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Another 'Assisted Dying' Bill

Does it pass the public safety test?

An Analysis of the Assisted Dying Bill [HL Bill 24]

by

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Executive Summary

Lord Falconer's Assisted Dying Bill [HL Bill 24] is the fourth of its kind to come before the House of Lords in the last ten years. None of its predecessors has made progress and the last one (Lord Joffe's Assisted Dying for the Terminally Ill Bill) was rejected in May 2006. This latest bill is little different from Lord Joffe's - it seeks to license doctors to supply lethal drugs to terminally ill patients to enable them to end their lives.

The bill contains no safeguards, beyond stating eligibility criteria, to govern the assessment of requests for assisted suicide. It relegates important questions such as how mental capacity and clear and settled intent are to be established to codes of practice to be drawn up after an assisted suicide law has been approved by Parliament. This is wholly inadequate for a bill, such as this, with life-or-death consequences. Parliament cannot responsibly be asked to approve such a radical piece of legislation without seeing the nature of the safeguards that would accompany it. On this measure alone the bill is not fit for purpose.

Like its predecessors, the bill places responsibility for assessing applicants for assisted suicide and supplying them with lethal drugs on the shoulders of the medical profession. Only a minority of doctors would be willing to participate in such acts if they were to be made lawful. An inevitable consequence, as evidence from the US State of Oregon has shown, is that many of those seeking physician-assisted suicide would find themselves being assessed by doctors to whom they had only recently been introduced and who could know little of them beyond their case notes. The implications of such 'doctor shopping' for thorough and proper assessment are obvious.

The bill also ignores expert medical evidence given to Parliament in recent years regarding the unreliability of prognoses of terminal illness at the range it envisages.

Other considerations aside, the bill fails the public safety test by a considerable margin.

ANOTHER 'ASSISTED DYING' BILL
Does it pass the public safety test?

Introduction

1. A Private Member's bill[1] has been introduced into the House of Lords by Lord Falconer of Thoroton. It seeks to license doctors to provide terminally ill and mentally competent patients with the means to end their lives - ie physician-assisted suicide. The last time the House considered such a bill was in 2006, when Lord Joffe's Assisted Dying for the Terminally Ill Bill was debated at length and rejected[2].

2. In this report we examine Lord Falconer's bill against the criterion of whether its enactment would put seriously ill people at risk of harm. We recognise that some people support legalisation of assisted suicide on grounds of autonomy and others oppose it as immoral. Our concern is not with personal choice or personal morality but with public safety. This has to be a primary consideration in all legislation.

3. In this report we focus on a number of first-order issues affecting the bill's fitness for purpose. We will present in due course a follow-on report covering a number of other, more detailed issues.

Analysis of the Bill

4. To qualify for assisted suicide under the terms of the bill, applicants must have been diagnosed as terminally ill (defined as having a prognosis of life remaining of 6 months or less) and they must be considered to have the capacity to make the decision to end their own lives, to have a settled wish to do so, to be acting voluntarily and not to be making the request as a result of coercion or other undue influence. The bill requires a request for assisted suicide to be assessed by two doctors in order to confirm that it meets these eligibility criteria.

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[1] Assisted Dying Bill (HL Bill 24) (Session 2013-14)
[2] 12 May 2006, Lords Hansard Columns 1184 to 1296

Safeguards

5. It is common ground between advocates and opponents of 'assisted dying' that legalisation should not put vulnerable people at risk of harm. It is important therefore to be clear about what safeguards the bill contains and how effective they would be. The safeguards in the bill may be said to fall into two groups - those for determining whether a request for assisted suicide should be approved; and those governing the provision of assistance with suicide once a request has been approved.

6. The bill contains some specific measures in respect of the second group. For example, it provides for a 'cooling off' period after a request for assisted suicide has been approved and it sets out arrangements for the supply of lethal drugs to an approved applicant. However, in respect of what might be called the first-level safeguards, it does no more than state eligibility criteria. Thus, the bill states[3] that two assessing doctors must confirm that an applicant "*has the capacity to make the decision to end their own life*", that he or she "*has a clear and settled intention to end their own life*" and that this intention has been arrived at "*voluntarily, on an informed basis and without coercion or duress*". It does not, however, mandate any minimum steps which a doctor conducting these assessments must take in order to be able to give the required confirmations. Instead it envisages[4] that "*codes of practice*" governing aspects of the assessment process will be issued by the relevant department **after** the bill has been enacted.

7. While it is not unusual to leave the detailed procedures for implementing legislation to subsequent codes of practice, questions such as how mental capacity, clear and settled intent, and freedom from coercion are to be established are critical and integral aspects of any proposal to license doctors to involve themselves in hastening the deaths of some of their patients. They cannot be pushed aside for consideration later as administrative matters. What is being proposed is a major change to the criminal law. If Parliament is to be able to judge whether such a change can be made without putting vulnerable

[3] Section 3(3)
[4] Section 8(1)

people at risk, it needs to see what measures would be put in place to give assurance that mental capacity, freedom from coercion, and clear and settled intent can be reliably established. While detailed codes of practice may well be necessary in the event that the bill were to become law, a decision to enact such a law cannot responsibly be taken without at least the nature of the assessment process being disclosed. As it stands, the bill is asking the House to approve legalisation of physician-assisted suicide in principle and to leave the safeguards for assessment to be drawn up later by others. Such an approach is not adequate for a bill involving life-or-death decisions of this kind. This lack of transparency regarding crucial issues of safety raises serious doubts as to the bill's fitness for purpose.

Ambit

8. The bill seeks to offer assisted suicide to terminally ill people with a prognosis of life remaining of six months or less. A select committee of the House under Lord Mackay of Clashfern, which examined a similar 'assisted dying' bill from Lord Joffe, was told by medical experts that prognosis of terminal illness at six months range is unreliable. The Royal College of General Practitioners told the committee 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*"[5]. A witness from the Royal College of Physicians told the committee that "*prognosticating may be better when somebody is within the last two or three weeks of their life. I have to say that, when they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor*"[6]. Reflecting this testimony the select committee recommended in its report 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*"[7].

9. Lord Falconer's bill ignores this expert evidence. It also ignores the evidence emerging from Oregon, where physician-assisted suicide was legalised in 1998 and where some terminally ill people who have

[5] House of Lords Report (Session 2004-05) 86-I, Paragraph 118
[6] House of Lords Report (Session 2004-05) 86-I, Paragraph 118
[7] House of Lords Report (Session 2004-05) 86-I, Paragraph 269

received lethal drugs from doctors on the basis of a six-months-or-less prognosis have gone on to live longer, sometimes much longer, before either using the drugs for suicide or dying of natural causes. A terminally ill patient's perception of the length of life remaining is likely to be an important component of any request for assisted suicide. Reliability of prognosis is therefore a crucial issue. At the range envisaged in the bill it is unreliable.

Doctors

10. Good laws have to be practical instruments, capable of being implemented as intended. Lord Falconer's bill envisages that assisted suicide will be provided by doctors - ie that it will be *physician*-assisted suicide. The Royal Colleges of Physicians, Surgeons and General Practitioners have all made clear their view that hastening a patient's death is not a proper part of clinical practice. In 2009, when the Director of Public Prosecutions conducted a public consultation on his draft prosecution policy in respect of assisted suicide, he was told by the Royal College of Physicians that a doctor's duty of care for patients "*does not include being in any way part of their suicide*"[8]. Surveys of medical opinion regularly show that the majority of doctors share this view and would not have anything to do with assisted suicide if it were to be made legal.

11. The bill contains a 'conscience clause'[9] allowing doctors to decline to participate in its provisions if they have "*a conscientious objection*" - though it is not clear whether this exemption would apply to doctors who declined to participate in assisted suicide on other grounds, such as a concern for patient safety. But this in itself raises a problem. There is a minority of doctors who support a change in the law and who may be willing to conduct assessments and write prescriptions for lethal drugs for patients whose regular doctors were unwilling to do so. Such doctors are, however, unlikely to have much knowledge of the applicants beyond their case notes. First-hand knowledge of a patient seeking physician-assisted suicide and, preferably, of his or her personal and family situation is crucial to a proper assessment process.

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[8] Letter from Royal College of Physicians to Director of Public Prosecutions dated 14 December 2009
[9] Section 5

A doctor who has only recently been introduced to a patient is in no position to make an authoritative assessment of that patient's mental state or of whether there may be factors in the patient's personal or family life which are influencing the request for assisted suicide.

12. Again, if we look at the experience of Oregon, we see from the official annual reports on the working of that State's physician-assisted suicide law that the median length of the doctor-patient relationship for those who have died in this way over the last 15 years was just 12 weeks[10], and it is clear that in many cases it was no more than a week or two. It is little wonder in these circumstances that research[11] published in 2008 in the British Medical Journal revealed that one in six of a sample of Oregon patients who had been supplied with lethal drugs with which to end their lives had been suffering from clinical depression which had not been detected by the assessing doctors.

13. Given the opposition of the majority of doctors in Britain to legalisation of physician-assisted suicide, it is to be expected that a similar pattern of 'doctor shopping' would be seen here in the event that such a law were to be enacted. Even if a patient's regular doctor were prepared to engage in the practice, he or she may know little about the patient beyond the consulting room given the fragmented nature of much primary care and the decreasing tendency for doctors to make home visits and to see patients in their family environments. Where the doctor has not met the patient before, serious assessment of such life-or-death requests is well-nigh impossible.

Mental Capacity

14. It is surprising, in view of the evidence that clinical depression is sometimes overlooked by doctors assessing assisted suicide requests in Oregon, that Lord Falconer's bill does not require referral for specialist psychiatric assessment either in all cases where a request for assisted suicide is made or at least in cases where the assessing doctor has doubts about the mental capacity of an applicant or suspects that judgement-impairing depression might be present. In this respect

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[10] Oregon Public Health Division, Report on Year 2012

[11] Prevalence of depression and anxiety in terminally ill patients pursuing aid in dying from physicians, BMJ 2008;337:a1682

Lord Falconer's bill is less demanding than was Lord Joffe's 2005 bill, which required referral for psychiatric examination in cases of doubt. Lord Joffe's bill was rejected and, as we have seen[12], Oregon's arrangements for capacity assessment, which his bill took as a model, have revealed defects. Against this background it might reasonably have been expected that this latest bill would provide more stringent requirements than either Oregon's law or Lord Joffe's bill. On the contrary, it mandates no requirements at all governing mental capacity assessment.

Monitoring and Control

15. The bill provides[13] for the Chief Medical Officers of England and Wales to "*monitor the operation of the Act, including compliance with its provisions*". It thereby places with the Department of Health the responsibility for deciding whether the criminal law has been broken. In doing so the bill is saying, in effect, that assisting the suicide of terminally ill people is a health care issue rather than an approved exception to the criminal law. Laws are more than just regulatory instruments: they also convey important social messages. The message conveyed by the bill - that assisted suicide should be seen as part of medical care - flies in the face of professional clinical guidance and the views of the majority of doctors.

16. The Health Department does, of course, have an interest, in that a breach of the criminal law by a doctor may also raise issues of fitness to practice. However, judgements as to whether the criminal law has been broken, whether by doctors or by anyone else, are the province of the Law Officers.

Discussion

17. The bill does not pass the public safety test. Its principal weakness is its failure to provide for any safeguards, other than basic eligibility criteria, governing the assessment of requests for assisted suicide. In a bill of this nature, where life-or-death decisions are involved, the

[12] See Paragraph 12
[13] Section 9

nature of the safeguards cannot be relegated to codes of practice to be drawn up following a change in the law. Parliament needs to be able to see clearly the nature of the safeguards proposed so that judgements can be made as to their reliability and practicability before it rules on whether or not the law should be changed.

18. While this is of itself sufficient to render the bill unfit for purpose, there is also a wider picture to be considered. Licensing doctors to supply lethal drugs to some of their patients in certain perceived circumstances in order to help those patients to commit suicide would represent a major change to the criminal law of this country. For the first time Parliament would be saying that some people (in this case doctors) might involve themselves with impunity in deliberately bringing about the deaths of others (in this case those who are terminally ill). Before Parliament could seriously consider going down that road, clear evidence needs to be presented that the law as it stands is not working properly; and, if that can be demonstrated, that what would be put in its place would be better and safer - safer, that is, for all of us, not simply for a minority of strong-minded people who are resolved that they want to end their lives.

19. In all the parliamentary and public debate on this issue over the last ten years, no convincing evidence has been adduced to support either of these propositions. The law that we have in this matter (the Suicide Act 1961) is clear. It is a criminal offence to encourage or assist another person's suicide, and the Act holds serious penalties in reserve to deter malicious assistance. The law recognises, however, that there could be highly exceptional circumstances where such assistance need not be prosecuted and it gives the Director of Public Prosecutions (the DPP) the discretion not to press charges where there is evidence that there has been serious soul-searching and genuinely reluctant and compassionate motivation. Moreover, the way in which the law is applied was set out with clarity in a prosecution policy published three years ago.

20. Under the present law instances of assisted suicide are rare - less than 20 cases a year cross the desk of the DPP. Prosecutions are even

rarer because, given the nature of the cases, they are unnecessary. What we are seeing is the combined effect of a law with penalties serious enough to make anyone minded to assist a suicide think very carefully indeed before proceeding and the discretion to temper justice with mercy where that is warranted.

21. Lord Falconer's bill, however, is seeking something else. It seeks to create a licensing system so that acts of assisted suicide can be approved in advance on the basis of prognoses of life remaining and subjective assessments of such things as mental capacity, settled wish and absence of coercion or other influence. As such, it represents, not an adjustment to the existing law, but a radical departure from it.

22. The fundamental problem with the safeguards in the bill, insofar as they may be said to exist at all, is that they are designed around the wishes of a small minority of strong-minded individuals who are clear in their minds that they want to end their lives rather than around the need to protect much larger numbers of more vulnerable people from self-harm. The bill is pervaded by a sense that those who request physician-assisted suicide will have thought long and carefully about their decision, that the doctors who assess their requests will know them and their families well and will be willing to participate in hastening their deaths and that it is possible for mental capacity, freedom from depression, settled intent and absence of coercion to be readily established. The reality is far removed from this vision.

23. We would be less than human if we could not empathise with people who are seriously ill and want to end their lives. The small number of cases where assistance with suicide has occurred readily attracts media attention and it is easy to make the mistake of assuming that changing the law would simply allow this very small minority of determined people to have their lives ended without legal objection. Again, the reality is very different. Licensing assisted suicide does not reproduce the status quo in legal form: setting up a licensing system changes the underlying dynamic of the law.

24. In Oregon the incidence of legal assisted suicide is nearly five times what it was when that State's physician-assisted suicide law came into force in 1998. Oregon's current death rate from this source is the equivalent of between 1,100 and 1,200 such suicides annually in England and Wales.

Conclusion

25. No one questions the sincerity or the humanity of those who support such legislation. We can all of us think of exceptional circumstances where we might feel that helping someone out of this life need not be legally or morally reprehensible. But the law that we have already has the discretion to deal with exceptional cases in an exceptional way. What is being proposed in Lord Falconer's bill - the creation of a licensing system for such acts - is something completely different. To create such a system would be to cross an important Rubicon. Parliament would not seriously consider enacting a law to license other criminal offences in certain prescribed circumstances, and it is difficult to see why it should be asked to do so in this case.

26. Laws, like nation states, are more secure when their boundaries rest on natural frontiers. The law that we have rests on just such a frontier - it rests on the principle that involving ourselves in deliberately bringing about the deaths of others, for whatever reason, is unacceptable behaviour. To create exceptions, based on arbitrary criteria such as terminal illness or mental capacity, is to create lines in the sand, easily crossed and hard to defend.

27. No convincing case has been advanced as to why these important considerations should be set aside. Moreover, for the reasons we have set out above, Lord Falconer's bill does not pass the public safety test.