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Clear thinking on the end-of-life debate

The Assisted Dying Bill (HL Bill 6): A Critique

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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.
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LORD FALCONER'S ASSISTED DYING BILL (HL BILL 6)

Introduction

1. Lord Falconer's Private Member's Bill will have its Second Reading on 18 July 2014. The Bill proposes to legalise what it calls 'assisted dying'. In plain language, that means licensing doctors to supply lethal drugs to terminally ill patients who request them and who meet certain criteria. If the House is to consider such a major change both to the criminal law and to the principles that underpin medical practice, it needs convincing answers to a number of important questions.

2. Foremost among these questions are:

- What evidence is there that the law as it stands is not working as it should?
- Where are the safeguards in Lord Falconer's Bill?
- If the Bill were to be passed into law, how could its provisions be enforced?
- What are the implications of medical opposition to such practices?
- Where is the evidence that such laws work satisfactorily elsewhere?
- How can the Bill's provisions be reconciled with social attitudes to suicide?

Is the law working as it should?

3. In 2011 Keir Starmer QC, the then Director of Public Prosecutions (DPP), told Lord Falconer's 'commission on assisted dying' that "*the law works well in practice*"[1]. It is a criminal offence to encourage or assist another person's suicide, and the law holds penalties in reserve that are serious enough to make anyone minded to engage in such acts think very carefully before proceeding. But the law also requires the DPP to examine any case that occurs and to decide, in the light of all the circumstances, whether a prosecution is needed.

4. These two faces of the law (of sternness and compassion) are complementary. The law's prohibition and the penalties it holds in reserve provide an effective deterrent against maliciously-motivated assistance with suicide and ensure that the small number of cases that occur are generally those where there has been serious soul-searching and genuinely compassionate motivation and where any assistance given has been reluctant and, in many cases, marginal. These cases are not such as to call for prosecution and they are not prosecuted.

5. There is nothing unusual about the way the law on assisted suicide works. Mr Starmer told Lord Falconer's 'commission' that "*there is discretion for all offences whether to prosecute or not. This is a particular version of it. But it's not unique by any stretch of the imagination: it's the way our law operates*"[2]. We would not seriously contemplate licensing other criminal acts in advance and in prescribed

[1] Keir Starmer QC, Oral Evidence to Lord Falconer's 'commission on assisted dying', 2011
[2] Keir Starmer QC, Oral Evidence to Lord Falconer's 'commission on assisted dying', 2011

circumstances, though we may recognise that there could be exceptional situations where an act that is illegal is not deserving of prosecution. We expect the law to be maintained in its integrity to protect all of us and exceptional cases to be dealt with exceptionally. That is what happens now in the case of assisted suicide.

6. A law licensing assisted suicide would remove the all-important deterrent. Under the present law anyone minded to put pressure on another person to end their life has to reckon with a spotlight being shone on his or her actions and with any malicious or manipulative motivation or behaviour coming to light as a result. Under an 'assisted dying' law, on the other hand, there is little to deter anyone from exerting improper influence on someone to seek assisted suicide. The only risk being run is that the application might be rejected. The law that we have is not perfect - no law is that. But it is safer than an advance licensing system.

Where are the safeguards?

7. Lord Falconer's Bill requires that a person making a request for assisted suicide "*has the capacity to make the decision to end their own life*" and "*has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress*"[3]. But it mandates no procedures that an assessing doctor must follow in order to be satisfied that these conditions apply - like, for example, seeking specialist help to assess mental capacity or digging below the surface to see what lies behind a request. Without these procedures the Bill is without safeguards. It is the equivalent of putting up notices on a railway embankment to warn the public against trespassing but not putting any fencing in place to discourage or prevent people from wandering onto the tracks. The Bill relegates the question of safeguards to codes of practice, which "*the Secretary of State <u>may</u> issue*"[4] at some future date - but only **after** Parliament has agreed to legalise physician-assisted suicide. This begs the question: how can Parliament reach an informed decision on whether these practices can be safely legalised until it has seen what the safeguards are and considered whether they are adequate? The Bill is, in effect, asking Parliament to sign a blank cheque.

8. Lord Falconer has defended this approach by arguing that "*it is standard parliamentary procedure for Bills to focus on principles and for detailed procedure to support these principles to be developed in codes of practice*"[5]. But protecting the public is an important principle of all legislation. Providing safeguards for assisted suicide can hardly be regarded as 'detailed procedure'. We are not talking about tax law or planning law or traffic regulations here, but about legislation with (literally) life-or-death consequences. These are issues which cannot be kicked into the long grass for others to deal with at some point in the future.

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[3] Section 3(3)
[4] Section 8(1) (our underlining)
[5] Letter to Members of the House dated 16 July 2013

9. In any case the Bill already makes detailed provision for other, second-order matters, such as witnessing forms and recording assisted suicide deaths. Important as these matters are, they pale into insignificance alongside how the life-or-death judgements envisaged in the Bill are to be made. Yet on these the Bill is silent.

10. The Bill defines terminal illness as "*an inevitably progressive condition which cannot be reversed by treatment*" as a consequence of which the patient "*is reasonably expected to die within six months*"[6]. This definition encompasses not only illnesses, such as advanced cancers, which might be expected to result in death in the short or medium term, but also fluctuating long-term conditions like, for example, MS, Parkinson's and heart disease. People with these and other inevitably progressive conditions can live for many years but, where they are frail or have other co-morbidities, they could be reasonably expected to die within six months. The Bill therefore brings within its ambit a wider range of people than just those with end-stage terminal illness.

Enforcement

11. Just as there are no safeguards in the Bill to guide how doctors should make the life-or-death decisions that it envisages, so there is no provision to ensure that, if the Bill were to be passed into law, its provisions could be enforced. The Bill provides[7] that "*the relevant Chief Medical Officer shall monitor the operation of the Act, including compliance with its provisions and any regulations or codes of practice made under it*". But it makes no provision to enable such monitoring of compliance to take place - indeed, the bill does not even require a doctor prescribing lethal drugs to a patient to report the fact. No doubt this too is seen as a candidate for subsequent codes of practice or regulations. But, if Parliament is to satisfy itself that legalised assisted suicide will not be abused, it needs to see at least the shape of any arrangements for oversight.

12. In this and other respects Lord Falconer's Bill is significantly less robust than was Lord Joffe's 2005 Assisted Dying for the Terminally Ill Bill. Lord Joffe's Bill contained specific provisions under which a doctor who supplied lethal drugs to a patient was required to report his or her action to a monitoring commission, which in turn was required to confirm that the conditions of the law had been observed. Lord Joffe's Bill also required a doctor who had doubts about a patient's mental capacity to refer the patient for specialist assessment. Lord Falconer's Bill makes no provision in these vital areas.

Doctors and 'Assisted Dying'

13. One of the principal obstacles in the path of any 'assisted dying' system is the opposition of those who would have to put it into practice - doctors. The

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[6] Section 2(1)
[7] Section 9(1)

opposition of the BMA and the Medical Royal Colleges reflects the views of the great majority of practising doctors. In a recent survey of its members by the Royal College of General Practitioners 77 per cent of respondents wanted to see the College's opposition to legalisation maintained. It is facile to put such opposition down to medical paternalism. The reality is that doctors, unlike single-issue political campaigners, are aware at first-hand of the vulnerabilities of seriously ill people and recognise that there are factors beyond a patient's clinical condition - such as the pressures of a patient's domestic situation or depression - which may underlie a request for 'assisted dying' but which in most cases they are in no position to assess with any degree of accuracy. It is inevitable, therefore, that most doctors would decline to participate in any 'assisted dying' regime.

14. The result of that, as can be seen in Oregon, is that many people seeking physician-assisted suicide would have to find a minority of willing doctors knowing little or nothing of them beyond their case notes who, by reason of their selection for the purpose, might be inclined to see suicide as an appropriate response to terminal illness. Nor is there anything in the Bill to prevent shopping around until a desired second opinion is obtained. This problem of 'doctor shopping' arises because it is proposed to foist assisted suicide onto a profession the majority of whose members do not consider it to be a proper part of clinical care.

Are these laws working overseas?

15. First, we need to be clear that 'assisted dying' in one form or another is the exception rather than the rule in international clinical practice. Only three countries in Europe (the Benelux countries)[8] and three out of 50 US States (Oregon, Washington and Vermont) have chosen to go down this road.

16. Lord Falconer's Bill purports to be modelled on Oregon's law. In fact, though the basic parameters are the same (physician-assisted suicide for terminally ill and mentally competent people), in a number of respects Lord Falconer's Bill is less tightly-drawn than Oregon's - for example, it contains no requirement to refer applicants for specialist psychological assessment in cases of doubt and, as we have observed above, it includes no requirement for doctors to report. The proponents of 'assisted dying' here in Britain assure us that Oregon's law is working well and that there has been no abuse of its provisions. This claim is, however, little more than wishful thinking. Oregon's law contains no audit system to shine a light on how individual cases of physician-assisted suicide are being handled. The published annual reports are no more than statistical analyses, listing how many assisted suicide deaths have occurred, how old the deceased were, what their underlying illnesses had been and so on. There is no way of forming a view of the thoroughness or otherwise with which requests are actually being handled.

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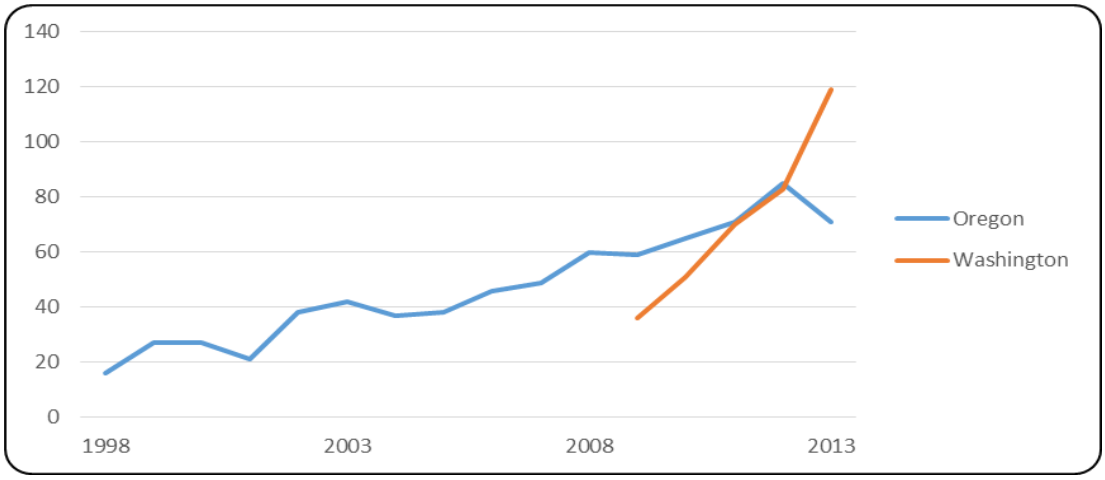
[8] Switzerland's assisted suicide law is *sui generis*. It dates from 1942 and does not constitute physician-assisted suicide.

17. Research has indicated that some clinically-depressed patients seeking assisted suicide in Oregon have been supplied with lethal drugs by doctors without being referred for specialist psychological assessment. The extent of this failure to comply with the law is not known. In the view of Oregon-based Professor of Psychiatry, Linda Ganzini, who led the research, its finding "*supports the need for more active and systematic screening and surveillance for depression to determine which patients should be referred for mental health evaluation".* Professor Ganzini has commented that the proportion of applicants for assisted suicide referred for capacity assessment in Oregon and Washington "*has remained very low and critics have called for mandatory mental health evaluation in all cases*"[9].

18. What the official annual reports do make clear is the upward trend in deaths from physician-assisted suicide since legalisation. Figure 1 shows the trends in Oregon and Washington - no data are currently available from Vermont.

Figure 1: Deaths from Physician-Assisted Suicide in Oregon and Washington



Oregon's 2013 figure takes no account of a large number of unresolved cases and is liable to upward revision in next year's report: the 2012 figure reported last year was similarly revised upwards in this year's report. As will be seen, the overall trend of assisted suicide deaths in both States has been upwards, with occasional dips in Oregon. Moreover, the recently-published statistical analysis for neighbouring Washington State shows a 43 per cent increase in such deaths between 2012 and 2013 alone. Washington's death rate from legalised assisted suicide has more than tripled in four years. Oregon's current death rate from this source, if it were to be replicated in England and Wales, would result in around 1,100 assisted suicide deaths annually if we had a similar law here. Washington's 2013 report also reveals that feeling a burden on others was cited by 61 per cent of those who received lethal drugs for assisted suicide as a reason for their request.

[9] "Lessons from Legalized Physician-Assisted Death on Oregon and Washington", Linda Ganzini, from "Palliative Care and Ethics", OUP 2014, Pages 266-280

Suicide and Social Attitudes

19. The law as it stands accurately reflects social attitudes to suicide. While we rightly treat people who attempt suicide with understanding and compassion, as a society we do not regard suicide as something to be encouraged or assisted. These attitudes underlie all the suicide prevention strategies that successive governments have introduced and all the 'suicide watches' where individuals are considered to be at risk of self-harm. Lord Falconer's Bill flies in the face of all this: it says, in effect, that there are some people (currently those who are terminally ill) whose suicides we should actually assist. This contradiction cannot be explained away simply by calling assisted suicide by the gentler-sounding phrase 'assisted dying' and by trying to argue that helping people who are terminally ill to end their lives is assisting their dying rather than assisting their suicide. Law-making is a serious business, especially where lives are at stake, and laws need to be based on accurate and widely understood use of language rather than on euphemistic constructs.

Conclusion

20. As legislators we have to think carefully about the consequences as well as the intentions of legislation. The criminal law exists, not to offer options to individuals, but to protect us, all of us, from harm, irrespective of our age, gender, race - and state of health. The law that we have rests on a clear and natural boundary - it rests on the principle that we do not involve ourselves in deliberately bringing about the deaths of other people. Introducing arbitrary exceptions to that principle, such as terminal illness, replaces a clear and natural boundary with a negotiable line in the sand.

21. There is much talk in this debate of compassion, but compassion cannot be applied selectively. Compassion may prompt us to empathise with a strong-willed individual who is completely clear about wanting to hasten death in preference to living with a terminal illness. But compassion for all terminally ill people requires that they receive the protection of the law and are not exposed to the unintended consequences of legislation designed to oblige a minority. An 'assisted dying' law may give some what they want but it has the potential to expose the less assertive to harm.

22. The Supreme Court has speculated[10] that this balance between choice and harm might possibly be met "*if no assistance could be given to a person who wishes to die unless and until a Judge of the High Court has been satisfied that his wish to do so was voluntary, clear, settled and informed*". The Family Courts already deal with complex and difficult situations of this nature. But that is not what Lord Falconer's Bill is proposing. It is proposing the creation of a licensing system for assisted suicide within the health service. That is a very different proposition.

[10] Judgment 25 June 2014 re Nicklinson, Lamb and Martin, Paragraph 123