

Assisted Suicide

1. Palliative care can address the suffering of a terminally ill person

Advocates of assisted suicide suggest that it would enable persons, who become terminally ill and find themselves in an unbearable situation, to avoid suffering a slow, drawn-out death.

In response to this the SCHB notes that:

Physical suffering can be adequately alleviated in all but the rarest of cases with up to 95% of patients having their pain and/or symptoms effectively relieved when treated by healthcare professionals with the relevant expertise^{1,2}. Similarly, patients with an illness such as motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death. But studies from the most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens.

In addition, the administration of short episodes of sedative drugs can be considered as an appropriate alternative, when persons are in the dying stages, to manage distress and restlessness. This can happen when patients are often barely conscious as a result of their disease (not because of the drugs) and are no longer capable of consciously working through their issues. In this case, palliative care helps patients (and sometimes also their families) by calming their terminal agitation.

Usually, the treatment is a matter of gradually increasing the level of drugs according to effect. However, there are occasions when a patient is very agitated and rapid use of larger doses of drugs is essential for the safety of the patient and others.

Nonetheless, there will always be rare occasions where a patient's symptoms cannot be completely controlled. Often these are patients who cannot resolve an issue or cannot cope with a symptom, such as with severe breathlessness. Some may also have significant psychological and/or spiritual distress which they find difficult to resolve. Indeed, almost all patients with uncontrolled pain have elements of this pain which cannot be recognised as physical. These individuals, who are already drowsy and dying of their illness, may then request some form of sedation to relieve the burden of otherwise intractable suffering, in which case it may be possible to manage their distress and agitation without side effects. In other words, drugs are administered and monitored to induce a state of decreased or absent awareness (unconsciousness) in order to increase comfort in the dying process rather than, in any way, shortening life³.

It is very unusual for palliative care to have to use continuous sedation to keep a lucid patient asleep in order to address the intolerable physical and/or mental distress. Indeed, sedating people deliberately to deal with their suffering is a rare occurrence in the UK.

However, it is important that patients with difficult symptoms are not promised complete relief since this is beyond the realm of medicine. In this regard, it should be noted that palliative care does not only seek to work in the area of medicine since it also endeavours to provide non-clinical support and the right environment for patients to express and work through their distress⁴. Thus, few patients request assisted suicide when their physical, emotional and spiritual needs are properly catered for.

¹ Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the rarest cases. See also Pain Control - BBC - http://www.bbc.co.uk/religion/ethics/euthanasia/euth_pain_control.shtml; Using Opioids to Control Pain, <http://www.painlaw.org/opioids.html>

² When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it usually lengthens life and improves its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

³ Nathan I Cherny, Sedation for the care of patients with advanced cancer, *Nature Reviews Clinical Oncology* 3, 492-500 (September 2006)

⁴ For example, with the consent of the patient, the number of visitors may be reduced so that he or she can work things through.

2. It is wrong to suggest that any person can ever lose his or her intrinsic human dignity

Advocates of assisted suicide suggest that individuals should be able to determine their own dignity and quality of life, unrestricted by the moral, cultural, religious, or personal beliefs of others. For example, it has been proposed that persons who fear that they will lose their dignity during the final stages of a terminal illness should be able to 'die with dignity' before these stages occur.

In response to this, the SCHB notes that:

It is incorrect and disturbing to suggest that any person can ever lose his or her human dignity. Though human dignity is not a scientific concept, it is something that everyone should always accept is found in everyone to an equal extent. This is in accordance with the ***United Nations' Universal Declaration of Human Rights*** which affirms in its preamble "*the inherent dignity and...the equal and inalienable rights of all members of the human family*" as "*the foundation of freedom, justice and peace in the world*".

At present, we live in a society where human dignity is universal and where each and every person is expected to acknowledge, respect and recognise the same dignity in other individuals. It cannot be created, modified or destroyed by an individual, a majority or a State. However, legalising assisted suicide would mean that the whole of society would accept that some individuals can actually lose their inherent human dignity and have lives which no longer have any worth, meaning or value. It would also mean denying the human dignity which is due to an individual, in order for him or her to be legally killed. In other words, it would give the message that human dignity is only based on subjective choices and decisions and whether a life meets certain quality standards.

In this regard, it should be noted that a society that no longer believes in the inherent dignity of human life cannot offer any valid argument against the taking of life of others, who may be considered unworthy of human dignity. It becomes a society that has lost its trust in the intrinsic value and meaning of life and cannot comprehend why it should be endured.

This is in complete opposition to a responsible benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost their autonomy. Therefore, in order to function consistently, society must reject the option of assisted suicide if it does not want to undermine basic and fundamental societal values.

3. Full and complete autonomy undermines the concept of human dignity

Advocates of assisted suicide suggest that a person's fear of disability and dependency should enable him or her to die while he or she is still autonomous and that assisted suicide would enable self-determination to exist. In other words, individuals have the right to take decisions concerning their own life and death situations in accordance with their own values and beliefs. These should not be imposed by a court, a physician or a family member. It is a question of freedom and equality in the face of death. Thus, advocates of assisted suicide suggest that nobody has the right to impose on the terminally-ill and the dying an obligation to live out their lives when they themselves have persistently expressed the wish to die.

In response to this, the SCHB notes that:

The recognition of every person's full, complete and total autonomy does not enable the concept of human dignity nor, for that matter, an interactive society to exist. Accepting such an extreme form of autonomy would represent the atomisation of each human being whereby every individual would live on a completely free and independent island. Society, as such, would then cease to exist.

Indeed, the very concept of human dignity is dependent on persons having relationships with one another in an interactive society. It is not based on an individual's own limited personal subjective views of himself or herself. In this respect, it should be noted that it is only because society believes in the human dignity of persons, that it respects their autonomy.

Moreover, being dependent on others should never be associated with a loss of dignity. All are born dependent on others, and many will die dependent on others. Being dependent on others is a basic characteristic of human existence.

POSITION STATEMENT: ASSISTED SUICIDE

In addition, the legalisation of euthanasia may undermine the autonomy and constitute a level of coercion on medical and other health care practitioners or individuals. They may then feel obliged to carry out an act of assisted suicide against their wishes or personal beliefs.

4. Human dignity is grounded on an interdependent society

Some supporters of assisted suicide argue that persons should be able to decide, for themselves, whether or not they have lost their dignity and that this decision does not have any consequence for other members of society.

In response to this, the SCHB notes that:

In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives. In other words, persons who consider that their lives are no longer worth living or that they have lost their dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse medical situations are also not worth living and should be ended.

Similarly, persons who believe that their lives are no longer worth living or that they have lost their dignity must also reject the worth, value and meaning that others, such as their family, friends and even society, are giving to their lives. However, to consciously deny and reject (without attenuating circumstances such as a psychological disorder) the value, meaning and worth given by others to our lives means putting oneself at the centre of all that matters. Moreover, to reject the intrinsic dignity that another person is seeking to give to our lives represents a denial of this other person's capacity to confer dignity which is tantamount to rejecting him or her as a person.

As Lord Walton of Detchant indicated in 1994 in the House of Lords: *"dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole"*.⁵

Thus, personal opinions about worth, meaning and value of human life matter to the whole of society.

5. Assisted suicide should not be considered as a medical procedure

It is often suggested that assisted suicide should be considered as a medical procedure undertaken by healthcare professionals.

In response to this, the SCHB notes that:

Assisted suicide actually undermines the traditional goal of medicine, namely to cure and care but not to harm or kill patients.

Moreover, research demonstrates that most sustained demands for assisted suicide are actually considered by persons suffering from existential problems or because they have an extreme concept of control and independence⁶. In other words, the argument in favour of assisted suicide is more about control than medicine. This is reflected in the fact that most physicians are opposed to the practice⁷ and that in some of the places where assisted suicide is legal, such as in Switzerland and the US state of Oregon, a physician does not need to be actively involved in the final administration of the lethal poison.

6. Assisted suicide would undermine the relationships of health care professionals with their patients

Advocates of assisted suicide suggest that curing disease and bringing about death are not mutually exclusive roles since the intention in both cases is to relieve suffering. It is further argued that the primary role of the physician is to care for his or her patients, which must therefore entail respecting their autonomous wish to die.

In response to this, the SCHB notes that:

⁵ Lord Alton of Liverpool, Lords Hansard Text, 7 July 2009, Column 630.

⁶ Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

⁷ Doctors change euthanasia stance, BBC News, 29 June 2006, <http://news.bbc.co.uk/1/hi/health/5123974.stm>

POSITION STATEMENT: ASSISTED SUICIDE

Crossing the boundary between acknowledging that death is inevitable and taking active steps to bring about death, with intent, fundamentally changes the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may become hardened to death and to causing death, particularly when patients are old, terminally ill, or disabled. Legalising assisted suicide would give persons, such as physicians, power that could be too easily abused, and a responsibility that they should not be permitted to have. It is not up to physicians to decide whether a life is happy or unhappy and worthwhile or not. If this happened they could become the most dangerous persons in a country. In very rare cases, physicians such as Harold Shipman⁸, may actually feel empowered in being able to provoke death.

In the light of these cases, many vulnerable groups of people may begin to mistrust the real intentions of their doctors.

7. Assisted suicide should not be legalised just because it is occurring in secret

Advocates of assisted suicide suggest that the practice of clandestine, illegal assisted suicide carries the greatest potential for abuse. They argue that the pressures that can influence end-of-life decisions will be more pernicious if assisted suicide remains an underground practice. Further, the gap between law and practice must be reconciled if respect for the rule of law is to be maintained.

In response to this, the SCHB notes that:

The law should not be changed just because something, which is illegal and unethical, such as murder, is being practised in secret. If this happened it would completely undermine the rule of law in a country.

In addition, by prohibiting assisted suicide, it is also possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged according to a good standard of fairness and compassion.

8. It is wrong to believe that opposition to assisted suicide is only based on non-secular belief systems

It has been suggested that only those with religious or other non-secular beliefs are opposed to assisted suicide and that they should not be able to oppose those who believe, instead, in the autonomy of the individual to choose when to die.

In response to this, the SCHB notes that:

The belief in the inherent dignity and inviolability of human life is, in fact, based on international globally accepted secular principles such as the **United Nations' Universal Declaration of Human Rights**.

Moreover, the **Council of Europe Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying**⁹, which is the latest text on the issue, indicates in Article 9.c. that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

- i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*
- ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;*
- iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.*

⁸ Harold Shipman: The killer doctor, BBC News, 13 January 2004, <http://news.bbc.co.uk/1/hi/uk/3391897.stm>

⁹ Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, <http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm>

POSITION STATEMENT: ASSISTED SUICIDE

These texts emphasise the universal, absolute, inalienable and intrinsic nature of the concept of human dignity. In other words, they support the notion that *no person* (including oneself) can lose his or her human dignity at any time in his or her life. Indeed, to reject such a notion would not only seriously challenge the whole concept of human dignity but would be an extremely serious precedent in a world that has fought so hard to endow all persons with the same dignity.

9. Distinction between acts and omission

Proponents of assisted suicide frequently refer to the lack of distinction between acts and omission. They argue that there is not a significant difference between actively killing someone and refraining from an action that may save or preserve that person's life¹⁰.

In response to this, the SCHB notes that:

In a medical context, there is a moral duty for the physician to undertake what is reasonable to save and preserve life.

If a physician consciously refuses to initiate certain lifesaving intervention in order to allow a patient to die, then this action could be considered as murder. If, on the other hand, a physician follows good medical practice and addresses the best interests and well-being of the patient and does not initiate futile and burdensome interventions and this, as a side effect, shortens the patient's life, then no objections would normally be brought against the physician.

In other words, the critical distinction between murder and good palliative care is related to the physician's intention, which is an extremely important concept in law.

10. Assisted suicide would undermine the protection due to the most vulnerable persons in society

Legalising assisted suicide is dangerous because vulnerable people may begin to consider death as a possible option for releasing family members, carers and the broader society from the responsibility of providing assistance. These vulnerable people, such as the elderly, may then believe that their death is a greater good and that they have a duty to pursue assisted suicide.

Vulnerable people need to know that they are valued and unconditionally accepted by the community. They need to know that society is committed first and foremost to their well-being, even if this does involve expenditure of time and money. Indeed, the manner in which the weakest and most vulnerable members of society are treated reflects the true identity of a society because it reveals its core values.

11. The request to die may not reflect the patient's real wishes

Generally, experience shows that once people receive palliative care and are comfortable, with their fears concerning suffering being addressed, they often change their minds about wanting to end their lives¹¹.

There is also good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can often be treated¹². States of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely confident that a request for a life to be ended does not arise from a disordered state of mind.

In other words, whilst many people are competent to make decisions about their wish for assisted suicide, many are not. This opens the possibility that a decision to end a person's life could be made by a second person such as a nominated proxy. The complexities arising from such conditions could lead to a serious abuse of power.

¹⁰ For example, it is considered morally wrong to push someone into a river to his or her death but there may not be a moral duty to leap into the river to save someone who is drowning.

¹¹ Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, *Lancet*, Vol. 338, 1991.

¹² Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, *The New England Journal of Medicine*, Vol 342, February 2000.

12. Neither suicide nor euthanasia should be seen as acceptable alternatives

The attempted suicide of an individual, such as a young person, is never seen as something to be encouraged in society. Instead, great concern is raised regarding the individual's state of mind and the fact that he or she may need psychological assistance or counselling. In other words, it would be completely unethical to help someone commit suicide in these circumstances. In the light of this, it is difficult to consider how any form of assisted suicide can be considered.

Conversely, if assisted suicide were decriminalised, a risk would then arise that the suicide of individuals, such as healthy young persons, would also be considered as acceptable to society at the very moment when the Scottish government is trying to reduce the very high suicide rates in some parts of the country with programmes such as **Chooselife** (www.chooselife.net).

Moreover, with euthanasia or assisted suicide, as opposed to suicide, another person must believe that it would be preferable for the person wishing to die not to continue living. In other words, euthanasia and assisted suicide, reflect the unacceptable belief by one person that another person has lost, or will lose, his or her dignity to such an extent that his or her life is not worth living and should be ended.

When society acknowledges the acceptability of one person being willingly involved in the death of another person, dangerous consequences as to the manner in which the whole of society considers the value, meaning and worth of human life are to be expected.

13. The legalisation of assisted suicide would lead to unworkable laws

Advocates of assisted suicide have suggested that legalising assisted suicide could give physicians some protection from the law.

In response to this, the SCHB notes that:

The legalisation of assisted suicide may impose upon medical professionals obligations which may be unworkable with the possibility of penalties (or prosecution) applying if these are not respected.

March 2010

Assisted Suicide

1. Definitions and general information

Suicide: An intervention by which a person ends his or her own life.

Passive Suicide: Suicide without an active intervention, whereby a person makes a conscious and contemporaneous decision not to accept or to withdraw from life-sustaining treatment with the aim of hastening his or her own death. Passive suicide recognises the right of a patient not to accept a medical intervention even if it may save his or her life. This right is recognised in most countries¹³.

Assisted Suicide: The act whereby a person aids, abets, counsels or procures a suicide or an attempted suicide of another individual.

Physician Assisted Suicide: The act whereby a physician prescribes a lethal medication to a person, but the person administers the dose himself or herself.

Palliative Sedation: Sedation in the context of palliative medicine is the monitored use of medications to induce varying degrees of unconsciousness to bring about a state of decreased or absent awareness (i.e. unconsciousness) in order to relieve the burden of otherwise intractable suffering¹⁴.

2. Principles and purpose

Assisted suicide is generally considered as a procedure that enables a certain amount of certainty to exist that a person consents to terminate his or her life. This is because it is the person himself or herself who undertakes the 'killing' action. For example, if a physician injects poison, with the patient's consent, in order to hasten his or her death, this is active, voluntary euthanasia. If, on the other hand, the physician places poison by the patient's side, and the patient takes it, this is assisted suicide. The individual assisting the person who wishes to take his or her life will only then be considered as an 'assistant' in the intervention and not the principal actor. Through assisted suicide one seeks to avoid any risk of non-voluntary or involuntary euthanasia.

3. History

The Hippocratic Oath, which was written in the 4th Century BC and attributed to the Greek Hippocrates (c.a. 460-380 BC) who was considered as one of the fathers of western medicine, unequivocally prohibits euthanasia and assisted suicide. It states that: *"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."*

In the 16th century, Thomas More, described a utopian community as one which would facilitate the death of those whose lives had become burdensome to them as a result of 'torturing and lingering

¹³ In the case of Airedale NHS v. Bland, Lord Mustill indicated that "If the patient is capable of making a decision whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue ...".

An example of an application of this judgement is given in the case where a woman paralysed from the neck down was given the right to die - BBC - 2002: <http://news.bbc.co.uk/1/hi/health/1887281.stm>

Another example was the decision by a young paralysed severely ill Swedish man connected to a respirator to end his life in a "suicide clinic" in Switzerland. This started a debate in Sweden concerning the legal framework for a paralysed person to end his or her life with assistance.

According to Swedish law, persons have the right to decide whether or not they want to continue their treatment. In this case, the young man could have decided to turn off the respirator, leaving him to a painful death by suffocation. Debate then arose since it was unclear whether the physician in charge would have been legally entitled to put the patient to sleep before switching off the respirator in order to help him die a painless death. Finally, the Delegation on Medical Ethics of the Swedish Society of Medicine presented new guidelines about withholding and terminating treatment in March 2007. It was made clear that a physician could terminate treatment in these situations, and should also relieve a patient from pain in situations where the patient has decided to end his life by refusing further medical treatment.

Ethically Speaking, Issue 8, July 2007, Office for Official Publications of the European Communities, p.37.

¹⁴ Nathan I Cherny, Sedation for the care of patients with advanced cancer, Nature Reviews Clinical Oncology 3, 492-500 (September 2006)

pain'. A century later, Francis Bacon suggested that it was part of a physician's duty to alleviate pain even if that meant killing the patient¹⁵.

4. England and Wales – Legislation, Case law

4.1. Developments

Section 1 of the **Suicide Act 1961** abrogated the rule of law in England and Wales which had previously made it a crime to commit (or to attempt) suicide. However, in section 2(1), the Act stipulated that a person cannot aid or abet another person in committing suicide and thereby underscored that the purpose of the Act was to discriminate suicide, and not establish an individual right to obtain suicide¹⁶.

In the past, the main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives. However, it also cast an unwarranted stigma on innocent members of the suicide's family and led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success¹⁷.

Since suicide ceased to be a crime in 1961, the question whether assisted suicide should also be decriminalised has been reviewed on more than one occasion.

In 1980, the **Criminal Law Revision Committee** indicated some divergence of opinion among its membership¹⁸. It also made a distinction between assisting a person who had formed a settled intention to kill himself or herself and the more heinous case where one person persuaded another to commit suicide, though a majority agreed that aiding and abetting suicide should remain an offence¹⁹.

In 1993, Hoffmann LJ indicated in the Court of Appeal (*Airedale NHS Trust v Bland* [1993] AC at 831) that *"the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why, although suicide is not a crime, assisting someone to commit suicide is."*

Following this decision by the Court of Appeal, the 1994 **House of Lords Select Committee Report on Medical Ethics**²⁰ drew a distinction between assisted suicide and physician-assisted suicide but its conclusion was unambiguous: *"As far as assisted suicide is concerned, we see no reason to recommend any change in the law. We identify no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection."*²¹

The House of Lords Select Committee also recognised the undesirability of anything which could appear to encourage suicide: *"We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."*²²

¹⁵ End of Life Assistance (Scotland) Bill, Policy Memorandum, Scottish Parliamentary Corporate Body 2010.

¹⁶ Luke Gormally, "Walton, David, Boyd and the Legalization of Euthanasia", in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995), p 125.

¹⁷ Judgements - The Queen on the Application of Mrs Dianne Pretty (Appellant) v Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) - House of Lords: <http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldjudgmt/jd011129/pretty-2.htm>

¹⁸ Criminal Law Revision Committee, 14th Report (1980, Cmnd 7844) in Judgements - The Queen on the Application of Mrs Dianne Pretty (Appellant) v Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) - House of Lords: <http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldjudgmt/jd011129/pretty-2.htm>

¹⁹ Criminal Law Revision Committee, 14th Report (1980), pp 60-61, para 135, in Judgements - The Queen on the Application of Mrs Dianne Pretty (Appellant) v Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) - House of Lords: <http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldjudgmt/jd011129/pretty-2.htm>

²⁰ House of Lords Select Committee Report on Medical Ethics, HL 21-1, 31 January 1994 - p 11, para 26.

²¹ House of Lords Select Committee Report on Medical Ethics, HL 21-1, 31 January 1994 - p 54, para 262.

²² House of Lords Select Committee Report on Medical Ethics, HL 21-1, 31 January 1994 - p 49, para 239.

POSITION PAPER: ASSISTED SUICIDE

The government in its response (May 1994, Cm 2553) accepted this recommendation: "As the Government stated in its evidence to the Committee, the decriminalisation of attempted suicide in 1961 was accompanied by an unequivocal restatement of the prohibition of acts calculated to end the life of another person. The Government can see no basis for permitting assisted suicide. Such a change would be open to abuse and put the lives of the weak and vulnerable at risk."²³

In February 2003, and following a proposal by Lord Joffe to introduce a *Patient (Assisted Dying) Bill*, a House of Lords Select Committee prepared a report entitled "**Assisted Dying for the Terminally Ill Bill**" in April 2005. This report indicated that if an assisted dying bill is considered, it should distinguish clearly between assisted suicide and voluntary euthanasia. This led Lord Joffe to re-introduced a new version of his bill entitled **Assisted Dying for the Terminally Ill Bill** into the House of Lords on the 9th of November 2005 in a form which would legalise assisted suicide but not euthanasia. However, this was unsuccessful.

In February 2010, the **Director of Public Prosecutions (DPP)** in England and Wales published his **Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide**. This policy was issued as a result of the decision of the Appellate Committee of the House of Lords in **R (on the application of Purdy) v Director of Public Prosecutions** reported at [2009] UKHL45, which required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" in cases of encouraging and assisting suicide²⁴.

4.2. Present situation

Committing or attempting to commit suicide is not, of itself, a criminal offence in England and Wales. However, assisted suicide is covered in England and Wales by the **Suicide Act 1961** which states that:

1. *The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.*
2. (1) *A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.*

(2) *If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.*

However, Section 2 of the **Suicide Act 1961** was amended with effect from 1 February 2010 by section 59 and Schedule 12 of the **Coroners and Justice Act 2009** which widened the possibility of prosecution to include encouraging or assisting the suicide or attempted suicide of another person²⁵. This updated the language and made it clear that section 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.

The **Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide** from the **Director of Public Prosecutions (DPP)** in England and Wales was published in February 2010. This did not, in any way, 'decriminalise' the offence of encouraging or assisting suicide and nothing in the policy could amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person²⁶.

However, the DPP's 2010 policy²⁷ indicated that public interest factors tending against prosecution were:

- (1) *the victim had reached a voluntary, clear, settled and informed decision to commit suicide;*

²³ Judgments - The Queen on the Application of Mrs Dianne Pretty (Appellant) v Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) - House of Lords: <http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldjudgmt/jd011129/pretty-2.htm>

²⁴ Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

²⁵ Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

²⁶ Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

²⁷ Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

POSITION PAPER: ASSISTED SUICIDE

(2) *the suspect was wholly motivated by compassion;*

(3) *the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;*

(4) *the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;*

(5) *the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;*

(6) *the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.*

In addition, the evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.

5. Scotland – Legislation, Case Law

5.1. Developments

In contrast to England and Wales, suicide was never legally prohibited in Scotland. Moreover, assisted suicide is not specifically defined in Scottish legislation since it would be dealt with under the legislation concerning homicide.

Euthanasia and assisted suicide became devolved matters for the Scottish Parliament under the **Scotland Act 1998**, Schedule 5 (Reserved Matters), Part II (Specific Reservations), Head J (Health and Medicines).

Moreover, in a response before the Scottish Parliament on the 11th of November 2004, the Deputy Minister for Health and Community Care indicated that the Scottish government had “*no plans to change the law.*”²⁸

On the 25th of October 2005, Mr. Jeremy Purvis MSP lodged a proposed physician assisted suicide bill in the Scottish Parliament. However, this proposal only attracted five out of the required 18 parliamentary supporters within the specified time limit of one month after the draft bill was submitted. This meant that the proposed bill did not continue through the legislative process.

However, on the 23rd of April 2009, Ms. Margo Macdonald MSP presented a Private Member's **Proposed End of Life Choices (Scotland) Bill** to the Scottish Parliament which obtained 20 signatures out of the required 18 parliamentary supporters²⁹. This meant that the proposed bill could continue through the legislative process and on the 20th of January 2010, Ms. MacDonald submitted her **End of Life Assistance (Scotland) Bill** to the Scottish Parliament.

5.2. Present situation

It should be noted that the term assisted suicide is not defined in Scottish law and would be regarded as homicide (a common law offence)³⁰.

The present situation is best characterised by the Deputy Minister for Health and Community Care, who indicated in a response before the Scottish Parliament on the 11th of November 2004, that “*Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification. There might be cases in which the circumstances of the offence would make a charge of culpable homicide more appropriate than one of*

²⁸ Scottish Parliament Official Report - 11.11.04:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

²⁹ <http://www.scottish.parliament.uk/s3/bills/MembersBills/index.htm>

³⁰ http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

POSITION PAPER: ASSISTED SUICIDE

murder, and a court would take all the circumstances of the case into account before sentence was pronounced. However, if the accused was convicted of murder, a sentence of imprisonment would be mandatory.”³¹

In Scotland, if the circumstances warrant it, attempted suicide may also (in very rare occasions) be prosecuted as a breach of the peace.

Since assisted suicide is not specifically defined in Scottish legislation, it may constitute the “art and part” of murder or culpable homicide³². Suicide is not a crime in Scots law and it is therefore not a criminal offence to attempt suicide. Encouraging or assisting another to take his or her own life is another matter, as the sympathy which the law has for the suicide does not necessarily extend to those who facilitate suicide. But there is no Scottish authority on this issue.

A person who assists another, whether in the form of giving advice or the provision of the means, might be criminally liable of recklessly endangering human life or of culpable homicide (not murder) because of the absence of malice³³.

6. Legislation, Case Law and Regulations - International

6.1. Council of Europe

European Convention on Human Rights:

Two articles of the European Convention on Human Rights (ECHR) protect the right to life, namely:

Article 2.1:

Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 8:

1. Everyone has the right to respect for his private and family life.....

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.

Council of Europe Parliamentary Assembly Recommendation 1418 (1999):

The latest provisions on the subject are included in Article 9.c. of the Council of Europe Parliamentary Assembly Recommendation 1418 (1999) which states that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that “no one shall be deprived of his life intentionally”;

ii. recognising that a terminally ill or dying person’s wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person’s wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

³¹ Scottish Parliament Official Report - 11.11.04:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

³² [Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003,](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp)

[http://www.coe.int/T/E/Legal_Affairs/Legal_co-](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp)

[operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp)

³³ Stair Memorial Encyclopedia, Criminal Law.

Case Law from the European Court of Human Rights:

Osman v United Kingdom:

In the case of *Osman v United Kingdom*, the applicants complained about the failure of the authorities to appreciate and act on what they claim was a series of clear warning signs that a certain individual represented a serious threat to the physical safety of Ahmet Osman (who died at the hands of this individual) and his family.

In 1998, after examining the case, the European Court of Human Rights³⁴ stated that:

“The Court notes that the first sentence of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. It is common ground that the State’s obligation in this respect extends beyond its primary duty to secure the right to life....”

Thus, Article 2, as set out above, contains a negative restraint on the State but also requires the State to take active steps for the protection of life.

In the end, the Osmans lost their case because, from the authorities’ perspective, the danger had not been an immediate one. But the European Court of Human Rights emphasised that blanket immunity of a duty of care by the police would be a breach of article 6 (Right to a fair trial) of the European Convention on Human Rights, but that there was no breach of articles 2 and 8.

The Osman case basically put a level of proportionality into the duty to protect lives with government authorities having to balance resources though they may not be able to respond to every emergency. Still, if they know of a genuine threat, then they are bound to take steps to prevent it.

Pretty v United Kingdom:

In *Pretty v United Kingdom*³⁵, the European Court of Human Rights indicated that a so-called ‘mercy killing’ was legitimately prohibited by the State under Article 2 of the ECHR:

“The consistent emphasis in all the cases before the Court has been the obligation of the State to protect life. The Court is not persuaded that the ‘right to life’ guaranteed in Article 2 can be interpreted as involving a negative aspect ... it is unconcerned with issues to do with the quality of life or what a person chooses to do with his or her life ... nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.”

“The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.”

Furthermore, the European Court of Human Rights did not consider that the United Kingdom’s blanket ban on assisted suicide was disproportionate in the context of Article 8:

“It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide.”

6.2. Other countries

On the 20th of January 2003, the Council of Europe published a document concerning euthanasia and assisted suicide containing the replies to a questionnaire from 34 countries of the Council of Europe and the USA,. In this report, only three countries (The Netherlands, Estonia and Switzerland) indicated that their legislation would not regard such an undertaking as an offence provided certain conditions were met³⁶.

Netherlands:³⁷

In the Netherlands, the ***Termination of Life on Request and Assisted Suicide (Review Procedures) Act*** came into effect on the 1st of April 2002. The Act incorporates an amendment to

³⁴ (1998) 29 EHRR 245

³⁵ Application No 2346/02; 29 April 2002

³⁶ **Ministers’ Deputies**, CM Documents, CM(2003)21 Addendum 2, 12 March 2003, Steering Committee on Bioethics -Report on laws and/or practices of member states with regard to the issues raised by Parliamentary Assembly Recommendation 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying.
https://wcm.coe.int/rsi/common/renderers/rend_standard.jsp?DocId=29357&SecMode=1&SiteName=cm&Lang=en

³⁷ Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

POSITION PAPER: ASSISTED SUICIDE

Article 293 of the Criminal Code to the effect that although any person who terminates another person's life at that person's express and earnest request remains liable to a term of imprisonment or a fine, such an act shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation and fulfils the stipulated due care criteria, by which the attending physician must:

- be satisfied that the patient has made a voluntary and carefully considered request;
- be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement
(note: it is not a condition that the patient is terminally ill or that the suffering is physical);
- have informed the patient about his or her situation and his or her prospects;
- have concluded, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
- have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in the four above indents; and
- have terminated the patient's life or provided assistance with suicide with due medical care and attention.

Similarly, any person who intentionally incites another to commit suicide, if suicide follows, is normally punishable under Article 294 of the Criminal Code by a term of imprisonment or fine, but commits no offence if the above due care criteria are fulfilled.

The new legislation also includes regulations regarding termination of life on request and assisted suicide involving minors. Children aged 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardian is required.

Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so.

In all cases, the physician must report his or her act to the municipal pathologist. The report is then examined by a regional review committee to determine whether it was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service, which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.

If the committee agrees that the physician has practised due care, the case is closed. If not, the case is brought to the attention of the Public Prosecutor who has the power to launch his own investigation if there is a suspicion that a criminal act may have been committed.

Approximately 16 million people live in The Netherlands, with around 140,000 dying every year. Each year, some 9,700 requests for euthanasia are made. About 3,800 of these actually receive euthanasia, of which some 300 are assisted suicides. Euthanasia therefore accounts for around 2.5% and assisted suicide 0.2% of all deaths in The Netherlands. In addition to these, there are about 1,000 deaths a year (0.7% of all deaths) where physicians end a patient's life without an explicit request³⁸.

Belgium:

In Belgium, the law does not allude to "assisted suicide" though the country has a similar law to The Netherlands. Thus the law does not specify the method to be used by the physician, even though he or she must describe it in the official form to be forwarded to the Federal Evaluation and Control Commission.

³⁸ House of Lords, Select Committee on Assisted Dying for the Terminally Ill Bill, Assisted Dying for the terminally ill Bill, Volume I, Report, 2005, paragraph 171; <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm>

Switzerland:³⁹

Swiss law is a special case in Europe. Article 115 of the Criminal Code specifies that what makes assisted suicide punishable is the existence of a selfish motive.

It should be noted, however, that the drafting of Article 115 was not motivated by medical considerations. Originally, in the 19th century, it was aimed at exonerating from punishment someone who lent a weapon to a friend wishing to commit suicide because of, for example, an unhappy love affair.

But Article 115 is now used for assisted suicide, which was not at all the legislator's intention. Thus, assistance to suicide goes unpunished, whilst doctors are not allowed to carry out euthanasia and may be sanctioned by their colleagues. According to the Academy which serves as a tribunal for the Swiss medical profession "*assistance to suicide does not form part of medical activity*" but it has decided to reconsider this rule.

Luxembourg:

As of March 2009, Luxembourg is the most recent country to have legalised euthanasia and assisted suicide. In the new legislation, individuals suffering from a terminal or incurable illness are able to have their lives ended after receiving the approval of two doctors and a panel of experts.

United States of America:

Oregon:

In the state of Oregon, assisted suicide has become possible since the ***Death with Dignity Act (1997)*** was passed on the 27th of October 1997. This allows patients who are residents of the state to request medical assistance in order to obtain drugs so that they can commit suicide when there is a diagnosis of terminal illness and a prognosis of death within six months. Two oral requests separated by 14 days must be made, and doctors or care staff are not forced to act against their consciences if they do not want to adhere to the measures in the act.

Furthermore, Oregon has a similar reporting mechanism to the Netherlands for monitoring of the deaths.

In Oregon less than 1 in 700 deaths is currently attributable to assisted suicide, whereas in The Netherlands the figure is more than 1 in 40, less than 10% of which are from assisted suicide while over 90% are as a result of voluntary euthanasia⁴⁰.

In Oregon 60 people died as a result of assisted suicide in 2008. Since assisted suicide was implemented in Oregon in 1997, there have been 401 deaths resulting from assisted suicide,⁴¹ an average of 36 each year, representing 0.001% of all deaths⁴².

Washington State

In 2008, Washington State gave terminally ill people the option of medically assisted suicide.

A patient must be at least 18, competent to make his or her own decisions and be a resident of Washington State.

In the new legislation, the patient makes two oral requests, 15 days apart. In addition, her or she must submit a written request witnessed by two people, including one person who is not a relative, heir, attending doctor, or connected with a health facility where the requesters live.

Two doctors must certify that the patient has a terminal condition and six months or less to live.

The first ***Washington State Department of Health Death with Dignity Act Report*** indicated that end of life concerns of the 44 participants who died in 2009, and gave reasons, were⁴³:

³⁹ Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

⁴⁰ House of Lords, Select Committee on Assisted Dying for the Terminally Ill Bill, Assisted Dying for the terminally ill Bill, Volume I, Report, 2005, paragraph 243; <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm>

⁴¹ 2008 Annual Report Oregon

⁴² In total 363,758 people died in Oregon in this 11 year period. In 2007 55,986 people died in Scotland. Applying the above proportion of assisted suicide in Oregon to this figure provides an estimated figure of 55 assisted deaths each year in Scotland. In End of Life Assistance (Scotland) Bill, Explanatory Notes, SP Bill 38-EN, 1 Session 3 (2010) <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-en.pdf>

POSITION PAPER: ASSISTED SUICIDE

- Losing autonomy 44 (100%)
- Less able to engage in activities making life enjoyable 40 (91%)
- Loss of dignity 36 (82%)
- Losing control of bodily functions 18 (41%)
- Burden on family, friends/caregivers 10 (23%)
- Inadequate pain control or concern about it 11 (25%)
- Financial implications of treatment 1 (2%)

Montana

In December 2009, the Montana Supreme Court ruled that nothing in the state's law precedent suggested that physician-assisted suicide was against public policy. Thus, patients were not legally prevented from seeking medical assistance to commit suicide.

The ruling freed physicians to prescribe life-ending drugs to the terminally ill without fear of prosecution⁴⁴.

March 2010

⁴³ Washington State Department of Health 2009 Death with Dignity Act Report. Data are collected from the After Death Reporting form.

At the time of publication, data are available for 44 of the 47 participants in 2009 who died.
http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf

⁴⁴ Montana paves way for assisted suicide, BBC News, 31 December 2009, <http://news.bbc.co.uk/1/hi/8436777.stm>