Living and Dying Well

Keeping the law safe for sick and disabled people

Assisted Dying: The Law

By Charles Foster

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

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1. Introduction

'Assisted dying' is not a legal term. It has been coined by campaigners to mean giving assistance to people who are terminally ill and request it in order to end their lives, either by giving them lethal drugs to take themselves (assisted suicide) or by administering such drugs to them (euthanasia). Some think that 'assisted dying' is an offensive euphemism. Offensive or not, it is convenient .

2. Background

2.1 The law of murder

2.1.1 A person commits murder if he unlawfully kills another, intending to kill him or to cause him grievous bodily harm.

2.1.2 The qualification 'unlawfully' relates to various possible defences (such as self defence). None of those defences is relevant in the context of assisted dying. In particular it is not a defence to murder that the victim consented to his death.

2.1.3 Accordingly 'euthanasia' is simply murder.

2.1.4 Murder attracts a mandatory sentence of life imprisonment. This means that the defendant is released when the Home Secretary, acting on advice, orders his release. The trial judge sets a minimum term, before which release is not considered.

2.1.5 Some of the most famous cases of euthanasia have been charged as cases of attempted murder. The best example is the case of R v Cox (1992). Dr. Cox killed his long standing patient, Lilian Boyes, by injecting her with potassium chloride. Potassium chloride had no therapeutic indication. It stopped her heart. Dr Cox made no secret of his intention to kill. He was charged with attempted murder, ostensibly on the grounds that there might be some doubt about the causal link between the injection and the death. In fact there was little doubt. A charge of attempted murder may have been levelled because of prosecutorial sympathy. Attempted murder does not carry a mandatory life sentence: all sentencing options are open. It may also have been thought that a jury, reluctant to convict Dr. Cox of an offence that carried a life sentence, would be more ready to convict of an offence in relation to which the judge had a wide discretion as to sentence.

2.1.6 The doctrine of 'double effect' is sometimes relevant in allegations of medical murder. The doctrine relies on a distinction between foreseeing a consequence and intending it. The classic example is the fatal administration of analgesic opiates to a dying patient. A doctor might give a dose to the patient that he foresees might kill him, but intending only to relieve the patient's pain. A doctor with this intention is not guilty of murder: he does not have the relevant intention.

2.1.7 The doctrine of 'double effect' is sometimes said to be an example of the sort of intellectual dishonesty in which the law must engage unless and until Parliament has the decency to enact an assisted dying law. The argument goes: 'Euthanasia happens all the time anyway. It is shrouded beneath the law of 'double effect'. Better to get the

practice out into the open, where it can be properly regulated.'

2.1.8 The argument is misconceived. First: it is simply not the case that 'double effect' is regularly invoked to excuse de facto euthanasia. The science of palliative medicine has advanced considerably in recent years, to the point where the proper administration of analgesics does not put patients' lives at risk. And second: the foresight/intention distinction has demonstrated its utility elsewhere in the law: it is not simply a ruse to excuse murderous doctors. Its presence in the law, like the acts/omissions distinction, reflects a generally held intuitive belief that there is a real ethical difference between the two elements.

2.2 The withdrawal of life-sustaining treatment

2.2.1 A competent adult has the right to refuse any treatment, including life-sustaining treatment.

2.2.2 This is illustrated well by the case of Miss B. She was paralysed from the neck down as a result of a bleed into her cervical spinal cord. She was maintained on a ventilator. She asked for the ventilator to be switched off. The only questions for the court were: (a) Was she capacitate? and (b) did she sufficiently understand the consequences of her request being acted on? The answer to both questions was yes. Accordingly the continued ventilation was unlawful. The ventilator was switched off and she died.

2.2.3 In the case of incompetent adults, the question to be asked in relation to any proposed treatment decision is: 'Is it in the patient's best interests?' Those interests are wider than the 'medical best interests'. Life sustaining treatment will only be lawful if it is in the patient's best interests.

2.2.4 The case of Tony Bland, which concerned the withdrawal of life-sustaining treatment, brought into sharp focus the distinction between acts and omissions.[i] That distinction is important for the wider assisted dying debate.

2.2.5 Tony Bland was crushed on the terraces at Hillsborough stadium. He went into permanent vegetative state (PVS). He could breathe, but had to receive artificial nutrition and hydration (ANH) through a feeding tube. It was decided that he was alive in the eyes of the law, but that to continue with the ANH (which was deemed to be medical treatment) was not in his best interests. It was therefore proposed to withdraw the feeding tube and stop the ANH. Why was this not murder? Because, said the House of Lords, the cessation of ANH was best characterised as an omission, not an act.

2.2.6 Many feel intuitively that there is a real moral distinction between acts and omissions, and that the law's insistence on that distinction is correct. It must nonetheless be acknowledged that there are various exotic thought experiments that can be used to demonstrate that in some very special circumstances active killing can be less blameworthy than killing by omission. These circumstances are unlikely to be replicated in the context of assisted dying. The distinction has done a fairly workmanlike job in the law.

2.2.7 There is an important legal difference between the case of Miss B (withdrawal of

life sustaining treatment is not only lawful but mandatory) and that of an equally capacitate patient (whom we will call X) who asks for and is given a lethal injection (this will be murder). There is an important factual difference too. What killed Miss B was not really the withdrawal of treatment, but the bleed into her spinal cord. What kills X is the injection. In the case of Miss B there is no killing at all: in the case of Y there is. Good ethics follows the facts, and should frown on the killing of X. Good law, in turn, should follow the ethics. In the existing law of England it does. A breakdown of the acts and omissions distinction would send damaging ripples throughout the law. Damage would be caused a long way from the arena of assisted dying.

3. The Suicide Act 1961 and the offence of assisting suicide

3.1 The Suicide Act 1961 decriminalised suicide.

3.2 Much of the motivation for the Act came from doctors who recognised that it was not in the interests of a patient who had attempted suicide to face subsequent investigation by the police, and possible prosecution.

3.3 When the Suicide Bill was being debated in Parliament, Parliament was reassured that the decriminalisation did not represent any change in the distaste with which suicide was viewed by society. The Joint Under-Secretary of State for the Home Department, moving the Suicide Bill's Third Reading, said:

'Because we have taken the view, as Parliament and the Government have taken, that the treatment of people who attempt to commit suicide should no longer be through the criminal courts, it in no way lessens, nor should it lessen, the respect for the sanctity of life which we all share. It must not be thought that because we are changing the method of treatment for those unfortunate people, we seek to depreciate the gravity of the action of anyone who tries to commit suicide.....' [ii]

3.4 He went on:

'I should like to state as solemnly as I can… that we wish to give no encouragement whatever to suicide… I hope that nothing that I have said will give the impression that the act of self-murder, of self-destruction, is regarded at all lightly by the Home Office or the Government.' [iii]

3.5 Section 2(1) of the Suicide Act created an offence of assisting suicide. It has subsequently been amended by the Coroners and Justice Act 2009 [iv]. The elements of the offence are now:

- doing an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

- intending that act to encourage or assist suicide or an attempt at suicide.

No actual or attempted suicide is necessary for the offence to be complete.

The encouragement/assistance can be given by a provider of 'information society' services – typically on a website. [v] [vi]

3.6 A prosecution under s. 2(1) requires the consent of the Director of Public

Prosecutions. [vii]

3.7 This is a very unusual offence, since it makes it unlawful to encourage or assist someone to do something that is not in itself unlawful. Part of the rationale for this apparent anomaly has already been indicated. Suicide is to be discouraged, but it is undesirable for several reasons (medical reasons prominent among them) for failed suicide attempters to face the criminal process.

3.8 The maintenance on the statute book of the offence of assisting or encouraging suicide serves several functions. First, it indicates that society values human life. Second, it indicates that the taking of human life is normally to be regarded prima facie as a wrong. Third, it is an expression of the UK's obligation under Article 2 of the European Convention on Human Rights (the 'right to life') to take positive steps to safeguard human life. Fourth, it recognises that people contemplating suicide will often be psychologically vulnerable and require specific protection against pressures from within themselves and from outside.

3.9 The offence is very wide. It is technically capable of being committed, for instance, if a taxi driver discovers en route that he is taking a patient to a place where she intends to commit suicide, seeks to dissuade her, but does not actually refuse to take her there. It is plainly undesirable that in such circumstances the taxi driver should face criminal sanction. A widely drawn offence is nonetheless desirable, since the circumstances in which blameworthy conduct can arise are very various. A widely drawn offence might be abused by insensitive or partisan prosecutors. It is for that reason that the DPP must specifically consent to every prosecution.

3.10 The DPP's policing of the way the offence is deployed seems to have worked well. There have been few prosecutions, and it is hard to think of cases in which the DPP's consent has been given to a prosecution that was obviously undesirable.

3.11 The fact that there have been few prosecutions does not begin to imply that the offence serves no purpose. The purposes have been set out at paragraph 3.8 above. One might argue that the fact that there have been few prosecutions (and relatively few investigations) indicates that the section is having its desirable deterrent effect.

3.12 There have been several recent calls for a change in the law to allow physician-assisted suicide. They have all been debated and rejected by Parliament.

3.13 Even the organisations campaigning for a change in the law (such as Dignity in Dying) recognise that there are some cases of encouraging and assisting suicide that should be met with a criminal sanction. It is unclear whether and if so how they say s. 2(1) should be reframed to allow that. It is hard to see how a significant reframing would not restrict the desirable elasticity of the section. It is also unclear what complaint if any they have with the way that the law has actually been used.

4. Legal milestones between 1961 and today

4.1 As palliative care has improved, the rhetoric and the legal language of those seeking a change in the law have changed. There is in theory no pain or distress that cannot be palliated, since sedation to unconsciousness is always an option if all other

palliative possibilities have been exhausted. It is extremely rare, at least in Britain where specialist palliative care exists, to need to resort to sedation to unconsciousness.

4.2 Accordingly courtroom efforts on behalf of pro-assisted-dying organisations have increasingly sought to establish that there is a right (often described in terms of autonomy) to meet one's death at the time, in the place and in the circumstances that one wishes. The English law is a very long way from this conclusion.

4.3 The language in which this contention has been increasingly framed is that of Article 8 of the European Convention on Human Rights. Article 8(1) reads: 'Everyone has the right to respect for his private and family life, his home and his correspondence.'

4.4 This is a very elastic article. It stretches to many parts of human life.

4.5 It is, importantly, a qualified, not an absolute, right. It is qualified as follows (8(2)):

'There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

4.6 Dianne Pretty, who had Motor Neurone Disease, sought to say that Article 8(1) extended to the circumstances of her death, and that that should compel the DPP to give her husband an immunity from prosecution under the Suicide Act if he helped her to die. The House of Lords held that Article 8 was not relevant to end of life decision-making, on the grounds that it dealt with how one lived, not how one died. [viii]

4.7 The European Court of Human Rights, considering Dianne Pretty's appeal from this decision, said that they were not prepared to exclude the relevance of Article 8 in end of life circumstances[ix]. In the case of Debbie Purdy the House of Lords decided that Article 8 did indeed apply to the end of life.[x]

4.8 This was an unsurprising and not particularly repercussive conclusion. It brings the UK law about the application of Article 8 to the end of life in line with the way Article 8 has been assumed to apply in other states that have signed the European Convention. It represents a very small incremental creep in the reach of Article 8 in the UK. The Strasbourg Court has not said that Article 8 *mandates* an assisted dying law in the signatory states, nor is it remotely possible that it will. There are three overlapping reasons:

(a) Article 2 of the Convention (the right to life) trumps Article 8 in all reasonably conceivable situations. The right to respect for one's private life, after all, presumes that one has a life to be protected. It will always be possible to say that provisions such as s.2(1) of the Suicide Act fulfil the state's obligation to protect the right to life. It will never be possible seriously to contend that Article 8 considerations should triumph over the Article 2 considerations.

(b) Article 8(1) is qualified by the considerations in Article 8(2). It will never be possible to say that the life-saving, vulnerable-person-protecting provisions of a law prohibiting assisted dying are plainly not provisions falling within the wider societal considerations

in 8(2).

(c) The Strasbourg court gives a wide 'margin of appreciation' to member states as to how they implement their Convention responsibilities. States' history, traditions and general ethos are all legitimate considerations in deciding on the width of that margin. In a matter as sensitive and as controversial as assisted dying will always be, it is inconceivable, even if points (a) and (b) above are ultimately found to be wrong, that the retention of something akin to s. 2(1) of the Suicide Act would not be found to fall squarely within the margin of appreciation.

4.9 The main consequence of the Purdy case was to require the DPP to formulate and promulgate the criteria he will use in deciding whether or not to prosecute someone for assisting or encouraging suicide. It is hard to believe that Debbie Purdy was ever in any real doubt about the prospects of her husband being prosecuted if he helped her to go to the Swiss Dignitas suicide facility: no Dignitas-type cases have ever been prosecuted, and the DPP had made it perfectly plain, in a set of criteria published on his website in the case of Daniel James, that someone in Mr. Purdy's situation was safe[xi].

4.10 Broadly, the final guidelines published by the DPP emphasise the relevance of the potential defendant's motivation, and downplay the relevance of the 'victim's' characteristics[xii].

4.11 It has already been observed that it is hard to see what complaint the advocates for a change in the law could have had in the light of the track record in England of prosecution for assisting or encouraging suicide. No plainly inappropriate prosecutions have been brought. In the light of the DPP's guidelines it is impossible to see why the campaigning organisations continue to exist. It is plain that no one will face prosecution who should not face prosecution. The law, meanwhile, continues to make an important declaration about basic principles, continues to protect the vulnerable, and continues to force would-be assisters or encouragers to consider their position very carefully.

Footnotes

i. Airedale NHS Trust v Bland [1993] AC 789

ii. Hansard: HC Deb 28 July 1961 vol 645: 1961(a): Cols 822-823

iii. Hansard: HC Deb 19 July 1961 vol 644: Cols 1425-1426

iv. See s. 59

v. See Schedule 12 of the Coroners and Justice Act 2009

vi. Sections 2A and 2B of the 1961 Act (inserted by the 2009 Act) expound the ingredients of the offence further.

vii. See s. 2(4)

viii. R (on the application of Pretty) v DPP [2002] 1 AC 800

ix. Pretty v UK [2002] 2 FLR 45

x. R (on the application of Purdy) v DPP [2009] 3 WLR 403

xi. Why Daniel James' death in a Swiss clinic was not a case for the prosecution,

The Times, 10 December 2008,
http://business.timesonline.co.uk/tol/business/law/article5315541.ece

xii. Policy for Prosecutors in respect of cases of encouraging or assisting suicide, Crown Prosecution Service, February 2010:
http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html