



Assisted Dying

Conclusions of the working party of the Association of British Neurologists

April 2011

Summary

In January 2011, Council of the Association of British Neurologists approved, by a substantial majority, the conclusions of a working group that in the context of severe disability and a neurological condition likely to prove fatal:

- **Administering medication with the intention of providing symptomatic relief even if this has the secondary effect of shortening life is consistent with good medical practice**
- **Interventions should not be given with the primary purpose of causing death.**

These conclusions have broad but not unanimous support of the wider Membership. A document summarising issues considered by the working group is available on request.

Assisted dying for adults with neurological disease who have capacity

In January 2011, Council approved, by a substantial majority, the conclusions of a working group of the Association of British Neurologists (Alastair Compston [chair], Heather Angus-Leppan, Lionel Ginsberg, Martin Rossor, Neil Scolding and Biba Stanton) that in the context of severe disability and a neurological condition likely to prove fatal:

- **Administering medication with the intention of providing symptomatic relief even if this has the secondary effect of shortening life is consistent with good medical practice**
- **Interventions should not be given with the primary purpose of causing death.**

The document that follows represents a summary of the issues considered by the working group and can be used to endorse and explain their conclusions which have broad, but not unanimous, support of the wider Membership.

1. Purpose of the statement

The Association of British Neurologists recognises that, by nature of the diseases for which neurologists take responsibility, the Association may be asked to offer an opinion on the general issues of assisted dying.

The aim of this paper is to assist representatives of the Association and its members in responding to enquiries from the public and individual patients with 'capacity' on the issue of assisted dying. In preparing a statement on this topic, the working party has sought advice from individuals with expertise on the relevant professional and ethical issues. Views have been sought from those thought likely to have opinions on both sides of the debate. The statement does not present an overall consensus; and it is not endorsed by some members of the Association.

Various terms are used to describe the situation in which a third party is involved in assisting an individual to die and, in the case of a doctor who intervenes or influences management to this end, physician-assisted dying. In this paper, the terms 'assisted suicide', 'assisted dying', 'physician-assisted dying *or* suicide' and 'euthanasia' are used interchangeably, reflecting the wording of relevant documents or statements to which we refer.

2. Background to the current debate on assisted dying

Assisted dying has assumed a prominent position in public debate over the past decade, with repeated initiatives aimed at introducing new legislation, and high-level media coverage of court cases and individuals from the United Kingdom attending, for example, the 'Dignitas' clinic in Zurich, Switzerland. It is appropriate, and perhaps a safeguard for society, that the medical profession brings to this debate its own experience in the assessment of evidence and formulation of opinion on matters where life and death decisions have to be made.

The working party recognizes that there may have been a change in public opinion on this matter in recent times with individuals who were formerly strongly opposed now leaning towards the acceptance of physician assisted dying, and even in some cases towards the acceptance of voluntary euthanasia. Conversely, others have reflected on the complex issues and experience of assisted dying in other jurisdictions and are now more opposed than before to alterations in legislation and medical practice in the United Kingdom. Some consider that a change in position is neither necessary nor appropriate, especially in the setting of modern palliative care; others that it is not possible to draft legislation free from

ambiguity and potential mis-application. A summary of some key events in this debate is set out in the Appendix to this paper.

3. Is it desirable for any one professional organisation to propose a generic position for use by its membership in discussions on assisted dying?

The issue of assisted dying touches on many personal and subjective aspects of compassion, free-will, autonomy, ethics, dependence and dignity of the individual, and the general principles of pastoral and clinical care in medicine. Therefore, it might be argued that it is unhelpful for any one professional organisation to declare a position, claiming overall consensus of its membership, however many caveats are used in formulating that statement. But contemporary society looks to experts and to the professions for information and guidance in these complex areas. Most neurologists are only occasionally involved with end-of-life management; others, by nature of sub-specialty interest, more often. But experience of progressive neurodegenerative diseases that may eventually prove fatal, and on which individuals and their carers seek advice, does place particular responsibility on the Association of British Neurologists to formulate a position, and for its representatives to deal with legitimate enquires on assisted dying from a carefully considered position.

4. Is it ever appropriate to accelerate the process of dying?

Careful consideration is required on how best to respond when an individual with capacity and incurable neurological disease requests assisted dying. The challenge is how to balance respect for autonomy of the individual with professional or personal views on dignity and the value of life, and without stepping outside the law as it currently stands. Whereas the Hippocratic Oath states: "I will give no deadly medicine to any one if asked, nor suggest any such counsel", the modernised version proposed by the British Medical Association (1997) states: "I recognise the special value of human life but I also know that the prolongation of human life is not the only aim of healthcare".

There are two main arguments in favour of endorsing the participation of doctors in assisting people to die. First is the issue of autonomy. This is the right of the individual to choose and decide their own fate. By this analysis, the concept of autonomy extends to decision-making over the 'right to die'. It is for patients alone to decide whether their life is worthwhile, and not for others to over-ride this judgment. Secondly, respect for human dignity strengthens the case for endorsing autonomous decisions. It follows that, in a democratic society, legislation should enable the development of appropriate facilities in the United Kingdom no longer making it necessary for individuals to travel and seek the assistance of more enlightened communities. The right of autonomy is closely linked to the view that it is merciful to acquiesce with the stated desire of the individual to die in the context of intolerable suffering that cannot be alleviated and in which, by nature of disease-related disabilities, that person is unable to act for him or herself. If Medicine is involved with 'birth and living', the profession should not shirk from participating in 'death and dying'. Helping people to die should therefore become part of the physician's brief.

The working group considers, however, that the crucial issue is the difference between active engagement in the process of dying and deliberately bringing forward that inevitable event. Therefore the working group has considered whether it is appropriate ever to advance the process of dying. Initially, consideration has been given to accelerating death through secondary effects (or 'double-effect') of pharmacological treatments administered primarily to manage distressing symptoms of neurological illness, especially breathlessness, pain and anxiety. The working group agrees with the long held position that prescribing analgesics and sedatives with the primary intent of relieving symptoms, even though such treatments may knowingly accelerate death, is appropriate and consistent with good medical practice.

Similarly the working group sees no reason to dissent from a second generally accepted principle in medical practice that there is not necessarily an obligation to institute or maintain treatments in a context where these are considered to be futile, or excessively intrusive and burdensome.

It follows that the request of the sentient patient with capacity to refuse the introduction of new therapeutic interventions should be respected, after full and detailed explanation by the caring physician, even if such refusal does inevitably accelerate death. This adheres to the principle of autonomy which is enshrined in medical practice and in law. However, the principle of autonomy does not extend to enforcing third-party participation in the 'right to suicide' of the individual, with which the doctor must comply.

Against that background, the question of withholding or withdrawing measures required for the maintenance of physiological functions *per se* in the individual who has capacity is much more complex. The working group considers this to be the most difficult issue on which to formulate a view. In this context, the life-supporting measures of ventilation, hydration and nutrition have each been considered.

Ventilation. It is, of course, common and accepted practice to withdraw assisted ventilation in the context of brain stem death. But the conflict of respecting autonomy and preserving life comes into particular focus in situations where the person with capacity, dependent on a ventilator, requests withdrawal of assisted ventilation – perhaps under circumstances where the clinical context has changed since the institution of ventilation, or the decision to ventilate was taken without full consideration of the longer-term implications of that management. Furthermore, situations may arise in which strong arguments are advanced that the original decision to ventilate the patient was ill-judged, or the individual regrets having allowed that intervention to be instigated. The General Medical Council has recently re-issued guidelines on this point. This situation has also been the subject of legal judgement (see Appendix).

These considerations are especially relevant to the case of Ms B, in whom it was judged unlawful trespass for doctors to have persisted with ventilation against the patient's wishes (see Appendix). However, the group has concerns about complying with the request to withdraw measures that directly support ventilation, once instituted, knowing that this will inevitably terminate life. In deciding how to proceed in the individual case, the working group recognises that discontinuing ventilation on the basis that this is futile and burdensome may subsequently require the management of distressing symptoms requiring sedation and other forms of management that amount to assisted dying through the mechanism of secondary effects. Fortunately this situation is very rare, and it would seem appropriate to seek advice from the courts, within the appropriate jurisdiction, if it arises.

The working group considers it important to emphasise the distinctions between:

- Agreeing to withdraw ventilation
- Maintaining the respiratory *status quo* knowing that this may not be adequate, and managing associated symptoms in the most appropriate way
- Electing to institute new life-supporting interventions, such as tracheostomy, needed to improve maintain adequate ventilation
- Deciding not actively to manage medical complications resulting from interventions or methods for assisting ventilation if already in place.

Hydration and nutrition. The working group considers that doctors have a duty to maintain basic care through the provision of fluids and nutrition. Accepting the principle that food and fluids may reasonably be withheld or withdrawn is seen as potentially open to misinterpretation and abuse. The patient with chronic neurological disease electing to starve or not to maintain fluid balance should be encouraged to eat and drink using the usual methods of swallowing; but not coerced into the use of a nasogastric tube or percutaneous gastrostomy if opposed to those forms of administering food and water (see also General Medical Council guidelines: 2010; paragraphs 47-49, and 109-125).

The working group does not consider that intervention is appropriate if, in the context of an expressed wish to refuse further active therapy, imbalances of nutrition and fluid have already led to a life-threatening condition such as acute renal failure. In this and equivalent situations, management is no longer a matter of maintaining physiological homeostasis but now involves the decision to treat a complication of the underlying neurological disorder. Any such management can reasonably be withheld.

Simply stated, in the context of the patient with capacity, the working group believes that there are differences between maintaining basic physiological functions by all reasonable means; electing not to introduce treatments needed to recover or maintain bodily functions that have become abnormal; and prescribing treatments for medical complications merely in order to prolong life.

5. Should doctors be actively involved in the public debate on a change in legislation towards establishing facilities for assisted dying in the United Kingdom?

The working group recognises that, if changes are set to occur, arguments can be offered for and against organising and arrangements for assisted dying in the United Kingdom rather than interacting more passively with facilities that lie outside our jurisdiction.

In general, lay attitude appears inversely related to the perceived proximity of having to make a decision on assisted dying. Surveys indicate that the greatest support for euthanasia is amongst healthy young males, for whom the expectation of needing to request assisted dying may seem remote; conversely, the groups most opposed and unsure on the propriety of a change in legislation are the disabled and elderly (EJ Emanuel *et al.* Attitudes and desires related to euthanasia and physician-assisted dying among terminally ill patients and their caregivers. *Journal of the American Medical Association*: 2000; 284; 2460-2468). The decision to choose euthanasia or physician assisted dying in the Netherlands is linked to higher levels of education, lack of religious belief and being able to die at home rather than perceptions on quality of care or altered mood.

Some organisations in the United Kingdom representing patients with incurable neurological diseases have elected not to express an opinion on assisted dying taking the position that choice lies entirely with the individual. That is also the view of some members of the Association of British Neurologists. However, the working group agrees that, however difficult and personal the issues, neurologists do have a responsibility to inform the debate on how best to shape emerging attitudes and any altered arrangements for assisted dying that may occur.

It is important, wherever possible, to retain the confidence of every patient - neither distancing the specialty from individuals who support a change in legislation by failure to address the issue nor abandoning individuals who seek advice to the arguments of pressure groups and articulate lobbyists. Individual views may appear to carry authority and polarise opinion but without necessarily being based on reliable evidence. For example, against the background of declared opposition to legalizing assisted dying in the United Kingdom by the majority of the membership of the Royal Colleges of Physicians and of General Practitioners and the British Medical Association, the statement that "most opponents of assisted dying are in a minority driven by faith" is unhelpful ([Lord] Joel Joffe: *The Times*, December 16th 2009).

Notwithstanding the damage done by a few notorious examples, patients expect to approach any doctor confident in the knowledge that actions towards intentionally accelerating their death will not happen. But it follows that neurologists must be prepared to discuss the issue of assisted dying, be sufficiently informed to explain the legal position, and make clear if their advice reflects strongly held personal views. Patients place confidence in knowing that professional guidance and support are fully informed and will not be misunderstood. The working group considers this to be a mutually protective context essential for

intimate discussion and appropriate pastoral care. But, in turn, this does require the membership of the Association of British Neurologists to engage with the debate.

The working group considers that participating in such discussions on assisted dying should not, of itself, compromise freedom of the individual practitioner. Even if it becomes policy that assisted dying is made available in the United Kingdom, this does not require active involvement in that process by any one member of the medical profession. The position is similar to that adopted by gynaecologists opposed to changes in legislation relating to abortion. Any doctor may distance him or herself from active participation in procedures that undermine his or her moral and ethical principles. It would never be appropriate to propose uniformity of behaviour, or active involvement amongst individual members of a particular specialty, even if legislation and the views of society were to change.

6. Is it possible to introduce assisted dying procedures that are fail-safe with respect to mistakes or altered intentions?

In the Netherlands, it is necessary for the patient requesting assisted dying to convince a physician that prolongation of life is unbearable. Further discussions then take place. If there is mutual agreement, the patient must then consult independently with another doctor who has specialist training in this area. The second doctor confirms or makes a provisional decision to proceed with assisted dying subject to further consideration by the patient and the physician who is directly involved. Failure to comply with the required procedures or document the process adequately leaves doctors liable to prosecution. Any Dutch physician has the right to opt out of active involvement in assisted dying. But whilst these precautions ensure much care in establishing the patient's intentions, they do not necessarily fully address the issue of coercion.

Those who offer advice to individuals considering assisted dying may have financial and related conflicts of interest. Vulnerable individuals may feel that they should relieve others of the burden of care or release assets that they control in life. There also may be a persuasive element through the provision of relative calm and apparent propriety in placing the management of assisted dying in a licensed facility that (for those who are able) suicide does not offer. Arguably, the endorsement emanating from legal and societal support for euthanasia may be far more influential than an altruistic decision taken by the patient in order to relieve others of the burden of care, or active encouragement by a third party having an undeclared vested interest in the patient's demise.

In addition to the concern that patients with neurological disease who are depressed or experiencing acute complications of uncertain prognosis should not use these services, the working group has concerns over the issue of mistaken intention; and the related problem of a change in attitude as the affected individual adjusts to increasing disability and resets his or her views on quality of life.

Not every clinical diagnosis is invariably secure. The nature of neurological illness involves additional uncertainty relating to the course of that illness and future availability of effective treatments. Prognostication is notoriously fallible especially when offered early in the course of a neurological illness that may run a protracted and unpredictable clinical course over several years.

7. Views of the membership of the Association of British Neurologists

It would be surprising if one view existed on such a complex set of issues amongst all neurologists practicing in the United Kingdom. Doctors who are frequently involved with end-of-life management have much greater experience of the complex circumstances that may arise. Of those providing written comments (approximately 25% of the Membership of the Association of British Neurologists, full and associate members), 14% have major reservations or are strongly opposed to the conclusions of this statement; 86% are fully supportive. The views of the remainder, the silent majority, are assumed to be neutral or supportive and not strongly in opposition. The most prevalent reasons for disagreement are:

- Concern that formulating a view on assisted dying is not a matter for the medical profession
- The professional view violates the rights of the individual and compromises autonomy
- A policy statement represents restrictive practice for the individual physician
- The present need for individuals wishing to die in the context of chronic illness to travel abroad is not humane and must change
- Guidelines cannot be detached from the pre-conceived ideas of their authors, and are therefore not fully motivated by concern for the individual patient
- Palliative care can never obviate the need for physician-assisted dying.

8. Summary

The conclusions that follow should be read in the context of the preceding text. They express uniformity of behaviour in situations that are clearly complex, sensitive and often ambiguous. But for the purposes of clarity, the arguments for and against a particular course of action are not repeated:

- It is the duty of the doctor to manage the end of life with sensitivity and dignity
- The individual who places their trust in Medicine as a caring profession should not be let down
- Mistakes with respect to the nature and outcome of illness may occur, especially early in the course of neurological conditions
- Personal attitudes to illness and dying may change as disability increases
- Withholding or withdrawing drug treatments and therapeutic interventions for an underlying disorder or its medical complications that are considered medically futile or excessively burdensome is consistent with good medical practice
- A doctor must use all reasonable means to maintain physiological functions that support life, must encourage the patient to do so, and must not compromise these either by act or omission.
- In the rare situations where the patient requests withdrawal of treatment or support of essential physiological functions, the courts should be consulted
- Administering a substance, medication or procedure with the intention of providing symptomatic relief even if this also has the effect of shortening life is consistent with good medical practice
- Interventions should not be given with the primary purpose of causing death even in the context of severe disability and an invariably fatal neurological condition and however merciful such an act may appear to be
- Many experts do not consider that legislation could safely be drafted in the United Kingdom that would protect the individual from the vagaries of convenience, coercion and mistaken intent
- The working party is opposed to any change that makes assisted dying an option within the legislation of the United Kingdom and that view is supported by most members of the Association of British Neurologists expressing an opinion
- Improved services for palliative care should be developed to improve end-of-life management.

Appendices:

[i] Assisted dying and the medical profession

The House of Lords' Select Committee on Medical Ethics, under the chairmanship of Lord Walton, reported on 'Euthanasia' in 1994. The medical, dental, nursing and legal professions and ethicists were represented; membership included individuals from each political party and cross-benchers, and was drawn from several religious denominations. On all but one issue, consensus was reached that "the right to refuse medical treatment is far removed from the right to request [or expect] assistance in dying". Whilst sympathetic to the circumstances of individual cases, the committee concluded that these could not be separated from the interests of society as a whole. The committee was not persuaded that any of the arguments it heard were "sufficient reason to weaken society's prohibition of intentional killing". Nor were those members of the committee, who visited facilities for assisted dying in the Netherlands, and spoke with individuals directly involved, convinced by the arguments they heard. The committee addressed the issue of coercion and concluded that "it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary and hence that any liberalization of the law in the United Kingdom could not be abused". They endorsed the use of medicines for symptom relief even if these accelerate dying through double-effects. They supported withdrawing or limiting treatments that had become burdensome and served no useful purpose other than prolonging life. They advocated the further development of services for palliative medicine. They were unable to reach consensus amongst themselves on the propriety of withdrawing food and fluids: "in the end, we concluded that this question is one which need not, and indeed should not, usually be asked".

In 2001, the Royal College of Physicians established a working group on euthanasia. This noted "the profession's established view that acts motivated by a clear intention to end a patient's life cannot be justified on ethical grounds" and concluded that "there is no current reason for abandoning" this view. The College re-affirmed this position in 2003 when Lord Joffe's first Assisted Dying Bill was proposed. In 2004, Lord Joffe introduced a revised second bill that led to further discussion within the Royal College of Physicians. It now became apparent that there was no internal consensus, and the College declared a position of "neutrality" – seen as a shift from former opposition by the pro-euthanasia lobby and thereby representing support for its position.

Many ordinary members of the College expressed concern at their lack of involvement in reaching this highly publicised new position. In response, the RCP conducted a consultation exercise in 2006 on the question "*(We) believe that with improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed.*" The response was a 73% majority in favour, i.e., opposing a change in the law. It was then suggested that the wording of the question was biased; a second exercise was conducted with a question worded by Lord Joffe himself: "*Do you believe that a change in legislation is necessary for the small number of terminally ill patients for whom palliative care does not meet their needs?*". The response was almost identical. The Royal College of Physicians therefore re-affirmed its former position that a change in the law regarding assisted dying could not be supported.

Near-identical sequences of events evolved within both the Royal College of General Practitioners and the British Medical Association. Both bodies also altered a former position of opposition through processes subsequently challenged on the grounds of not being fully representative. In each case, formal consultation followed and showed there to be no change in the profession's long established view against a move towards legislation allowing assisted dying. The BMA, in response to the Director of Public Prosecution's *Draft Guidance on Assisted Dying*, recently re-affirmed its opposition.

A comparable process may now also be unfolding at the Royal College of Nursing (RCN). In October 2009 the RCN declared a change in its longstanding position of opposition to assisted dying to one of neutrality, following a poll of 175,000 of its 390 000 total membership. (Of the 1200 respondents, 49% supported a change in policy in favour of assisted dying and 40% opposed.) Opposition to this was then widely expressed. The Nursing & Midwifery Council (NMC), the statutory nursing body and regulator for nursing and midwifery professions, has maintained the position that assisted dying remains illegal, and that nurses should play no role in its promotion or facilitation.

The working group learned, informally, that in the Netherlands, where assisted dying is legal and doctors actively involved in the process, the frequency of these events is reducing. Evidently, many doctors regret that the medical profession was not more actively involved in debating the issues with ethicists and politicians who championed this decision, and in advising on the legislation when this was being drafted and enacted. However, for example, around 20% of patients with motor neurone disease in the Netherlands do opt for euthanasia or physician-assisted suicide and this proportion did not alter significantly between 1994 (20%) and 2005 (17%: Maessen *at al.* Trends and determinants of end-of-life practices in ALS in the Netherlands. *Neurology* 2009: 73; 954-961). The procedure was

audited five years after introduction of the Euthanasia Act in the Netherlands (van der Heide *et al.*, End-of-life practices in the Netherlands under the Euthanasia Act. *New England Journal of Medicine* 2007: 356; 1957-1965). 1.7% of all deaths over that period were attributed to euthanasia and 0.1% occurred as the result of physician assisted dying using neuromuscular relaxants, barbiturates or opioid analgesics. Both rates were lower than before the introduction of legislation (2.6% and 0.2%, respectively). These reductions were attributed to the impact of improved palliative care. Death through secondary effects of medication, given for relief of symptoms without the request of the patient, occurred in 0.4%. An alternative explanation is that the apparent reduction in declared rates of assisted dying "may have resulted from the increased application of other end-of-life interventions, such as palliative sedation", the latter not being classified as euthanasia, and being adopted by (for example) 15% of patients with motor neurone disease. Furthermore, around 20% of acts of physician-assisted dying in the Netherlands are considered to be secondary effects of medication and so not subject to formal notification. During its visit to the Netherlands, the House of Lords committee estimated that around 1000 patients per annum, considered not to have capacity (usually in the context of dementia), were subjected to euthanasia following permission granted by relatives, lawyers and attending physicians; and that this arrangement was open to misinterpretation.

[ii] Assisted dying: the current legal position

The General Medical Council issued guidelines for doctors in 2002 on *Withholding and withdrawing life-prolonging treatments*, developing further advice already published as part of *Good Medical Practice*. These were updated and amended in *Treatment and care towards the end of life: good practice in decision making* (2010). These documents take as their starting point the issue of whether or not all means at their disposal should be offered by doctors to prolong life under all circumstances; who should be involved in such decisions; the legality of withholding or withdrawing treatments; the responsibility doctors have to keep up to date on clinical advice in this area; and the alignment of doctors' judgments with those of society at large. The guidance confirms that the law prohibits euthanasia and assisted suicide. It emphasises that patients with capacity have a right to refuse treatment even when that decision accelerates death, and that doctors are legally bound to respect these decisions. Conversely, there is no legal or ethical obligation on a doctor to institute a treatment that is considered not to be clinically indicated. Faced with that dilemma, the doctor should involve another medical practitioner or take legal advice. The decision to start a treatment should not be adversely influenced by anticipating difficulties that might arise if it subsequently became clear that the treatment should reasonably be withdrawn. The sections dealing with artificial nutrition and hydration (paragraphs 22-24 and 78-83) focus on when to start artificial means of nutrition and hydration; and the propriety of stopping these after a trial period, when the patient is deemed to be close to death, or – in the case of chronic disorders – where the prognosis is poor and the means of maintaining nutrition and hydration burdensome or constituting an additional cause of suffering. The guidance indicates the need to take independent professional or legal advice if there is dispute between members of the healthcare team. Conspicuously absent from the document is mention of how a doctor should proceed in circumstances where the patient with capacity requests that means of maintaining nutrition, hydration or ventilation are withdrawn, and the doctor does not support that request.

In a High Court judgment from 2002, Dame Elizabeth Butler-Sloss found that an NHS Trust (acting for the doctors involved) committed unlawful trespass in refusing the request of Ms B, who was tetraplegic following recurrent haemorrhage into a high spinal cord cavernoma and judged over the critical period to have had full mental capacity, to withdraw artificial ventilation upon which she was entirely dependent. A strategy for gradual weaning with symptomatic control of any resulting distressing symptoms was discussed but refused by Ms B. Dame Elizabeth Butler-Sloss considered that the 'weaning process appears to have been designed to help the treating clinicians and the other carers and not in any way designed to help Ms B. If the one-way weaning process were to be carried out as suggested by the doctors there would be a risk that she would die in discomfort and possibly in pain, even though that is not what they intended. It was obviously an unrealistic and unhelpful programme' (www.courtservice.gov.uk/judgmentsfiles/j1075/B_v_NHS.htm). That judgment was challenged on the basis that it failed to distinguish between the right to refuse treatments because they are futile or burdensome and refusal that had putting an end to life as its primary intention. In recognising the right to commit suicide by refusing treatment and requiring doctors intentionally to assist that act, the judgment was seen as inconsistent with the existing law on assisted suicide (J Keown, *Journal of Medical Ethics* 2002: 28; 238-9).

Through her solicitors, Ms Debbie Purdy (who has multiple sclerosis) formally requested the Director of Public Prosecutions to set out the circumstances in which her husband would be prosecuted if, at some point in the future, he was to assist her to go abroad for assisted dying in a jurisdiction where the practice is legal. The Director of Public Prosecutions refused her request in the High Court, and her appeal was subsequently rejected by the Court of Appeal. Subsequently, however, the House of Lords, arguing that the prosecution of assistants, regardless of the place of the

suicide, would undoubtedly have been the intention of those who framed the 1961 Suicide Act, allowed Ms Purdy's further Appeal and required the Director of Public Prosecutions 'to prepare an offence-specific policy identifying the facts and circumstances which he would take into account when deciding, in cases such as Ms Purdy's, whether or not to prosecute'.

Judgment in the cause of R (on the application of Purdy [Appellant]) v the Director of Public Prosecutions was heard by Lord Phillips of Worth Matravers and Lord Hope of Craighead. Their legal opinions are detailed and carefully expounded. They do not set out the circumstances and conditions that might tend towards a decision to prosecute an 'aid' in the case of an assisted dying carried out overseas; rather they consider the more fundamental primary question of whether the aid should be subject to the UK legal process at all – given that the act of suicide is executed outside the UK. They set the question in an historical context, drawing on this legal background in a conventional way to reach their conclusions.

Lord Phillips of Worth Matravers concentrates on the question of "territorial jurisdiction over criminal offences" – i.e., whether acts committed outside the jurisdiction by United Kingdom citizens expose that person to prosecution in a British court under domestic legislation. His argument starts from the position that the Suicide Act of 1961 decriminalised suicide but explicitly did not decriminalise assisting suicide: the latter remains an offence. He then points out that under extant law, "a person who was present at the suicide of another and who assisted or encouraged the suicide, was guilty of murder as a principal in the second degree". He then mentions, however, that "as a general rule, English criminal law does not extend to acts committed outside the jurisdiction" – but, importantly, that "since the time of Henry VIII, murder [including manslaughter] has been recognised as an exception to this rule." He therefore concludes that "if a British subject accompanies a relative, who is also a British subject, to Switzerland and assists in Switzerland the relative to commit suicide.... that person will under English law commit the crime of murder and will be subject to the jurisdiction of the course of England and Wales in relation to that offence."

Lord Hope of Craighead explores a different aspect of the same question. He considers the situation of an offence that consists of more than one component part, the initiation occurring in a country or jurisdiction different to that in which the act is completed: under these circumstances, which might be the relevant jurisdiction? He indicates that in order to protect "the vulnerable or the easily led" the principle must apply that an act commenced in the United Kingdom falls within the compass of English law; and he cites much in the way of precedent and accepted legal teaching in support of this.

Both Law Lords place emphasis on interpreting the *intention* of those who framed the 1961 Suicide Act; both argue that the prosecution of assistants, regardless of the place of the suicide, would undoubtedly have been that intention. These considerations form a core of their judgment and subsequent requirement of the Director of Public Prosecutions to respond to Ms Purdy's original request.

In response to these events, a *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* was issued for consultation by the Director of Public Prosecutions in draft form (September 2009), subsequently amended and the final policy put into effect from February 25th 2010. In summary, the Crown Prosecution Service requires the consent of the Director of Public Prosecutions before an individual is prosecuted under section 2 of the Suicide Act (1961) amended by Section 59 and Schedule 12 of the Coroners and Justice Act 2009, for the offence of encouraging or assisting suicide – directly, by intent, or involving another person - through activity in England or Wales wherever in the world that suicide, or the intention to commit the act, subsequently takes place. Two conditions are to be met: evidence that an offence was committed and a decision that prosecution is in the public interest. The Guidance points out that when an offence may have been committed, "it has never been the rule that a prosecution will automatically follow". Regarding the evidence, the Director of Public Prosecutions indicates that the police are obliged to investigate all cases of assisted dying: "it remains murder or manslaughter to cause the death of someone who wishes to commit suicide but is unable to do so"; and "even genuine and clear expressions of intent from someone who wishes to end his or her life" do not legally permit such acts of assistance. The "public interest" comments are the core of the document. Factors favouring prosecution relate to acting in circumstances where capacity and intention are in doubt: coercion and pressure to act were used; the person could have taken their own life without assistance; and evidence that assisting with suicide was motivated other than by compassion. Paragraph 14 reads: "[Public interest factors tending in favour of prosecution] The suspect 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". Factors tending against prosecution include: clear intent by the patient; acting entirely through compassion; evidence that the suspect played a minor role in assisting the patient to die, argued against assisted suicide or only acquiesced reluctantly; and that any mitigating circumstances were operative close to the time when assistance to die was provided.