the evidence in any particular case, whether a prosecution is needed.

7. Assisting suicide is a rare offence. On average less than 20 cases a year, throughout the whole of England and Wales, cross the desk of the DPP. To put this figure in perspective, an assisted suicide law such as Oregon's, on which the proposals before Parliament are to a large extent modelled, would lead to over 1,500 such assisted suicides annually here[1].

8. The law is not perfect - no law is. But it does the job it was designed to do - to deter malicious activity while allowing for discretion to be exercised in appropriate cases. There is a fundamental difference between accepting that an individual breach of the criminal law may not need to be prosecuted and creating a licensing regime for all such acts. Laws are more than just regulatory instruments. They convey social messages. An 'assisted dying' law sends the message that, if you are terminally ill, ending your life is something that it is appropriate to consider.

No serious evidence has been put forward to suggest that the law as it stands is not fit for purpose. Such evidence is a necessary preliminary to any consideration of whether assisted suicide should be legalised.

Doctors

9. A fundamental principle of clinical practice is that medical treatment must not be given in the knowledge or with the intention that it will bring harm to the patient. In 2009 the Royal College of Physicians wrote to the then Director

[1] Calculated by applying the death rate from legalised assisted suicide in Oregon in 2014 to the number of deaths in England and Wales.

of Public Prosecutions that a doctor's duty of care for patients "*does not include being in any way part of their suicide*"[2].

10. The British Medical Association and the Royal Colleges of Physicians, General Practitioners and Surgeons are opposed to a change in the law, as are significant majorities of their members. The Association for Palliative Medicine (APM), the professional body for doctors who specialise in treatment and care of the terminally ill, is near-unanimous in its opposition. A recent survey of its members indicated that only four per cent would be prepared to engage in assisting the suicides of their patients.

11. A survey of 1,000 GPs in May 2015 revealed that only one in seven would be willing to undertake a full assessment of a patient's eligibility for assisted suicide. While a minority of doctors could certainly be found who would be prepared to engage in these practices, the result would be the 'doctor shopping' that is to be seen in Oregon - whereby people seeking assisted suicide search out, or are directed to, a minority of doctors who are willing to conduct such assessments but have no prior knowledge of them as patients.

A law licensing doctors to supply lethal drugs to terminally ill patients would raise serious difficulties both for the ethical principles of medicine and for the practical implementation of any legalised assisted suicide regime.

The Bills Before Parliament

12. Aside from these fundamental issues, the proposals which have been put forward for changing the law raise a number of serious difficulties in regard to the implementation of an assisted suicide law. Here we focus on three of them - the inadequacy of safeguards; the problems of assessment by doctors; and the respective roles of doctors and the courts.

Safeguards

13. It is common ground to both sides of the 'assisted dying' debate that, if there were ever to be a law licensing assistance with suicide, it would have to be surrounded with stringent safeguards to protect vulnerable people. However, the adequacy of the few safeguards that have been proposed is seriously open to question.

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

Terminal Illness

14. A terminal illness has been defined as "*an inevitably progressive condition which cannot be reversed by treatment*" and as a consequence of which the patient "*is reasonably expected to die within six months*". This definition would bring within the ambit of an assisted suicide law not only people who have been diagnosed with illnesses, such as metastatic cancer, that are normally regarded as terminal but also much larger numbers of people with longer-lasting chronic illnesses, such as MS or Parkinson's or heart disease, which are not usually regarded as terminal but are nonetheless incurable and life-limiting. Such illnesses often have a pattern of ups and down and it would be possible for a doctor to say, at one of the low points, that the patient could be reasonably expected to die within the next six months, especially if the patient is elderly and/or suffering from a range of co-morbidities. In reality the proposals now before Parliament would apply not only to people normally regarded as terminally ill but to large numbers of others with a variety of chronic illnesses who could be reasonably expected to die within six months.

15. Moreover, prognosticating the course of a terminal illness is itself fraught with difficulty. A select committee of the House of Lords was told by the Royal College of General Practitioners in 2004 that "*it is possible to make reasonably accurate prognoses of death within minutes, hours or a few days*" but that "*when this stretches to months, then the scope for error can extend into years*"[3]. Predicting that someone will die from a terminal illness within six months is little more than guesswork.

Capacity Assessment

16. Lord Falconer's bill includes a provision requiring a doctor who has doubts about the existence of the required level of mental capacity to refer an applicant for assisted suicide for specialist assessment. This is an improvement on Lord Falconer's last bill and it is certainly a step in the right direction. However, a similar provision in Oregon's assisted suicide law has proved ineffective. Independent research in Oregon has revealed that some of those who have ended their lives there using legally-supplied lethal drugs had been suffering from clinical depression. Their depression had not, however, been detected by the doctors assessing them and they had not been referred for

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

specialist psychiatric evaluation. The researchers concluded that Oregon's assisted suicide law "*may not adequately protect all mentally ill patients*"[4].

17. Oregon's experience highlights the need for capacity assessment to be conducted by mental health professionals rather than relying on a generalist doctor, who may have little experience of capacity issues, to spot signs that something is wrong. This is not to say that people seeking assistance with suicide are necessarily mentally ill. Mandatory referral is necessary partly because of the serious and irrevocable nature of the request and partly because depression is a very common - and understandable - feature of terminal illness.

Settled Intent and Freedom from Pressure

18. Lord Falconer's bill requires that a doctor who agrees to consider a request for assisted suicide must be satisfied that the applicant "*has* a *clear and settled intention to end their own life"* and that the decision has been reached voluntarily and without pressure or duress. It does not, however, require a doctor considering such a request to take any minimum steps to establish that these conditions are met. It does not, for example, require that the doctor should have known the patient previously or that any actions should be taken to ascertain whether the request is a considered one or a transient response to a diagnosis of terminal illness.

19. Similarly, there is no requirement in the bill that a doctor who is asked by a patient for assistance with suicide should dig deeper into the request to see whether there are family or other pressures which might be influencing it. Nor does the bill distinguish between pressure applied by others and internalised pressure, such as a desire to remove a care or financial burden from the shoulders of others.

20. In these two vital areas (establishing how settled is a wish to die and whether any untoward pressures are at work) no safeguards are offered beyond generalised conditions. These conditions are not safeguards: they are no more than broad parameters for assisted suicide. If Parliament is to be satisfied that such practices could be legalised without putting vulnerable people at risk of harm, it needs to see specific provisions translating these broad parameters into concrete safeguards. That has not been done.

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

21. The task of producing safeguards has been kicked into the long grass of 'codes of practice' which Whitehall and others are expected to determine at some future date[5]. The advocates of legalisation have argued that it is normal for codes of practice to fill in the details of legislation approved by Parliament. But safeguards for assisted suicide are not the kind of details that are normally relegated to codes of practice. They are of the essence of such life-or-death legislation and Parliament needs to see them **before**, not after, deciding whether the law can safely be changed. In reality, the issue of safeguards has been side-stepped and Parliament is being asked to sign a blank cheque.

In the few places where safeguards have been proposed they are inadequate. Elsewhere they exist only in the form of generalised parameters for assisted suicide and provide no safeguarding regime.

Medical Assessment

22. Under these proposals prime responsibility for deciding who should and who should not be given assistance with suicide would rest with doctors. Some of the criteria proposed are relevant to medical practice. It is not unreasonable to ask a doctor to give a professional opinion of whether someone is terminally ill, to offer a prognosis of the course of that illness and to advise on what treatments, palliative or otherwise, might be appropriate and available. The survey of GPs referred to above[6] indicated that four out of ten would be prepared to offer such limited advice in respect of a request for assisted suicide.

23. However, these assessments also involve the making of judgements that lie outside the field of medicine. We have already drawn attention[7] to the important questions of how the settled nature of a request for assisted suicide is to be ascertained and how it can be established that such a request is voluntary and free from pressure of any kind. These are essentially personal, domestic or social questions rather than medical ones.

24. A doctor who has known a patient well for some considerable time, has visited the patient regularly in his or her home environment and has had serious discussions with the patient about dying may possibly be in a position to make knowledge-based judgements about such matters. But in today's

[5] See Clause 8 of Lord Falconer's Bill
[6] See Paragraph 11
[7] See Paragraph 18 and 19

world of busy multi-partner GP practices and declining home visits doctors often know little of their patients' lives beyond what they pick up in the consulting room and they do not have the time or resources to set about investigating such matters.

25. This problem would be exacerbated by the unwillingness of most doctors to engage in assisted suicide. As we have observed above[8], only a small minority would be prepared to make judgements of this nature and there is every likelihood that the 'doctor shopping' that exists in Oregon would be seen here in Britain.

While it is fair to ask doctors to provide advice on strictly medical aspects of a request for assisted suicide (such as diagnosis and prognosis), they are ill-placed to make judgments involving personal or social issues (such as settled intent or freedom from pressure).

The High Court

26. It is important to understand clearly what is being proposed here. Lord Falconer's bill proposes that, if two doctors are satisfied that a person seeking assisted suicide meets all the criteria, the request should be passed to a judge of the High Court for endorsement. It does not, however, require the Court to undertake any investigations of its own, but simply to confirm the prior judgements that doctors have made. Yet without conducting such inquiries the Court would be ill-placed to challenge those judgements.

27. Realistically, therefore, what we are looking at here is a regime of physician-assisted suicide (i.e. assessment and decision-making by doctors) with the Court being asked to consent to those decisions. While this may seem at first sight to offer a possible additional safeguard, in reality it has the potential to make the process of assessment less rather than more rigorous.

28. The problem has been well expressed by the Association for Palliative Medicine:

"*We believe it is insufficient and potentially confusing to divide responsibility for the same decision between doctors and the Court. It has the potential to produce situations in which each party to an assisted suicide decision takes*

[8] See Paragraphs 10 and 11

spurious comfort from the involvement of the other and no one is fully accountable for the outcome"[9].

29. The proposed involvement of the High Court in decision-making in this difficult and sensitive area is not without merit. The Court already considers cases not dissimilar to those envisaged in these bills, including (for example) requests for life-support to be terminated or cases concerning blood transfusions. But it does not do so on the basis of confirming prior decisions by others. The role of the Court in such cases is to consider all the evidence, including advice from doctors and other specialists and discussions with interested parties, and to reach its own independent conclusions.

30. That is fundamentally different from the hybrid scheme which Lord Falconer's bill envisages. Doctors are already accustomed to providing advice to the courts on strictly medical questions and, as we have observed above[10], in a recent survey four out of ten GPs said they would be prepared to provide advice to the Court on the strictly medical aspects of a request for assisted suicide. In contrast, the regime now being proposed - of the Court being asked, in effect, to rubber-stamp prior decisions by doctors - is quite different.

The High Court is accustomed to making judgments that balance the rights of individuals against those of the wider community. But in such cases it conducts its own inquiries and reaches independent judgments. The proposed hybrid regime blurs accountability for decision-making and is potentially dangerous.

Conclusion

31. This is a complex and sensitive issue and there is room for honourable and sincerely-held opinion on both sides of the debate. Concepts such as compassion, dignity and autonomy are common currency to both sides of the debate. The essential question before Parliament is whether doctors should be licensed to supply lethal drugs to terminally ill patients who ask for them and are thought to meet certain conditions.

[9] Letter to Members of the House of Lords dated 9 January 2015
[10] See Paragraph 22

32. The onus rests on those who wish to change the law to demonstrate that the law as its stands is unsuitable and that what they would put in its place would be better.

33. No serious evidence has been produced that the law is not working as it should. The law accurately reflects social attitudes to suicide. Assisting suicide is a rare offence. The penalties that the law holds in reserve are sufficient to make anyone minded to assist a suicide think very carefully before proceeding. And the ability of the Crown Prosecution Service to exercise discretion in appropriate cases means that genuinely compassionate assistance is not punished.

34. The safeguards which have been put forward, insofar as they may be said to exist at all, are defective. They place decision-making with doctors, the majority of whom are unwilling to engage in such practices. In crucial areas, such as establishing that a request for assisted suicide is entirely voluntary and free from pressure, they require no minimum steps to be taken to ensure that the prescribed criteria are met. And they blur responsibilities between doctors and the courts.

35. The evidence that is emerging from the handful of jurisdictions overseas which gone down the 'assisted dying' road is variable but in no case reassuring. Oregon, which is held up by campaigners for legal change here as a model to follow, is revealing a rising death rate from legalised assisted suicide, failures to detect clinical depression in people seeking it and the phenomenon of 'doctor shopping'. Claims that there has been no abuse of Oregon's legislation are without foundation as there is no investigative machinery in place to scrutinise how requests for assisted suicide are being handled in practice. And, this year, the first attempt has been made to relax the terms of Oregon's law. In neighbouring Washington State in 2013 more than six out of ten of those who requested assistance with suicide gave as a reason that they did not want to be a burden on others.

36. In May 2015 the Scottish Parliament rejected a bill to legalise assisted suicide. Last year the Welsh Assembly voted against changing the law. We would urge the Westminster Parliament, in considering these two Private Member bills, to reflect carefully on the serious implications of such legislation for society and especially for its most vulnerable members.