END-OF-LIFE LAW AND ASSISTED DYING IN THE 21ST CENTURY: TIME FOR CAUTIOUS REVOLUTION?

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

2011

ALEXANDRA MULLOCK

School of Law
# List of Contents

Abstract........................................................................................................................................... 6
Declaration.......................................................................................................................................... 7
Copyright Statement............................................................................................................................ 7
Dedication........................................................................................................................................... 8
Acknowledgements............................................................................................................................ 9
The Author......................................................................................................................................... 10
Introduction....................................................................................................................................... 11
Chapter 1 - Irreconcilable Differences............................................................................................ 15
  1.1 Introduction.............................................................................................................................. 16
  1.2 What are we talking about? .................................................................................................... 20
  1.3 The debate.............................................................................................................................. 23
  1.4 Valuing life............................................................................................................................. 24
  1.5 Legalisation is dangerous: abuse and the slippery slope....................................................... 26
  1.6 Caring not killing................................................................................................................... 28
  1.7 Autonomy.............................................................................................................................. 30
  1.8 Mercy...................................................................................................................................... 31
  1.9 Dignity...................................................................................................................................... 32
  1.10 Acts and omissions................................................................................................................. 33
  1.11 Conclusion............................................................................................................................... 35
Chapter 2 - Cutting the Thread of Life.......................................................................................... 36
  2.1 Introduction.............................................................................................................................. 36
  2.2 The law.................................................................................................................................... 36
  2.3 Killing or letting die? Crossing the Rubicon.......................................................................... 40
  2.4 Better off dead?....................................................................................................................... 48
2.5 The continuing role of the court……………………………………53
2.6 PVS, minimally conscious or locked-in?…………………………54
2.7 Who should we save?………………………………………………57
2.8 The interloper…………………………………………………………60
2.9 Consent: a better way through the moral maze?………………61
2.10 The conjoined twins – Re A………………………………………64
2.11 Conclusion……………………………………………………………72

Chapter 3 – Caring not Killing?…………………………………………75
3.1 Introduction……………………………………………………………75
3.2 The non-medical mercy killer………………………………………76
3.3 Death as a side-effect: the doctrine of double effect………………79
3.4 Do doctors ever cause death?………………………………………81
3.5 Foreseeing or intending death?………………………………………82
3.6 Is the doctrine of double effect ethically acceptable?………………88
3.7 Are we flogging a dead doctrine?……………………………………90
3.8 Tension between palliative care and PAD…………………………95
3.9 Is palliative sedation a covert form of euthanasia?…………………97
3.10 What the patient wants………………………………………………100
3.11 Double effect or futility?……………………………………………104
3.12 Conclusion……………………………………………………………105

Chapter 4 – Complicity in Suicide………………………………………107
4.1 Introduction……………………………………………………………107
4.2 Which acts might render one liable for assisting in suicide?……….109
4.3 The case of Dianne Pretty…………………………………………..114
4.4 Suicide tourism………………………………………………………119
4.5 The case of Mrs Z……………………………………………………121
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4 The medical perspective</td>
<td>212</td>
</tr>
<tr>
<td>7.5 A compromise in end-of-life care</td>
<td>213</td>
</tr>
<tr>
<td>7.6 Drawing a coherent legal line</td>
<td>215</td>
</tr>
<tr>
<td>7.7 The advantages of PAS over current policy</td>
<td>218</td>
</tr>
<tr>
<td>7.8 Reforming homicide law</td>
<td>220</td>
</tr>
<tr>
<td>7.9 Conclusion</td>
<td>222</td>
</tr>
<tr>
<td>Bibliography</td>
<td>224</td>
</tr>
<tr>
<td>Articles and Books</td>
<td>224</td>
</tr>
<tr>
<td>Reports, Consultation Papers and Guidelines</td>
<td>238</td>
</tr>
<tr>
<td>Newspapers and Online News Reports</td>
<td>239</td>
</tr>
<tr>
<td>Cases</td>
<td>245</td>
</tr>
<tr>
<td>Legislation</td>
<td>248</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>249</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>250</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>251</td>
</tr>
</tbody>
</table>

Bibliography .................................................................................. 224
Articles and Books .......................................................................... 224
Reports, Consultation Papers and Guidelines .................................. 238
Newspapers and Online News Reports ............................................. 239
Cases .............................................................................................. 245
Legislation ...................................................................................... 248
Appendix 1 ...................................................................................... 249
Appendix 2 ...................................................................................... 250
Appendix 3 ...................................................................................... 251
Abstract

The University of Manchester

Alexandra Mullock

Doctor of Philosophy

End-of-Life Law and Assisted Dying in the 21st Century: Time for Cautious Revolution?

December 2011

In the medical context, it is an accepted (yet controversial) fact that doctors may sometimes legitimately hasten death when providing palliative care to dying patients. Or even, in relation to treatment decisions leading to withdrawal or omission, some doctors may choose death over life for certain patients and yet we seldom hear of doctors in the dock for intentional killing. Where complicity in suicide is concerned, it seems that the compassionate lay person has little reason to be fearful of criminal reprisal. The question, however, of whether a person suspected of complicity in suicide, or a doctor suspected of intentionally causing the death of a patient, will be greeted by sympathy or condemnation is a legal minefield. A range of diverse legal, moral and circumstantial factors will determine firstly, whether one is prosecuted and secondly, whether one will be subject to juridical disapproval and possible incarceration.

This thesis sets out to explore whether continued obfuscation, together with turning a blind eye to possible breaches of the law, is the best approach to the moral dilemma over what should be permitted in assisted dying and end-of-life law. This is not a rhetorical question with a trite answer. Such obfuscation may be viewed as having certain advantages. This thesis explores the legal and ethical issues in the context of recent developments, societal concerns and international influences in order to examine whether the current legal position in respect of homicide and complicity in suicide is tenable. The analysis invites the conclusion that whilst some legal change is both desirable and necessary, any legal reform should seek to facilitate a cautious compromise that reflects the legitimate concerns of those opposed to legal change.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and she has given the University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://www.campus.manchester.ac.uk/medialibrary/policies/intellectual-property.pdf), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in the University’s policy on presentation of thesis.
Dedication

For Tony, Mary and Amelia

With all my love
Acknowledgement

I have been extremely fortunate to have been supported by some truly exceptional people. My supervisors, Suzanne Ost and John Coggon have been not only brilliant but also extremely kind. I am very grateful for all their wonderful advice and encouragement as well as their outstanding contribution to research on this topic, which has provided me with an ongoing source of inspiration. Supervisory support during the first year was provided by Margot Brazier and Charles Erin, and I am indebted to them for their kindness and encouragement during this period, and especially to Margot for her ongoing support as principal investigator and now mentor.

The AHRC Project on the Impact of the Criminal Process on Health Care Ethics and Practice provided me with the opportunity to embark on this PhD and I am extremely grateful to the Law School for their support, and to all the lovely people involved in the project. I am particularly grateful to Margot for leading such a fantastic project and for giving me this opportunity.

Without the love and support of my family this thesis would not have been possible. To my parents, I am so very grateful for your unconditional love and absolute belief in my ability to succeed, as well as all your practical baby/dog sitting assistance. To my daughters, I am grateful for your patience and understanding over my other ‘baby’ and I am very happy that I will now have more time for you. To my in-laws, I am so fortunate to have your love, support and practical assistance, and most of all to have your lovely son, which brings me to my final and most important acknowledgement. To Tony, although this PhD bears only my name it has truly been a joint endeavour as I could not have done it without your support and devotion to me and our daughters, for which I will be eternally grateful.
The Author

Alexandra Mullock (LLB (Hons), PGCE, LLM) is a lecturer in the School of Law at the University of Manchester, and a member for the Centre for Social and Ethical Policy and the Institute for Science, Ethics and Innovation.
End-of-Life Law and Assisted Dying in the 21st Century: Time for cautious revolution?

Alexandra Mullock

Introduction

If one’s life is blighted by suffering so terrible that death seems preferable, the substantive law is clear in its condemnation of those who might help to bring death forward. Regardless of motive, the law says ‘no’ to assisted dying on request. Look beyond the letter of the law, however, and a different picture emerges. Despite the clear criminal prohibition, the law in practice is actually quite sympathetic towards those who might, under certain circumstances, cross the line from caring to killing. Particularly where assisting in suicide is concerned, the chances of one being prosecuted as a consequence of assisting another to commit suicide are extremely low. This is especially true where the so-called victim travels abroad for an assisted suicide. Thus, if continued prohibition serves to deter most from assisting in suicide whilst overlooking those who do so compassionately, we might observe that the legal status quo is working reasonably well as a de facto compromise between legalisation and prohibition. The views of those opposed to the legalisation of assisted suicide or euthanasia are respected by the criminal prohibition, while individuals determined to have an assisted suicide have had certain rights of autonomy legally endorsed.1 Alternatively, does this compromise position fail to respect the views of either the pro or the anti legalisation lobby? Is the so-called prohibition as effective as a sleeping watchdog, while those pressing for meaningful rights remain entirely dependent on helpful relatives (and an expensive Swiss clinic) in the absence of any substantive right to die?

In the medical context, it is an accepted (yet controversial) fact that doctors may sometimes legitimately hasten death when providing palliative care to dying patients. Or even, in relation to treatment decisions leading to withdrawal or omission, some doctors may choose

1 Via the House of Lords decision in Purdy [R (On the application of Purdy) v Director of Public Prosecutions [2009] UKHL 45, [2009] WLR 403], which I discuss in detail in chapter 4.
death over life for certain patients and yet we seldom hear of doctors in the dock for intentional killing. But the question of whether a person suspected of complicity in suicide, or a doctor suspected of intentionally causing the death of a patient, will be greeted by sympathy or condemnation is a legal and ethical minefield. A range of diverse legal, moral and circumstantial factors will determine firstly, whether one is prosecuted and secondly, whether one will be subject to juridical disapproval and possible incarceration.

This thesis sets out to explore whether continued obfuscation, together with turning a blind eye to possible breaches of the law, is the best approach to the moral dilemma over what should be permitted in assisted dying and end-of-life law. This is not a rhetorical question with a trite answer. Such obfuscation may be viewed as having many advantages and this thesis sets out to balance the advantages and disadvantages of continuing to discourage but then overlooking certain behaviour which assists others to die, in comparison to bringing such behaviour into a legitimate model of assisted dying.

Thus, in chapter one I set out an introduction to my subsequent exploration. I consider how sociological factors and interrelated medical developments have combined to increase societal desire to reform the law. After briefly considering the perils of the terminology, my introductory chapter sets out the parameters of the debate about assisted dying; identifying the principal ethical issues and arguments which have driven the debate forward. The sheer volume of literature on this topic defies review, but I have endeavoured to provide an overview of the most significant contributions throughout my analysis of the issues and arguments.

The main body of this work, in chapters two to five, provides an examination of the law and associated ethical issues. First, in chapter two, I examine what is permissible in relation to killing by omission, focusing on the House of Lord’s decision in Bland in order to examine the parameters of killing and letting die in the medical context. In addition to providing a fresh analysis of this medico-legal dilemma, I consider whether alternative routes to death for patients in Permanent vegetative state (PVS), within the parameters of passivity, might offer a less troubled solution. Moving to more active killing in chapter three, I focus mainly on palliative interventions which might be viewed as sharing a similar domain to euthanasia. I examine whether the doctrine of double effect in end-of-life care is indeed dead, (as recent

---

medical evidence indicates), or whether the picture, across the range of medical practice, is more complicated. Exploring the empirical evidence over possible death hastening and the apparently increasing use of palliative or terminal sedation, I question both the legal status (of) and the ethical justification for ending the conscious life of people who might not have consented. My analysis in chapters two and three invites the conclusion that while the current law on homicide has evolved in a less than satisfactory manner, some of the problems might be alleviated by rethinking our approach to consent and enhancing patient participation in end-of-life decision making rather than reforming the law.

In chapters four and five I turn my attention to the law and prosecutorial policy on assisting in suicide. Chapter four presents an analysis of assisted suicide cases, examining how the Suicide Act 1961 has provided an uncertain and highly discretionary prohibition which has taxed successive prosecutors and criminal courts alike. More recently, with Human Rights challenges leading to increased recognition of the individual’s autonomous right to seek an assisted suicide, I consider whether such developments together with possible shifts in societal attitudes have pushed the respective law to breaking point. This theme continues in chapter five with an analysis of post Purdy prosecutorial policy. This chapter considers the implications of the Policy, both in relation to key specific factors and with respect to the wider implications such a policy might bring to bear on this area of law.

In chapter six, I look beyond our national boundaries to see how other jurisdictions have legitimised modes of assisted dying. Focusing on both the US State of Oregon and our European neighbours in the Netherlands, I explore how (respectively) physician-assisted suicide and assisted dying on request have been legalised. Given the cultural and societal differences between these jurisdictions and our own, certain aspects of comparison may, of course, be of limited value. Nevertheless, we can explore whether these regimes have successfully and ethically (according to their own original ethical intentions) implemented legal assisted dying, or whether, as many predicted, legalisation has led to abuse and unethical consequences. Furthermore, observing the experiences of these jurisdictions provides the opportunity to consider the societal impact of legalised assisted dying and whether breaking down traditional taboos leads to undesirable developments.

---

3 See ‘Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’, available at http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html
Finally, my concluding chapter draws together the findings from previous chapters in order to answer the central question of the thesis before, ultimately, striving to provide some resolution to the intractable problem of what should be permissible in ending life in order to end suffering. I propose that whilst some legal change is both desirable and necessary, we do not need to completely re-haul our approach towards assisted dying in the way that some jurisdictions, such as the Netherlands, have, via their legalisation of both euthanasia and physician-assisted suicide. Rather, I argue, the law on assisting in suicide should be re-drafted in order to facilitate a more morally coherent, open and better regulated system within which terminally-ill, mentally competent adults might be permitted (subject to satisfying a number of requirements) to obtain assistance in suicide within the jurisdiction.

By contrast, I propose that our homicide law should remain fundamentally unchanged in order to maintain the prohibition against active euthanasia. I argue that whilst any moral distinction between assisted suicide and euthanasia may be slight or even non-existent, there are nevertheless valid practical reasons to permit one but not the other. I do, however, advocate a more nuanced approach to our homicide law which would better reflect the moral difference between different types of intentional killings, taking into account the motivation of the accused. Furthermore, in answer to some of the present difficulties and tensions within end-of-life care, I propose that patients approaching this stage of life should be encouraged to engage more with the medical options available in order to promote a more informed consensual model of end-of-life care.
CHAPTER 1
IRRECONCILABLE DIFFERENCES

1.1 Introduction

English law is, at least on the face of it, unequivocal in its prohibition of euthanasia and assisted suicide. The common law offence of murder stands in the way of anyone motivated to commit a mercy-killing or euthanasia and in fact, there is no legal difference between a violent murderer and a person who kills at the request of the victim in order to relieve terrible suffering. Upon conviction, either variant of killer will be subject to the compulsory life tariff in prison. Similarly, the Suicide Act 1961 identifies a person complicit in suicide as being on the wrong side of the criminal law and thus, subject to a maximum of 14 years behind bars. But despite the clear message conveyed by the criminal law, the law in action communicates mixed messages. The respective prohibitions are mitigated by a range of factors which provide some relief to the would-be mercy-killer, merciful doctor or assistor in suicide. Combining, as it does, criminal law with aspects of medical law, this area of law, which might be termed ‘end-of-life law’, could be viewed as unique in the extent to which the law says one thing but actually does another. Thus, we see quite astonishing levels of obfuscation. As I explore in chapters 2 and 3, in the medical context, actions or measures which hasten or even cause death may be permitted, either because such measures are deemed to be omissions, or, because the doctor is justified in (inadvertently) hastening death in order to prevent suffering via the doctrine of double effect. But whereas a doctor may sometimes legitimately invite death in, the lay person who, for example, decides to withdraw treatment from a brain damaged relative, will never be viewed as having acted appropriately under the law. Conversely, on the issue of assisting in suicide, the lay person seems to be privileged over health care professionals. Provided a lay person appears to be ‘wholly

---


2 Legally speaking ‘hastening’ death is exactly the same as causing death, it is the Doctor’s intention which determines whether any medical intervention breaches the criminal law. See R v Adams [1957] Crim LR 365.

3 Double effect is examined in chapter 3.
motivated by compassion’ in assisting - but not encouraging - a mentally competent adult to have, for example, an assisted suicide abroad, prosecution is extremely unlikely. The fact that the law prohibits assisted suicide even when death occurs abroad and yet not a single prosecution has followed any of the many cases of ‘suicide tourism’ might be seen as demonstrating the incoherence of the current law.

Interestingly, Roger Brownsword’s framework for appraising law suggests three key determinants - which follow ‘rule of law’ theories - upon which to assess the rationality of any particular law.4 First, from a formal perspective, rules should not conflict or contradict each other. Second, from an instrumental perspective, the way that rules are applied and administered should accord with what is set down by the law and finally, substantively, the rules should adhere to the main principle and overall objective of the law. Whilst such an appraisal might be more straightforward where a less morally contentious law is concerned, a degree of irrationality in certain aspects of end-of-life law is perhaps unsurprising when one considers how this area of law is so afflicted by its conflicting objectives. Whilst the law maintains its prohibitive stance in order to protect the vulnerable and deter those who would harm others, it also seeks to facilitate (or at least not censure) appropriate medical options which appear to be in the best interests of the patient, as well as not impinging (too much) upon the autonomous choices of competent adults seeking an assisted suicide. Thus, the strictness of the substantive law on assisted suicide and murder is tempered by a number of factors to do with prosecutorial policy, pragmatic flexibility within the medical context and jurisprudence, thus presenting a strict message but a sympathetic response, which together, might be seen to present a morally coherent approach. But if the law says one thing but then obfuscates the issue by permitting apparent exceptions which tolerate examples of the very thing which is supposed to be prohibited, the rationality of such a law is clearly open to question.

Alongside the issue of rationality, the question of whether the current law is sufficiently coherent, from both a legal and moral perspective, is also relevant in the ongoing debate about the legal position. Thus, this thesis attempts to unravel the various strands of the

assisted dying debate, examining the law and recent developments in order to consider how the law might achieve a coherent and rational balance between respecting the wishes of those who choose death whilst promoting and protecting life.

While the law has remained doggedly steadfast yet clearly, and increasingly, sympathetic in practice, the debate about helping people towards death via assisted dying, euthanasia, assisted suicide or whatever other term is utilized in this context, is a debate which has perpetuated across time. Occasional bursts of vigour as a result of tragic cases or individual efforts and campaigns to change the law have, from time to time, enlivened the debate but generally the debate has rumbled on with little prospect of progress. Views on this contentious issue are unsurprisingly polarised, with little or no prospect of compromise on the main points of the debate and so stalemate has endured. In comparison to other controversial moral dilemmas, such as embryo research or abortion, which have been subject to what might be described as legal resolution,\(^5\) the opposing sides of the debate over assisted dying seem unwilling to accept any of the competing claims.

More recently however, the debate may be viewed as having gained some momentum. Although there is no political will to bring about legal change, and in spite of the public apparently being generally in favour of legal change,\(^6\) it seems that any MP who is publicly supportive will suffer the consequences.\(^7\) But members of the House of Lords have been less reticent. Parliamentary activists such as Lord Joffe and Lord Falconer have endeavoured to bring about statutory reform via their respective proposals, which, in spite of defeat, compelled legislators to consider the conflicting issues more closely.\(^8\)

---

\(^5\) Both having been legalised, subject to the 14 day rule in respect of embryo research (see section 3 Human Fertilisation and Embryology Act 1990), and various limitations with respect to abortion (see the Abortion Act 1967).

\(^6\) See for example the House of Lords - Assisted Dying for the Terminally Ill Bill - first report, (paras.215-225) which reported on a number of polls (e.g. MORI, British Social Attitudes (BSA)) that demonstrated that the general public were overwhelmingly in favour of euthanasia for people suffering unbearably and/or suffering from a terminal illness. For example, a BSA poll showed ‘an increasing majority in favour of doctors being allowed to end the life of a patient suffering from a painful incurable disease’, rising from 75% in 1984 to 82% in 1994.

\(^7\) For example, the Liberal Democrat MP, Dr Evan Harris, who had expressed his public support for the legalisation of assisted dying, lost his seat at the 2010 general election following a Conservative smear campaign which labelled Dr Harris as ‘Dr Death’. See ‘Lib Dem MP Evan Harris loses Oxford West and Abingdon’, 7 May 2010. Available at http://news.bbc.co.uk/i/hi/uk_politics/election_2010/england/8667863.stm

\(^8\) The last incarnation of Lord Joffe’s Assisted Dying for the Terminally Ill Bill was rejected by a small majority in the House of Lords in 2006, whilst Lord Falconer’s proposed amendment to the Coroners and Justice Bill 2009,
Meanwhile, two women uniquely affected by the prohibition on complicity in suicide brought their personal challenges to the courts. First Dianne Pretty, who suffered from motor neurone disease, sought to gain immunity for her husband in the event that he assisted in her suicide. Later, a multiple sclerosis sufferer, Debbie Purdy sought clarification over how the law might apply to her own future plans to seek an assisted suicide. Although Mrs Pretty failed in her attempt to win a ‘right to die’ via a husband-assisted suicide, Debbie Purdy succeeded in her quest to obtain the right to know more specifically how the Director of Public Prosecutions exercises his discretion over the decision to prosecute under the Suicide Act. Both cases have highlighted the human rights dimension to assisted dying and, as a relatively recent phenomenon, human rights legislation has led to important developments with respect to assisted suicide. In Pretty, for example, Article 2 of the European Convention on Human Rights: the right to life, was held to be a shield rather than a sword in response to Mrs Pretty’s appeal that Article 2 conferred a right to die at a time of one’s choosing. Article 3: the right not to suffer torture or inhumane and degrading treatment, with Mrs Pretty’s illness portrayed as subjecting her to exactly that, was similarly rejected as not conveying any right to be assisted to escape from life. Article 8 however proved more successful in Purdy. The right to respect for private and family life was held by the House of Lords to convey rights to determine issues surrounding one’s death. This represents an important development, and, as I shall discuss in chapters 4 and 5, there may yet be more far reaching implications from this decision.

Meanwhile, and particularly in relation to Purdy, so-called assisted suicide ‘clinics’, particularly Dignitas in Switzerland, where non-selfish assistance in suicide is not a crime, have created a dilemma for UK authorities by facilitating an option for assisted suicide for non-Swiss nationals. This option of ‘suicide tourism’ has been taken up by a not insignificant number of UK residents, thereby exerting pressure on UK prosecuting which would have created an exception to the Suicide Act 1961 for competent adults travelling abroad to die, was also defeated.


I discuss Mrs Pretty’s human rights claims in more detail in chapter 4.

Founded in 1998 by the Swiss lawyer, Ludwig Minelli, Dignitas is a non-profit organization set up to assist those with ‘medically diagnosed hopeless or incurable illness, unbearable pain or unendurable disabilities.’

Reports suggest that by 2010, 134 UK citizens had died at Dignitas. For the past few years, approximately 25 UK citizens per year have died at Dignitas. Thus at the time of writing (November 2011) we might estimate that approximately 160 UK citizens will have travelled to Dignitas in order to die. See http://www.guardian.co.uk/news/datablog/2010/feb/25/assisted-suicide-dignitas-statistics
authorities with respect to both the legality of assisting a person to travel abroad for suicide, and to the question of when it is in the public interest to prosecute for assistance in suicide more generally. As one might expect, the possibility of having an assisted suicide abroad has enlivened the debate at home, prompting increasing interest in the question of what is and what should be permitted with respect to assisted dying. From a global perspective, other jurisdictions, such as the Netherlands, Belgium, Luxembourg, the US States of Oregon and Washington, have even legalised some forms of assisted dying, thus providing a comparative example of what legalisation might look like.\textsuperscript{13}

Sociological factors are also highly relevant in providing some context to the above developments. Otlowski has considered some of the interrelated factors which contribute to societal pressure,\textsuperscript{14} citing the decline of religion and ‘the institutionalization of the process of dying’ as two important factors.\textsuperscript{15} Thus, in an increasingly secular society where medical science has provided the opportunity for more people to worry about dying for longer periods of time, it is only natural for people to look to medical options for having a ‘good death’. Moreover, as our ability to care for the expanding elderly population seems to be under some strain amid allegations of neglect and even abuse,\textsuperscript{16} it is hardly surprising that some people might prefer death over a period of mounting decrepitude at the mercy of strangers in a care home or hospital. Perhaps crucially, the generation currently confronting this rather grim prospect are the post-war generation, sometimes termed ‘babyboomers’,\textsuperscript{17} who have enjoyed relative prosperity and opportunity in a society which seems increasingly unwilling to let nature take its course in matters of life and death. As I shall consider, some of the sociological factors which precipitated legal change in the Netherlands may be present, at least to some degree, within the UK. Thus, we might consider whether sociological factors together with other recent developments have pushed the law to breaking point.

\textsuperscript{13} See for example (respectively), The Termination of Life on Request (Review Procedures) Act, Article 3.1 of the Belgian Law of Euthanasia, The Oregon Death with Dignity Act, The Washington Death with Dignity Act. For a time, euthanasia was also legalised in the Northern Territory of Australia by the Rights of the Terminally Ill Act 1995, but this was overturned in 1997. Some provision for legal euthanasia also exists in Japan and Columbia.


\textsuperscript{15} Ibid, p.1.

\textsuperscript{16} For example, an investigation by the Health Service Obudsman revealed that the NHS had “failed to provide even the most basic standards of care” for a number of elderly people. See ‘NHS shamed over callous treatment of elderly’, \textit{The Telegraph}, 14 February 2011. Available at \texttt{http://www.telegraph.co.uk/health/healthnews/8324569/NHS-shamed-over-callous-treatment-of-elderly.html} See also, \texttt{http://www.bbc.co.uk/news/health-15279794}

\textsuperscript{17} See ‘Why baby boomers want the ultimate freedoom’ at \texttt{http://www.bbc.co.uk/news/magazine-11550760}
With all this in mind, this chapter seeks to provide an overview of the ethical debate before I consider specific elements of the law, alongside the relevant moral issues, in the subsequent four chapters on the legal position in respect of killing and letting die, potentially fatal palliative care and assisted suicide. It is first, however, imperative to determine exactly what is under consideration.

1.2 What are we talking about?

The terminology employed in the debate over assisted dying is notoriously confusing. ‘Assisted dying’ is an ambiguous term which arguably encompasses a range of behaviour. At one end of the spectrum we have minor assistance in suicide, which might be almost inconsequential in terms of contributing to the suicide, whilst at the other end of the culpability spectrum, we have active killing on merciful grounds, regarded legally as murder but generally termed ‘euthanasia’ or ‘mercy-killing’ in this context. Moreover, the term ‘assisted dying’ might be seen to mean different things to different people, and, the fact that the term has effectively been hijacked by the pro-legalisation lobby only heightens the problems of interpreting the terminology. Indeed, the perils of language in this context are well documented. Accordingly, it is essential to determine exactly what is under consideration and, for the purposes of this thesis, which terminology will be utilized.

The word ‘euthanasia’ derives from the Greek words eu, meaning ‘good’, and thanatos, meaning ‘death’. Modern usage of the word denotes an action perpetuated in order to provide what we might regard as a good death, defined by the Oxford English Dictionary as ‘a gentle and easy death, the bringing about of this, especially in the case of incurable and painful disease’. An alternative definition was considered by the House of Lords Select Committee on Medical Ethics: ‘a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering.’ But despite the positive implications of both contemporary and traditional definitions of euthanasia, some opponents of any relaxation to the current law are keen to link the term ‘euthanasia’ to the Nazi eugenics atrocities of the 1930s and 40s. Thus, the evil potential of advocating the supposedly ‘good’


19 House of Lords Select Committee on Medical Ethics, Report, HL Paper 21-I (Session 1993-1994) [20].
death that euthanasia offers is highlighted via a link to the murderous activities of an evil regime.\(^\text{20}\) Whilst such a link clearly presents a red herring in the context of the modern debate, it does illustrate the tension within the terminology.

The word ‘euthanasia’ generally might be thought to carry medical connotations, involving cases where doctors provide lethal treatment in order to end suffering. We might contrast this with the non medical equivalent act, where a partner or relative takes active measures to end the suffering of a loved one; more commonly deemed a ‘mercy-killing’. Moreover, depending on the circumstances surrounding the action, different forms of euthanasia can be identified: voluntary euthanasia involves a request from the patient to die, in contrast to non-voluntary or even involuntary euthanasia, where no such request has been made and indeed, where involuntary euthanasia is concerned, the patient has articulated a desire to live. Furthermore, euthanasia might be categorised as active or passive, depending on whether death was caused by an act (such as a lethal injection) or omission (such as withdrawing life-support). Here, I will deem euthanasia to mean instances where active measures are taken to cause death, although, as I explore in the next chapter, causing death by omission rather than action does not, in my view, dictate the moral character of the decision to cause death.

The Dutch have adopted a narrow meaning of the word ‘euthanasia’ which denotes only active medical killing on request and, for the purposes of this thesis, and in the interests of using straightforward language, I shall follow their example, taking the word ‘euthanasia’ to mean only active consensual killing carried out by a medical professional, unless otherwise indicated. Where consideration is given to equivalent acts carried out by non-medics, such as where a relative is motivated by mercy to kill a seriously-ill person, I shall term such actions mercy-killings.

The term ‘assisted suicide’ is less complex, meaning action taken in order to assist, aid, help, encourage or facilitate the suicide of another person, where the final act which causes death is taken by the person wanting to die rather than the agent who is assisting. Until quite recently, the Suicide Act 1961 utilized the words ‘aiding, abetting, counselling or procuring’ to denote assistance in suicide. This terminology was updated by an amendment to the Coroners and

Justice Act 2009,\textsuperscript{21} so that the terms ‘encouraging or assisting’ now indicate potential liability under the Act. Nevertheless, tension resides in our understanding of the moral significance and nature of any given act of assistance, and with respect to our understanding of the terminology employed by the Suicide Act. Whilst many might view certain acts of ‘assisting’ in suicide as potentially benevolent, the same probably cannot be said about ‘encouraging’ a suicide. As I explore in chapters 4 and 5, the new terminology might be seen as reflecting both prosecutorial and juridical perceptions of unacceptable or inexcusable complicity in suicide compared to that which is excusable: to reluctantly and compassionately ‘assist’ being excusable, in contrast to cases whether the defendant has been rather too enthusiastic in ‘encouraging’ the suicide of another.

Assisted suicide may be further categorised in relation to the nature of the assistor; ‘physician-assisted suicide’ (PAS) involving assistance from a doctor (acting in his/her medical capacity), with such assistance by others simply being termed ‘assisted suicide’ or more specifically, ‘relative-assisted suicide’ (RAS) or ‘friend or family-assisted suicide’ (FAS).

Returning to the broader question of what is meant by ‘assisted dying’, I do not propose to embrace the narrow meaning advanced by some sections of the pro-legalisation lobby. For example, the organisation ‘Dignity in Dying’ have adopted the following definition of assisted dying:

An assisted death is where a doctor prescribes a life-ending dose of medication to a mentally competent, terminally ill adult at their request, and the patient then chooses to administer the medication themselves. Assisted dying is different to euthanasia and assisted suicide. Euthanasia is a term often used to describe life ending medication being administered by a third party. Assisted suicide refers to providing assistance to die to someone who is not dying.\textsuperscript{22}

Clearly, by distinguishing assisted dying from euthanasia and assisted suicide for non terminally-ill people, the organisation is attempting to disassociate their objective (to legalise PAS for the terminally ill) from other types of assisted dying. Thus, their aim in projecting a narrow understanding of what constitutes an assisted death might be viewed as an effort to

\textsuperscript{21} Where the potential offence under section 2 of the Suicide Act 1961 occurred on or after 1 February 2010, the amendment provided by section 59 and schedule 12 of the Coroners and Justice Act 2009 applies.

\textsuperscript{22} See, \url{http://www.dignityindying.org.uk/assisted-dying.php}
portray this as a clinical option of last resort, distanced from traditional concepts of suicide and euthanasia and perhaps more akin to a form of end-of-life care. For the purposes of this thesis, however, and in the interests of pursuing a more objective exploration of the issues, assisted-dying shall encompass both euthanasia and assisted suicide carried out by both physicians and lay people. Assisted-dying should not be regarded as including examples of assisting in suicide where the assistor has facilitated the death of another in circumstances where the death of the victim might be regarded as a ‘tragedy’ in every sense of the word, there being no rational grounds for desiring death, rendering the defendant’s motives clearly suspect. This type of unjustified assistance, or, perhaps more aptly termed, encouragement in suicide is well-illustrated by the case of Wallis.\textsuperscript{23} Here, the defendant was convicted after he actively encouraged and then facilitated the suicide of a friend; a troubled young woman who suffered from minor mental health problems.

1.3 The debate

As Coggon has observed, it is no exaggeration to say that the literature on the subject of assisted dying is ‘staggering’.\textsuperscript{24} Were I to present a detailed review of the literature, there would be little space remaining in which to attempt a thesis. Accordingly, throughout this thesis there will, of course, be consideration of the most influential contributions to the debate, together with other relevant works but, for the purpose of this introductory chapter, I seek only to provide the reader with a brief overview of the debate by identifying the most significant arguments and contributions.

Predictably, the opposing arguments and issues which inform the debate are primarily principled and value-laden, with extremely entrenched ethical conflict over what is and what should be acceptable in relation to assisted dying. Because the differences between, for example, what John Harris\textsuperscript{25} and John Keown\textsuperscript{26} would like the law to look like, are principles

\textsuperscript{23} R v Wallis (1983) 5 Cr App Rep (S) 342.
\textsuperscript{25} See for example J Harris, The Value of Life: An Introduction to Medical Ethics (1985) London; Routledge and Kegan Paul.
which neither party would willingly cast aside, resolution is clearly difficult if not impossible. As Holm has argued:

...any move from the now prevailing status quo in most countries, i.e. that euthanasia is illegal will be a move that only involves loss seen from the point of view of a strict opponent of euthanasia.\(^\text{27}\)

On top of some quite extreme polarisation, the debate is also complex and diverse. Even where there is agreement on outcome, there may be disagreement about why a particular outcome is desired, with further divergence over the nature and scope of any solution. But in spite of deep polarisation, some recent and influential contributions have explored the possibility of compromise in order to move the debate forward.\(^\text{28}\)

1.4 Valuing life

Perhaps the most important moral barrier to legalising assisted dying is the sanctity of life doctrine. Many opponents of assisted dying, such as Keown and Finnis, would argue that legalisation is wrong primarily because of a perspective that life is intrinsically valuable and thus should be protected.\(^\text{29}\) The view that life is intrinsically valuable might often be founded upon a religious perspective, although those advocating this view insist that the intrinsic value of life is important irrespective of faith.\(^\text{30}\) As one might expect, across the range of opinions most people would seem to agree that life is valuable to some degree, but the extent to which any ‘value’ is founded in intrinsic worth or instrumental opportunity is contentious. At one end of the spectrum, a vitalist perspective supports a view that life is intrinsically precious and should be maintained all costs. Although there may be few supporters of a truly vitalistic perspective,\(^\text{31}\) as Keown has argued, confusion between the meaning of sanctity and vitalism has clouded understanding.\(^\text{32}\) In contrast to a vitalistic or sanctity perspective, others

\(^\text{30}\) Ibid.
would argue that life is only valuable when it has a certain quality which enables the subject to derive enjoyment from their existence so that life is viewed as being, on balance, more beneficial than burdensome. Philosophers such as Rachels, Harris, Glover and Singer, distinguish between simply being alive in the biological sense and having a life worth living. These scholars have developed John Locke’s theories surrounding consciousness, advancing the view that life is valuable only in so far as the person whose life it is regards their continued existence as beneficial. For example, according to Harris:

...[S]o long as someone has genuinely ceased to value life, and prefers death to continued existence, then they are not morally wrong to take their own life and neither is anyone who assists them or who acts for them where they cannot act on their own behalf.  

For many of those who oppose any legal change however, the inviolability of life is the most important reason for resisting assisted dying. Thus the sanctity principle holds that although life should not always be maintained at any and all cost, there is an intrinsic value to life irrespective of the person’s capacity to enjoy life and notwithstanding that a person may feel their life to be a great burden. Sanctity principles do not yield to autonomy, although they may be seen to yield to the need to show mercy and alleviate suffering, so that, for example, potentially life-shortening doses of analgesia may be justified via the doctrine of double effect.  

It is also interesting to note that the idea that life is inviolable, has presented a rare opportunity to unite religions in a consensus that assisted dying should not be permitted. Because of the theological nature of this argument however, its relevance in a secular society is open to question. For example, Jackson argues that because sanctity principles reflect a religious perspective, such principles have no place in secular law. But others have argued


34 See Harris (Ibid) p.83.


that sanctity principles are not necessarily founded upon a religious perspective.\textsuperscript{38} Thus, whilst secular versions of the sanctity argument might be most compelling to those who (coincidentally?) also have a strong religious faith,\textsuperscript{39} it is true that valuing life is not confined to those with a religious faith. There seems almost universal consensus that life is, to some degree, valuable. It is the extent to which this argument should present a barrier to those who no longer value their own lives; either because they are incapable, or because they have competently determined that death is the lesser evil, upon which there is intractable conflict.

### 1.5 Legalisation is dangerous: Abuse and the slippery slope

Others might argue that assisted dying is wrong, not (only) because of religious or even secular concerns regarding the value of life, but because of concerns that some people might be vulnerable or that it would be difficult to prevent abuses and maintain limitations. Some theorists who are primarily opposed to assisted dying on principled grounds, have also argued on practical, empirical or purportedly logical grounds that legalisation would be dangerous.\textsuperscript{40} The idea is that if one is not persuaded of the wrongness of assisted dying on sanctity principles, there are other less intangible reasons to oppose legalisation. Predictably, such concerns tend to focus on the effect legalisation might have on vulnerable individuals if somehow their lives came to be viewed as having less value. The elderly are also potentially vulnerable, and, as Biggs argues, elderly women in particular may choose death in order to avoid being a burden:

...if active euthanasia were to be permitted as a right, what is to prevent the endorsement of this right being translated into a duty? ...The experiences of women in the Cheyenne and Inuit societies who were expected to withdraw from their communities once they had outlived their usefulness as carers, are indicative of the dangers which could flow from laws permitting euthanasia.\textsuperscript{41}

---

\textsuperscript{38} For example Paterson argues from a secular natural law perspective that it is always morally wrong to intentionally kill another. (See C Paterson, \textit{supra} n.31).


Alternatively McLean has argued that not wanting to be a burden is a relevant and potentially justifiable reason for choosing death over life: ‘Indeed, being a burden – rather than simply perceiving oneself to be one – is arguably a morally acceptable and perfectly reasonable factor to take into account when planning for the future.’\(^{42}\) Although we might recognise that it could be potentially painful and upsetting to be a burden, and that we would naturally hope to avoid this, it is doubtful whether many people would accept ‘being a burden’ as a morally relevant factor which should allow access to an assisted death.\(^{43}\) Moreover, in reality, the feeling – whether real or perceived – that one is a burden, would be likely to come alongside physical and possible mental deterioration, and so it is likely that the anguish of being a burden would be just one aspect of what might be described as existential suffering.\(^{44}\)

The consequent concern that the option of an assisted death would inevitably become a duty for those who have become burdensome to their families (and/or wider society), links into slippery slope arguments for holding legalisation at bay. Such ‘slippery slope’ or ‘thin end of the wedge’ concerns rest on the presumption that we are unable to legalize one thing without inviting other more morally dubious, or even outright evil, things to the table. So, from an empirical perspective, it may be argued that no safeguards could possibly guard against abuse, mistake and general slippage from the acceptable to the unacceptable. Thus, any legalised model of assisted dying would defy effective regulation. Another strand to this argument holds that from a logical perspective, if we allow assisted dying because, for example, we respect the autonomous wishes of a person suffering from a devastating terminal illness, we should also respect the autonomy of people wanting to die for other reasons, or perhaps no good reason at all.\(^{45}\) Equally, if we are legitimising euthanasia in order to prevent suffering, then what is to stop us killing everyone who is suffering irrespective of there being a request. This is a brief summary of an argument that many appear to find compelling, notwithstanding that many others would refute the central premise of slippery slope

---


\(^{43}\) Although R Hardwig, for example, argues that there may be a duty to die. See ‘Is there a duty to die?’ Hastings Center Report 27, no.2 (1997) 34-42.

\(^{44}\) Interestingly, in the Netherlands, a debate about whether assisted dying should be available for those suffering existentially has been central to the ongoing phenomenon of assisted dying on request. See A Mullock, S Ost ‘Pushing the Boundaries of Lawful Assisted Dying in the Netherlands? Existential Suffering and Lay Assistance’, *European Journal of Health Law* 18 (2011), 163-189. I consider these issues in more detail in chapter 6.

\(^{45}\) For example see Keown (supra n.26) chapter 7.
allegations, and so I return to consider the perils of the slippery slope at greater length in chapter 6.

1.6 Caring not killing

Fear over possible consequences and side-effects has also perpetuated concern that legalization would take medicine in the wrong direction. For example, Gormally has argued:

One of the conspicuous dangers of legalization is that, before long, euthanasia would be seen as a convenient ‘solution’ to the heavy demands on care made by certain types of patients. Medicine would thereby be robbed of the incentive to find genuinely compassionate solutions to the difficulties presented by such patients.47

Like Gormally, the majority of palliative care specialists seem convinced that good palliative care and legal physician assisted dying are mutually exclusive. Indeed, the very ethos of palliative medicine rests on the ideal that it is possible to live until natural death without suffering, so the conflict with assisted dying is obvious. And notwithstanding the particular philosophy of (some) palliative doctors and nurses, the evidence suggests that doctors generally are not in favour of the legalisation of any form of medical assisted dying, whatever their specialism.48 Such opposition clearly stems from concerns that any physician involvement in killing is the antithesis of what doctors are trained and employed to do. Thus, the argument runs, to cross the line from caring to killing would be profoundly detrimental to the doctor/patient relationship. Patients may lose trust in doctors, fearing that the doctor may dispatch them rather than struggle to maintain health and life. Moreover, as the General Medical Council argued in their evidence to the House of Lords Select Committee on Assisted Dying, the ethical foundations of the medical profession would be damaged:

48 See C Seale, ‘Legalisation of Euthanasia or Physician-assisted Suicide: Survey of Doctor’s Attitudes’ (2009) 23 Palliative Medicine 205, 209. The survey revealed that the majority of doctors were opposed to any legalisation of PAS or euthanasia and opposition was particularly high amongst palliative doctors.
A change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities and their relationships with patients. Acting with the primary intention to hasten a patient’s death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence.\(^{49}\)

By contrast, some proponents of medically assisted dying would argue that the understanding that a doctor will comply with a request for an assisted death in order to prevent suffering serves only to promote the doctor/patient relationship. Moreover, that the relationship of trust is enhanced by the patients’ perception that his doctor will do all that is necessary (on request) to alleviate suffering. This perspective has been crucial to the legalisation of medically assisted dying in the Netherlands, where, notwithstanding societal differences and other factors which determine the quality of the doctor/patient relationship, the evidence suggests that patients enjoy enhanced relationships with physicians as a consequence of the possibility of a legal medically assisted death.\(^{50}\)

Another argument which is advanced by some quarters of the pro-legalisation lobby in relation to the role of doctors, contends that doctors are already covertly engaging in assisting dying, and so legalisation would invite such practices ‘above ground’, where they will be subject to scrutiny.\(^{51}\) Moreover, the ability to regulate and control what is (arguably) already occurring will prevent and reduce harm rather than facilitate it. The flaw in this argument is that the evidence (at least in this jurisdiction) that doctors are practising what might be deemed as euthanasia is largely speculative and, as I explore in chapter 3, most medical interventions that might invite suspicion of euthanasia occur immediately prior to the time at which the patient was in any case expected to die, thus clouding our understanding of the nature of the doctor’s act.

---


\(^{42}\) See also LR Kass, N Lund, ‘Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession’ (1996) 35 Duquesne Law Review 395, 402, 408-10, for an argument which supports the absolute taboo on PAS.


1.7 Autonomy

On the other side of the debate, for some, individual rights of autonomy and self-determination are the most important grounds for legalizing assisted dying. This focus on self-determination accords with the (apparently) increasing importance of autonomy generally within medical ethics and law, a position which derives from the liberal perspective that we should all have the right to self-determination and thus, we should respect this right in others. For example, in his evidence to the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, Harris argued that ‘when we are denied control at the end of our lives, we are denied autonomy.’ Similarly, Dworkin has argued that, ‘Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.’ Principles of consistency might also be seen to require a legal system which allows competent adults to refuse even life-sustaining treatment, in what might be viewed as a bid for suicide, to similarly respect autonomous decisions to die by more active measures.

But whereas there may be almost universal agreement that autonomy is important to some degree, not all would agree that we should go so far as to allow people to determine when they die and subsequently receive assistance in so doing. Moreover, such assistance might compromise the autonomy of the assistor, who might feel that they would rather not provide assistance but, for whatever reason, feels obliged to comply. Another concern is that the autonomy of vulnerable people will be constrained by a policy (of legal assisted dying) which, as discussed above, might be seen to invite the perception that dependent people are burdensome and thus should seek death in order to remove the burden from others.

Although the concept of autonomy – in its basic guise relating to the ability to self-determine – might seem straightforward, the concept is actually complex and subject to conflicting and varied interpretations. For example, Coggon has argued that there are three relevant

---


53 Para.41.


55 For example see Re B (Adult: Refusal of Medical Treatment) [2002] EWHC 429(Fam); [2002] 1 FLR 1090.
understandings of autonomy, with the potential for each to demand different outcomes. O’Neill’s work also considers contrasting accounts of autonomy, with a minimalist view which equates autonomy with ‘sheer choice’, whereas a non-minimalist view would expect choice to meet other standards. In common with O’Neill, some feminist accounts of autonomy view the minimalist approach to autonomy as essentially selfish. For example, Donchin argues that autonomy is essentially a masculine concept which overlooks the contextual subtleties in society. Thus, as we see, the apparently straightforward argument that competent adults should be free to self-direct themselves, is far from straightforward within the context of the end-of-life debate.

Unsurprisingly therefore, the question of which account of autonomy (for example, that of Harris or O’Neill?) is the most appropriate standard on the issue of assisted dying, to which any legal change should seek to give effect, is particularly vexed. While Harris’s unfettered autonomy would enable people to choose freely, such choice would inevitably impact upon both those called upon to assist and those who might be vulnerable to the option of death. For this reason, the issue of autonomy in assisted dying should, in my view, be treated with some caution in order to take account of the wider impact of allowing people to choose death.

The emergence and development of human rights has also gained momentum through the increasing importance of autonomy, particularly in health care, prompting some to argue that there is, or at least should be, a right to die. As discussed above, the court’s interpretation of human rights legislation – which read literally does not support any right to die – has unsurprisingly not recognised that any such right might flow from the legislation. More generally in health care, whilst we enjoy negative rights of autonomy, via the inviolable right of mentally competent to refuse even life sustaining treatment – which in the absence of consent would represent an assault upon the bodily integrity of the individual- we have neither the right to insist upon life-ending nor life-sustaining treatment.

59 For example see R English ‘No rights to last rites’ (2001) 151 New Law Journal 1844.
60 Re B (Adult: Refusal of Treatment) [2002] EWHC 429 (Fam); [2002] 1 FLR 1090.
1.8 Mercy

Leading on from the importance of respecting autonomy, another key argument advanced in favour of assisted dying is that to force people to go on living, enduring terrible suffering, against their wishes, is cruel and inhumane. The familiar cry is that ‘we would not subject an animal to such suffering’, thus, the argument runs, we should legalise assisted dying in the interests of compassion and mercy. As Rachels outlines:

Terminal patients sometimes suffer pain so horrible that it can hardly be comprehended by those who have not actually experienced it. Their suffering can be so terrible that we do not like even to read about it or think about it; we recoil even from its description. The argument from mercy says: euthanasia is justified because it puts an end to that.\(^{62}\)

Of course, palliative experts would argue that proper end-of-life care can adequately alleviate such suffering and so there is no justification for allowing euthanasia on the grounds of mercy or beneficence and I shall return to consider these issues in more depth later.\(^{63}\)

1.9 Dignity

For others, the fear of physical pain is not the most important reason for allowing assisted dying. Rather, indignity is for some the most important argument in favour of legal change. Indeed the most prominent right-to-die organisation in the UK recently changed its name to ‘Dignity in Dying’. The central proposition in relation to dignity is that we should allow people to die with dignity at a time of their own choosing. Moreover, respect for human dignity has been described as ‘the most important feature of Western political culture.’\(^{64}\) The rise of the importance of dignity corresponds to some extent with the primacy of autonomy within the medical context and the two concepts might be viewed as being interrelated on the issue of assisted dying. The perception that one’s autonomy is breached when one is

---

63 See chapter 3.
compelled to endure the indignities that the dying process might involve combines the two arguments into one central reason for permitting assisted dying.\textsuperscript{65}

The problem with framing an argument around dignity, however, is that there is a great deal of tension over its meaning. For some, dignity in dying means having an assisted death but others within the palliative care movement argue that dignity in dying implies a natural death which is free from pain due to palliative care. As Biggs notes, ‘It is the fluidity of the concept of human dignity that enables the hospice movement and the pro-euthanasia lobby to share the common goal of avoiding pointless pain and suffering at the end of life.’\textsuperscript{66} Clearly the meaning of dignity is highly context specific and, as McCrudden observes, ‘instead of providing a basis for principled decision-making, dignity seems open to significant judicial manipulation.’\textsuperscript{67} Despite this, I agree with McCrudden that the increasing respect for dignity is a positive force even if we are unable to define it in a way that accords with legalistic reasoning.

### 1.10 Acts and omissions

The debate about what is morally appropriate in end of life dilemmas has also turned upon the legal and moral distinction between acts and omissions. Thus, it is acceptable for health care professionals to bring about death via an omission once the duty to treat has expired but not to take corresponding active measures, irrespective of the arguably causative and consequential equivalence of acts and omissions in this context. In the wake of the decision in the case of \textit{Bland},\textsuperscript{68} in which the House of Lords determined that it was lawful to withdraw life support from a young man in a persistent vegetative state,\textsuperscript{69} much ink has been expended in attempting to unravel the legal and ethical minefield sown by this decision.\textsuperscript{70} As I explore in the next chapter, from a philosophical perspective, the justification for ruling that it is

\textsuperscript{65} For example this is the central argument utilized by the organisation ‘Dignity in Dying’. See http://www.dignityindying.org.uk/assisted-dying.php
\textsuperscript{68} \textit{Airedale NHS Trust v Bland} [1993] 1 All ER 821 (HL).
\textsuperscript{69} Following a crushing injury sustained in the Hillsborough tragedy.
\textsuperscript{70} For example, see JM Finnis, ‘Bland:crossing the rubicon’, \textit{Law Quarterly Review} (1993) 109, (Jul) 329-337, also, D Price, (supra n.26), and J Keown (supra n.26).
lawful to cause death by omission but not a causally equivalent action is difficult for many to reconcile, even presenting a rare opportunity for opponents in the debate to agree on this issue. Given that several of the Law Lords were troubled by the paradoxes raised by this case, the ethical storm which ensued was hardly surprising. For example, Lord Mustill said:

The acute unease I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable.\(^71\)

If the legal construction of what is permissible appears to be under some strain on the issue of the morality of an act versus an omission, a further question relating to consistency (raised above) links into this quandary. From a consequentialist perspective, many have argued that if it is acceptable to cause death via an omission, how can causing the exact same result (death) via an act be viewed any differently? Furthermore, a slow death may arguably be far worse than an immediate demise following a lethal injection. For example, Rachels opines;

...the process of being ‘allowed to die’ can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless... The doctrine that says that a baby may be allowed to dehydrate and wither, but may not be given an injection that would end its life without suffering, seems so patently cruel as to require no further refutation.\(^72\)

Similarly, those opposed to any intentional killing from a sanctity perspective would argue that purposely ending life is always wrong irrespective of how it is achieved. The decision in Bland also raises many questions about how we should assess what is in the best interests of patients with severe and permanent brain injuries. If, as Lord Mustill believed, neither continued life nor death was in the interests of Anthony Bland,\(^73\) how can we attempt to resolve what is in the best interests of such patients? As Lord Hoffman argued,\(^74\) it seems intuitively or morally wrong to view Anthony Bland as a being with no interests at all, and so

---

\(^{71}\) Supra, n.68, para.885.


\(^{73}\) Lord Mustill (in Bland, supra ,n.68) said ‘The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind.’

\(^{74}\) Lord Hoffman (ibid) said ‘it is demeaning to the human spirit to say that, being unconscious, he can have no interest in his personal privacy and dignity, in how he lives or dies. Anthony Bland therefore has a recognisable interest in the manner of his life and death.’
the question of how best to resolve such cases without either imposing false interests upon people whose biographical life is over, or, treating such people as less than human, is extremely challenging. Moreover, having considered many of the ethical arguments on each side of the debate, how can we attempt to resolve the much wider dilemma of what is in the best interests of society on the issue of assisted dying generally?

1.11 Conclusion

I have considered many, but by no means all, of the arguments which may be raised in the ethical debate over assisted dying. With respect to the moral conflict outlined in this chapter, it seems that the arguments against legalisation have, so far, proved compelling to the legislature. The fact that the legislature has set its face against euthanasia has inevitably set the judiciary - as the group called upon to determine the boundaries of the respective prohibitions – on a conservative path. Thus, it is a trite observation that those opposed to assisted dying seem to have their wishes far more fully recognised and represented by the legal prohibition against assisted suicide and euthanasia, than do their opponents on the other side of the debate. But despite the clear fact that the law prohibits assisted dying and thus seeks to discourage it, as I shall discuss in subsequent chapters, the law in practice - within a system of criminal justice - is prepared to quite blatantly overlook many incidents of assisted dying, particularly in relation to assisting in suicide. It seems that the law has evolved in order both to provide solutions to medical dilemmas and to adapt itself to societal pressure. This means that many of the arguments in favour of assisted dying are in fact tacitly, and sometimes even quite overtly, acknowledged by the law in action.

The subsequent chapters reflect upon the legal position, together with pertinent aspects of the ethical debate in the light of recent, and some not so recent, developments. Thus, I seek to consider whether, having regard for the competing ethical claims, and, in view of the competing dangers of both legalising and not legalising assisted dying, the current legal status quo is satisfactory in the 21st century.

75 For example, prosecution policy on encouraging/assisting suicide includes, in its factors tending against prosecution, a factor pertaining to the so-called victim’s ‘voluntary, clear, settle and informed decision to commit suicide’. This clearly identifies autonomy as being crucial to the DPP’s exercise of prosecutorial discretion.
CHAPTER 2
CUTTING THE THREAD OF LIFE

“How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law and nothing I have said casts doubt on the proposition that the doing of a particular act with the intention of ending life is and remains murder.”

2.1 Introduction

As Lord Browne-Wilkinson’s lament in the case of Bland (above) indicates, the ethical inconsistency which pervades the legal position in respect of withdrawing medical treatment in order to allow a patient to die is widely regarded as unsatisfactory. This chapter seeks primarily to grapple with the legal and ethical complexities of withdrawing life-sustaining treatment from patients who are not able to participate in decisions about whether they should live or die. Although the dilemma of sanctioning death in this context does not address the question of voluntary euthanasia, such cases are instructive as to the parameters of medical killing, and thus important to any study of end-of-life law. Before examining how the House of Lords justified a decision which they knew would lead to Anthony Bland’s death, I first set out the legal principles pertaining to action (and inaction) causing death in this context.

2.2 The law

It is a well established principle that English law prohibits active euthanasia through the common law criminal provisions relating to murder. In the medical context intentionally and actively ending the life of another person is murder irrespective of the health of the victim,

---

2 For example, see R v Cox (1992) 12 BMLR 38.
the consent of the victim, or any merciful motive on the part of the defendant.\(^3\) A conviction for murder must invoke a mandatory life sentence,\(^4\) and so it would seem that the message is quite clear. However, despite a seemingly unequivocal legal position, it might be argued that the law is far from clear particularly where the medical profession is involved. Whilst a lay person accused of a murder driven by mercy might invoke the partial defence of diminished responsibility or else face a lengthy spell in prison for murder, the doctor facing a possible murder charge in the context of providing euthanasia will look to other legal devices which I shall explore in this and the following chapter.

The question of whether a doctor’s actions have crossed the line of the criminal law (with regard to not killing but not necessarily maintaining life) will therefore depend on a number of legally constructed determinations relating to both murder and gross negligence manslaughter. Firstly, in relation to the doctor’s role in the patient’s death (the *actus reus*); should the doctor’s action be viewed as a positive act or a failure to act in a situation where there was a duty to undertake some positive action? Obviously a doctor owes a duty of care to her patient and thus, is amongst a category of defendants who may be liable by omission under English law.\(^5\) But if a treatment is deemed futile or burdensome, and is therefore not clinically desirable, or if a competent adult patient refuses to consent to treatment, then the duty to treat expires and so a doctor will not subsequently be rendered criminally liable for omitting or failing to treat such a patient. For example, the tragic case of *B v NHS* confirmed the principle that a competent adult has an inviolable right to refuse even life-saving treatment.\(^6\) Moreover, treatment in the face of a competent refusal amounts to battery.\(^7\)

---

\(^3\) Note also that when a determination is to be made regarding the withdrawal of life-sustaining treatment, section 4(5) Mental Capacity Act 2005 provides: ‘Where the determination relates to life-sustaining treatment [the person making the decision] must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.’

\(^4\) Although a ‘belief’ by the defendant that the murder was an ‘act of mercy’ is a relevant factor which may count towards a reduction of the minimum period of imprisonment under the Criminal Justice Act 2003, section 269, Sch 21, [11(f)].

\(^5\) Generally speaking, unlike some jurisdictions (e.g. France) English law does not impose a positive duty to act in order to save the life of another unless the defendant has a specific positive legal duty to safeguard the health and life of another because, for example, of their relationship, or because the defendant has created the danger in question. For example, a doctor has a positive duty towards her patients, parents have a positive duty towards their children (e.g. *R v Gibbins and Proctor* (1918) 13 Cr App Rep 134), and a positive duty may exist when one has undertaken to care for a vulnerable person (e.g. *R v Stone and Dobinson* [1977] 2 All ER 341, CA).

\(^6\) See *B v NHS Hospital Trust* [2002] 2 All ER 449.

\(^7\) Ibid. Ms B was awarded nominal damages for battery following the hospital’s continued treatment of her following her refusal.
If there does appear to be culpability through an identifiable actus reus, either through an act or a failure to act, it will then be necessary to assess whether the doctor’s role was sufficiently causative. With any ‘result’ crime, where conviction depends on proving that the suspect caused the bad consequence, showing causation can sometimes be problematic but problems are multiplied within the medical context, where victims are invariably not in good health to begin with. Thus, where doctors or other health professionals are under suspicion, the issue of causation will rest on whether the patient died as a result of the doctor’s act or omission, or, in situations where there is some uncertainty, whether, and to what proportion, death resulted from a combination of the doctor’s actus reus and the patient’s poor health. In the latter situation, the question will hinge on whether the doctor’s role was a sufficiently significant contributing factor. Causatively speaking, the doctor’s act need not be the sole (or even perhaps most overwhelming) cause of death, but it must at least be a significant contributing factor. In practice, as I shall discuss in chapter 3, establishing that any doctor accused of patient homicide actually caused the patient’s death is often the most significant hurdle faced by the prosecution. Unsurprisingly, proving beyond all reasonable doubt that a doctor’s conduct caused the death of a person who was in any case dying, is often impossible.

If there seem to be sufficient grounds to allege that the doctor did cause the death of the patient, the next question is whether the defendant had the requisite criminal mind or mens rea. Thus, the doctor’s actions in relation to her mental state at the time of the actus reus will then be scrutinised in order to determine whether the mens rea for murder was present. On this point, the question being: did the doctor intend to kill or seriously injure her patient? The finding of criminal ‘intention’ does not necessarily require proof that the defendant did ‘want’ or ‘desire’ the death or serious injury of the victim. The law requires only for there to be sufficient evidence upon which a jury may conclude that the defendant acted (or failed to act) with the realisation that death or serious injury was a virtually certain consequence of the act or omission in question.\footnote{R v Woollin [1999]AC 92(HL).} If it seems that intention was present, either directly or obliquely, then the doctor may face a murder trial. Alternatively, although not relevant to the issues considered here, if it is clear that the doctor possessed no such intention and had instead committed a terrible, and ultimately fatal, mistake, liability will be determined.
according to the perceived degree of negligence. Evidence that the mistake (negligence) was very serious or gross may then give rise to a prosecution for gross negligence manslaughter.⁹

And so it seems that in order to avoid being prosecuted for murder, a doctor must not intentionally (or perhaps actively) kill but neither must she necessarily maintain life. Thus, the legal landscape may be summarised by the words of A H Clough, a Victorian poet, who wrote, ‘thou shalt not kill, but need’st not strive officiously to keep alive’. Interestingly, although Clough’s words prophesized the key principle underpinning the law, as well as becoming a sort of mantra for doctors, it was not his intention that these words should be taken literally. As Kuhse and Singer point out, Clough’s poem was:

[A] biting satirical attack on those who profess to respect the Ten Commandments, but in fact betray their spirit at every point. For Clough the idea that it is alright to allow people to die, as long as one does not actually kill them, is just this sort of betrayal of the spirit of the commandment.¹⁰

To some extent, the ethical tension surrounding what is permissible in relation to not killing but letting die is reflective of the contrast between Clough’s unfortunate and inadvertent legacy and his intended moral message.

This chapter therefore seeks to explore the legal and ethical landscape for doctors suspected of killing their patient through an omission or the withdrawal of life-sustaining treatment (the next chapter will address the law in relation to more active killing). I consider the tragic case of Anthony Bland and the storm of academic debate prompted by the House of Lords’ decision. After exploring whether alternative justifications for sanctioning death hold any greater appeal than the route taken, I suggest that the issue of consent might be developed in order to accord more rights to patients in a permanent vegetative state. Because my reflections focus on not only the reasoning in Bland, but also other potential routes which the Lords might have chosen to sanction Bland’s death, stopping short of actively terminating his life, I conclude this chapter by considering the conjoined twins case (Re A¹¹). In Re A the court had no option other than to sanction active killing in order to achieve the desired

---

⁹ Did the behaviour of the doctor show a disregard for the life and safety of the patient? Was the defendant’s conduct reprehensible? For example see R v Adomako [1995] 1 AC 1.


consequence and so I conclude this section by asking whether the defence of necessity might be similarly utilised in order to end the life of a patient in PVS.

2.3 Killing or letting die - Crossing the Rubicon?

Is the court to assume the role of God and decide who should live and who should die? Is Anthony Bland to die because the quality of his life is so miserable? Does this mean that the court would approve the euthanasia of seriously handicapped people? And what about the manner of his death? Can it ever be ever be right to cause the death of a human being by deliberately depriving him of food?12

The tragic case of Anthony Bland13 set the legal parameters regarding a doctor’s duty to a patient in a permanent vegetative state14 (PVS). In 1989 Anthony Bland sustained crushing injuries and deprivation of oxygen in the Hillsborough stadium disaster, which led to catastrophic and irreversible damage to his higher brain centres leading to his being in a state of PVS. By the time the case reached the House of Lords, Anthony Bland had been in PVS for three and a half years and medical opinion unanimously concurred that there was no hope of improvement or recovery. Anthony Bland’s family supported the hospital’s application to withdraw life sustaining treatment from Anthony, saying that although Anthony had never expressed any opinion regarding his wishes in the event that he found himself in such a terrible predicament, it was their view that he ‘...certainly wouldn’t want to be left like he is.’15 As one might expect, Anthony’s predicament had a devastating effect on his family. In a fascinating article written some years after this case unfolded, one of the neurologists responsible for Bland’s treatment, Dr J Howe, wrote of Bland’s family:

Certain that their son would not have wanted to be kept alive in a vegetative state and beyond recovery, they saw no purpose in continuing the treatment... Gradually his limbs became more contracted, but at no time was there any sign of awareness or

---

12 Hoffman LJ in Bland (see n.1 above) para. 825.
13 See n.1.
14 At the time this was known as a persistent vegetative state. This state is defined as ‘a clinical condition of unawareness of self and environment in which the patient breathes spontaneously, has a stable circulation and shows cycles of eye closure and opening which may simulate sleep and waking’ (The Royal College of Physician guidance 2003).
15 2 WLR 316 at paragraph 797.
communication. His mother and sister began to find it difficult to visit. His father had nightmares about his son and the care team became disheartened.16

As Howe reports, the controversy that blew up around Bland’s fate came as something of a surprise to those involved in his care. Having confirmed Bland’s terrible brain damage and consequent vegetative state quite soon after the Hillsborough tragedy, both the medical team and the Bland family agreed that continuing to prolong the patient’s life would serve no purpose. According to Howe, such treatment withdrawal was established within medicine, particularly in the US and Canada, as accepted practice in such a case and indeed, such decisions are made every day in hospitals. Thus, a date was set to withdraw life-sustaining treatment and, as a precaution, Howe wrote to the Sheffield Coroner to inform him of the intended course of action. To Howe’s shock, the Coroner wrote back to say that to undertake such a course of action would be tantamount to murder. This dire warning was confirmed to be true by the police and so, greatly dismayed by the view of the authorities, Mr and Mrs Bland initially rejected the hospital’s suggestion of applying for a declaratory court order. Eventually however, following an infection which took hold of their son and necessitated surgery, the Bland family decided that a court application was necessary and the rest is legal history.

The legal determination of Bland’s fate rested on whether it would be lawful for the medical team to withdraw artificial hydration and nutrition, together with antibiotic treatment for infection, from the patient, thereby allowing him to die. In a conceptually and morally challenging ruling, the House of Lords unanimously agreed that the NHS Trust could lawfully withdraw life sustaining treatment. Their decision hinged on several issues: whether artificial hydration and nutrition constituted ‘treatment’ or basic care; whether or not there was a duty to continue with such treatment; whether withdrawing the feeding tubes constituted an act or an omission; and crucially, what course of action was in the best interests of the patient? In addition to these extremely complex legal and ethical questions, the Lords were also compelled to consider wider moral issues, such as the importance and extent of the sanctity of life principle.

Emily Jackson has succinctly summarized the main points upon which their Lordships agreed:

• First, the lords were unanimous that the principle of the sanctity of life, while important, was not absolute.

• Secondly, artificial nutrition and hydration was agreed to be medical treatment and not basic care.

• Thirdly, the Lords – with some notable reservations – accepted that withdrawing artificial nutrition and hydration was an omission rather than an action.\(^\text{17}\)

• Fourthly, prolonging Tony Bland’s life had ceased to be in his best interests.

• Fifthly, since treatment was no longer in his best interests, the doctor is no longer under a duty to prolong his life, and treatment withdrawal could not constitute the actus reus of murder. Indeed, Lord Browne-Wilkinson and Lord Lowry went further and suggested that if continued treatment was not in Tony Bland’s best interests, the doctors might actually be under a duty to cease treatment.\(^\text{18}\)

Ultimately therefore, the rationale for facilitating Bland’s death was founded upon an interpretation of the law, as applied to the facts in hand, which held that although the doctors did intend to cause death, they were not criminally culpable because there was no actus reus generated by an omission in this context because the duty to continue treating the patient had lapsed.

This decision, which led to the death of Tony Bland nine days after the cessation of treatment, re-ignited a debate which had quietly simmered for a number of years over the morality of withdrawing life support from a permanently insensate patient.\(^\text{19}\) Huxtable has considered how pre Bland theorists grappled with this dilemma (showing ‘remarkable clairvoyance’) and, in doing so, provided the House of Lords with some academic food for

\(^{17}\) The Lords struggled with the dilemma of how a physical act (namely, switching off a life-supporting piece of equipment or withdrawing a nasogastric tube) might be regarded as an omission. For example, Lord Browne-Wilkinson resolved this issue by stating, ‘...if, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient’s stomach, that would not be an act of commission... In my judgement, essentially what is being done is to omit to feed or ventilate: the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission. Supra n.1 at para.882.


\(^{19}\) Prior to Bland, a US case, Re Quinlan (1976) NJ 355 A 2d 647, had prompted a debate over the morality of withdrawing treatment from a patient in PVS. The American court empowered the patient’s father with the ultimate decision on the basis that he would do what he thought his daughter would wish, as a substituted judgement. Thus, Quinlan’s father determined to withdraw the ventilation on which his daughter relied. Following removal from the ventilator however, Miss Quinlan continued to breathe unaided and survived for a further decade.
thought upon which to ponder Bland’s fate.\textsuperscript{20} As Huxtable notes, although there were some differences in opinion, the theorists seem to concur in ‘...their somewhat tautologous and inherently questionable claims that the doctor is innocent because he should be innocent.’\textsuperscript{21} Thus, a cynical observation might be that the House of Lords were set on a course which would lead to Bland’s death, because that was the morally preferable option, and the justifications for facilitating death would be constructed one way or another. In the event, the preferred justification rested on the claim that causing Bland’s death was not criminally culpable because the ‘measures’ that led to it were negative rather than positive. Moreover, such negative ‘measures’, otherwise known as omissions, are not culpable where there is no duty to take action because continued treatment is not in the best interests of the patient. As Glover outlines:

What we might call the ‘acts and omissions doctrine’ says that, in certain contexts, failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has the identical foreseen bad consequences.\textsuperscript{22}

Thus, the debate over the Lord’s chosen rationale centres on the question of whether the ruling constitutes a logical and ethically defensible solution to an extreme dilemma, or, whether the ruling rests upon a morally dubious distinction which renders the law both incoherent and hypocritical. The legitimacy of the decision, resting as it does upon the acts/omissions doctrine, is viewed as particularly hypocritical to those who consider letting someone die to be morally equivalent to killing them. For example, Lord Mustill, who was especially troubled by this element of the dilemma, stated:

...however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable. By dismissing this appeal I fear

\textsuperscript{20} R Huxtable (\textit{Euthanasia, ethics and the law: From conflict to compromise}, 2007, Routledge Cavendish, pp116-123) provides an account of the academic debate and key contributors over this period including, for example, the contributions of Williams (e.g.‘Euthanasia’, \textit{Medico-Legal Journal}, 1973, 41:14-34.), Kennedy (e.g.‘Switching off life-support machines: The legal implications’ \textit{Criminal Law Review}, 1976, 443-452), and Skegg (e.g.‘The termination of life-support measures and the law of murder’, \textit{Modern Law Review}, 1978, 41:423-436).

\textsuperscript{21} Ibid, p.122.

that Your Lordships’ House may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen.\textsuperscript{23}

Lord Browne-Wilkinson expressed similar concerns.\textsuperscript{24} From both a sanctity perspective and from a consequential perspective, it matters not whether death was due to an act or an omission. As Harris has argued, ‘...what matters is how our actions and decisions affect the world and other people, not whether our responsibility for the effect is positive or negative.’\textsuperscript{25} Indeed, it may even be argued that having taken the decision to bring about a patient’s death it is more beneficent to swiftly end life rather than have them slowly fade away.\textsuperscript{26}

Indeed, across the spectrum of opinion, whilst there is predictable disagreement over what the House of Lords should have done, there is widespread agreement that the ratio of the decision is ‘morally and intellectually misshapen.’\textsuperscript{27} For example, Ashworth opines that ‘the proper solution is not to warp the concepts of omission, duty, knowledge and causation but to provide for ...cases to be determined on new principles of justification...rather than concealing the reasons behind the act/omission distinction.’\textsuperscript{28}

For those, such as Finnis and Keown, who are opposed to any relaxation in the law,\textsuperscript{29} the ruling crossed a dangerous line in sanctioning Bland’s death; their key concern being that the decision would lead to further unwelcome developments leading to slippage down a perilous slope towards widespread euthanasia. As Keown observed, ‘Hoffman LJ said that it was “absurd to conjure up the spectre of eugenics” as a reason against the decision in Bland.

\textsuperscript{23} Supra n.1 at 887.
\textsuperscript{24} For example; ibid at para. 887; ‘The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable.’
\textsuperscript{26} For example, Lord Goff supra n.1 at para.865 says; ‘...it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies.’ This point was raised by James Rachels, who wrote, ‘...the process of being ‘allowed to die’ can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless...’ J Rachels in ‘Active and Passive Euthanasia’ (1975) 292 New England Journal of Medicine 79-80.
\textsuperscript{27} Lord Mustill, Supra n.1.
However, once Quality supplants inviolability, there is no reason in principle why the quality threshold should stop at pvs.’ 30 Moreover, according to Keown, the House of Lords completely misconstrued the sanctity of life principle. He argues that the House of Lords mistakenly understood a vitalistic approach rather than a proper understanding of the sanctity principle. Thus, faced with an apparent choice between vitalism and a quality of life approach, the Lords chose the latter. Keown opines that the true version (or at least his construction) of the sanctity or inviolability principle, allows for omissions or even acts which might result in death under certain circumstances provided the agent does not intend to cause death. This is founded upon the doctrine of double effect, which holds that in certain situations an agent is not culpable for the potential bad consequences of his actions provided he intends only the good consequences. In end-of-life care, (as I discuss at length in the following chapter) this doctrine traditionally lends itself to doctors administering pain relief and/or sedative medication to dying patients whose death might be hastened by the drug treatment. Thus, Keown argues that a morally preferable route to allowing Bland’s death would have been to determine that the doctors did not intend to kill Bland, but rather intended only to discontinue futile treatment. Whether the (already contentious) doctrine of double effect would support a justification for allowing Bland to die on the basis that the doctors intended only to discontinue treating, but not to cause the patient’s death by such discontinuation, is, in my view, doubtful. Moreover, from a logical perspective, if Keown and Finnis are correct to contend that the decision has placed us at the start of a slippery slope, it is difficult to see how their preferred approach would save us from this peril. Sanctioning Bland’s death on the understanding that the consequence is morally acceptable provided the doctors did not intend it, would not remove or reduce any potential for slippage. Another option available to the House of Lords, according to McGee, who has dismissed Keown’s claim regarding intention,31 would have been to rest the decision on causation rather than any legal distinction between acts and omissions. This argument puts any moral

30 Keown, ibid, at p.496.
31 A McGee, ‘Finding a Way through the Ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia’, Medical Law Review, 2005 13(3):357-385. McGee’s paper focuses mainly on J Keown and J Finnis’ arguments regarding the implications for intention in this context. McGee rejects Keown’s contention that withdrawing treatment from a patient in PVS should be justified by reference to the doctrine of double effect, so that the doctors do not intend death but merely foresee it as a side-effect to a beneficial course of action. McGee counters that such a position is untenable as the perceived benefit (putting an end to a burdensome existence) is only achieved as a consequence of the so-called side-effect (death). Stauch and McLachan have also considered a causal distinction (see above, n.28).
difference between acting and not acting to one side, contending instead that there is a clear *causal* difference between killing a person and letting them die naturally. Such a causal distinction may, depending upon one’s viewpoint, equate to a moral as well as a legal significance between the two courses of action. As McGee argues:

In withdrawal, we are not taking control of death in the way we do in the practice of euthanasia because the issue in withdrawal is when we should stop *artificially prolonging* life and allow nature to take its course.  

McGee contends that in rejecting the proposition that the doctors would not be causing Bland’s death, (for example, Lord Mustill\(^\text{33}\) cited the clear connection between the doctors’ actions and Bland’s death as evidence that in withdrawing Bland’s life-support the doctors *would* cause his death) the House of Lords overlooked a more compelling argument than the one they ultimately chose. Notwithstanding that ‘but for’ having his life support withdrawn Bland might be alive today, is McGee correct to say that the actual and ultimate physiological cause of Bland’s death was his original injury sustained at Hillsborough? Determining what ultimately killed Anthony Bland is not straightforward. In one sense Bland might be seen to have died from his injury, as it rendered him unable to maintain his life without medical assistance. But with respect to establishing a cause of death, it is clear that Bland died of starvation/dehydration as a direct consequence of a medico-legal decision. I suggest a sensible conclusion would be to attribute Bland’s death to multiple causes: his injury and the withdrawal of treatment. Moreover, in cases such as this the context of the dilemma is crucial. In a scenario involving withdrawing treatment from a patient in PVS, the causal difference between killing a person and letting them die (by discontinuing the struggle to maintain life) might have a moral significance which is clearly not present in other situations where people have been found liable for omissions.\(^\text{34}\) However, as Price identifies, such a context specific argument may be problematic:

\(^{32}\) Ibid.

\(^{33}\) *Bland*, (see n.1) at para.895.

If “allowing nature to take its course” could not amount to a *sine qua non* of death, then a deliberate failure to treat a patient with straightforward death-averting therapy such as antibiotics could never generate liability.\(^{35}\)

It may be misleading to say that if we determine that in some circumstances “allowing nature to take its course” is not criminally causative then in *all* circumstances letting people die from their physical problems cannot be criminally causative. We can (and already do), distinguish between situations when it is ethical to allow nature to prevail and those where it is not. Whether this amounts to a rational argument equating to causation is less certain. Whilst McGee’s argument suffers from a similar problem to the distinction between acts and omissions – because it may be unconvincing that a proposed *legal* distinction amounts to a meaningful ethical distinction – it is, I would argue, marginally more satisfactory than the act/omission distinction, and certainly more rational than Keown’s suggestions regarding intention.

Clearly, given the highly varied nature of views on this morally contentious issue, determining the best approach as to how we should resolve the dilemma over how to treat people such as Anthony Bland will be challenging. Logically, it may seem perverse to argue that once we have determined that a person is better off dead it is morally preferable to let them die slowly than to kill them. Indeed, the argument which questions whether there is any moral difference in killing rather than letting die in this context is extremely compelling. However, for many people there is a morally significant difference which renders killing worse than letting die in this particular context. Moreover, the doctor’s role in this dilemma is crucial. Doctors engaged in caring for very sick patients often withdraw treatment because it is no longer in a patient’s interests to have life prolonged, either because the patient is in PVS, or more frequently because the patient is dying or because the patient has suffered terrible brain damage and there is no hope of recovery. Thus, withdrawing life-sustaining treatment seems to fall squarely within a range of ‘duties’ which a doctor might anticipate. By contrast, asking doctors to administer lethal injections in order to achieve the same end arguably does not sit comfortably within a doctor’s duties. Moreover, as I discussed in the previous chapter,\(^{36}\) doctors generally do not support proposals to change the law in order to

---


\(^{36}\) See p.28.
sanction euthanasia. Furthermore, it might also be argued that if there is to be any relaxation upon the prohibition of active killing, it should be founded upon the principles of autonomy and beneficence, and not on the basis that a person who is conclusively going to die as a consequence of having treatment withdrawn might as well be killed. Despite the argument that it might be more merciful to kill such a patient than to let them wither away, evidence suggests that sedation and analgesia alleviate any such suffering if indeed it exists at all for patients in PVS. Reporting on Anthony Bland’s death, Dr Howe wrote:

Good nursing care ensured that he looked peaceful to the end, the mode of his death appeared no different to other deaths in hospital. In the application, we had stated that the feeding tube would be left in place in case drugs were needed, but none were. About four days after we had stopped using the tube one of the nurses asked why we did not just remove it. This seemed like a nice idea, especially since it was clear that it was not needed. We took out the feeding tube and the urinary catheter, and removed every piece of medical equipment from the room. When Mr and Mrs Bland came back to sit with their son, they looked around the room in amazement and then Mr Bland said, “That is the first time he has looked like our Tony since the day he left for Sheffield.” For the first time in my working life I realised how intrusive medical kit can be. His death was peaceful and his parents were with him when his breathing stopped. Mr and Mrs Bland believe that their son died at Hillsborough in 1989.38

2.4 Better off dead?

Ultimately therefore, post Bland, the decision to terminate treatment and consequently to allow the lives of patients in PVS to end is dependent on ‘best interests’ determinations. As Lord Goff said in Bland, ‘if the treatment is futile...it is no longer in the best interests of the patient to continue it.’39 On the issue of futility, Keown is anxious to emphasize that the court’s decision confirmed that it was the treatment that was futile rather than the life of the

37 See n.28.
38 See n.16.
39 See n.1 at para.871. This principle has since been adopted in the Mental Capacity Act 2005 which states that it is not in a patient’s best interests to continue a treatment that is ‘futile, overly burdensome to the patient; or where there is no prospect of recovery.’
patient. Others, such as Price, have questioned this, saying ‘...it was inevitably the futility of his life that was in issue, not the continued treatment.’ Given that the ‘treatment’ did exactly what it was designed to do in keeping Bland alive, it seems more rational to agree with Price on this point. The treatment can only be regarded as futile if there is no purpose in continuing it, and unless it is agreed that the patient’s life serves no purpose and has become burdensome (and futile?) the treatment does have a purpose. Thus, the futility of the treatment rests upon the patient’s life being deemed futile. Of course, saying that any person’s life is ‘futile’ may be morally unpalatable for some, but, as Anthony Bland (being insensate) did not suffer his fate it is difficult to perceive his continued existence as burdensome to him. Continued treatment was arguably emotionally, and from a resources perspective, burdensome to everyone around Bland. From Bland’s perspective, as a previously healthy and conscious individual, it might be said that his continued life was undignified and tragic but, because Bland did not suffer, it is doubtful whether it is plausible to say his life was a burden to him. Thus, the dilemma of determining which course of action was in Bland’s best interests was a particularly thorny aspect of the decision.

Determining futility and consequent best interests has involved, at least with respect to identifying the medical possibilities, recourse to Bolam principles regarding what practices are accepted as ‘reasonable and proper’ according to medical opinion. As McLean has argued, quite apart from the fact that the Bolam test has been widely criticised and since modified, in this context the presumption that the decision is an inherently medical one ‘disguises the value-laden nature of the decision itself.’ But the extent to which the decision is inherently medical and/or moral is another challenging aspect of such cases. For example,

---

40 See Keown, (n.29).
41 See Price, n.35.
43 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582. The case of Bolam, together, more recently, with Bolitho v City and Hackney HA [1997] 4 All ER771, provide the guiding principle as to the standard of care expected of a doctor in consideration of whether a doctor has breached the duty of care for clinical negligence purposes.
44 See Bolitho, ibid.
in *Re S (Adult Patient: Sterilisation)*,\(^46\) recognising ‘judicial divergence’ on the approach, Thorpe LJ said:

...the Bolam test is applied only at the outset... In deciding what is best for the disabled patient the judge must have regard to the patient’s welfare as paramount consideration. That embraces issues far wider than the medical.\(^47\)

More recently however, the Mental Capacity Act (MCA) 2005 has codified some of the issues to be considered by the Court of Protection before life-sustaining treatment is to be withdrawn from a patient who has not made an advance decision or appointed a donee of a lasting power of attorney.\(^48\) Thus, under s.4(6) of the MCA the following matters should be considered (‘so far as is reasonably ascertainable’) when determining ‘best interests’:

(a) The person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) The beliefs and values that would be likely to influence his decision if he had capacity, and

(c) The other factors that he would be likely to consider if he were able to do so.

Whilst this consultative approach represents a step in the right direction in recognising the importance of wider non medical issues, it will always be difficult to try and second guess an incompetent person’s true autonomous desire. As Donnelly argues, ‘...it is important to remember that even close friends or family members cannot always know the past preferences or the relevant beliefs and values of the person lacking capacity.’\(^49\) While Donnelly points out that elderly people may express their wish not to be kept alive out of fear of being a burden, which may in fact reflect a need for reassurance, it is equally possible that relatives may seek to represent a patient as wanting to carry on living through a personal desire to see life maintained, particularly where children are involved.\(^50\) There may even be tension amongst those close to the patient over the preferred course of action. Such conflict was evident in the tragic US case of Terri Schiavo, when Mrs Schiavo’s husband was

\(^{46}\) [2000] 3 WLR 1288.


\(^{48}\) A donee of lasting power of attorney may refuse consent to life-sustaining treatment only if the instrument confers such power. To become operative, lasting powers of attorney must be registered with the Public Guardian. See section 9 Mental Capacity Act 2005.


\(^{50}\) For example see *Re Wyatt (A Child) (Medical Treatment: Parent’s Consent)*, [2004] EWHC 2247 (Fam).
convinced she would rather die, while her parents believed the opposite.\textsuperscript{51} In this jurisdiction the case of \textit{Re G} reflected a similar tension.\textsuperscript{52} The patient’s mother was opposed to the withdrawal of treatment while his girlfriend was convinced that he would not want to be kept alive in his condition. In addition to attempting to construct a picture of what the patient might have wanted, the profound difficulty in making any sound assessment of the best interests of a patient who in reality appears to have no interests of any kind is one of the most troubling aspects of this extremely difficult dilemma.\textsuperscript{53} Fenwick has considered this very problem, arguing that if patients in PVS are thought to have no interests, how can we determine best if, ‘...no pool exists from which to draw the ‘best’. The derivation is, therefore, simply not logical, yet this seems overlooked in judgements thus far.’\textsuperscript{54}

Also pertinent to the issue of withdrawing treatment from an incompetent patient, is a ‘rather curious’\textsuperscript{55} amendment to section 4 of the Mental Capacity Act 2005, which, in response to completely erroneous concerns that the MCA would encourage covert euthanasia, provides an additional consideration to be taken into account when deciding whether continued treatment is in an incapacitated person’s best interests. Section 4(5) provides:

‘Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.’

In practical terms this must mean that if a doctor decides that further treatment is futile and, having regard for all the circumstances, that sustaining life is no longer in the best interests of the patient, the doctor should only withdraw treatment provided he/she does not ‘desire’ the death of the patient. The precise meaning of ‘desire’ in this context is obviously open to debate, but it is difficult to envisage any doctor declaring an unwillingness to withdraw treatment when it is clinically indicated on grounds of futility because they have in their heart a desire to see a particular patient dead. As Coggon concludes, ‘...the section has been put

\textsuperscript{51} For more details of the Schiavo case see Brazier and Cave, \textit{Medicine, Patients and the Law}, 5\textsuperscript{TH} Edition, 2011, Penguin books, p.567.
\textsuperscript{52} \textit{Re G} [1995] 2 FLR 528.
\textsuperscript{53} As Lord Mustill said, ‘[T]he distressing truth which must not be shirked, is that the proposed conduct is not in the best interests of Anthony Bland, for he has no interests of any kind.’ At para.894.
\textsuperscript{55} Jackson, Supra n.18, p.951.
into the Act as part of a negotiation, but is in fact a sorry compromise. We may only assume that its lack of force is a foreseeable but unintended consequence of its insertion.\(^{56}\)

With all this in mind, we should note that although the judiciary, and not the medical profession, are the ultimate arbiters of ‘best interests’ in this capacity, the legal decision will (assuming that the relatives are in agreement with the medics), naturally rest upon the medical evidence and, provided it is capable of withstanding logical analysis,\(^{57}\) such evidence will generally be determinative. Notwithstanding Thorpe LJ’s comments in Re S,\(^{58}\) only in exceptional circumstances might a court be willing to question medical opinion. For example, in the recent case of An NHS Trust v J\(^{59}\), the court was unwilling to sanction immediate withdrawal of treatment from J, a 53-year-old woman who had been in PVS for three years. Instead, Sir Mark Potter P refused to grant the order sought in order to consider the effectiveness of an innovative treatment involving an insomnia drug (zolpidem).\(^{60}\) This ‘stay of execution’ came despite the fact that J’s family and the medical team advocated immediate withdrawal of treatment and feared that any revival of the patient would cause her to suffer. The zolpidem proved ineffective however, and, in the face of opposition from all those who cared for J, the court was unwilling to go any further by submitting the patient to a brain scan prior to withdrawing treatment, despite evidence which indicated that a scan might determine more conclusively whether the patient retained any consciousness.

But whether it is, in reality, doctors or judges who have the determining role in deciding when it is best to bring a particular patient’s life to a close, we might question whether either profession is sufficiently (morally) qualified to do so. With respect to the judiciary, extensive legal training and judicial experience is not necessarily indicative of great moral wisdom. Equally, whilst medical training and medical practice should be founded upon ethical principles, the focus is invariably on restoring health with comparatively minimal attention to medical ethics, and no real assessment of the doctor’s moral character.


\(^{57}\) See Bolitho v City and Hackney HA [1997] 4 All ER771.

\(^{58}\) See above, n. 46.


\(^{60}\) Evidence suggested that zolpidem might induce some consciousness in patients in PVS, however after three days of receiving zolpidem J was unresponsive.
2.5 The continuing role of the Court

Mindful of the extremely controversial implications of their decision, their Lordships attached a requirement that before treatment is discontinued in a case involving a patient in PVS, a declaration should be sought from the courts in order to prevent slippage from the principles set down in Bland. However, as Brazier and Cave have observed, ‘[T]he carefully constituted limitations built into Bland to keep that decision within bounds were eroded step by step.’ Brazier and Cave refer to a number of cases where the issue of whether the patient was truly in a PVS was inadequately addressed prior to the withdrawal of life-support. For example, in Frenchay Healthcare NHS Trust v S, the accidental disconnection of a feeding tube to a patient who was thought to be in PVS following a drug overdose two-and-a-half years previously, prompted the application to confirm the legality of discontinuing treatment. The Court of Appeal granted the declaration despite there being no independent medical opinion to confirm whether S was in PVS. Evidence of restlessness and distress, for which S had received treatment, cast some doubt as to the patient’s true condition. As Ost has observed:

The Frenchay decision may thus serve as an indication that the law has taken the first step down the slippery slope. In determining that treatment can be withdrawn from PVS patients, despite the existence of uncertain PVS diagnosis, the judges arguably failed to place PVS patients’ welfare at the core of their decision.

A similar observation may be made with respect to the court’s lack of determination to assess the level of consciousness in An NHS Trust v J. It is also worth noting that the court’s role in sanctioning withdrawal of artificial nutrition and hydration (ANH) for patients not conclusively in PVS seems to be acknowledged by the General Medical Council guidelines on the withdrawing and withholding of ANH:

---

61 The Lords stated that a declaration that withdrawal is lawful requires evidence that: (1) every effort should have been made to provide rehabilitation for at least six months; (2) diagnosis of irreversible PVS should not be confirmed until at least 12 months after the injury; (3) diagnosis should be agreed by at least two independent doctors, and; (4) generally the views of the patient’s immediate family will be given great weight. Per Lord Goff para.870-871.
65 [1994] 2 All ER 403.
67 Supra n. 59.
‘Where you are considering withdrawing artificial nutrition and hydration from a patient in PVS, or condition closely resembling PVS, the courts in England, Wales and Northern Ireland currently require that you approach them for a ruling.’

This approach is also sanctioned by the British Medical Association in their guidance on withholding and withdrawing life-prolonging medical treatment, which arguably further expands the ratio of *Bland* by sanctioning withdrawal from patients with other non-terminal conditions such as severe dementia or stroke victims. The legitimacy of withdrawing such treatment from patients in PVS from a human rights perspective has also been confirmed in *NHS Trust A v M: NHS Trust B v H*, with the decision that to do so does not breach Article 3 of the European Convention on Human Rights.

### 2.6 PVS, minimally conscious or locked-in?

Clearly, diagnosing PVS is extremely challenging, and because of its rarity, establishing a universal set of suitable criteria upon which diagnosis should rest is far more difficult than with other more prevalent conditions. More recently, the complexities involved in diagnosing PVS, and the inherent dangers of withdrawing life-support from brain damaged patients, have been starkly illustrated by a number of cases in which patients thought to have been in PVS have proved in fact to be in a minimally conscious state (MCS), or even sentient but suffering from a condition known as ‘locked-in’ syndrome.

---

70 [2001] 1 All ER 801.
71 Article 3 provides that ‘No one shall be subject to torture or inhuman or degrading treatment or punishment.
73 Ibid, p.87, ‘In a review of 1000 UK doctors in specialities likely to encounter vegetative patients 46 percent had never encountered one, 31 percent had seen less than five and 10 percent more than ten.’
74 Following *Bland* the House of Lords’ Select Committee on Medical Ethics recommended that PVS should be defined and a code of practice developed. In April 1996 the Royal College of Physicians produced a set of guidelines, *The Permanent Vegetative State*, which were updated in 2003: *The Vegetative State: Guidance on diagnosis and management*. 
In November 2009 a story emerged that raised some disturbing evidence about our assumptions over patients in PVS. According to initial reports a Belgian man, Rom Houben, had, for 23 years been trying in vain to communicate his consciousness to doctors and nurses who had concluded that he was in PVS. In the years following his injury, which he sustained in a road accident, only Houben’s mother regarded him as being sentient until he was assessed by Steven Laureys, a medical scientist in the coma science group at Liege University in Belgium. Following a brain scan, Laureys found that Houben’s cerebrum was functioning and subsequently it was apparently discovered that Houben was able to make some limited voluntary movements which seemed to enable him, with the assistance of a carer, to communicate via a keyboard. Subsequently, and following a dispute as to whether Houben’s contribution to this means of communication was valid, it was revealed that there was in reality no such communication. In fact Houben’s mother and carer had - in their desire to have Houben’s life recognised as being full and deserving of respect - dishonestly represented the patient. But despite this rather misleading story, Laureys estimates that as many as 40 percent of patients described as ‘vegetative’ are still being misdiagnosed, and, a number of patients are reported to have suffered such a misdiagnosis.

Other recent research by Professor Adrian Owen, considered by Skene et al, suggests that some patients in a vegetative state may be able to follow instructions leading to a pattern of brain activity that can be observed by a brain scan. Professor Owen asked 17 patients diagnosed as vegetative or minimally conscious to imagine carrying out particular activities.

75 Houben’s story was widely covered in the media. See for example, The Sunday Times, 29th Nov.2009.
77 Scientific evidence does not support the contention that Houben was genuinely communicating via his carer. Evidence indicated that it would be impossible for Houben to communicate so quickly without any visual link to the keyboard. See http://www.theness.com/neurologicalblog/?p=1286, and, http://www.wired.com/wiredscience/2009/11/houben-communication/.
78 See ‘No miracle as brain-damaged patient proved unable to communicate’, The Guardian, available at www.guardian.co.uk/world/2010/feb/19/miracle-patient-facilitated-communication
79 The Sunday Times, 29th November 2009, also reported that a New Zealander, Nick Chisholm, became locked-in after a rugby accident. Viewed as being in PVS he heard the doctors asking his mother if she wanted them to withdraw life-support. His mother refused and eventually he recovered sufficiently to be able to communicate his consciousness.
82 For example, playing tennis or walking from room to room.
which are associated with activity in specific areas of the brain. Two of the seventeen patients, both of whom were thought to be in a vegetative state manifested changes which indicated consciousness. Subsequently both patients were re-diagnosed as being in MCS.

Of course, in response to concerns that such patients are erroneously being consigned to death, some may counter that such an existence is in any case worse than death. To be minimally conscious or locked-in and conscious of one’s inability to communicate or engage any autonomous experiences seems objectively worse than being vegetative, for a person in PVS does not suffer the indignity and frustration of their fate. As Skene et al have observed:

‘it should not be assumed that minimal consciousness would give us more reason to keep such patients alive; the reverse may be true. In such a life, unlike in VS (vegetative state), a patient clearly has interests, including an interest not to suffer, that might be compromised by continued existence, something not true of other patients in VS.’

This view is illustrated by a recent application to the court by Tony Nicklinson, a stroke victim with locked–in syndrome, who has, with the support of Dignity in Dying, launched a legal and media campaign to win the right to die by active euthanasia. In an article in the Guardian, Nicklinson is reported to have communicated the following in his court application:

I need help in almost every aspect of my life. I cannot scratch if I itch, I cannot pick my nose if it is blocked and I can only eat if I am fed like a baby – only I won’t grow out of it, unlike the baby. I have no privacy or dignity left. I am washed, dressed and put to bed by carers who are, after all, still strangers... I am fed up with my life and don't want to spend the next 20 years or so like this. Am I grateful that the Athens doctors saved my life? No, I am not. If I had my time again, and knew then what I know now, I would not have called the ambulance but let nature take its course.

An alternative view however, also raised by Skene et al, is that there is evidence to ‘show that people with disabilities value their own quality of life more highly than those who observe

---

83 See n.81, p.260.
them, even their carers who know them well.\textsuperscript{85} Whilst this observation related to people with physical disabilities rather than those with serious cognitive impairment, it does highlight the perils of making objective assessments of people with either physical or mental disabilities. On a more positive note, it is possible that the research carried out by Laureys and Owen et al will eventually herald developments which will enable patients with MCS or locked-in syndrome to participate in decision-making over life-ending treatment withdrawal. Notwithstanding that there will be obvious difficulties in ascribing competence in the full sense to people who appear vegetative,\textsuperscript{86} developments which enable some, even quite limited, participation in the decision-making process would open the door to a degree of autonomy not currently possible. As a recent case involving a failed application to sanction withdrawal of ANH from a minimally conscious woman demonstrates,\textsuperscript{87} any development which allows the voices of such patients to be heard will be welcomed by relatives (and doctors) who might feel that death would be the preferred option.

### 2.7 Who should we save?

Drawing this part of my discussion to a close, we might ponder whether the inherent difficulties of satisfactorily diagnosing PVS mean that we should never (in the absence of evidence of a competent desire not to have life sustained in such circumstances, or even without a legally binding advance directive) consign an apparently vegetative person to death.\textsuperscript{88} Unless we have conclusive and extremely clear evidence, as was the case in Bland, that the patient is in PVS, it is arguably unethical to do anything other than err on the side of caution and continue treatment. If we existed in a society in which the NHS were adequately

\textsuperscript{85} See n.81, p.252.
\textsuperscript{86} Under sections 2 and 3 of the Mental Capacity Act 2005.
\textsuperscript{87} See [2011] EWHC 2443 (Fam). The case involved an application to the Court of Protection by the female patient’s mother and sister, who argued that the patient (M) would not want to live such a “pointless existence”. However, Baker J ruled that the preservation of life was a fundamental principle of law, and as M seemed to have some positive experiences, it was not in her best interests to have treatment withdrawn. See also, ‘Judge rejects family’s right to die case’, The Telegraph, 29 September 2011. Available at http://www.telegraph.co.uk/health/healthnews/8794013/Judge rejects familys right to die
\textsuperscript{88} See the Mental Capacity Act 2005. Sections 25(5) and (6) provide special rules for advance refusals of life-sustaining treatment. The patient must have included in the directive an acknowledgement that his intention to refuse treatment should stand even where the consequences of such refusal might be death. The directive must be in writing and signed by the patient, or a representative in the patient’s presence, and the signature must be witnessed.
resourced, so that the constant barrage of difficult resourcing choices could be avoided, it might, in the interests of non-maleficence, be ethically preferable to maintain the lives of all those not unequivocally confirmed to be in a vegetative state. This is unless, of course, the decision to maintain life conflicted with their known wishes, in which case autonomy should, in my view, triumph. But clearly we do not enjoy an adequately resourced health system. The reality of our severely overstretched system leads me to reach a more pragmatic conclusion. As Lord Browne-Wilkinson observed:

Given that there are limited resources available for medical care, is it right to devote money to sustaining the lives of those who are, and always will be, unaware of their own existence rather than to treating those who, in a real sense, can be benefited, e.g. those deprived of dialysis for want of resources?\(^{89}\)

Whilst resourcing issue were *legally* irrelevant to the specific issues pertaining to the House of Lords’ decision in *Bland*, as Lord Brown-Wilkinson’s words demonstrate, it was acknowledged as being morally impossible to separate the decision from the wider context of healthcare provision. As previously mentioned, Bland’s PVS diagnosis was very clear (given that his brain scan conclusively revealed no evidence of cortical activity), so it could be said with certainty that he was unable to benefit from continued treatment when compared, for example, to patients suffering renal failure. If the same cannot be said of patients in MCS or those suffering from locked-in syndrome, how can resourcing considerations be reconciled generally with the decision to discontinue life-support given the problems in ascertaining PVS? Consider for a moment a worst-case-scenario:

- B has been in a vegetative or minimally conscious state (the doctors are not sure which but they think PVS is more likely) for a period of two years following a road accident. During that period there has been no apparent improvement although in reality B is in MCS and thus experiences some awareness of his surroundings etc, although he is unable to communicate. The hospital in which B resides is suffering a budget crisis. Mindful of the enormous expense of keeping B alive, the hospital reviews B’s case. The decision to withdraw life-sustaining

---

\(^{89}\) See n.1 at 879. Also, Lord Mustill said, at 896: ‘The large resources of skill, labour and money now being devoted to Anthony Bland might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come...In social terms [this argument] has great force, and it will have to be faced in the end.’
treatment in B’s best interests is taken, a court order is obtained, and subsequently B dies. B’s family think it is what B would have wanted. B was initially aware of what is happening and feels some distress but the sedative and analgesic medication, which was administered to B, alleviated most of the physical discomfort.

- In the same hospital, C has just died of renal failure. A period of inadequate dialysis due to severe resourcing limitations resulted in C’s death before a suitable organ for transplantation could be made available. In the weeks before he died, and upon realising that his prognosis was very bad, C was initially very distressed by his predicament but most of his subsequent distress and physical pain was controlled by sedative/analgesic medication.

As terrible as B’s demise is, C’s demise may be seen as a greater tragedy in many respects. Although both B and C might both have suffered distress before death, C, unlike B, had the capacity for independence and the ability to engage in a conscious existence. Consequently, C might be viewed as having more to lose. Equally society, and particularly C’s loved ones, would lose more in comparison to the consequential loss to society of B, who was effectively already lost. Thus, if difficult resourcing choices must be made, in the interests of justice we might question the grounds for excluding vegetative, or even minimally conscious people from such assessments. Skene et al90 have addressed the issue of distributive justice in this context, saying that despite the evidence that some patients may be wrongly diagnosed as being vegetative, a conservative approach towards patients who respond positively on a brain scan, leading to a refusal to withdraw treatment from those in MCS, is undesirable because of the consequent negative effect on our overstretched health budget. Harris has reflected upon the many people who die as a result of decisions made about funding in the NHS, concluding that:

All these people, and thousands more, have died as a direct and avoidable consequence of decisions taken by government about which they are not consulted, and to which they certainly do not consent. This is the real problem of euthanasia, and it is a sad irony that those concerned about euthanasia have concentrated on the tip of the iceberg represented by voluntary euthanasia, and have neglected the much larger, more

---

90 Supra n.81.
significant and more sinister covert euthanasia, widely practised in the area of health care, and particularly by the government itself.  

2.8 The interloper

Another strand to the debate about the moral inconsistency of the law in this area pertains to the fact that whereas a doctor is permitted to end the life of a patient via the withdrawal of treatment, a lay person doing exactly the same would be criminally culpable. For example, this inconsistency has been considered by Brock, and Huxtable, as being problematic and, taken out of context, it clearly breaches the rule of law to have people treated differently for identical acts or identical omissions. But, context is everything on this issue. The difference between how the law treats a lay person and a medical person (doing their job) is well established. As Lord Mustill said in the case of R v Brown, ‘Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability.’ If I persuade a friend with some medical knowledge to perform a minor surgical procedure in order to avoid the NHS waiting list, my friend’s action will constitute an offence under the Offences Against the Person Act 1861, regardless of the consequences or the fact that I consented. Conversely, even if a procedure carried out by a doctor is performed extremely negligently, resulting in a terrible injury, no criminal act will have been perpetrated unless the patient dies, in which case a prosecution for gross negligence manslaughter may follow. This may seem unfair but there are good reasons for allowing only qualified personnel to perform certain tasks. Obviously, it might be argued that an omission (not feeding a patient) does not require any technical skill or specialist medical knowledge but this line of argument focuses on one small element of the patient’s care. It is the decision not to continue saving the patient, rather than the determinative omission, that must remain a predominantly medical and legal matter. Moreover, such a patient will probably need

---

91 J Harris, (supra n.25) p.85. See also G Garbutt, P Davies, ‘Should the practice of medicine be a deontological or utilitarian enterprise?’ Journal of Medical Ethics (2011) 37, 267.
93 See Huxtable, supra n.20.
95 See Brown (Ibid).
96 Although there will, of course, be possible civil liability, and, depending on the seriousness of the allegations against the doctor, the GMC may investigate and the doctor may be punished and even struck off the medical register.
medical care until death to ensure any suffering is minimised. Accordingly, a lay person who intrudes in order to end a patient’s life would thus commit an act rather than an omission and will naturally be viewed less favourably.

In actual fact however, it seems likely that a lay person withdrawing treatment in certain circumstances, for reasons only of beneficence, would be treated quite sympathetically by the courts. As Huxtable discusses, in a case involving a mother (R v Watts) who was alleged to have disconnected her severely brain-damaged daughter’s tracheotomy tube, although the defendant was initially convicted of involuntary manslaughter, her sentence of 18 months was suspended and her conviction was subsequently quashed by the Court of Appeal. Thus, although the lay person, unlike the doctor, would almost certainly be prosecuted, any conviction and consequent punishment will be subject to juridical and judicial discretion.

2.9 Consent: A better way through the moral maze?

Having considered the alternative routes to Anthony Bland’s death proposed by Keown and McGee (above), and the moral difficulty with the act/omission distinction, I suggest that there was, in fact, another, more morally coherent way in which the court might have resolved this terrible dilemma by instead adopting a novel approach to consent. Indeed, the House of Lords considered the possibility that continuing to treat the patient was an affront to his bodily integrity; for example, Lord Browne-Wilkinson said:

In my view the correct answer to the present case depends on the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If in the circumstances they have no right to continue artificial feeding, they cannot be in breach of a duty by ceasing to provide such feeding.

Although the issue of consent runs through much of the rhetoric in Bland, the Court did not feel able to discontinue treatment because Bland had not consented because of the clear fact

---

97 For example, where it had been decided by the medical team (and perhaps also the court) that treatment should be withdrawn. Or, alternately where a dying patient had been made the subject of a do not resuscitate order.

98 [1998] Crim LR 833. Mrs Watt’s daughter, Abigail, had been deemed not for resuscitation.

99 See Huxtable (supra n.20 ) p.127.

100 See n.1 at 883.
that he had not refused consent either. He was, as we know, silent on this issue. The silence of such patients is a widespread problem. Young people especially will seldom have expressed a view about their wishes should they find themselves in PVS and so we are left with a dilemma. As Hoffman LJ stated:

Does this mean that people who have not expressed their wishes in advance and are now incapable of expression must lose all right to have treatment discontinued and that those caring for them are in every case under a corresponding duty to keep them alive as long as medical science will allow?\(^{101}\)

As we know, the answer to this question will depend upon whether it appears to be in the patient’s best interests to have such treatment continued, but I would argue that this approach does not adequately address the crucial issue of consent, or the issue of respect for the bodily integrity of incompetent people. Clearly, when Anthony Bland first arrived at hospital following his devastating injury, the medical team did not concern themselves with the fact that there was no consent to treat the patient because there is legal justification for treatment without consent in emergency situations. In any case, as Anthony was aged just 17 and therefore not a legal adult, his parents, had they been immediately available, could, and surely would, have consented on his behalf.

Following the initial life-saving measures taken by the hospital, the right to administer further medical care would have been dependent upon such being in the best interests of an incompetent patient, as outlined above. And, as we have seen, an important part of the Court’s decision to cease prolonging Bland’s life was based on the conclusion that it was not in his interests to continue treatment. But in my view, the Court’s reflections on consent did not adequately (or at least expressly) address the fact that in absence of knowing exactly what Anthony Bland would have wanted, it seems extremely unlikely that he, or indeed anyone, would wish to be kept alive in such a condition. I would argue that the vast majority of people, if asked, would say that they would not wish to be kept alive in a state of PVS and thus, if given the opportunity, would not consent to it. One might predict that a minority of people with a vitalist perspective would dissent,\(^{102}\) but otherwise I suggest that an

\(^{101}\) Ibid, at 828.

\(^{102}\) Although, as I discussed in chapter 1, vitalism is not a perspective held by many and even those strongly committed to the sanctity of life principle might presumably prefer death provided the doctor did not intend to kill.
overwhelming consensus exists on this issue. Admittedly, this may be an intuitive and inherently speculative view. However, there can be little doubt that their Lordships took the view that they themselves would not wish to be maintained in such a state of limbo between life and death, and this ‘feeling’ clearly influenced the ruling. Interestingly, this perspective has been recognised as important in some US cases. For example, with respect to Re Quinlan, Ost has observed that:

a principal reason behind the court’s decision that Karen Quinlan’s treatment should be withdrawn was the perception that the majority of people would not desire a continuation of their treatment if permanently unconscious.

Ultimately however, the decision to withdraw Karen Quinlan’s ventilation was effectively signed over to her father, who was sure that she would not want the treatment continued. While the substituted judgement approach of the American courts might be seen to take greater account of what the patient might have wanted (or at least what his/her next of kin think the patient would have wanted), the problems that I outlined above, with respect to the UK’s consultative best interests approach attach equally if not more to the substituted judgement approach. Thus, there may be disagreement amongst the patient’s family as in Re G, or, the next of kin may have their own reasons for wishing life to be maintained at any cost. Moreover, as Butler Sloss LJ pointed out in Bland:

Although the American decisions are often based upon the principle of achieving the right of an incompetent patient to make decisions as if competent through the device of the substituted judgement, in many cases the distinction from best interests is blurred as Handler J pointed out in Re Jobes, and in some cases it is clearly an objective assessment of best interests and the decisions are persuasive support for considerations far wider than the factor of pain to be taken into account in balancing the critical equation.

Thus, my contention is that there is a moral imperative to allow people who are conclusively in PVS to die, unless there is clear evidence that they would object. To this end, there should

---

103 Supra n.19.
104 See Ost (supra n.66) p.95.
105 Discussed above (p.51)
106 529 A.2d 434, 456.
107 At p.822.
be a rebuttable presumption that patients who are indisputably in PVS would not consent to the continued invasion to their body if they were able to participate in the decision. This presumption would compel doctors to withdraw life-sustaining treatment from patients in PVS in exactly the same way that doctors are compelled to cease treating competent patients who do not consent.

Naturally, this approach might alarm those who feel that life should be maintained at all, or almost all costs. In response, I would suggest that just as we currently require people to execute an advance decision in order to prevent treatment without consent,\textsuperscript{108} we should require an advance decision which states that the patient consents to being kept alive in PVS. Such an enduring form of consent would be subject to settled principles in respect of what is in the best interests of an incompetent patient, so that the existing approach would prevail in the event that such a patient found themselves in the position of Anthony Bland. And, having regard for the Court’s decision in \textit{Burke},\textsuperscript{109} a patient’s right to demand treatment would be subject to the treatment being clinically indicated. Thus, the advance consent would not amount to any ‘right’ to have a course of treatment continued indefinitely, but it would at least remove the presumption that the patient did not consent to be maintained in PVS.

In drawing to a close my discussion of \textit{Bland}, it should be noted that if the House of Lords missed the opportunity to bring some much needed moral coherence to this troubled area of law, they were severely limited in their choices by the settled legal principles pertaining to murder. While it may seem morally misshapen to rule that it is acceptable to facilitate death through an omission but not an act, we should recognise that it would have been very challenging, given the clear prohibition on active killing, to do otherwise. It is therefore extremely interesting to consider another case in which the Court of Appeal succeeded in sanctioning a clear example of active killing, albeit in quite different circumstances.

\subsection*{2.10 The conjoined twins - \textit{Re A}\textsuperscript{110}}

The desperate story of a Maltese couple and their conjoined twin daughters unfolded before the eyes of the world in 2000. The Court of Appeal were faced with parental opposition to the

\textsuperscript{108} Under the Mental Capacity Act 2005, see Sections 24, 25 and 26.
\textsuperscript{109} \textit{R (Burke) v General Medical Council} [2005] 3 FCR 169. This case is considered in more detail in chapter 3.
separation of the Attard twins, famously known as ‘Jodie’ and ‘Mary’, without which it was expected that the girls would die of congestive heart failure within a time span of between six months and two years. The tragic dilemma which confronted the court centred on whether it could be legal to separate the twins in order to save the stronger child (Jodie) whilst sacrificing the weaker twin (Mary) who was reliant on her sister’s heart and lungs for life. It seemed that in the absence of any legitimizing principle the separation would amount to the murder of Mary. Although there was some deliberation about whether the separation might amount to a withdrawal of life-support (Mary being reliant on Jodie for life-support), the Court of Appeal reached the conclusion that the separation would inescapably and actively cause Mary’s death, thereby satisfying the actus reus of murder.\(^ {111}\) Similarly, the suggestion (by Johnson J at first instance and Walker LJ on appeal) that it was not in Mary’s best interests to have her life maintained was rejected by the majority of the Court of Appeal. On the question of mens rea, according to the Woollin rationale it was apparent that the medical team intended to cause the death of Mary as they would carry out the operation realising that death was ‘virtually certain’.\(^ {112}\)

In spite of the obvious challenges of circumventing settled legal principles, the majority determined that the surgeons would not be criminally liable on the basis that the defence of necessity was applicable in these circumstances. This is interesting to my debate, because in the Netherlands, as I will consider in greater detail in chapter 6, the defence of necessity has provided the theoretical foundations of legalised assisted dying upon request. Thus, before reflecting on the Court’s rationale in applying this defence in Re A, it is worth outlining the legal foundations of necessity in England and Wales.

Involving, as it does, competing evils and moral dilemmas, the concept of necessity as a defence has understandably invoked judicial fear of spurious defence pleas cloaking immoral compulsions. Even where such compulsions have perhaps been born of desperation rather than immorality, the defence of necessity has been rejected for obvious policy reasons. In London Borough of Southwark v Williams,\(^ {113}\) for example, the Court of Appeal rejected the defence of the homeless defendants for trespassing and squatting on council property, stating

\(^{111}\) An analogy with Bland was rejected. Brooke LJ dismissed the suggestion that Jodie represented a form of life support (at para. 1027).

\(^{112}\) R v Woollin [1998] 4 All ER 103. Brooke LJ recognised that a jury would be likely to convict on the basis of the Woollin test. (at 1029). Only Walker LJ suggested that Mary's death might be viewed as an unintentional side-effect.

\(^{113}\) [1971] CH 734
that if permitted, ‘Necessity would open a door which no man could shut… the plea would be an excuse for all sorts of wrongdoing.’

Thus, in the absence of statutory intervention the courts have sought to limit the application of necessity, whether used as an excusatory or justificatory defence. In its excusatory guise, necessity has been described as ‘essentially the same thing’ as duress of circumstances.\textsuperscript{114} Accordingly, the basis of both duress of circumstances and necessity in its excusatory form is that a defendant’s criminal act may be excused in an emergency situation where the defendant acted to escape death or serious injury, either to save himself or another. As with self defence, the actions of the accused are objectively assessed on the basis of proportionality.

Turning to necessity as a \textit{justification} rather than as an excuse; in this capacity, necessity may be used in a situation where the criminal actions of the defendant can be justified in defence of his own or another’s interests. As Ashworth identifies, the defendant’s actions may be justified because they are viewed as being a ‘lesser evil’ than the evil which would have occurred in the absence of the defendant’s actions.\textsuperscript{115} Justificatory necessity clearly invokes utilitarian principles in balancing competing evils against one another,\textsuperscript{116} but whether used as justification or excuse, the underlying principle of necessity is that it may be utilized in exceptional circumstances where normal human instincts of self-preservation or altruism compel a person to commit a crime.

The leading authority on necessity and homicide, \textit{R v Dudley and Stephens},\textsuperscript{117} famously involved shipwrecked sailors who, after being adrift for four days, killed and ate the cabin boy in order to save themselves from starvation. This gruesome case presented the court with the problem of whether it could ever be morally acceptable to sacrifice the life of another to save oneself. Guided by policy considerations, the court found the three defendants guilty of murder. Lord Coleridge CJ stated that to allow such a killing, even taking into account the

\textsuperscript{114} Shaylor [2001] 1 WLR 2206 (CA Crim.div.). A former MI5 member was convicted of breaching the Official Secrets Act 1989.


\textsuperscript{116} Classic utilitarian thinking based on the work of Jeremy Bentham would assess the morality of an action on the extent to which it promoted good or positive consequences as opposed to bad (harmful) ones. A further modification of the theory (preference utilitarianism) allows for determinations of morality to include individual value preferences. See for example, Peter Singer, \textit{Rethinking Life and Death: The Collapse of our Traditional Ethics}, (1994), New York, St Martins Press.

\textsuperscript{117} (1884) 14 Q.B.D. 273.
desperation of the starving defendants’ plight, would ‘absolutely divorce the law from morality’.\textsuperscript{118} Also key to the court’s decision was the principle that a person should not be the judge in their own cause of the value of their life, coupled with wider concerns over the implications of invoking necessity for any criminal offence.\textsuperscript{119} Just over a hundred years later, the principle that such a defence is not applicable as a defence to murder was affirmed in the case of \textit{R v Howe},\textsuperscript{120} when the defendant’s plea that he killed under duress in order to avoid a similar fate himself was rejected. In assessing the defendant’s plea, the court held that neither duress nor necessity was available as a defence to murder. Central to both cases is the principle that the law will not allow a person to choose their own life above that of another. As Ashworth notes, ‘[T]he law should not recognise that any individual has the liberty to choose that one citizen should die rather than another.’\textsuperscript{121}

Despite the reluctance of English courts to allow the defence of necessity to establish a firmer footing within the common law, developments have occurred within the particular context of certain medical cases involving conflicting interests. In its justificatory capacity, necessity has a clear application in cases where there is a difficult choice between two courses of action, one of which may be unlawful. In \textit{F v West Berkshire Area Health Authority},\textsuperscript{122} consideration of the mentally disabled patient’s best interests was crucial in determining whether sterilisation was unlawful in the absence of valid consent. In balancing the conflicting interests of the patient, the court held that sterilisation was the lesser of the two evils, the other ‘evil’ obviously being pregnancy. Lord Goff said; ‘A man who seizes another and forcibly drags him from the path of an oncoming vehicle, thereby saving him from injury or even death, commits no wrong.’\textsuperscript{123} Following \textit{Re F}, ‘best interests’ considerations appeared to be crucial to the utilization of the defence of necessity. This presented some difficulty in \textit{Re Y (Mental Patient: Bone Marrow Donation)},\textsuperscript{124} when the court was compelled to make a decision as to whether it was lawful, in the civil context, to perform a bone marrow extraction on a mentally disabled young woman (Y) in order to save her sister, who was in

\begin{thebibliography}{99}
\bibitem{118} Ibid at 287.
\bibitem{119} Ibid at 288. Coleridge LJ ‘it is quite plain that such a principle once admitted might bemade the legal cloak for unbridled passion and atrocious crime’.
\bibitem{120} [1987] AC 417
\bibitem{121} Supra, n.115, at 229. For further discussion of the defence of necessity generally within English law, see I Dennis, ‘On necessity as a defence to crime’, (2009) 3 \textit{Criminal Law and Philosophy}, 29-49.
\bibitem{122} [1990] 2 AC 1
\bibitem{123} Ibid at 74
\bibitem{124} [1997]Fam 110
\end{thebibliography}
dire need of a bone marrow transplant to cure her leukaemia. Evidently it was in the best interest of Y’s sister for the operation to go ahead, but to what measure could it be perceived to be in Y’s best interests? Expressing reservations, Connel J accepted the evidence that the donation was in Y’s best interests as her sister’s death would have a very detrimental effect upon Y. As Jonathon Rogers observed, Connel J refrained from justifying the intrusion to Y on utilitarian grounds, preferring legitimization based on ‘best interests’ considerations. Although, as both approaches involve balancing exercises, the extent to which a utilitarian application of necessity differs from a best interests approach in practice is unclear.

Returning to the dilemma facing the court in *Re A*, as we have seen, the case of *Dudley and Stephens* provided the court with a precedent which unequivocally set the law against the use of necessity as a defence to homicide. However, the ability to distinguish upon the facts of a similar but not identical case, in order to circumvent precedent, enabled the court to surmount this obstacle.

Brooke LJ adopted Sir James Stephen’s formulation of the grounds upon which the doctrine of necessity may be invoked:

(i) the act is needed to avoid inevitable and irreparable evil;

(ii) no more should be done than is reasonably necessary for the purpose to be achieved;

(iii) the evil inflicted must not be disproportionate to the evil avoided.\(^{126}\)

With this formulation in mind, the court dismissed the policy considerations outlined by the court in *Dudley and Stephens* on the basis that these were unique circumstances. The distinguishing fact in *Re A* was that, unlike the starving sailors, this was not a matter of the beneficiary choosing her own life above that of her sister. Also crucial to the decision was the fact that Mary was in any case ‘designated’ for death by circumstances or nature, and her ongoing existence would eventually cause the death of her sister.\(^{127}\) Thus, it was argued that the separation would not amount to a divorce between the law and morality, it being the

---


\(^{126}\) Supra n. 110, at 240

\(^{127}\) Ward LJ suggested that the separation could have been justified on quasi self-defence grounds.
lesser of two evils. Following the ruling the separation went ahead. As anticipated, Mary died immediately whilst Jodie survived and prospered.

Notwithstanding their assertions that the circumstances of Re A were ‘unique’, the court evidently felt some unease at overturning years of settled criminal doctrine by allowing necessity as a potential defence to murder. Consequently Ward LJ sought to limit the applicability of the defence of necessity by stating:

Lest it be thought that this decision could become authority for wider propositions, such that a doctor, once he has determined that a patient cannot survive, can kill the patient, it is important to restate the unique circumstances for which this case is authority. They are that it must be impossible to preserve the life of X without bringing about the death of Y, that Y by his or her very continued existence will inevitably bring about the death of X within a very short period of time, and that X is capable of living an independent life but Y is incapable under any circumstances (including all forms of medical intervention) of viable independent existence.\(^\text{128}\)

In spite of these words, the wider implications of allowing necessity as at least a potential defence to murder has provoked a debate over the applicability of necessity to a case involving euthanasia. The decision in Re A has been greeted with alarm by some,\(^\text{129}\) who fear that the legal obstacles against active euthanasia have been unacceptably eroded. For example, Elizabeth Wicks writes; ‘There is a danger that the conflicting rights to life, although essential to this judgement could be overlooked in future cases if a judge were predisposed to permit a mercy killing.’\(^\text{130}\) And, in a similar vein, Jenny McEwan expresses concern that ‘The Court of Appeal has opened the door for lawful acquittal where euthanasia is the reason for the killing, and it can only be a matter of time before such cases are before the court.’\(^\text{131}\)

\(^{128}\) Ward LJ at 1018
\(^{130}\) Ibid at 22.
\(^{131}\) Ibid at 248. For a different and very interesting perspective, see J Harris, ‘Human beings, persons and conjoined twins; An ethical analysis of the judgement in Re A’ (2001) 9 Medical Law Review, 221.
With this in mind, there has been some speculation as to whether distinctions could conceivably be drawn in a case involving euthanasia in order to break free from the limitations set down by Ward LJ. Suzanne Ost has analysed the grounds upon which precedent was cast aside in *Re A*, arguing that the judgement of Brooke LJ may indicate that necessity could prove relevant to a case involving euthanasia. Firstly, a doctor who provides euthanasia is not disregarding the patient’s interests in the same way that the interests of the poor cabin boy were disregarded by *Dudley and Stephens*. Rather the doctor is acting in the interests of the patient in the same way that the doctors were acting in the interests of the viable twin in *Re A*. As to the second policy issue of a potential ‘divorce’ between the law and morality, I agree with Ost that, in applying utilitarian principles consistent to those applied in *Re A*, it is arguable that releasing a patient from unbearable pain and suffering when all other ways of doing so have been exhausted could undoubtedly be seen as the lesser of the two evils. Moreover, it might even be argued that releasing an individual from an existence devoid of any conscious experience (PVS) is a lesser evil than extending such an existence. Interestingly, Lewis agrees with Ost on the point that the ‘inevitable and irreparable evil’ referred to may be likened to the unbearable pain and suffering of a person requesting euthanasia, and, where this suffering cannot be alleviated by means other than euthanasia it is arguable that in killing the patient a doctor does no more than is ‘reasonably necessary’ to avoid the ‘evil’. On the final issue however, that the evil must not be disproportionate to the evil avoided, Ost writes that ‘this may seem to be the most difficult element to prove in a case of euthanasia.’ In contrast, Lewis sees other factors as presenting a greater barrier against the utilization of necessity in such a case, arguing that because of the disparity of the choices facing doctors involved with conjoined twins in comparison to doctors involved with patients seeking euthanasia, it is unconvincing to draw the conclusion that *Re A* opens the door to euthanasia.

In the intervening years since the ruling in *Re A*, the fact that no one has attempted to invoke the defence of necessity on the issue of euthanasia might indicate that Ward LJ’s limitation has proved effective. On the other hand, we very seldom see prosecutions for murder in the context of mercy killing/euthanasia and, given that there are other options for the mercy killer

---

134 Ost, supra n. 132, p113.
in the dock (which I explore in the following chapter), it is not surprising that necessity remains exactly where the Court of Appeal left it.

Before moving away from necessity, in order to bring this chapter to its close, I propose one further hypothetical scenario. Consider for a moment how the development in Re A might be applied to a case such as Bland, as an alternative to the morally dubious act/omission distinction. Let us imagine that the reservations of Lords Mustill and Browne-Wilkinson had been shared by the remaining Lords in Bland and thus, the justification based on an omission being not culpable was rejected, as were the other avenues of legal justification that I have explored in this chapter. Could the defence of necessity be applicable in such a case?

Fundamentally, the original ‘divorce from morality’ objections to necessity being invoked to defend murder, might be set aside on the basis that Bland’s predicament is so desperate that his death, after three and half years of being in PVS, would release him from his tragic condition. Obviously, as there seems to be conclusive evidence that patients in PVS do not suffer, it could not be argued that ending Bland’s life was necessary in order to end his suffering (as an ‘evil’), as in the analysis provided by Ost and Lewis. However, if Bland’s existence is viewed as conferring no benefit upon him in the present, and, with respect to his dignity, bodily integrity, and the futility of his ongoing existence, together with the devastating effect this has on his family, such continued existence might be viewed as an ‘evil’ which should be avoided. Moreover, prolonging Bland’s life presented a great burden to the hospital and, arguably, also to society at large (through the cost of prolonging such a life), which further adds to the ‘evil’ that his life-prolonging treatment involved. Admittedly, the term ‘evil’ is perhaps not the most appropriate way to describe either the condition of PVS or the burdens which it invokes. However, as I have argued above, there is a consensus that being in PVS is universally regarded as a fate worse than death. Thus, in a utilitarian balancing exercise, Bland’s continued existence would seem to present a greater evil than the alternative. Given that the House of Lords conducted a balancing exercise not dissimilar to this, I would argue that the decision in Bland was in fact utilitarian in nature. Moreover, because of the difficulty in assigning ‘interests’ to a person in PVS, determining the best interests of such individuals is, in reality, more akin to a utilitarian balancing exercise which incorporates wider concerns such as the impact of the decision upon the patient’s family.
Another relevant consideration is that, unlike the dilemma of the conjoined twins where active killing was unavoidable in order to achieve the desired result, the solution to the dilemma of a patient in PVS (death) can be achieved via withdrawal of treatment. Thus, concern that actively ending the life of Bland would have involved inflicting a disproportionate evil to the one which was being avoided might be put aside. Withdrawing treatment on the grounds of necessity would also address the concern that no more should be done than is reasonably necessary in order to achieve the purpose. Admittedly, this does return us, to some degree, to the act/omission distinction. However, because the justification for sanctioning death rests upon necessity, because it is the least bad solution to a terrible dilemma, (rather than because it is not in a patient’s best interests and achieving the result by omission removes liability), arguably a less morally misshapen solution emerges. The obvious danger in such a utilitarian approach would be that we might, assuming the slippery slope argument has merit, expand this justification to other patients not in PVS. We might, for example, equally determine that other incompetent patients’ lives present an ‘evil’ which should be ameliorated via death. But while this concern should not be ignored, we should remember that slippery slope concerns, if they do have any merit, might pertain equally to any justification for sanctioning death.

2.11 Conclusion

In this chapter I have considered how the House of Lords tried but failed to determine a morally coherent solution to a terrible dilemma in the case of Bland. Whilst the outcome – Anthony Bland’s death – was the best outcome in such tragic circumstances, the chosen rationale for achieving the result is less than satisfactory. If we have objectively determined that some people in PVS are simply better off dead, rather than continuing an existence which is characterised only by indignity and continuous affronts to their bodily integrity, then, as I have argued, there are less morally and intellectually misshapen ways for facilitating this than the route selected by the House of Lords in Bland.

One of the most tragic aspects of Anthony Bland’s story after he was cut down at Hillsborough, is the fact that his family felt sure that he would not want to be maintained in such a condition, but were unable to prevent it until the House of Lord’s ruling. Because Anthony was silent on the question of consent, doctors were compelled to treat him until the
court determined that such treatment was not in his best interests. I have suggested that a better approach, which would afford more respect to those in PVS, would be to apply a rebuttable presumption that the patient did not consent to the continued assaults that treatment (after the PVS diagnosis) involved.

Alternatively, after considering the defence of necessity, I have argued that we should also consider justifying such life-ending measures on the basis that necessity prevails upon us to discontinue prolonging the life of patients in PVS because it is the least worst option under the circumstances. While both my suggested alternative routes to sanctioning death may be controversial, they are, I would argue, more morally coherent than the route chosen by the House of Lords in Bland. And, crucially for many, neither approach need involve recourse to active (non/involuntary) euthanasia. Obviously, the fact that neither proposal need involve active killing means that allegations of hypocrisy over sanctioning inaction - but not equivalent action - may still be forthcoming. However, because the justifying rationale of both proposals is not focused on the means of achieving the end, but rather the reasons for so doing, I would argue that either suggestion would be a less morally misshapen route to the desired consequence.

I have also, in this chapter, explored some of the recent clinical evidence about apparently vegetative and minimally conscious individuals. While diagnosing PVS remains problematic, recent scientific advances seem to show that we are moving towards a more accurate means of determining whether patients are truly vegetative or minimally conscious. And, after considering the ethical perils of withdrawing life-sustaining treatment from those whose precise diagnosis has not been determined, I have concluded that although we should tread carefully, we should not prioritise apparently (but not conclusively) vegetative patients over other patients in the way that we allocate resources.

This chapter has focused upon hard cases which have compelled the law to evolve in order to resolve terrible medico-ethical dilemmas. Although these dilemmas have not involved assisted dying as framed by the law, they have prompted the courts to determine the boundaries of acceptable medical killing, which has to some extent defined the permissible limits of euthanasia. As well as illustrating how the law has struggled to evolve in a morally coherent manner, the tragic story of Anthony Bland shows that a fundamental problem in life and death decision-making involves determining what is best for patients whose wishes are
unknown. Thus, the issue of consent is crucial to developing a better route through the moral maze. The issue of consent is also a key theme of the next chapter, which focuses on end-of-life care. As my examination of the legal and ethical implications of certain palliative interventions demonstrates, the difficulties within end-of-life law and medical practice lies not necessarily with what is done and how such practices are justified, but rather with respect to ensuring that the competent patient has provided meaningful consent while able to do so.
CHAPTER 3
CARING NOT KILLING?

3.1 Introduction

Inevitably, the very nature of the doctor’s role in treating seriously ill patients and, more specifically, providing palliative care to dying patients, will sometimes invite questions regarding the doctor’s role in a patient’s death. As Magnusson has observed:

[T]he reasons are clear enough: medical practitioners come armed and dangerous. They have authority to dispense potentially lethal quantities of drugs in hierarchical environments – including hospitals – where their orders are followed without question.¹

Perhaps paradoxically, the legal minefield which doctors must traverse before they may legitimately allow a patient on life-support to die from his or her underlying health problem, need not trouble the doctor who takes more active steps to bring death forward in a different context. If a terminally ill or elderly patient is suffering as death draws closer, large doses of analgesia and/or sedative medication, may legitimately be administered in order to kill pain notwithstanding that this might have the effect of hastening the patient’s death. Thus the medication has a double effect and it is this principle which forms the main focus of this chapter.²

Whilst the doctrine of double effect has, over the years, been the subject of a great deal of debate in relation to assisted dying,³ it might be argued that the modern debate has moved on. Recent clinical evidence suggests that the doctrine is no longer relevant to palliative care.

² Not confined to the issue under consideration, the double effect doctrine is an important principle which underpins a number of areas in medicine. For example, a surgeon who cuts into her patient and thereby causes harm, does so in order to carry out a procedure which will hopefully cure or even save the patient so that the harm inflicted by the surgeon is merely a side-effect of proper medical treatment. The DDE has a special application to abortion where causing the death of the foetus is sanctioned as an unintended side-effect of acting in the best interest of the mother.
However, as I explore in this chapter, the evidence from the broader context of end-of-life care is far from clear.

In seeking to bring the debate up to date, I also focus on palliative or terminal sedation, and how double effect might apply when a doctor puts a patient in a state of continuous deep sedation until death. After discussing the empirical evidence in relation to the use of palliative sedation, I consider the legal and ethical tension surrounding this intervention. I look at whether, if some characteristics of deep continuous sedation invite comparisons with euthanasia, our view of this form of end-of-life treatment should be re-appraised? But before discussing the legal and ethical implications in relation to what doctors do, it is interesting to compare how the non-medical mercy killer might fare in the dock.

3.2 The non-medical mercy-killer

A friend or relative who stands accused of murder for killing a person where the motive is indisputably merciful may be viewed, in tactical legal terms, as having one key advantage but also a couple of disadvantages in comparison to the doctor similarly accused. Whereas a doctor may rely on well established legal distinctions or justifications relating to their clinical role, which are subsequently considered at length, for obvious reasons the lay person has no such clinical escape routes. Thus, for the non medical mercy-killer, avoiding a mandatory life sentence for murder will - assuming that the actus reus and mens rea of murder are present – depend primarily upon the defendant’s ability to convince the jury that at the time of the killing, he was suffering from diminished responsibility under section 2(1) of the Homicide Act 1957. The defence is available to those:

Suffering from such abnormality of mind (whether arising from a condition of arrested development or any inherent causes or induced by disease or injury) as substantially impairs his mental responsibility for his acts or omissions.4

When successful, this partial defence to murder will result in a conviction for voluntary manslaughter, an offence which carries no minimum sentence.5 Although there is of course

the possibility of a potentially culpable doctor utilizing the defence of diminished responsibility, it is unlikely to be appropriate for obvious reasons. Whereas a relative of the victim will almost invariably be able to demonstrate that the stress and strain of caring and worrying for the victim affected his mental responsibility for his actions, a doctor will not be subject to the same degree of stress in relation to any one patient.

From its enactment in 1957, the partial defence of diminished responsibility had an immediate application in cases where the defendant’s motivation for killing was mercy. Huxtable\(^6\) has explored the development and application of this defence in relation to mercy killers. He notes that in 2005 the Law Commission\(^7\) briefly (and temporarily) proposed to bring mercy killers, at least in cases where there is clinical evidence to support the defendant’s mental abnormality, specifically under the ambit of section 2(1).\(^8\)

An array of cases demonstrates how aptly diminished responsibility may be applied to a relative providing euthanasia for a loved one.\(^9\) It seems evident that juries are comparatively willing to accept a defence of diminished responsibility where the defendant clearly had merciful motives, notwithstanding that there may only be what might be regarded as rather tenuous evidence of mental abnormality. Thus, the partial excusal for what would otherwise be murder is legitimized by means of a medical appraisal of the defendant, which is dependent upon a sympathetic psychiatric assessment which links the defendant’s motive to a medical condition. Thus, provided the defendant’s motive was clearly merciful, and not motivated by greed, for example, and, provided he or she seemed to be suffering stress as a

---

\(^5\) Although, as the maximum sentence available for a conviction of voluntary manslaughter is a life sentence, it remains possible, if unlikely, that a conviction could result in a life sentence.


\(^8\) The proposal was withdrawn the following year.

result of caring for the deceased, a compassionate psychiatric assessment will provide a medical justification for what would otherwise be murder. As Ost contends:\(^\text{10}\)

This raises the question of whether there is a legal fudge going on here; medicalisation through the practical operation of the diminished responsibility defence makes the mercy killer’s actions more excusable at law, even where the reality is there may be no medical cause for his or her actions.\(^\text{11}\)

Equally telling is the fact that judges are rarely moved to invoke harsh sentences, with either community sentences or suspended sentences generally being deemed appropriate.\(^\text{12}\) Where custodial sentences are passed down, the term is generally short in the context of homicide, and/or is often reduced on appeal. For example, 73-year-old George Webb’s two year sentence for manslaughter, after suffocating his 75-year-old wife during her suicide attempt, was reduced to 12 months by the Court of Appeal in January 2011.\(^\text{13}\) Even where the conviction is for murder, a sympathetic response might be forthcoming. For example, in 2010, Francis Inglis’s nine year sentence for the murder of her severely brain damaged son was reduced to five years on appeal.\(^\text{14}\)

Interestingly, Huxtable provides a compelling examination of relevant cases, sentencing policy, and the legal and ethical underpinnings of diminished responsibility, questioning the comparative willingness to recognise a mental abnormality in cases involving a mercy-killing and whether this is ‘really fair or accurate’?\(^\text{15}\) Although Huxtable approves of the clemency shown by the courts, he concludes that:

The appropriation of diminished responsibility is particularly questionable, as is the recurrent mantra that mercy killing is murder. Neither quite captures the lived, and legal, reality of mercy killing.\(^\text{16}\)


\(^{11}\) Ibid at p.518.

\(^{12}\) Neither Lawson, Wragg or Heginbotham were given a custodial sentence.

\(^{13}\) Discussed in M Brazier, E Cave, Medicine, Patients and the Law (2011) Penguin, p. 554.

\(^{14}\) Ibid, p.553. As Brazier and Cave note, the jury’s verdict in Inglis was ‘much criticised’. See also, ‘Jury heckled over murder verdict for mother Francis Inglis who “acted out of love”’ (2010) The Times, 21 January.

\(^{15}\) Supra n.6, page 42.

\(^{16}\) Ibid, page 53.
I agree with Huxtable that the perpetuation of mercy-killing as murder does not reflect reality either with respect to the circumstances surrounding such killings or the apparent moral perception held by society.\(^{17}\) As my ensuing discussion will illustrate, the problem of the perception of moral culpability being at odds with potential legal culpability is thematic of the entire debate over assisted dying. Consequently, we see a range of devices being utilized in order to counteract the law. The relative who kills for merciful reasons may not be labelled a murderer but is almost certain to be convicted of manslaughter. The doctor who kills for merciful reasons may be far less likely to be able to avail herself of a defence such as diminished responsibility, but nevertheless she is far more likely to leave court with her criminal record untarnished in the very unlikely event that a trial even takes place.

### 3.3 Death as a ‘side-effect’ - The doctrine of double effect

The established rule [is] that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient’s life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful.\(^{18}\)

When a doctor’s duty to maintain life comes into conflict with the duty to relieve the suffering of a patient in pain who is approaching death, the use of pain relieving medication in quantities which may be instrumental in hastening death places the doctor on the cusp of legality. But where a lay person dispensing such an ‘overdose’ would almost certainly fall foul of the criminal law, the doctor may invoke the doctrine of double effect (DDE) to dispel any allegations of wrong doing. This doctrine means that doctors may, under certain circumstances, hasten death provided that they administer clinically appropriate pain-killing drugs with the aim of alleviating pain rather than with the aim or intention of causing death:

---

\(^{17}\) As I discussed in chapter 1, opinion polls indicate that a majority of the general public believe that some form of assisted dying should be legalised. See for example the House of Lords - Assisted Dying for the Terminally Ill Bill - first report, (paras.215-225) which reported on a number of polls (e.g. MORI, British Social Attitudes (BSA)) that demonstrated that the general public were overwhelmingly in favour of euthanasia for people suffering unbearably and/or suffering from a terminal illness. For example, a BSA poll showed ‘an increasing majority in favour of doctors being allowed to end the life of a patient suffering from a painful incurable disease’, rising from 75% in 1984 to 82% in 1994.

‘This doctrine can be summarized crudely as saying that it is always wrong intentionally to do a bad act for the sake of good consequences that will ensue, but that it may be permissible to do a good act in the knowledge that bad consequences will ensue. The doctrine is explained in terms of the difference between intended and foreseen consequences.’

The ethical justification for the doctrine is clearly founded on beneficence, so that a doctor can help a patient who is experiencing great pain (as death approaches) by administering analgesic drugs to relieve suffering in order that the patient should experience a less painful - if somewhat hastened - death. Moreover, any possible allegations of maleficence, with respect to hastening death, may be justified on the basis that the overriding imperative, with respect to relieving pain and suffering, is benevolent.

The fact that the DDE permits doctors to knowingly cause death to patients under certain circumstances seems apparent, but such actions are lawful provided the primary objective of the physician is to relieve pain rather than to kill. This was confirmed in the case of R v Bodkin Adams, when the defendant was acquitted following the death of his patient through an overdose of opiates. The patient, who, interestingly, had named Bodkin Adams as a beneficiary in her will, died as a consequence of large doses of heroin and morphine prescribed and administered by Dr Adams. Setting out the essence of the DDE, the judgement stated that a doctor, ‘...is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life.’ However, ‘...if the acts done are intended to kill and do, in fact, kill, it does not matter if life is cut short by weeks or months, it is just as much murder as if it were cut short by years.’

Accordingly, provided the doctor dispenses appropriate pain relieving medication such as is clinically indicated, and not a drug which has no therapeutic or pain relieving function, such

---


21 Dr Adams inherited a chest of silver and a Rolls Royce car following the death of his patient, Mrs Morell. Huxtable casts doubt on the perception of Bodkin Adams as a ‘good’ doctor whose motives were to treat rather than kill. See Huxtable, supra n.6, page 98.


23 Ibid.
treatment will be deemed appropriate. This theory was tested in the case of Dr Cox, and, notwithstanding that he was tried for attempted murder rather than murder, a conviction ensued. The fact that Dr Cox administered a drug (potassium chloride) which had no analgesic properties or other therapeutic benefit, and which was certain to kill the patient, made it impossible for the court to ignore the fact that the defendant intended to hasten death, albeit on merciful grounds. If Dr Cox had instead utilized a massive dose of an analgesic, such as diamorphine, his guilt would have been far more difficult to ascertain in the unlikely event that he was even to have stood trial. As Williams opines:

[T]he rather worrying problem with the intention test in Cox is the suggestion that if he had used pain-killing medication, he would have been found not guilty regardless of his intent and even if the results were identical.25

In the vast majority of suspected doctor-hastened deaths both intention and causation are extremely slippery concepts. Turning first to causation, who can be sure that a terminally ill person in the final throes of their illness dies conclusively from the illness or from the increasing doses of analgesic or sedative medication needed to manage pain, or, in fact, from a combination of the two? Consequently, establishing the extent of the doctor’s role in causing the death of a dying patient is both factually and legally problematic.

### 3.4 Do doctors ever cause death?

In Adams Devlin J instructed the jury that: ‘Cause means nothing philosophical or technical or scientific. It means what you twelve men and women sitting as a jury would regard in a commonsense way as the cause.’26 As one might expect, there are obvious difficulties in establishing the exact cause of death of a patient who is close to death or, at the very least, in poor health, and, in order to relieve suffering, is given increasing doses of analgesia and/or

---

24 R v Cox (1992) 12 BMLR38. Dr Cox was convicted of attempted murder following the death of his patient, Lilian Boyes. Mrs Boyes died from an overdose of potassium chloride, a drug with no pain relieving properties. The defendant escaped a murder conviction only because a causal link between his actions and the victims death could not be sufficiently established. The hasty cremation of Mrs Boyes and consequent lack of forensic evidence meant that Dr Cox’s act could not conclusively be shown to have caused death. This fact led to the charge being one of attempted murder rather than murder. Dr Cox was sentenced to serve 12 months in prison although this was suspended for one year. The GMC found that Cox had acted in good faith and he returned to medical practice. See R Goff, ‘A matter of life and death’ (1995) Medical Law Review, 3(1), 1-21.

25 Supra n.3, p.39.

sedative medication. The issue of what might be regarded as a fatal dose of analgesia in such circumstances depends largely upon how much tolerance for a particular drug a particular patient has accrued, together with the nature of the underlying health problem. Some patients might survive a dose of diamorphine large enough to kill a horse because they have built sufficient tolerance to the drug over the preceding period. Others, in a weak state, might die as a result of a minor overdose of a drug to which they are not accustomed. Also, if a patient who is riddled with cancer, from which they are expected to die within hours or days, actually succumbs to a hefty dose of analgesia and/or sedative medication prescribed to alleviate great pain and distress, it would arguably be misleading, and extremely unjust, to allege that the doctor rather than the cancer had caused the patient’s death. Because of these difficulties, in addition to the conceptual complexities of legal causation, it is unsurprising that the best approach is viewed as one of ‘commonsense’. Arguably, all but the most inexperienced of doctors should have a working knowledge of what constitutes an appropriate dose in contrast to a fatal dose (not that inexperience provides any sort of excuse). But with so many variables present in each patient, and in the context of a rather strained health system, it is easy to see why this issue is shrouded in uncertainty. Ultimately therefore, within the context of double effect, it is unsurprising that without extremely compelling evidence that the doctor purposely killed the patient, it is almost impossible to establish liability in such cases. As the following discussion demonstrates, even if a doctor’s act can be conclusively linked to the patient’s demise in this context, such evidence will not equate to liability for murder unless the doctor is held to have intended to cause death.

3.5 Foreseeing or intending death?

Essentially the DDE permits acts which might otherwise invoke criminality because, when the test for intention is applied to doctors in this context, a more lenient or flexible interpretation of what actually constitutes ‘intention’ appears to be utilized. Williams notes that in the medical setting, ‘...the whole concept of mens rea itself is fraught with the inherent

27 For example, where gross negligence manslaughter is concerned, the fact that the accused is inexperienced and has not, for example, ever before administered or performed a particular procedure, will not provide any sort of defence. See R v Prentice [1993] 4 All ER 935, CA. Equally, inexperience does not mitigate for civil liability. See Wilsher V Essex Area Health Authority [1986] 3 All ER 801, CA.

28 Intention to kill or cause grievous bodily harm being the requisite mens rea for murder.
problems of assessing intention, and the dangers of subjectivity, semantics, ‘constructability’ and ‘decontextualisation.’ In a more typically violent (and non medical) alleged murder, the criminal test for intention is satisfied when the defendant either obviously desires the consequence, or, in cases where there is no such clear desire, the defendant acts foreseeing that such actions are virtually certain to cause the death or very serious injury of the victim. The current test as to what level of foresight of consequences constitutes intention was established in *R v Woollin*. Thus, a jury in a murder trial (where the evidence over mens rea is inconclusive) will be directed to consider whether the defendant foresaw that their actions were virtually certain to kill or cause very serious harm to the victim. If so, the jury are entitled (but not compelled) to find that the defendant did intend such consequence, thereby satisfying the mens rea for murder.

The suitability of such a test in the context of a doctor attending to a gravely ill patient has predictably been questioned. For example, Keown is highly critical of applying the *Woollin* rationale to cases involving doctors. He writes:

*Woollin* is a retrograde step. First, it suggests that doctors engaged in proper palliative care... intend to kill – a gross misrepresentation of their state of mind...Secondly, Woollin raises wholly unnecessary doubts about the lawfulness of proper palliative care...Thirdly, because of the doubts it creates, Woollin may have a chilling effect on the provision of much needed palliative care and leave patients dying in pain and distress. A ruling that hinders good medicine is clearly bad law.

However, in post *Woollin* cases which have tested this theory, discussed below, Keown’s fears seem not to have transpired. It seems that the doctor’s degree of foresight of consequences is not scrutinised in quite the same way as that of the lay person. Rather, the doctor’s motive seems determinative, and, provided the primary motive which compelled the

---

29 Supra n.3, p.7.
30 For example, by fatally shooting the victim.
31 For example, if the victim and the defendant are engaged in a violent fist fight which results in the death of the victim. Assuming that there are insufficient grounds to use the defence of self-defence, the question of whether the defendant intended some harm or serious harm will determine whether the defendant will be charged (and convicted) of murder or unlawful act manslaughter.
32 [1999] AC 92(HL). The defendant’s conviction for murdering his infant son by throwing him against a hard surface was quashed. Lord Steyn said ‘a result foreseen as virtually certain is an intended result.’ Other cases such as *R v Nedrick* [1986] 3 All ER 1, *R v Hancock* [1986] Crim L R 180, have led to the development of the current approach.
doctor to act was to relieve pain and suffering rather than to cause death - even arguably where death might be seen as the only way left to end suffering - that doctor will be held not to have intended the death of the patient. It may be contended therefore, that this doctrine amounts to a special defence for doctors but this is far from clear. In Arthur, Farquharson J, echoing the sentiments of Devlin J in Adams, said there ‘is no special law in this country that places doctors in a separate category and gives them extra protection over the rest of us’. However, an assessment of the cases - including Arthur - in which this theory has actually been tested would seem to demonstrate that Farquharson’s words are palpably untrue.

For example, in 1999, David Moor, a general practitioner (GP), was charged with murdering his patient, 85 year old George Liddell, by administering a large dose of diamorphine. Dr Moor’s trial followed his public admission that he had, in the context of relieving pain, helped at least 10 patients to die via large doses of diamorphine. Subsequent adverse publicity prompted his regional health authority to look more closely into Dr Moor’s practices and, more specifically, the circumstances surrounding the death of George Liddell. Evidence from toxicologists revealed that levels of diamorphine in the blood of the deceased far exceeded that which the doctor admitted to having administered, and, although an undetected serious heart condition resulted in the deceased having the appearance of a terminally ill person, in fact, Mr Liddell was not suffering from terminal cancer as Dr Moor had alleged. Given the poor health and advanced age of the deceased the exact cause of death could not be ascertained, however, the fact that Mr Liddell died just 20 minutes after the defendant’s final injection, indicated that diamorphine played at least some role in causing death. Whilst we may only guess at the precise rationale of the jury in returning a ‘not guilty’ verdict in this case, the judge’s direction, which followed some interesting exchanges between the defendant and judge (Hooper J), are demonstrative of a far less stringent approach to the issue of intention than that which might be expected in a more typical murder trial. For example, Hooper J put the following questions to the Dr Moor:

34 (1981) 12 BMLR 1, at 5. Doctor Arthur was acquitted of attempted murder following his treatment of a baby with Down’s syndrome who had been rejected by his parents. Dr Arthur ordered nursing care only and then prescribed a drug which suppressed the child’s appetite following which the child died.
Hooper J: ‘You said in evidence that when you gave the final injection you intended to put Mr Liddell to sleep. Did you think he would wake from that sleep?’

Dr Moor: ‘No’

Hooper J: ‘Death was therefore virtually certain?’

Dr Moor: ‘Highly probable’

Hooper J: ‘If he had wakened, would you have given a further similar injection and put him to sleep again?’

Dr Moor: ‘Yes’

Hooper J: ‘If he was sleeping he would not have been eating or drinking?’

Dr Moor: ‘No’

Hooper J: ‘And death would have been inevitable?’

Dr Moor: ‘Yes’

As Arlidge observed, ‘These answers came very close to an admission of intent to kill’. However, in directing the jury, rather than providing a direction that dealt with the requisite degree of foresight of death, which, following on from the above exchange (and assuming causation was deemed present) would arguably have made it almost impossible for the jury not to return a guilty verdict, Hooper J formulated four questions which concerned firstly causation and then mens rea. Thus, if the jury should determine that Dr Moor’s act caused the death of the victim, they were invited to consider the following:

Has the prosecution satisfied you so that you are sure that Dr Moor’s purpose in giving the intramuscular injection was not to give treatment which he believed in the circumstances (as he understood them) to be a proper treatment to relieve

---

38 Supra, n.33, p. 33.
39 Ibid.
George Liddell’s pain and suffering? If the answer to question 3 is ‘No’, your verdict must be ‘Not guilty’.  

Then, in the final question put to the jury (in the event that the previous question was answered in the affirmative), the direction simply requested that the jury consider whether the defendant ‘intended’ to kill his patient. No reference to foresight of consequences was included in the direction. Ultimately therefore, the issue of intention seem to rest on whether the defendant’s purpose was to provide ‘proper treatment’ regardless of whether that might include hastening the victim’s death and irrespective of whether the defendant regarded the consequential death as highly probable, virtually certain or inevitable.

In addition to Hooper J’s sympathetic interpretation of the legal test for intention in Moor, the tone of the direction was exceedingly respectful of the defendant; an attitude which seems to typify such cases, where to even question the ‘good’ doctor is an affront to the noble profession. For example, Dr Moor was described by Hooper J as ‘a man of excellent character... (with) many admirable qualities.’ And similarly that it might be considered ‘a great irony that a doctor who goes out of his way to care for George Liddell ends up facing the charge that he does.’ But given Dr Moor’s earlier admission that he had ‘helped’ so many of his patients in just the same way as was alleged during his trial, was it really so ironic that he should find himself in the dock charged with murder?

A similar – although perhaps more disconcerting - story unravelled in the trial of Dr Howard Martin. The 71 year old GP was acquitted of murdering three of his patients despite some quite overwhelming evidence that pointed towards the defendant’s culpability. Dr Martin was alleged to have administered fatal overdoses of morphine to all three of the victims, but, as with the allegations against Dr Moor, the issues of causation and intention were shrouded in factual and semantic uncertainty. At the very least, the defendant’s palliative skills were demonstrably quite appalling; a fact which was confirmed when the GMC suspended Howard

---

40 Ibid, page 38.
41 Judicial deference to the medical profession can be seen in both the criminal and civil context. Whilst the traditional reverence might have re-balanced in recent years, there remains some reluctance to question the word of the doctor. For an interesting discussion of civil litigation on this point, see A Maclean, ‘Beyond Bolam and Bolitho’ (2002) Medical Law International, 5(3), 205-230. See also, Lord Woolf ‘Are the Courts Excessively Deferential to the Medical Profession?’ (2001) 9(1) Medical Law Review 1.
42 Ibid.
43 Ibid.
44 See ‘Doctor cleared of murder investigated over 12 other deaths’, The Independent, Friday 16 December 2005.
Martin from practising medicine. Although it is undoubtedly no more than a sinister coincidence that Howard Martin once practised alongside the late Harold Shipman, Dr Martin’s trial prompted an investigation into a further 12 cases involving suspicious deaths following pain-relieving treatment administered by Dr Martin.

It may be argued that in both Moor and Martin, as in other such cases, the juries simply determined not to find that the necessary intent was present because they recognised that the defendants were motivated by compassion, despite there being sufficient evidence to satisfy the legal test for intention. Kennedy and Grubb have inferred that this approach is determinative, stating that doctors in this context simply have a non-culpable intention to cause death. Alternatively, as Price suggests:

It may be almost impossible for a jury to apply the distinction between intended and merely foreseen side-effects, particularly where the evidence is equivocal, e.g. where only analgesia is administered.

What is clear, however, is that the judiciary do not apply quite the same legal test to doctors confronted with a possible life sentence for murder compared to that which is applied to cases involving alleged non-medical murders. As Norrie observes, context is crucial. It is impossible to treat terms such as ‘intention’ and ‘foresight’ as morally neutral. This observation is clearly demonstrated in practice; the issue of foresight seems to be overlooked in favour of a more motive-centred assessment of the defendant, which focuses mainly upon the issue of whether the defendant doctor’s actions might be viewed as proper treatment in the circumstances. Predictably, when this approach is coupled with judicial reluctance to suspect any doctor of murder, any such trial is set on course for an acquittal. For this reason, despite judicial assertions to the contrary, it is difficult to view the DDE as providing anything other than a special defence for doctors. This is illustrated by the fact that no doctor, except Cox, who was in any case convicted of attempted murder, has ever been found

---

45 However, to date, these investigations have not yielded sufficient evidence to warrant further prosecution.
46 Huxtable notes this possibility (supra n. 6, p. 97) by reference to Wilson’s commentary on Woollin, such that the direction provided to the jury could adopt a permissive rather than imperative tone, so that the jury would be free to determine ‘intention’ on common sense principles. Wilson suspected this might occur in a case like Adams. See W Wilson, ‘Doctrinal Rationality after Woollin’, Modern Law Review, 62: 448-463.
culpable for murder in the context of providing what might be described as euthanasia. While this does not mean, given the nature of their work, that it is necessarily morally wrong for doctors to be treated differently from other suspected murderers, we might question whether it is legally acceptable. Moreover, is it morally or legally acceptable to fudge this issue by providing a smoke screen which conceals the truth? If it is morally desirable to make context specific distinctions, and I would argue that it is, we should at least do so in an open way that is capable of being scrutinised. As Ost contends, ‘the doctrine is being used as a curtain behind which judges can allow moral judgements to influence the conclusion as to the physician’s intention and legal culpability.’ Arguably, to deny that the DDE effectively provides a special defence for doctors who intentionally kill their patients in the context of providing palliative care is to deny that it is ever justifiable (or necessary?) for doctors to kill their patients in order to end terrible suffering. This permits the courts to be seen to uphold the prohibition on euthanasia whilst at the same permitting what might be described essentially as a covert form of euthanasia. Opinions divide on whether this is a desirable state of affairs.

3.6 Is the doctrine of double effect ethically acceptable?

The ethics of double effect are complex. Williams, for example, has considered how various theorists view choice and responsibility through the prism of foresight and intention. For the purposes of this discussion, I briefly focus on the debate in relation to the ethics of double effect in practice.

It may be contended that such a fudge or moral compromise is desirable because it allows doctors to beneficently provide mercy where appropriate, using their professional discretion without allowing the potential abuse or harm that might flow from a more legally honest position. Moreover, it is the ambiguity in relation to the doctor’s true intentions which allows them to ‘help’ patients suffering terribly at the end of life. Alexander McCall Smith supports this very argument:

---

50 S Ost, supra n.10.
51 Supra n.3, p.42-53. Williams considers how consequentialist thinkers such as Hart and Kuhse believe that choice equates to responsibility, in contrast to those (e.g. Gormally, Finnis, Price) who believe that an agent is not responsible for side effects which are peripheral to the central aim.
Doctors know full well what they are doing when they increase a dose of diamorphine, but they need not describe their act, to themselves or to others as an act of killing. This approach has been described as hypocritical, but if it accords with a moral distinction which is meaningful for doctors, then why should they be denied the comfort it affords them? The moral life is possibly more subtly nuanced than some of the proponents of euthanasia would have us believe. We live by moral metaphor, and the metaphor of helping rather than killing, may be a valuable one to those whose duty it is to look after the terminally ill.\textsuperscript{52}

On the other hand, it is apparent that the DDE may equally be utilized by a doctor whose motives are less than beneficent. If such a doctor determined that it was desirable to dispatch dying patients promptly to avoid having them lingering on for days or weeks whilst they waited for death, the DDE would serve that doctor well. As Stephen Wilkinson observes:

...it also opens up the possibility of health carers abusing the doctrine and using it as a way of ‘smuggling in euthanasia by the back door’. In other words the acceptance might make it possible to kill patients intentionally while pretending that their death is an unintended side effect.\textsuperscript{53}

It seems apparent that there is truth in both perspectives. A ‘good’, well intentioned doctor may from time to time rely on the DDE as a valuable ethical device which enables that doctor to provide a more comfortable, less distressing (and hastened) death to a patient who would in any case die within a short period. But equally, although hopefully far less often, a ‘bad’, or even wicked doctor, might utilize the shield of double effect to conceal intentional and less beneficent action which cuts short a patient’s life. The case of Harold Shipman provides a graphic example of how a wicked man might hide behind the image of a well meaning doctor. It is possible that Shipman partially concealed some (although by no means all) of his murders behind the DDE, and although there were several other reasons why Shipman was able to continue his murderous practice for so many years, it may be that double effect served him rather well.\textsuperscript{54}

\begin{flushright}
\textsuperscript{52} A McCall Smith ‘Euthanasia: The Strengths of the Middle Ground’ (1999) 7 Medical Law Review 194-207.
\textsuperscript{53} ‘Palliative Care and the Doctrine of Double Effect’, in Donna Dickinson, Malcolm Johnson, and Jeanne Samson Katz (eds), Death, Dying and Bereavement, 2\textsuperscript{nd} edn (Sage; London, 2000) 299-302.
\textsuperscript{54} See the Shipman Enquiry, available at http://www.shipman-inquiry.org.uk/
\end{flushright}
But the spectre of one serial killer does not provide sufficient reason to condemn the doctrine if it is a valuable device which genuinely enables doctors to help patients experience a better death. If there is a concern over double effect, it is more in relation to doctors like Bodkin Adams; doctors for whom heavy-handedness in the administering of analgesics - in order to dispatch dying patients sooner rather than later - arguably becomes a matter of convenience rather than a matter of concern for patient welfare. Hopefully such doctors are a rare exception. In the vast majority of cases where double effect has factored in a patient’s death it is almost certain that the end was hastened for purely beneficent reasons and such hastening effect might be quantified in minutes or hours rather than days or weeks. However, over recent years the debate has moved on somewhat from a legal and ethical examination of the DDE towards a more clinical assessment of whether proper and effective care at the end of life should ever necessitate any shortening of life. Many palliative specialists refute the proposition that appropriate and effective palliative care might involve hastening death. Accordingly, it might be said that whilst the DDE was perhaps historically necessary, advances in palliative care, particularly with respect to understanding the effects of analgesic and sedative drugs, have rendered the doctrine a ‘relic’ of a time before it was possible to make patients comfortable until life came to its natural end.

3.7 Are we flogging a dead doctrine?

Irrespective of whether the DDE provides a special defence for doctors and whether this might be considered as an acceptable state of affairs, continuing advances in palliative care have called into question whether the DDE is even necessary in this context. Palliative specialists argue that advances in palliative medicine have made it possible for even those whose physical symptoms would previously have resulted in them suffering a painful death, to experience a pain-free death that is not in any way medically hastened. For example, Wilks has observed;

It (DDE) is a relic of a time before doctors developed palliative skills, and when the relief of pain depended on the use of powerful drugs given in sufficiently high dosage to threaten the patient’s life. With the development of good, although far from

universal palliative care, in which careful attention is paid to dosage and outcome, the
double effect concept is not only irrelevant, but a positive barrier to informed and
honest debate on end-of-life care.\textsuperscript{56}

Thus, it may be argued that the DDE is simply no longer necessary and serves now only to
shield those doctors who either intend, for whatever reason, to kill their patients, or, those
whose inadequate palliative skills render them unable to effectively make their patients
comfortable as death approaches without overdosing them and thereby hastening the end. The
body of cases might be seen as supporting the latter contention as it is invariably GPs
appearing in the dock rather than palliative-care or other hospital specialists. Moreover, a
shift in prosecution policy, whereby gross negligence manslaughter charges are increasingly
pursued as an alternative to a murder charge in this context, might also be seen to support the
view that doctors who resort to such heavy handed techniques are unskilled practitioners
rather than purposeful killers. For example, Dr Michael Stevenson\textsuperscript{57} avoided a custodial
sentence in 2007 after pleading guilty to the manslaughter of a 58 year old woman who died
following an overdose of diamorphine. Another patient survived a similar overdose. Dr
Stevenson was struck off by the GMC who ruled that his conduct in both incidents
‘demonstrated a disregard for patient safety.’\textsuperscript{58}

In a study of world-wide literature on the use of opioids and sedatives at the end of life,
Sykes and Thorns, conclude that although the DDE might be seen as a ‘valid ethical device, it
is, for the most part, irrelevant to symptom control at the end of life.’\textsuperscript{59} This study assessed
the effects of both opioids and sedatives on survival, finding that in the context of palliative
care, neither opioid nor sedative use was associated with shortening life:

[W]e suggest that there is no evidence that the use of opioids or sedatives in palliative
care requires the doctrine of double effect as a defence. We have specifically examined
the role of this doctrine in relation to symptom control and found that in 238 patients in a
specialist palliative-care unit (89 percent receiving strong opioids and 48 percent
receiving sedation) there was no evidence that the doctrine needed to be invoked in

\textsuperscript{56} Michael Wilks ‘Medical Treatment at the End of Life-A British Doctor’s Perspective’, page 17, in (eds) C A
\textsuperscript{57} ‘Fatal overdose GP is struck off’, http://news.bbc.co.uk/1/hi/england/cumbria/8256145.stm
\textsuperscript{58} Ibid.
\textsuperscript{59} Nigel Sykes and Andrew Thorns, ‘The use of opioids and sedatives at the end of life’, The Lancet Oncology,
relation to any morphine therapy. In fact, the doctrine was only possibly relevant to two patients who were treated with sedatives. To exaggerate its (DDE) involvement perpetuates a myth that satisfactory symptom control at the end of life is inevitably associated with hastening death. The result can be a reluctance to use medication to secure comfort and a failure to provide adequate relief to a very vulnerable group of patients.

The conclusion is that whilst a properly managed regime of opioids will satisfactorily manage pain without the side-effect of hastening death, there may be very rare occasions (2 deaths in 238) where, in addition to the physical symptoms, mental syndromes necessitate sedation as a therapeutic response which may possibly have a life-shortening effect. Thus, there seems to be a consensus amongst palliative experts that:

...this double effect doctrine has been widely misunderstood by those who have little experience in the use of opiates to treat terminal pain, since the appropriate titration of analgesics and sedatives does not shorten life.

The evidence, as both Huxtable and Lewis have noted, is indeed compelling. But is it sufficiently significant to invite a complete re-assessment of the DDE and its role in modern medicine? It should be noted that Sykes and Thorns are palliative care experts reviewing findings drawn from specialist palliative care units and so the study does not assess deaths which occur outside these confines. The results of a recent and more widely drawn study undertaken by Seale, of a survey on end-of-life decisions made in the UK in 2007-2008, provides an account of deaths occurring in a wider variety of settings and, interestingly, is therefore more representative of overall death experiences. At this point it is useful to note that mortality statistics for 2006 showed that 35 percent of people died at home or in a care

---

60 In both cases, the condition of the patient had already been noted to be deteriorating and they were very disturbed.
61 Supra n.59, p317.
62 Mental syndromes such as ‘agitated delirium, severe anxiety, and fear’, supra n.59, p.312.
64 After assessing this issue, Huxtable writes; ‘The overwhelming message... is that the double effect simply will not be present in cases where pain is managed using opioids, in accordance with accepted standards of practice.’ Supra n.6, p.91.
home and 58 percent of all deaths occurred in hospital with the remaining deaths occurring in a hospice or elsewhere.\(^{67}\)

Although Seale’s survey reveals that double effect measures\(^{68}\) are far less common than suggested by earlier estimates,\(^{69}\) the findings do not quite accord with those of Sykes and Thorns. There will, of course, always be different results in even very similar surveys where questions are worded differently. However, in relation to Seale’s results from palliative doctors, the findings are very similar. Overall Seale’s paper reports upon a survey which was completed by a range of medical practitioners comprising GPs, neurologists, palliative specialists and specialists in care of the elderly, as well as other hospital specialists who are involved in treating dying patients. Of the deaths surveyed\(^{70}\) 17.1 percent involved alleviating symptoms\(^{71}\) with estimated double effect.\(^{72}\) Double effect decisions are, however, reported at a particularly low rate by palliative medicine specialists (1.7 percent) compared, for example, to GPs (17.8 percent) and other hospital specialists (18.8 percent). It should be noted however that: ‘[E]ven where decisions are taken with the belief that they may hasten death, it appears that in nearly a third of cases they are not regarded by respondents as in fact having affected the length of life.’\(^{73}\) Thus, of the 17.1 percent in which there was estimated double effect, only two thirds (11.4 percent) are likely to involve actual shortening of life. In relation to Seale’s findings with respect to palliative care specialists, two thirds of 1.7 percent (1.13 percent) is getting closer to the findings reported in Sykes and Thorns’ study and so perhaps the respective surveys have revealed more similar results than first inspection might indicate.


\(^{68}\) Alleviating symptoms partly intending to end life or knowing that there will be probable or certain hastening of death.

\(^{69}\) Seale studied a similar survey conducted in 2004, in which 33% of deaths were said to involve estimated double effect. Seale’s most recent survey re-worded some of the original key questions in order to adjust for the original wording which was thought to have encouraged overestimation.

\(^{70}\) Doctors reported on the most recent death on which they had attended during the previous 12 months.

\(^{71}\) For the purposes of Seale’s survey ‘alleviating symptoms’ means providing any drug to alleviate pain and/or other symptoms.

\(^{72}\) From the 17%, 2% were reported as partly intended to end life and 15.1% were reported to involve knowledge of probable or certain hastening of end of life.

\(^{73}\) Supra n.66, p203.
Evidently palliative specialists attend a comparably greater number of deaths than most other doctors,\textsuperscript{74} and so this research provides evidence to indicate that Wilks may well be correct in his view that the DDE is, at least to some extent, ‘a relic of a time before doctors developed palliative skills’,\textsuperscript{75} as it seems evident that those with specialist palliative skills do not (or at least hardly ever) rely on double effect. On the other hand, if Seale’s findings are accurate, how should we view those non-palliative specialists for whom the DDE remains relevant and (presumably) valuable? If proper treatment at the end of life does not – or almost never\textsuperscript{76} – involve hastening death, why do some doctors cling to the doctrine? Are they simply not sufficiently skilled in treating dying patients, and so when faced with a distressed dying patient the instinct to bring matters to a merciful end is overwhelming? A recent survey by the National Audit Office found that only 29 percent of doctors and 18 percent of nurses received any pre-registration training in end of life care,\textsuperscript{77} thus lending strong evidence to support this view. Although, viewed comparatively, other evidence suggests that the UK is leading the way in palliative care. According to a relatively recent report,\textsuperscript{78} the UK has the highest level of spending (measured in terms of the ratio of services) in Europe.

Alternatively, does this issue turn on something other than a simple lack of specialist training, such as the fact that the very nature of the patient’s death (in a non-specialist palliative unit) might warrant a more assertive course of action at the very end? For example, if a patient is dying at home and has not received specialist palliative care, a GP or nurse visiting to provide care at home might feel that it is necessary, as death draws nearer, to increase analgesia to ensure that the patient will not suffer during the period until the next home visit. Access to palliative care is, unfortunately, limited. As Jeffrey notes ‘Patients with advanced cardiac failure or end-stage pulmonary disease share many of the needs of patients with advanced cancer, yet have little or no access to specialist palliative care teams.’\textsuperscript{79} Moreover, with evidence that the majority of people would rather die at home,\textsuperscript{80} it is apparent that the

\textsuperscript{74} Seale reports the annual deaths as a percentage attended by these doctors as follows; GPs attend 8,547 deaths, palliative specialists attend 27,435 deaths, neurologists attend 1,614 deaths, care of the elderly specialists attend 16,942 deaths, and other hospital specialists attend 46,970 deaths.

\textsuperscript{75} Supra n.56.

\textsuperscript{76} According to the work of Sykes and Thorns and Seale, somewhere between 0% and 1.13%.

\textsuperscript{77} See the National Audit Office’s report ‘End of Life Care’, supra n.65.

\textsuperscript{78} C Centeno, D Clark and J Rocafort et al. ‘Facts and indicators on palliative care developments in 52 countries of the WHO European region: results of an EAPC Task Force.’ \textit{Palliative Medicine} 21 (2007), 463-471.

\textsuperscript{79} Supra n. 63, p.33.

\textsuperscript{80} Consequently end-of-life strategy is aiming to provide the means to allow more people to die at home. See National Audit Report, supra n.65.
pinnacle of good palliative care may not currently be achievable without subjecting patients to a form of institutional end-of-life care which is incompatible with their wishes, thus lending some strength to the argument that double effect remains clinically valid.

### 3.8 Tension between palliative care and PAD

Perhaps the most likely explanation of the conflicting evidence over DDE is a combination of factors. A lack in specialist palliative training together with factors relating to the situation and nature of the death are crucial, but I suggest that a difference in attitude amongst the medical specialists also contributes to how the facts in relation to this issue are presented. Has professional (palliative) reluctance to recognise that it is ever clinically desirable or necessary to hasten the end of a patient’s life clouded the palliative perspective on this issue? Certainly, palliative practitioners might be seen as having signed-up to an approach that rejects the idea that it is ever necessary to hasten death, such that palliative medicine is aligned to a philosophy aimed at helping people not only to ‘...die peacefully but to live until you die.’

Thus, might it be that any opposition to the very concept of abbreviating life affects the palliative perspective over patient deaths where there may have been a very small - sometimes almost inconsequential - element of life shortening?

Patients who are expected to die generally do so. In the period leading up to death, patients are subject to interventions which might be seen as having an effect on longevity. Sometimes the fact that a patient dies following, for example, a palliative dose of diamorphine, is purely coincidental. But sometimes it seems inevitable that administering a drug that depresses respiratory function will hasten the death of a weak patient, if only by a few hours. As I have already discussed, there are also obvious challenges in establishing causation in cases where patients were on the cusp of natural death. Thus, it may be accurate to say that such interventions are not legally causative, because it would be difficult if not impossible to prove (beyond reasonable doubt) that a dying patient died due to analgesia rather than their underlying terminal condition. While the facts surrounding such interventions might sometimes point to death hastening, it is understandable that a non-contentious explanation

---

should be preferred. Moreover, if doctors engaged in palliative care are made to fear allegations over hastening death, then their desire to avoid such allegations may detrimentally affect their care of dying patients. Thus, fear over the negative implications of the DDE, as noted by both Keown and Sykes and Thorns (above), provides compelling motivation for rejecting the doctrine.

We should not be surprised that a recent study, which reported upon UK doctors’ opinions about medically assisted dying found that palliative doctors and, to a lesser extent, specialists in elderly care were more opposed than other doctors to voluntary euthanasia and physician-assisted suicide. In relation to terminally ill patients, 73.4 percent of palliative doctors said that voluntary euthanasia definitely should not be allowed compared to 36.5 percent of GPs and 32.2 percent of other doctors. On the issue of terminally ill patients requesting physician-assisted suicide, 63.2 percent of palliative doctors were definitely opposed, compared to 35.1 percent of GPs and 34.7 percent of other doctors. Overall, the study concluded that the majority of British doctors do not support legalising any form of assisted dying but it is interesting to see that opposition is particularly strong amongst palliative doctors and to a lesser degree, amongst doctors involved in elderly care. As Seale observes, ‘in both of which specialities doctors have more experience of caring for people who die.’ And, given such strength of feeling from these quarters, it is unsurprising that the response rate from palliative specialists (67.3 percent) was much higher than the overall response rate (42.1 percent).

Although these findings do not relate directly to the DDE, the fact that there is evidence of greater opposition to the concept of assisted dying amongst palliative specialists when compared to other doctors, arguably might account for some degree of the difference in findings from Seale’s survey on deaths involving estimated double effect. There can be no doubt that palliative specialists are better at palliative care than other doctors and so there is significantly less chance that proper care carried out in a palliative unit might hasten death when compared, for example, to a patient dying at home with GP care, but perhaps this is not the only factor. A doctor opposed to any form of assisted dying, who may also be fearful of inviting suspicion over practices with possible double effect, will be understandably reluctant to estimate that end of life care might ever involve abbreviating life.

---

83 In the survey, ‘euthanasia’ refers to voluntary euthanasia where a person requests help in dying.
84 Supra n.82, p.209.
3.9 Is palliative sedation a covert form of euthanasia?

In recent years the appropriateness of deeply sedating patients nearing the end of life has emerged as a ‘source of a restless ethical debate’.85 This issue is extremely relevant to any discussion of double effect and assisted dying generally, and, according to the data, deep sedation prior to death may account for more instances of shortening life than pain relieving analgesia. As Sykes and Thorns revealed, any life shortening in a specialist palliative unit is more likely to involve medication for sedation than pain relief. Moreover, Seale’s survey on end of life decisions86 included a question regarding sedation which had not been included in previous surveys. The results found that 16.5 percent of deaths involved continuous deep sedation (CDS) prior to death, a figure which seems very high, particularly when compared to the results from other countries where the same question was asked, although it should be noted that the question enquired into the presence of CDS and not whether it had a life shortening effect. Comparatively, in the Netherlands in 2005, there was reported deep sedation in 8.2 percent of deaths, and in Belgium in 2001 this question resulted in a figure of 8.3 percent.87 However, in both Belgium and the Netherlands, CDS, together with the withdrawal of artificial hydration and nutrition where applicable, is acknowledged as an alternative to voluntary euthanasia. Consequently, it might be viewed as unsurprising that CDS appears to be more prevalent in the UK where the option of a more overtly assisted death is not available. Thus, the legal and ethical nature of this intervention requires greater attention. As Mason and Laurie suggest, ‘while terminal sedation could be used in the normal process of good medical practice, it is equally likely to represent an instance of euthanasia hiding under emollient terminology’.88

Seale’s results from his survey into end-of-life decisions might have prompted his subsequent survey into the practice of CDS,89 which revealed even more widespread practice, with 18.7

86 Supra n.66.
87 Ibid at p.201.
percent of doctors who had attended a dying patient reporting using CDS. The survey found that CDS was more likely to be utilized for young patients and those dying of cancer rather than for elderly patients. Seale reported that CDS is associated with higher rates of request from either the patient or relative for a hastened death, and, amongst those doctors who reported the use of CDS, there is more likely to be support for legalizing voluntary euthanasia and/or physician assisted suicide together with a non religious background or belief. According to the report, in most cases sedation was used for less than 24 hours (30.6 percent) or somewhere between one and seven days (61.1 percent), although in 8 percent of cases, doctors reported instituting CDS more than a week before the patient’s death. In response to such findings, the question that calls to be answered is whether such apparently widespread use of CDS falls within the context of proper palliative care, or whether, as a recent article in the Times\textsuperscript{90} suggested, this practice amounts to ‘slow euthanasia’? Unfortunately, given that the survey reveals only that CDS takes place without addressing whether CDS is in fact regarded as having a life-shortening consequence, it is only really possible to consider, rather than answer, this question. However, in relation to this issue, Seale observed, ‘Sedation in itself does not directly kill a patient, but it does put them to sleep and is associated with other things such as the withdrawal of fluids and ventilation.’\textsuperscript{91}

For this reason the practice of palliative or terminal sedation inhabits an uncertain and potentially murky realm. Whilst it has a clear therapeutic role, it also sends patients into a sleep from which they will never awaken. As Margaret Battin observes, from the patient’s perspective, being terminally sedated is tantamount to having a lethal injection:

...the patient has no further conscious experience and thus can achieve no goods, experience no significant communication, satisfy no goals. Furthermore, adequate sedation, by repressing respiratory function, may hasten death. Thus, although it is always technically possible to achieve relief from pain, at least when the appropriate resources are available, the price may be functionally and practically equivalent, at least from the patient’s point of view, to death.\textsuperscript{92}

\textsuperscript{90} ‘Doctors practise ‘slow euthanasia’ on dying patients’, \textit{The Times}, October 28 2009.
\textsuperscript{91} Ibid.
\textsuperscript{92} M P Battin, \textit{The Least Worst Death; Essays in Bioethics on the End of Life}, Oxford University Press, 1994.
Consequently, and depending partly upon one’s views of ‘personhood’,\(^{93}\) it may be argued that the use of CDS prior to death is almost an admission that it may occasionally be necessary to end life in order to end suffering. Thus the question of how often and to what measure CDS hastens death is important. As previously mentioned, Sykes and Thorns found that such sedation would only very rarely result in life shortening in a specialist palliative unit.\(^{94}\) And, as a palliative expert reported to the House of Lords Select Committee on The Assisted Dying for the Terminally Ill Bill, the benefits of sedation as part of end-of-life care are undisputed:

Good palliative care includes also assessing, and constantly re-assessing during the course of a terminal illness, the most appropriate pain-relieving drugs and dosages to prescribe for each patient. In cases where death is imminent, this can involve terminal or palliative sedation which means using “proportional doses of a sedative for symptom control and the alleviation of distress.”\(^{95}\)

Therefore, I do not propose to question the fact that the use of palliative or terminal sedation can provide a valuable means of alleviating the suffering of dying patients. My main concern rests upon the findings of Seale’s survey over the issue of when CDS is instigated and at which point death might be regarded as being sufficiently imminent in order to justify putting a patient into a deep state of sedation. And crucially, are patients being made aware of the nature of this intervention?

If, as Seale’s study reveals, 8 percent of cases reportedly involved CDS for more than a week prior to the patient’s death, might we assume that in these cases CDS would almost certainly have a life shortening effect? It seems reasonable to contend that this assumption must be true, if only because an already weak patient would not then be able to eat or drink and would almost certainly not be artificially hydrated from the point at which CDS was instigated, at the same time as having their respiratory function compromised by the drugs. Accordingly, if a patient whose death was hastened because of CDS nevertheless managed to survive for


\(^{94}\) Supra n.59.

\(^{95}\) Dr Teresa Tate, from the National Council for Hospice and Specialist Palliative Care Services giving evidence for the House of Lords Select Committee on The Assisted Dying for the Terminally Ill Bill 2005, at para.83.
more than seven days, one might question just how *imminent* death actually was, and consequently just how ethically acceptable it was to utilize CDS in such a case.

Interestingly, Cellarius\(^96\) considers early terminal sedation where CDS might hasten death by a matter of weeks or months, rather than merely hours or days, suggesting that we should question both the assumption that this is ethically unacceptable and that the ‘imminence condition’\(^97\) is a pre-requisite for CDS. Cellarius contends that the traditional ethical justifications for terminal sedation, which are, according to Cellarius; autonomy, proportionality and double effect, may equally be applied to a case of early terminal sedation. This might be true, provided that the grounds for invoking CDS are carefully examined, particularly with respect to examining the patient’s wishes on the matter. Seale’s research, however, suggests that insufficient attention is focused on the ethics of invoking CDS.

### 3.10 What the patient wants

Misgivings over the morality of using CDS upon patients who are not imminently about to die are particularly highlighted by the factors cited for instigating CDS. Seale’s survey reveals that the doctors who reported using CDS (although not necessarily in those cases where the patient did not die for over a week) did so at the request of the patient in just 12.8 percent of cases. In 9.8 percent of cases CDS was invoked upon the request of another,\(^98\) and presumably, in the remainder of cases the doctor determined that it was in the best interests of the patient to be deeply sedated. Of course, one might expect a doctor defending the use of CDS to defend the practice of invoking CDS without an explicit request, on the basis that it might heighten the distress of a dying patient to have to spell out the proposed course of action in order to ascertain that it accorded with the patient’s wishes. Also, at the point at which CDS is instigated, the patient’s mental capacity may be diminished, rendering any such conversation futile. But consent is clearly an ethical and legal imperative and it seems apparent that what is required is greater engagement with the patient during the period before mental capacity is undermined by illness and distress. If we are to justify an intervention which will terminate the conscious life of the patient, we should be sure that the patient in

---


\(^97\) Namely that death is imminent.

\(^98\) A relative, carer or even a nurse.
question has participated in the decision as far as possible. As Quill et al have observed, 'some competent terminally-ill patients reject terminal sedation. They believe that their dignity would be violated if they had to be unconscious for a prolonged period of time before they die.' Thus, it seems apparent that more effort should be made to attempt to ascertain the wishes of the patient before deep sedation is instigated. Moreover, conversations about suffering and death may help a patient to cope with their last days of life by addressing concerns about the dying process. The General Medical Council have recognised the importance of such patient participation with recent guidance which encourages advance care planning by highlighting the benefits of such planning in end-of-life care.

Interestingly, an example of the benefits of such advance care planning for the end-of-life can be seen in the case of Linsell. Anne Linsell suffered from motor neurone disease and, fearing the final ravages of the disease, sought a declaration from the High Court that in the event of extreme suffering due to choking, it would be legal for her doctor to administer a large dosage of diamorphine with possible death-hastening consequences. Anne Linsell withdrew her application after receiving assurances that such a palliative intervention was already permissible and that she would not be left to suffer, notwithstanding that appropriate treatment may hasten death.

The case of Burke focused on the applicant’s fears over a similar issue in reverse, namely the withdrawal of life sustaining artificial hydration and nutrition, and his consequent fear that his life would be cut short because of a medical decision taken without his consent at a point when he is no longer able to communicate his wishes. Mr Burke challenged General Medical Council guidance on the withdrawal of artificial hydration/nutrition, invoking

---

100 See GMC Guidelines, Treatment and care towards the end-of-life: good practice in decision-making 2010, paragraphs 50-55.
102 R (On the application of Burke) v General Medical Council [2005] EWCA Civ 1003, Mr Burke’s application to the European Court of Human Rights was also unsuccessful. See Burke v UK (Application 19807/06)(2006).
103 Withholding and Withdrawing Life-prolonging Treatments: Good practice in Decision –making (GMC: London, Aug 2002). Para.81 provides ‘....Where death is imminent and artificial hydration and/or nutrition are already in use, it may be appropriate to withdraw them if it is considered that the burdens outweigh the possible benefits to the patient.’
Articles 2, 3 and 8 of the European Convention on Human Rights, to challenge the legality of the professional guidance. Following a controversial decision at first instance in which Munby J ruled that there may be circumstances in which a patient such as Mr Burke would have the right to demand a treatment from his doctors, irrespective of their clinical opinion, the Court of Appeal confirmed that, subject to the law (on murder), the issue is one which must be determined clinically. Whilst the court sought to allay Mr Burke’s fears that his life would be cut short against his wishes, their decision confirmed that withdrawing/withholding artificial hydration and/or nutrition may be appropriate when the clinical assessment indicates that the burden outweighs the benefit.

In stark contrast to Burke, the tragic case of Kelly Taylor illustrates how other patients might seize upon such palliative options almost as a means of facilitating suicide. Mrs Taylor, a young woman suffering from terminal heart, lung and spinal syndromes, embarked on a plan to stop eating and drinking in order to die. She asked the High Court to authorise the initiation of sedation and palliation at her request in order to alleviate suffering, at which point she wanted her advance directive declining food and hydration to come into effect.

Unsurprisingly, Kelly Taylor’s doctors were resistant to her plans. From a legal perspective, a mentally competent adult has an inviolable right to refuse medical treatment irrespective of her reasons for doing so. Since artificial hydration and nutrition is confirmed as ‘treatment’, this element of Mrs Taylor’s living will would have been relatively unproblematic. Equally, a decision to stop eating and drinking can be competently reached and accordingly must be respected. Separately, Mrs Taylor’s requests might be difficult to resist, but collectively the implications were problematic. What remained to be determined was whether a person embarking upon such a suicidal mission should expect medical support

104 Article 2; the right to life, Article 3; the right not to be subjected to inhuman or degrading treatment. Article 8; not to have his physical and psychological integrity and dignity infringed under the right to respect for private and family life.
106 The Mental Capacity Act 2005 provides that a mentally competent adult is entitled to expect an advance decision as to a refusal of treatment to be respected provided it meets the statutory requirements, in relation to the specified circumstances and specified treatments.
108 See Bland, supra n.18. Artificial hydration and nutrition were deemed ‘treatment’ rather than basic care, which enabled the House of Lords to justify their decision to withdraw treatment from a patient in a permanent vegetative state in order to bring about the death of the patient.
in the form of palliation. Whilst *Burke* confirms that a patient may not demand a particular treatment, patients with legally binding advance directives to refuse life-sustaining treatment who find themselves in need of palliative treatment, should arguably expect such palliation as is clinically indicated in order to alleviate suffering. In fact, the High Court avoided the dilemma of determining this issue as Mrs Taylor abandoned her plan and withdrew her application. Huxtable has examined this case, highlighting the difficulty in accepting that what - even a competent - patient *wants*, corresponds directly to what a patient *needs*. 110 Coggon has also considered this case, commenting that, ‘...the whole of Mrs Taylor’s decision-making *could* be seen as an attempt at getting something she was not (legally) due.’ 111 As Coggon observes, this case illustrates how ‘power games’ between clinicians and patients can expose ‘...the fragility of the line between clinical and moral judgment.’ 112

A not altogether dissimilar power struggle, although one which had nothing to do with palliative care, resulted in the death of a suicidal patient, Kerrie Wooltorton, in 2009. 113 After ingesting anti-freeze, Ms Wooltorton called an ambulance in order to avoid dying alone and in pain. The somewhat paradoxical act of calling an ambulance while maintaining a clear wish to die presented medics with a terrible dilemma. Upon admission to hospital, whilst still conscious, Ms Wooltorton presented a legally executed advance directive (under the Mental Capacity Act 2005) which rejected any life-saving treatment, but accepted treatment which might alleviate any suffering prior to death. Although she suffered from an untreatable personality disorder, Ms Wooltorton was regarded as legally competent and thus, able to reject any life-saving treatment. 114 Consequently Ms Wooltorton’s wishes were respected. But unlike Mrs Taylor, Kerrie Wooltorton did not request any treatment which might be viewed as facilitating death. Death was achieved entirely by omission following Ms Wooltorton’s desperate act, and so the medics were merely required to refrain from saving the patient in the context of an emergency. Both women however, demonstrated some

---

112 Ibid.
114 It has been confirmed that mental illness is no bar to the presumption of competence. See *Re C (Adult: Refusal of medical treatment)*[1994] 1 All ER 819.
understanding of the medico-legal issues which would determine whether they were able to get what they wanted, and, both cases illustrate the tension between clinical and ethical matters in medical decision-making.

3.11 Double effect or futility?

Returning to the central issue of CDS, if deep sedation does hasten death, the law might dispel any allegation of wrongdoing because it is beneficial, and thus death is a side effect. But, if the practice of deeply sedating dying patients might be justified on the basis that any life-shortening is incidental to the primary purpose of relieving suffering, should the DDE automatically extend to this element of palliative care or is there a meaningful distinction between sedation and pain relief? Glenys Williams has argued that there is a moral difference, calling into question whether it is even appropriate to include palliative or terminal sedation within the concept of double effect. Williams concludes that although sedation may be viewed as intrinsically beneficial in the same way as analgesia, the withdrawal of artificial nutrition and hydration (ANH), which is directly associated with CDS, has no beneficial effect. Accordingly, where the death of the patient is caused by CDS together with withdrawal of hydration etc, it is impossible to view death as a side effect of a beneficial act because withdrawing ANH is not intrinsically beneficial. Thus, any justification for CDS together with the withdrawal of ANH should rest upon the fact that continued life-sustaining treatment is futile and burdensome, rendering the doctor’s duty to ‘strive officiously to maintain life’ extinguished.

For this reason, it might be argued that the clinical utilization of CDS, which as Seale’s report suggests, is conceptually and practically viewed in the same way as the utilization of analgesia, is somewhat at odds with the possible legal implications. If, as Williams contends, it is inappropriate to invoke the DDE, and thus, any legal justification for sedating and withdrawing treatment should rest upon the fact that the doctor merely omits to continue the treatment subsequent to the evaporation of the duty to continue, should we be concerned? Whereas withdrawal of artificial hydration/nutrition in the case of a (naturally) unconscious patient on the verge of death is legally and arguably morally unproblematic - because it is

evidently futile to continue and death is in no way hastened - the same cannot be said of patients who are sedated despite not being about to die. Notwithstanding that it may be clinically desirable to invoke CDS, it might arguably be the sedation which determines that continued treatment and artificial hydration is futile, rather than the underlying health of the patient. Thus, in those cases where death occurs several or more days after the institution of deep sedation, CDS invokes a self-fulfilling prophecy of futility which might not be either legally or ethically defensible in the absence of a patient’s request to be deeply sedated and/or a clearer cessation of the doctor’s duty such as is required for patients in PVS.

### 3.12 Conclusion

This chapter has explored the rather troubled relationship between palliative care and assisted dying. Whereas a lay person suspected of mercy killing must put him/herself under psychiatric scrutiny in order to avoid a murder conviction (and even then will be guilty of manslaughter), health care professionals might be seen as walking a tightrope between caring and killing. With respect to the relationship of the law to the doctrine of double effect, I have discussed how a combination of factors conspires to present what is tantamount to a special defence for doctors who are suspected of murder in this context. Of course, there is no clear legal authority which recognises such a defence, but it is clear that the doctor’s degree of foresight is simply not examined according to the usual foresight based test for intention. Similarly, the criminal test for causation might be seen as ill-suited to any examination of culpability in the medical context. Thus, unless there is an obvious act which signifies euthanasia, such as that demonstrated by Dr Cox, doctors’ actions are often shrouded in legal and ethical uncertainty. Despite this uncertainty, I would argue that it is necessary to view doctors within the context in which they operate, and so some obfuscation might be justified. Although existing criminal law concepts seem less than well-suited to an examination of culpability in the medical context, as McCall Smith argued,\(^{116}\) there are advantages to compromising in order to avoid patients suffering because of concerns that necessary and effective pain relief or sedative medication might prove fatal. With this in mind, I have argued that there may be reasons, other than the strictly clinical, why palliative experts are keen to dispel the idea that hastening death is ever necessary or appropriate.

---

\(^{116}\) Supra n. 52.
Palliative or terminal sedation raises further questions about the extent to which the line between killing and caring is being blurred. As I explore later (in chapter 6), the fact that palliative sedation is recognised in the Netherlands as a clear alternative to assisted dying on request is perhaps indicative of the nature of the intervention. The higher rates of this intervention in the UK, in comparison to the Netherlands, might be seen as showing that our lack of legal (or at least express) assisted dying compels both doctors and patients to turn to the closest available alternative. As with the administration of potentially fatal doses of analgesia, the question of whether this approach is ethically sound should turn upon not only the question of whether such an intervention is in the best interests of the patient, but also whether it is what the patient wants. Unfortunately, it seems that in practice, health care professionals address these issues paternalistically, without necessarily exploring what the wishes of the patient are. Patients such as Burke, who want to extend life as long as possible, are told that their wishes will only be respected provided the doctor agrees. Patients who would prefer to abbreviate the dying process are told that doctors are carers not killers. At the same time, there is evidence that doctors sometimes engage in hastening death in order to prevent suffering, but not necessarily, or even often, because it is what the patient has expressly asked for.

Despite these concerns, my examination of the medico-legal and ethical issues in this chapter does not, in my view, invite conclusions either that patients are being killed against their wishes or that patients are suffering terribly because legal euthanasia is unavailable. The main problem lies in medical reluctance (and perhaps opportunity), driven by a number of factors, to engage with patients in order to prioritise consent in end-of-life care. I return to consider this further in my final chapter.
CHAPTER 4

Complicity in Suicide

4.1 Introduction

Unusually, the Suicide Act 1961 provides an offence which makes it unlawful to assist another in carrying out an act which itself is not a criminal offence. Prior to the 1961 Act it was a criminal act to commit suicide or to attempt suicide. The obvious fact that so many offenders were beyond the reach of the law, and those who were available for arrest clearly needed help rather than punishment, prompted Parliament to reconsider the law. Accordingly, the Suicide Act 1961 was enacted in order to banish the ridiculous scenario of subjecting survivors of suicide to possible criminal liability, while at the same time the Act created a deterrent, in section 2(1), for those who might ‘aid, abet, counsel or procure the suicide of another’. In an increasingly secular society, the Suicide Act sought to remove criminality from desperate individuals attempting suicide and instead, focus it upon those who might assist such vulnerable individuals. More recently, the language of the Suicide Act has been amended and updated by section 59 of the Coroners and Justice Act 2009, so that the offence in question now criminalises ‘encouraging or assisting’ in suicide.

Upon first appraisal the words provided by section 2(1) of the Suicide Act appear to be relatively straightforward. Historically, however, the question of which behaviour actually constituted ‘aiding, abetting, counselling or procuring the suicide of another’ has proved to be problematic. Whilst the change to ‘encouraging or assisting’ the suicide of another represents an even clearer description of the offence, it remains to be seen whether the semantic amendment will in fact bring greater clarity to this troubled area of law. Creating the greatest uncertainty in relation to who might be found culpable, however, is the provision relating to

---

1 This situation is unusual although not unique. Section 2 of the Female Genital Mutilation Act 2003 provides a similar provision.
2 Section 2(1) Suicide Act, since amended by the Coroners and Justices Act 2009.
4 The changes were instigated in order to promote public understanding of the offence and to make it clear that the offence can be committed via the internet, in response to concerns about encouraging suicide online. For further details see: http://www.justice.gov.uk/publications/docs/circular-03-2010-assisting-encouraging-suicide.pdf
prosecutorial discretion over the decision to prosecute under the Act. Section 2(4) provides that ‘no proceedings shall be instituted under this section except by or with the consent of the Director of Public Prosecutions’. Whilst there is, for any offence, some element of prosecutorial discretion over the decision to prosecute, the express requirement placed upon the DPP to consider whether a person suspected of complicity in suicide should be prosecuted is relatively unusual. More generally, in the words of the then Attorney-General, Sir Hartley Shawcross: ‘It has never been the rule in this country – I hope it never will be – that criminal offences must automatically be the subject of prosecution.’\(^5\) Thus, for example, with a minor offence where a person has clearly acted out of character and there is no victim (or at least no real harm done to the victim), the police or subsequently the CPS might determine that despite sufficient evidence to merit a prosecution, there is no societal interest or practical purpose in pursuing a prosecution. Conversely, when the suspect has caused significant harm in an obvious and intentional example of criminal behaviour, such as section 18 (Grievous Bodily Harm) of the Offences Against the Person Act 1861, it would appear that in the interests of the victim and for wider societal reasons, the CPS would be compelled to pursue a prosecution provided there was sufficient evidence.

Notwithstanding the general discretion over the decision to prosecute, where complicity in suicide is concerned, the DPP is instructed to be sure that any prosecution is justified. Essentially, section 2(4) necessitates a moral appraisal of the suspect’s behaviour in order to determine whether it is ‘right’ to pursue a prosecution. Unsurprisingly, this provision has presented considerable doubt about how cases will be regarded by the prosecuting authority, leading to great uncertainty over which behaviour actually constitutes an offence which is likely to be prosecuted, especially with respect to the public interest factors determining the decision to prosecute. Accordingly, in this chapter I attempt to provide some analysis of the legal position, and what exactly constitutes the offence of assisting a suicide. I also explore the recent human rights assaults upon the law made by Pretty and Purdy,\(^6\) examining some of the key ethical arguments and considering whether the decision of the House of Lords in

---

\(^5\) In response to the Adjournment debate in the House of Commons on January 29, 1951 (Hansard, HC vol.483, col. 679, paras 681-682. This discretionary element to the decision to prosecute is known as the ‘expediency’ principle. See R Daw, A Solomon, ‘Assisted suicide and identifying the public interest in the decision to prosecute’, Criminal Law Review 2010, 10, 737-751.

Purdy may yet have more far reaching implications. The following chapter will explore prosecution policy.

4.2 Which acts might render one liable for assisting a suicide?

Since 1961, a contradictory array of cases provides some instruction, although little clarity, as to the practical application of the law. Such cases have invariably raised interesting ethical and legal questions over this area of law but more recently, a new dimension to the debate has emerged. Fresh assaults upon the Suicide Act, both as a result of human rights legislation and as a consequence of the phenomenon of ‘suicide tourism’, whereby suicidal individuals have travelled abroad to die in a jurisdiction where assisted suicide is legal, have significantly undermined the validity of the law in the 21st century. It is this recent onslaught which provides the main focus for this chapter.

Given the recent amendment to the Suicide Act, the vast majority of the jurisprudence relates to the question of ‘aiding and abetting’ the suicide of another, although, given that the law itself remains apparently unchanged, covering the same behaviour previously covered under the original language, the semantics may be incidental to the question of which acts, under which circumstances, the courts have deemed sufficiently heinous to be deserving of punishment. The precise meaning of the words provided by section 2(1) of the Suicide Act was considered in the case of Attorney General v Able and others, a case which involved a challenge regarding the legality of publishing a booklet which sought to provide advice to those wishing to commit suicide. The Attorney-General hoped to avoid future prosecutions of the ‘respectable’ members of the pro-euthanasia society, the Voluntary Euthanasia Society (VES), by preventing them from continuing to distribute the booklet. Woolf J (as he then was) stated that in the event that a recipient of one of the booklets took, or attempted to take, his or her own life, and the prosecution could show that the society intended the booklet to facilitate suicide and had distributed the booklet to the recipient with this aim in mind, an offence under section 2(1) of the 1961 Act would have been committed.

---

7 According to Ministry of Justice guidance (supra n.4), ‘The scope of the law remains the same so these changes do not make liable to prosecution anyone who was not liable before’.

8 [1984]1 All ER 277, [1984] QB 795 (QBD)
Thus, it appears that the courts have, at least on occasion and in theoretical terms, where no actual prosecution was involved, adopted a very strict interpretation of the wording in section 2(1) of the Act, so that a person may face prosecution despite having never met, or even spoken to, the person committing or attempting to commit suicide. This approach has now clearly been extended to online encouragement.\(^9\) In practice however, section 2(1) of the Suicide Act has been interpreted far less doggedly and in fact no one has ever been prosecuted for merely publishing or distributing information aimed at instructing the suicidal. Following the decision in *Able*, the VES ceased circulation of the booklet, although by that time the booklet had already been implicated in a number of suicides, and still no one from the VES was prosecuted.\(^10\) More recently, others have published such self-help suicide manuals with impunity. For example, Derek Humphry, founder of the Hemlock Society, wrote his best selling ‘Final Exit’, which is freely available in English book shops and on the internet alongside other such instructive material produced by Mr Humphry. Similarly, the Australian Dr Philip Nitschke, who had practiced voluntary euthanasia in the Northern Territory of Australia during the temporary legitimization of the practice,\(^11\) has published advice on the internet as well as holding suicide workshops for those aged over fifty in English seaside retirement havens.\(^12\) In addition to this, Dr Nitschke has developed a suicide drug testing kit, which is available for sale on the internet, in order that one might test the potency of suicide drugs available via the internet from countries such as Mexico.\(^13\)

Turning to actual prosecutions and consequent convictions, the body of cases demonstrates a far less strict approach to the evidential issue of which acts more generally might constitute an offence, than Woolf J’s decision in *Able* might suggest. For example, in *R v Chard*,\(^14\) the defendant was prosecuted for having provided the deceased with a quantity of paracetamol tablets in the knowledge that the deceased wished to have the option of taking her own life. His Honour, Judge Pownall QC, in the Old Bailey, directed the jury to find the accused not

---

\(^9\) See Ministry Of Justice guidance (supra n.4).
\(^11\) Euthanasia was legalised in the Northern Territory of Australia by the Rights of the Terminally Ill Act 1995, but this was overturned in 1997.
\(^12\) See, ‘“Dr Death’ Philip Nitschke reveals secrets of a peaceful exit’, *The Times*, May 6 2009.
\(^13\) See, ‘“Dr Death’ sells euthanasia kits in UK for £35’ *The Observer*, March 29 2009.
guilty (which they did), stating that the defendant had merely provided the deceased with the option of suicide and that is not enough for a conviction under the Suicide Act 1961.\footnote{For further discussion see Margaret Otlowski, \textit{Voluntary Euthanasia and the Common Law} (1997), Oxford University Press.}

The only consistency in convictions can be seen in cases where the defendant has clearly demonstrated a sinister desire to have the victim dispatched. I mentioned the case of Wallis in chapter 1,\footnote{\textit{R v Wallis} (1983) 5 Cr App Rep (S) 342.} - where the defendant actively encouraged and assisted a young mentally ill friend who suffered from suicidal whims - as a clear example of ill motivated and morally inexcusable complicity in suicide. Similarly, in \textit{Mcshane},\footnote{(1977) 66 Cr App Rep 97, Court of Appeal, Criminal Division.} providing the means of suicide together with actively encouraging the suicide (which did not go ahead) resulted in a conviction. In this case, the clear evidence that the defendant actively encouraged her mother to commit suicide in order to inherit her estate provided conclusive evidence of bad motive. Ultimately therefore, the question of whether ‘providing the pills’ constitutes aiding and abetting a suicide seems to depend on the circumstances of the case, with factors such as motive and whether the defendant encouraged the victim to go ahead with the suicide proving decisive.

Where doctors are implicated it seems that there has perhaps traditionally been even less prosecutorial appetite for pursuing such prosecutions. Although, as I discuss in the next chapter, the Policy for prosecutors presents an apparent change of direction on this issue, with a factor in favour of prosecution where the suspect is acting in their role as a physician or other health professional or worker.\footnote{See the \textit{Policy for Prosecutors in respect of cases of encouraging or assisting suicide}, available at \url{http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html}.} Any actual evidence of the Crown Prosecution Service looking upon medics less favourably is yet to be seen however, and with so few cases involving doctors coming under scrutiny either pre or post Policy, it is difficult to ascertain whether doctors have in fact been more favourably regarded in the past. One example, however, does provide some food for thought. Consider the case of Doctor Michael Irwin, a retired General Practitioner and right-to-die campaigner, who was struck off the medical register by the GMC for professional misconduct after he admitted to obtaining 60 temazepam pills in order to help a terminally ill friend to die.\footnote{See ‘Euthanasia doctor is struck off’, BBC News, 27 September 2005. Available at \url{http://news.bbc.co.uk/1/hi/health/4286470.stm}.} Dr Irwin, who is a well-
known right-to-die campaigner, travelled to the Isle of Man in order to assist in the proposed suicide, but by the time he arrived his friend had become too ill to take the tablets. The CPS decided not to prosecute Dr Irwin for an offence under section 1(2) of the Suicide Act although he was cautioned by the police for possessing a class C drug (temazepam) with intent to supply. Dr Irwin has also avoided prosecution following investigations into his actions in helping other suicidal ‘friends’ to make the necessary arrangements to travel abroad for an assisted suicide, sometimes making financial contributions or even accompanying them to Dignitas. Recent reports suggest that Irwin has helped numerous friends, and yet he remains unprosecuted. Arguably however, Irwin’s recent excursions to Switzerland have placed him in the role of ardent right-to-die supporter rather than in the role of physician, and so his previous occupation may be almost incidental. Either way, Irwin’s enthusiasm for complicity in suicide would appear to put him at serious risk of prosecution. The DPP however, has come to the interesting conclusion that because Irwin is elderly, a custodial sentence would be inappropriate, rendering a prosecution pointless. One senses a power struggle between the DPP and Dr Irwin, with Irwin flouting the law in the face of prosecutorial refusal to provide any sort of platform for Irwin’s views. Irwin might relish his day in court for the opportunity (to expound his arguments for legalizing assisted dying) that prosecution would bring, but the DPP seems determined to resist.

Other examples of cases involving apparent suicides in this context, where there appears to be a more rigorous and consistent prosecution policy, is where the defendant’s action goes beyond merely assisting in suicide, falling into the realms of homicide. Huxtable identifies a number of cases, where the court’s reluctance to convict for murder or manslaughter in cases that clearly amount to a mercy killing are treated as complicity in suicide. But, as the recent case of Giderdale illustrates, an apparent example of complicity in suicide, may

---

20 For example, Irwin recently assisted in the suicide abroad of Nan Maitland, an elderly woman who wanted to avoid the prolonged dwindle towards death. See ‘British woman takes own life at Dignitas because she did not want to die of old age’ The Telegraph, 3 April 2011.
21 See “Dr Death’ escapes prosecution over Dignitas suicide because of his age’ The Telegraph, June 26, 2010.
24 Unreported. Kay Giderdale was prosecuted for attempted murder for her role in her seriously ill daughter’s suicide. The jury acquitted Giderdale and the trial judge rebuked the DPP for pursuing such a prosecution following the defendant admission that she has been complicit in suicide. See The Guardian, ‘Kay Giderdale’s case: A clear verdict on the law’s confusion on assisted suicide’, 25 January 2010, available at http://www.guardian.co.uk/uk/2010/jan/25/kay-giderdale-case-expert-view
equally be prosecuted as a homicide offence where the facts might be seen to indicate more active assistance, and at times the line between complicity in suicide and active homicide may be blurred. Despite the fact that all evidence indicated that Mrs Gilderdale was a caring mother who had reluctantly and compassionately assisted in her daughter’s bid for death, the DPP was not deterred from pursuing this prosecution. The DPP perhaps regretted this decision following Gilderdale’s acquittal and a public rebuke from the trial judge, which prompted the DPP to issue an explanation for his decision to prosecute.\footnote{See \url{www.cps.gov.uk/news/press_statements/questions_about_kay_gilderdale_decision/} See also, ‘DPP defends decision to prosecute mother in attempted murder case’ \textit{The Guardian}, Tuesday 26 January 2010. Available at \url{http://www.guardian.co.uk/uk/2010/jan/26/keir-starmer-kay-gilderdale}} Moreover, this case raises interesting questions about the relationship between the evidential issues and the public interest issues in a suspected offence under the Suicide Act compared to a suspected case of homicide. Obviously, as this was an attempted murder prosecution, the discretionary element over the decision to prosecute, whilst present to some degree, was not expressly relevant, as it is under the Suicide Act. Thus, it may be argued that the defendant’s motives were irrelevant if she had, as the CPS asserted, gone beyond merely assisting suicide into the realms of homicide. Whilst this position may be legally defensible, the morality (and fairness) of taking into account motive in cases of assisted suicide but effectively ignoring motive in very similar cases, where the victim needed more active assistance, is clearly questionable. Interestingly and by contrast, where a doctor is suspected of murder in this context, motive seems crucial. Recalling my discussion in the previous chapter, for example, with respect to the trial of Dr Moor,\footnote{Discussed in chapter 3, p.83-85.} the question of liability seemed to hinge primarily upon the doctor’s motives in administering such a large dose of diamorphine. Admittedly, we do not know exactly why the jury did not convict Moor and so my observations regarding motive are speculative.\footnote{For example, it might be that the main reason Dr Moor was found not guilty was because the jury were not convinced that he caused the victim’s death.} Nevertheless, Mrs Gilderdale’s acquittal for attempted murder was arguably founded upon the fact that this was a case of assisted suicide, rather than one of attempted murder. In the event that Mrs Gilderdale’s actions had clearly supported a case of attempted murder rather than assisted suicide, whilst we can only speculate, it seems unlikely that the judge would have directed the jury to consider the defendant’s motive as this would only be legally relevant to sentencing following conviction. Of course, the context arguably justifies there being a distinction between a doctor providing (even fatal) pain relief and a mother helping her daughter to die. But remember that Mrs Gilderdale was, as her daughter’s carer,
effectively placed in the role of a health care professional and so the respective roles of the suspects becomes blurred in these circumstances.

Gilderdale’s case also provides an interesting contrast to another maternal homicide case which occurred almost contemporaneously. Frances Inglis was jailed for nine years (reduced on appeal to five),\(^{28}\) for the murder of her severely brain damaged son, whom she injected with a lethal dose of heroin because she was convinced that her son would not wish to have his life maintained in such a condition.\(^{29}\) A decisive distinguishing fact between the two cases seemed to be that whereas the wishes of Gilderdale’s daughter were abundantly clear – she had previously attempted suicide – Inglis’s son was silent on the issue.

Interestingly, Huxtable has considered the legal implications of a range of cases involving actual or suspected assisted suicides which involve a wide range of activities from ‘(p)ills, pillows and pistols’ to assisting a ‘suicide tourist’.\(^{30}\) The myriad contradictory cases explored by Huxtable undoubtedly supports his view that this is an area ‘rife with uncertainty’, and, as I intend to discuss, a combination of human rights challenges together with the opportunities now available for assisted suicide abroad, has added a new dimension to the debate.

### 4.3 The case of Dianne Pretty

The much publicized human rights challenge by the late Dianne Pretty did not succeed in persuading either the House of Lords or The European Court of Human Rights (ECtHR) that there should be any exception or adaption to the existing law.\(^{31}\) Mrs Pretty, who suffered from motor neurone disease, had hoped that the European Convention on Human Rights (ECHR), recently incorporated into the Human Rights Act 1998 (HRA) would enable her to succeed where her fellow sufferer, Annie Lindsell,\(^{32}\) had previously abandoned a similar legal challenge. Initially, in a letter dated 27 July 2001, written on her behalf, Dianne Pretty sought a declaration from the Director of Public Prosecutions, to give an undertaking not to

\(^{29}\) Ibid.
\(^{30}\) See Huxtable, supra n.23, see chapter 3, p.60.
\(^{31}\) Supra n. 6.
\(^{32}\) Anne Lindsell died from Motor Neurone Disease in 1997, following an aborted challenge to the law regarding assisted suicide. As I discussed in the previous chapter (p.101), Ms Lindsell dropped her challenge following medical assurances that the palliative care available to her would be sufficient to control her pain and distress in the final stages of her illness, notwithstanding that this might hasten her death.
prosecute her husband in the event that he assisted in her suicide in accordance with her wishes. Following the DPP’s refusal, Mrs Pretty sought judicial review on the grounds that her human rights were violated. Following the rejection of her case by both the Divisional Court and the House of Lords, Mrs Pretty failed in her appeal to the ECtHR, consequently clearing any remnant of doubt regarding a possible conflict between the ECHR and English law in relation to persons wishing to obtain assistance with suicide.

The thrust of the case involved a challenge to the legality of the 1961 Suicide Act in light of Articles 2,3,8,9 and 14 of the ECHR. One of Dianne Pretty’s main contentions was that the right to life enshrined under Article 2 should be interpreted to include a right to end one’s life. Article 2(1) provides:

> 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.

With respect to this provision, both the House of Lords and the ECtHR held that this relates to the manner in which a person conducts his or her life, not the manner in which he/she departs from it, thus no negative aspect or entitlement may be inferred from the law and so no ‘right to die’ may be derived from Article 2.

Similarly, Mrs Pretty’s Art.3 argument, that the lack of legal assistance in suicide compelled her to suffer ‘inhumane and degrading treatment’, was rejected. The court reasoned that any inhumane and degrading treatment came by virtue of Mrs Pretty’s disease, rather than by the prohibition on complicity in suicide and thus, there was no legal right to provide her with assistance to escape life in order to escape her disease.

The claimant’s argument also attempted to invoke specific rights from the broad right of self-determination provided by Article 8, which provides:

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

2. There shall be no interference by a public authority with the exercise of this right except such as 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.

In response to the argument that Article 8 confers rights of autonomy which include a right to decide when or how to die, the House of Lords was unequivocally clear that although Article 8 protects the physical, moral and psychological integrity of the individual, including rights over the individual’s own body, there is nothing to suggest that such rights of autonomy might extend to confer a right to decide when or how to die. The ECtHR, however, took a different view on this point, giving rise to a debate - which I shall return to presently – over whether the European Court’s treatment of Article 8 in this case determines that such a right to die may be engaged as a consequence of the autonomous rights provided by Article 8(1), and if so, whether such authority should be followed as a principle of precedent:

In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity… The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention.33

Regardless of this, however, both courts agreed that, even if such rights existed under Article 8(1), Article 8(2) provides that any interference with autonomous rights in this context is proportionate, with respect to the need to protect vulnerable people in society, and thus, the offence under the Suicide Act was in accordance with human rights law.

Both the House of Lords and the ECtHR were also unconvinced by Mrs Pretty’s argument regarding Article 9, which protects the right to freedom of thought, conscience and religion. Given that the Courts were not persuaded by arguments relating to the other Articles, it was thus inevitable that Mrs Pretty’s Article 14 argument (in respect of her right to enjoy Convention rights and freedoms without discrimination) would fail.34 To no avail, Dianne Pretty argued that the Suicide Act discriminates against disabled people, who, as a group, will

34 Article 14 being reliant on other breaches of Convention rights.
often be unable to commit suicide unaided because of their physical dependence on others, whereas able-bodied people could take the decision to end their own life and carry out their plan autonomously.

Naturally, this case precipitated a flurry of debate and, predictably, those in favour of the autonomous rights of the individual condemned the ruling. For example, Tur opined:

“... it could be held that the interests of the individual are being sacrificed in order to establish an important social policy.”

Clearly, Mrs Pretty’s interests were sacrificed for the (supposed) greater good, a sacrifice that might be justified if it is, as some have argued, impossible to protect the vulnerable from a permissive policy on assisted dying. But if one believes that adequate protections can be constructed, rejecting Mrs Pretty’s appeal seems far less acceptable.

Coincidently, an almost identical moral dilemma, Ms B’s case, played out around the same time as Pretty, prompting some philosophical comparison between the cases. On the same day that the European Court ruled that Diane Pretty should live out her natural life, Ms B’s wish to have treatment withdrawn was finally carried out and she died peacefully in her sleep. But while the philosophical dilemma was very similar, the legal dilemma was altogether different. Unlike Mrs Pretty, Ms B was not terminally ill. She was however, ventilator dependent. Thus, death could be achieved by withdrawing Ms B’s life-support and, as we know, the law is clear on this issue; competent adults have an inviolable right to refuse even life-sustaining treatment. They do not, as the court confirmed in Pretty, have any

37 As I discussed in chapter 1, see p.26.
38 Ms B and an NHS Hospital Trust [2002] EWHC 429 (Fam).
right to die, unless of course such death can be achieved via an omission or the withdrawal of treatment, once the doctor’s duty to act has expired.

Somewhat paradoxically, there was a form of agreement from opposite sides of the debate on this issue; either both or neither woman should have a right to die. Keown argued that allowing Ms B to exercise her suicidal desire to have treatment withdrawn completely undermines the law’s prohibition on assisted suicide. Thus, Keown asks: ‘What is the moral difference between intentionally assisting suicide by an omission and by an act?’ 40 Notwithstanding that to continue to treat Ms B against her competent wishes would present an assault upon her bodily integrity, as well as forcing her to endure years of a life she found unbearable, Keown argued that her wish should not have been respected because it is a step too far in the wrong direction. Confusingly, Keown also states, ‘[T]his is not to argue that the courts should always require doctors to override refusals of treatment which are suicidal.’ 41 The question of which kind of bodily invasion (upon competent adults refusing treatment) is justified, according to Keown, is not clear. Whilst he supports withdrawing treatment that is too burdensome, his message seems to be that this is only acceptable provided the patient is not seen to be exercising any sort of suicidal right to die, or alternatively perhaps, provided that the doctor can been seen to facilitate such a death without being seen to intend it.

A less conflicted ethical appraisal of these two cases was provided by Singer, 42 who, for rather different reasons agrees with Keown that Ms B and Mrs Pretty should not be treated differently, observing that:

> We have arrived at the absurd situation where a paralysed woman can choose to die when she wants if her condition means that she needs some form of medical treatment to survive; whereas another paralysed woman cannot choose to die when or in the manner she wants because there is no medical treatment keeping her alive in such a way that, if it were withdrawn, she would have a humane and dignified death. 43

Thus, a consequentialist approach is advocated by Singer, so that we look to the reasons and the results rather than merely determining legitimacy according to the means of achieving the result. As I explored in chapter 2, the relationship between the law and morality - over what

41 Ibid.
43 Ibid.

118
can be achieved via the legal construction of inaction compared to action - is particularly strained. However, where complicity in suicide, rather than euthanasia, is concerned, and despite Mrs Pretty’s defeat, it is clear that the law is able, at least to some extent, to look beyond the distinction between an act and an omission, particularly when the actual suicide occurs abroad.

4.4 Suicide Tourism

Since Dianne Pretty’s challenge, another option for those hoping for an assisted suicide has presented itself in the form of ‘right to die’ clinics in Switzerland, where non-selfish complicity in suicide is not an offence. Arguably, if Dianne Pretty had had the opportunity of an assisted suicide abroad, together with the financial resources to facilitate this expensive one-way trip, her legal challenge might have been avoided. But the question of whether Mr Pretty would have breached the Suicide Act, or at least been prosecuted for any breach, in the event that he had assisted his wife to travel abroad for such a purpose has, until recently, been less than clear.

With respect to whether it is even an offence to assist in a suicide abroad, it has been argued that the fact that the actual suicide occurs abroad removes any potential liability under section 1(2) on the grounds that the Suicide Act does not fall within a category of offences regarded as having extraterritorial ambit. This issue is highly contestable, and, despite the best efforts of the House of Lords in Purdy to resolve this question – of which more later – it appears that some residual doubt lingers.

But aside from the territorial issue, the very real need for clarification as to whether it is an offence to assist in a suicide abroad and if so, when it might be regarded as being in the public interest to prosecute such an assisted suicide has become increasingly relevant as a stream of British citizens have travelled to receive assistance with suicide at the Swiss clinic, Dignitas, in Zurich. Evidence suggests that since 2002 over 150 UK citizens have travelled to Dignitas to receive the fatal assistance which was unavailable to them at home. Despite

47 Discussed above, p.18.
48 See chapter 1, n.12.
Police investigations into these deaths have been no subsequent prosecutions against those assisting friends or relatives to travel to Zurich in this context. Accordingly, the question of when and if such a prosecution might be pursued has driven the recent legal and ethical debate over what is and what should be permissible.

As knowledge of the facility offered by Dignitas and another Swiss organization, Exit, has entered the public domain, an apparently increasing number of UK citizens have considered assisted suicide as a real alternative to the end of life choices offered at home. Although there are other jurisdictions, such as the Netherlands, Belgium and the US states of Oregon and Washington, where assisted suicide and/or euthanasia is permitted under certain circumstances, the legal regime in Switzerland is the only one open to non residents. Consequently Switzerland has developed a rather unfortunate reputation for ‘suicide tourism’. Since 1942 the Swiss legal code has provided that so long as the person assisting the suicide is doing so altruistically, and is not in any way acting out of self-interest, there is no offence. 49 Unlike the majority of other jurisdictions where some form of assisted dying is legal, the Swiss law does not stipulate that assisted suicide should be physician-assisted. The legality of assisting suicide in the absence of selfish motives applies to all, and this derives from an historical justification based upon honour rather than any medically derived justification. 50 Accordingly, there is no substantive requirement for a medical precondition, the only requirement being that the person wishing to die has mental capacity. 51 In practice however, physician assistance is essential to the availability of the assisted suicide service provided by right-to-die organizations such as Dignitas, and the doctor will assess the health of the victim in order to determine whether he/she should be permitted to die. Thus, the fatal dose of barbiturate necessary for the suicide is obtained from a doctor, who may only prescribe the means of suicide, which will then be taken by the so-called victim at the

49 Article 115 of the Swiss penal code states: ‘A person who, for selfish motives, aids or abets another person in suicide will be punished with imprisonment up to 5 years.’ For a fuller examination of Swiss law see Griffiths, Weyers and Adams, Euthanasia and the Law in Europe, (2008) Hart Publishing.


51 An administrative court ruling in Zurich in 1999(Verwaltungsgericht des Kantons Zurich, Entscheid der 3 Kammer VB Nr 99.00145, 1999) added the requirement that there be ‘a condition indisputedly leading to death’, however the court failed to specify which conditions should be covered by this term and even raised the question of whether mental conditions might be included. In 2006 the Swiss Federal Supreme Court (Schweizerisches Bundesgericht, Entscheid 2A.4812006,2006) ruled that an incurable, permanent, serious mental disorder can be comparable to a serious physical condition, thus a doctor who prescribes lethal drugs for a mentally ill patient does not necessarily violate the rules of medical practice in this regard. See Griffiths, Weyers and Adams, supra n.49.
Dignitas apartment with the assistance of a volunteer nurse, following a consultation with the patient. Generally, the doctor sees the patient at least twice before allowing him or her to access the fatal medication.

In 2003 two such cases came to the public’s attention. First, a terminally ill man, Reginald Crew, and later a couple described as having ‘health troubles’, Robert and Jennifer Stokes. All three travelled to ‘Dignitas’ in order to receive help in dying. Mr Crew travelled to Dignitas with his wife and following her return to the UK, Mrs Crew was questioned by police over her role in her husband’s death. It was clear that since Mr Crew was completely physically dependent upon his wife, she had been instrumental in assisting his passage to Switzerland. Despite the clear implications of the law set down by Woolf J in the Able case, Mrs Crew was not prosecuted. Using the discretion afforded by section 2(4) of the Suicide Act, the DPP evidently adopted a sympathetic approach towards Mrs Crew, saying that there was ‘insufficient evidence’ and ‘no public interest’ in pursuing a prosecution.

The case of Robert and Jennifer Stokes was more controversial since neither was terminally or seriously ill, or for that matter seriously disabled. Thus, the couple enjoyed sufficiently good health to be able to arrange their own deaths in Zurich and so there was no question of an offence under the Suicide Act having being committed. Their case does, however, raise potentially disturbing questions regarding the availability of assisted suicide in Switzerland and particularly the role of Dignitas. I return to this issue later.

Since 2003 many more such cases have been reported, but until the death of the former young rugby player, Daniel James, we could only draw upon the fact that not a single person had been prosecuted for guidance as to the legality of assisting in such a suicide. Thus, the DPP’s published decision in the James case, together with the legal challenge launched by Debbie Purdy, have gone some way towards clarifying when a person is likely to be prosecuted for assisting in suicide. Accordingly, I will explore these cases, together with another legally significant case, that of Mrs Z, in chronological order, before examining prosecution Policy in the following chapter.

---

52 A doctor writing a prescription for assistance in suicide must act according to Article 11 of the narcotics law, which requires that the drug be used, dispensed and prescribed according to the established rules of medical practice.

53 See above, p.109.

54 Page 2 www.bbc.co.uk/1/hi/uk/2951387.stm

55 R (Application of Debbie Purdy) v Director of Public Prosecutions, [2008] EWHC 2565
4.5 The case of Mrs Z

Until Debbie Purdy’s application, only one case involving a potential ‘suicide tourist’ had come under judicial scrutiny. This case, *A Local Authority v Z (An Adult: Capacity)*, focused on the role of the local authority in preventing their patient from travelling to Switzerland, but it is nevertheless instructive as to judicial thinking, particularly with respect to the perception of a patient’s right to seek assisted suicide in Switzerland. The case involved a 65 year old woman known only as Mrs Z. Mrs Z had cerebellar ataxia, a condition which attacks the part of the brain which controls motor function. The condition is incurable, irreversible and terminal, and by the time the case came before the court Mrs Z had become increasingly disabled with serious restrictions of motor control, speech and hearing difficulties together with signs of Parkinson’s disease. Although she was still living at home with the care of her husband, Mrs Z required extensive support from her local authority.

Stricken by her increasingly limited physical ability, Mrs Z had attempted suicide in 2000 and, despite a subsequently more positive period, by late 2003 she had resolved to travel to Switzerland in order to end her life at Dignitas. Initially her husband and adult children were opposed to the idea. However, through persistence, she eventually persuaded them that her wish should be facilitated. At this point, the husband informed the local authority of his intention to make all the necessary arrangements to assist his wife’s travel to Dignitas. In response, the local authority concluded that Z was a vulnerable adult and consequently sought to invoke the inherent jurisdiction of the High Court to prevent Z from being taken out of the country. On the 29th of November 2004, Black J, sitting in Manchester, granted a temporary injunction restraining Mr Z from removing his wife from England or Wales. A psychiatric assessment was hastily arranged and the matter was then brought before Hedley J sitting in the High Court.

Following confirmation by the psychiatrist that Mrs Z did in fact have legal capacity, and that her decision to travel to Switzerland was an autonomous one, the court held that its inherent jurisdiction to determine and give effect to the ‘best interests’ of the patient was not invoked. Thus, there was no basis in law for prohibiting Z from taking her own life. As Hedley J remarked, ‘In the circumstances here, Mrs Z’s best interests are no business of mine.’ This ruling clearly supports both the law in relation to suicide and the existing legal theory regarding the autonomous rights of competent patients, but does this decision provide any

---

57 Ibid, at para.13
encouraging developments for those seeking a more substantive right to die? Unsurprisingly the court found no grounds upon which to distinguish the issues relating to the existence of any ‘right to die’ in this case from those issues settled by the decision in the Pretty case. Moreover, although the right to life under Article 2 of the European Convention was inextricably linked to the rights provided by Articles 3 and 8, namely the right not to be subjected to torture or degrading treatment and the right to respect for private and family life, Article 2 did not provide a ‘right to die’. Hedley J affirmed that despite any potential infringement of the autonomy rights found under Article 8, prohibition of assisted suicide is justified in order to protect vulnerable patients from possible abuse. But in spite of his adherence to the Pretty rationale, Hedley J was evidently moved to prevent any interference with the self determining rights of Z, saying, ‘…in the context of a person of full capacity, whilst the right to life is engaged, it does not assume primacy (at the hands of another especially) over rights of autonomy and self determination’.

Although the focus of Re Z relates to a local authority’s duty towards ‘vulnerable’ adults, the court also discussed the legal position of the person prepared to assist in the suicide. In consideration of section 2(1) of the Suicide Act, the court affirmed that the actions of Mr Z, in making arrangements to take his wife to Dignitas and escorting her there, did potentially constitute a criminal offence. However, having regard for the discretionary powers of the DPP, Hedley J stated his belief that such a rare provision was generally only to be found where Parliament recognized that despite such an act being criminal, it was not necessarily in the public interest to prosecute in respect of it. Thus, the court accepted that although Mr Z had breached the Suicide Act, the decision to prosecute Mr Z was entirely in the hands of the police and Crown Prosecution Service in accordance with the exercise of prosecutorial discretion.

It seems apparent that Re Z has removed some of the legal obstacles potentially preventing physically disabled people from travelling abroad to obtain an assisted suicide. Although Hedley J was clear in his message that there is no right to be assisted in suicide, his ruling confirms that there is a right for competent adults not to be prevented from travelling to a jurisdiction to avail themselves of an assisted death which is legal within that jurisdiction.

58 Ibid, at para.18
59 For further discussion and case commentary see Peter De Cruz ‘The Terminally Ill Adult seeking assisted suicide abroad: The Extent of the Duty owed by a Local Authority.’ Medical Law Review 2005, 13(2) 257-267.
4.6 The case of Purdy: Part 1

I want to avoid the situation where I am too unwell to terminate my life. I want to retain as much autonomy as possible. I want to make a choice about when the quality of my life is no longer adequate and to die a dignified death. The decision is of my own making. Nobody has suggested this to me or pressured me to reach this view. It is a decision that I have come to of my own free will.

Although the case of Mrs Z might be seen as an encouraging development in reinforcing the autonomous rights of the mentally competent adult, the case also confirmed that assisting a person to travel abroad for the purposes of an assisted suicide would place an individual at risk of criminal liability. Despite quite clear evidence that the DPP together with the prosecuting authorities are extremely reluctant to find it in the public interest to prosecute a case involving a ‘suicide tourist’, there obviously remains some risk of liability. Thus, the inherent uncertainty and unpredictability as to when such liability might be invoked was the motivation behind Debbie Purdy’s application for Judicial Review of the Suicide Act. Ms Purdy, who, as previously mentioned, suffers from multiple sclerosis, did not require from the Court any right to die, although her ongoing support to the pro-legalisation campaign illustrates that she hopes that such a right may eventually be forthcoming. Rather, she hoped to gather information pertaining to the likelihood of her husband being prosecuted in the event that he assisted her to travel abroad for an assisted suicide. Ms Purdy, whose application was supported by ‘Dignity in Dying’, was unwilling to have her Cuban husband, Omar Puente, run the risk which Mr Z, Mrs Crew and others have taken. She cited her husband’s nationality and lack of fluent English as traits which may disadvantage him in the event that he is investigated following assisting her to travel abroad for an assisted suicide. In an emotional plea, Debbie Purdy stressed that despite her desire to go on living as long as possible, in the absence of any guidelines she would feel compelled to travel abroad to die alone whilst she remained capable of doing so - thus ending her life sooner than she would wish - rather than waiting until her physical condition deteriorated to the point that

---

60 R (on the application of Debbie Purdy) v DPP [2008] EWHC 2565 (QB), (2008) 104 BMLR.
61 Debbie Purdy, para. 59, Purdy, HL.
62 See Chapter 1, p.18.
independent travel became impossible. Thus, clarification of the law was sought in order to allow Ms Purdy to make her final arrangements.

Despite many factual parallels between the cases of Dianne Pretty and Debbie Purdy, the legal objectives of the respective applications were quite different. Whilst Mrs Pretty sought to obtain from the DPP a proleptic grant of immunity from prosecution for her husband in the event of his active assistance in her suicide, Ms Purdy sought to compel the DPP to publish criteria as to the circumstances in which consent will or will not be given for a prosecution under section 2(1) of the Suicide Act. Ms Purdy’s contention was that the restrictions on assisted suicide imposed by the Act are not ‘in accordance with the law’ pursuant to Article 8(2) of the ECHR because the decision of whether to prosecute someone for the offence is determined by the exercise of an unfettered executive discretion. Both Mrs Pretty and Ms Purdy, however, sought to argue that the provisions of Article 8 ECHR, with respect to the rights of self determination granted by this law, were infringed by section 2(1) of the Suicide Act. Drawing on significant elements of the European Court’s decision in Pretty, counsel for Ms Purdy attempted to persuade the court of the significance of the following statement of the ECtHR:

The applicant (Mrs Pretty) in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention.

In response to the contention that Ms Purdy’s rights were similarly subject to interference, and to the surprise of those who had understood that the decision of the ECtHR in Pretty had interpreted Article 8(1) as protecting such rights, Scott Baker LJ and Aikens J sitting in the Divisional Court held that the expression that the court is ‘not prepared to exclude that it constitutes an interference’ is inconclusive, being a ‘good deal less firm’ than stating that it would constitute an interference. Moreover, the court held that it was in any event bound by the House of Lords upon this issue rather than the European Court. The principle of whether the Divisional Court should follow the House of Lords or the ECtHR was outlined by Lord Bingham in Kay v Lambeth Borough Council, such that unless the ECHR had undermined the policy considerations which had affected the House of Lords’ decision, the lower court

---

63 Purdy, HC (supra n. 55) at para.67.
64 Purdy, HC (supra n. 55) at para.36.
65 [2006] 2 AC 465, [2006] UKHL 10
should follow the Lords rather than the European Court. Accordingly, the House of Lords’ interpretation of Article 8(1) was significantly narrower than that of the E CtHR and would not be of assistance to Ms Purdy’s case. Responding to the problem of following the appropriate precedent where there are conflicting authorities, the applicant contended that the House of Lords have, by implication in a claim by the Countryside Alliance regarding the Hunting Act 2004,66 since accepted that the law regarding the engagement of Article 8 is as enunciated by the E CtHR in the Pretty decision. Although the court accepted that their Lordships in the Countryside Alliance case had generally supported the broadening of the scope of Article 8(1) to cover personal autonomy, they held that this presented no reference to the dichotomy between the decisions of the House of Lords and E CtHR in Pretty. Thus, the court concluded that Article 8(1) is not engaged on the facts of Ms Purdy’s case.

Turning to the issue of whether the interference with rights under Article 8(1) created by s.2(1) Suicide Act is, pursuant to Article 8(2), ‘in accordance with the law’, or not, the court held that the Suicide Act is sufficiently clear and precise. This being so, any possible infringement of rights under Article 8(1) are ‘in accordance with the law’ and so there is no requirement that the DPP promulgate a specific code setting out the criteria to be applied when the DPP or Crown Prosecution are deciding whether or not to prosecute a person alleged to have committed an offence under section 2(1) of the Suicide Act.

Counsel for Ms Purdy also directed the court to a statement of the E CtHR in the case of Herczegfalvy v Austria,67 which said that, ‘if a law confers discretion on a public authority, it must indicate the scope of that discretion, although the degree of precision required will depend upon the particular subject matter.’ The same case also states that the requirement under Article 8(2) is that a domestic law must indicate the scope of any discretion so as to ‘offer a minimum degree of protection against arbitrariness required by the rule of law in a democratic society.’68 Accordingly, the claimant’s contention is that the general code for crown prosecutors, promulgated by the DPP under section 10 of the Prosecution of Offences Act (POA) 1985, for determining whether criminal proceedings should be instituted or continued fails to provide the minimum degree of protection from arbitrariness.69 Therefore, just as the DPP has promulgated specific codes setting out the criteria to be applied when deciding whether to prosecute alleged offences of domestic violence, rape, driving offences

67 (1992) 15 EHRR 437 at para.89
68 Ibid at para.91
69 For further discussion of the general Code see Daw and Solomon (supra n.5).
and football offences, a specific code should be promulgated in respect of sections 2(1) and 2(4) of the Suicide Act. The court was not persuaded by this line of argument, stating that as a matter of public policy it is desirable to have a degree of flexibility which the statutory requirement for permission to prosecute under section 2(4) of the Act provides. In addition to which, having already determined that neither domestic legislation and/or common law provides a duty upon the DPP to elaborate on the Act in question, the court held that the general code provided by the DPP under s.10 of the POA is sufficiently clear and precise in this context. Furthermore, the court said that there are ‘special reasons’ why the DPP has promulgated specific codes in relation to domestic violence, football offences etc. Namely, such offences are particularly prevalent social problems which may be more easily identifiable than a possible offence under section 2(1) of the Suicide Act. Thus, given the prevalence of such offences it was ‘clearly imperative that the public should understand the specific criteria’ employed by prosecutors for these offences.

In response to the claimant’s allegation that the discretion afforded by section 2(4) of the Suicide Act represents an unfettered power of the executive, the court rejected this argument on the basis that the scope of the discretion concerns only one offence which is clearly defined in section 2(1) of the Act, although they did concede that this definition was in ‘broad terms’. In consideration of the fact that the wording of section 2(1) of the Suicide Act may cover an ‘almost infinitely varied’ number of factual circumstances, the court went on to say that evidence from the Crown Prosecution Service regarding the actual number of cases prosecuted, such number being very low, indicates that any concerns over the exercise of the executive’s power in this context are unfounded.

Thus the Divisional Court followed the House of Lords rationale in Pretty, holding that no specific code could be promulgated without careful consultation and extreme circumspection. Conclusively, whilst expressing ‘great sympathy for Ms Purdy, her husband and others in a similar position’, the court held that Ms Purdy’s human rights under Article 8 ECHR are not infringed. Any possible infringement of autonomy rights granted by Article 8(1) is justified.

70 See Supra n.55, paras 13 to 26, regarding the provisions of The Prosecution of Offenders Act 1985, and statements made by the House of Lords, obiter dicta, in respect of this issue in Pretty.
71 Supra n.55, at para.86.
72 Ibid at para.80.
73 At para.78.
74 According to CPS records of all the cases in the past 10 years concerning persons travelling abroad to commit suicide, only 8 cases were identified.
75 Pretty, Supra n.6, Lord Bingham at para.39.
76 Supra n.55 at para.84.
under Article 8(2), and the scope of the discretion to prosecute under section 2(4) of the Suicide Act for an offence under section 2(1) is ‘in accordance with the law.’ This being the case, a change in the law would be necessary to allow assistance to those seeking suicide abroad and, ‘only Parliament can change it.’

Whilst we might have predicted that the Court would feel unable to depart from the ratio of the House of Lords in Pretty in order to follow the European Court, their reasoning had highlighted the tension between the two interpretations of Article 8. Thus, Ms Purdy was granted leave to appeal. Before discussing the appeal, and in the interests of presenting the legal developments as they occurred, it is first necessary to consider the case of Daniel James. Decided within weeks of each other, the cases of Purdy and James are irrevocably linked. It seems no coincidence that the DPP made the decision to issue a public statement outlining the reasons for his decision in the James case contemporaneously to Ms Purdy’s (initially) unsuccessful application to compel the DPP to promulgate a code of practice. Equally, the DPP’s decision in James was extremely influential to the House of Lords’ ruling in Purdy.

**4.7 The suicide of Daniel James**

The death of the young sportsman, Daniel James, at Dignitas in September 2008, prompted speculation that the first prosecution under section 1(2) of the Suicide Act for assisting in a ‘suicide tourism’ case was imminent. The fact that Daniel was so young and not terminally ill seemed to distinguish his death from the others which had come under prosecutorial (and public) scrutiny. Because Daniel sought suicide as an escape from his severe disability, his case also raises extremely difficult questions over society’s view of disabled people, and which ‘conditions’, if any, should give rise to potentially excusable complicity in suicide. Thus, the decision not to prosecute Daniel’s parents and a friend of the family for their role in his suicide provided a very interesting analysis of evidential and public interest factors considered relevant when considering whether to prosecute a defendant suspected of assisting in a suicide abroad. At the time, setting a prosecutorial precedent by issuing such a public

---

77 Ibid, para.84
79 A version of the following analysis can be found in my commentary on the case: A Mullock, ‘Prosecutors making (bad) law?’ Medical Law Review 2009, 17(2), 290-299.
statement, the DPP’s response raised the question as to whether the DPP was effectively promulgating a ‘Code of Practice’ pertaining to those assisting ‘suicide tourists’. It seemed that the DPP was responding in no small part to Ms Purdy’s application, and, at the very least, the statement was clearly intended to be informative of prosecution policy in this context.

Daniel James, who was just 22 years old, had on several occasions played rugby for England youth teams before he sustained a serious spinal injury during a rugby training session in March 2007. Spinal cord compression and the dislocation of two vertebrae resulted in tetraplegia, causing paralysis from the chest down, together with a loss of independent hand or finger movement despite retaining some mobility and strength in his shoulders, biceps and triceps. Immediately following his accident, Daniel was determined to prove the medical diagnosis incorrect. But ultimately he came to accept the view of his consultant that it was unlikely he would see any significant improvement. At this point Daniel became suicidal. Frequently articulating his wish that he had died of his injuries, Daniel told his psychiatrist that as a ‘dynamic, active, sporty young man who loved travel and being independent, he could not envisage a worthwhile future for himself now.” Following his return home from hospital Daniel made several suicide attempts and it was after his third failed attempt in February 2008 that he contacted the Swiss clinic, Dignitas, to ask for assistance in dying. Daniel’s correspondence with Dignitas serves to further illustrate his wish to die.

By May 2008 Dignitas had accepted Daniel’s application and made arrangements for a Swiss doctor to provide the barbiturate prescription for Daniel’s suicide. As previously mentioned, under Swiss law, a doctor is permitted to prescribe a lethal drug for the purposes of an assisted suicide only after examining the patient in person and assessing the medical condition(s) giving rise to the desire to die. Accordingly, Daniel arranged to meet the doctor on two occasions prior to his assisted suicide, which was arranged for Friday 12 September. His parents, however, attempted to persuade him to reconsider. In a report dated 2 July 2008, Daniel’s psychiatrist wrote that Daniel:

...clearly understood that no other parties, be they professionals or family members wished him to pursue this course of action and was clearly aware that he could reverse his decision at any point. He remained firmly of the opinion that support from any

---

81 Decision on Prosecution (n 5) at para 6.
82 Ibid at para 7.
agency would not be helpful for him or change his decision.\textsuperscript{83}

With respect to Daniel’s mental capacity, ongoing assessments confirmed that he had full capacity. In a report dated 11 March 2008, his Consultant Psychiatrist concluded that:

...he (Daniel) has full capacity... He is fully aware of the reality and potential finality of his decision, displays clear, coherent, logical thinking processes in order to arrive at his decision and had clearly weighed alternatives in the balance.\textsuperscript{84}

Once the arrangements were in place, Daniel’s state of mind was further reviewed and it was accepted by his doctors that Daniel retained mental capacity and that his decision to end his life was not driven by mental illness.

For their part, his parents were apparently ‘relentless’ in their efforts to persuade Daniel to carry on living. During his interview, Daniel’s father said '[w]e pleaded with him not to do it and change his mind and live... There would be nobody happier to hear him say he’d changed his mind and he didn’t want to do it.'\textsuperscript{85} Eventually they accepted their son’s resolution and began to assist him in arranging his suicide. It was on the matter of organising flights that a family friend also became engaged in the enterprise of assisting Daniel. The friend, who remains nameless throughout, had initially offered assistance to arrange for Daniel to travel in order to consult specialists who might aid his recovery. At this point, Mark and Julie James took up their friend’s offer of help, albeit help with a rather different purpose than that which was originally envisaged. Thus, flights to Zurich were arranged by their friend, including a return flight for Daniel in case he changed his mind.

With all necessary arrangements in place, Daniel signed a declaration dated 27 August 2008, witnessed by his doctor, stating that he wished to travel to Switzerland for an assisted suicide and for his body subsequently to be returned to England. Daniel travelled to Zurich with his parents and on 12 September 2008 they attended the clinic where a doctor assisted in Daniel’s suicide. Mark and Julie James were with Daniel when he died. Post mortem blood samples confirmed that the cause of death was a fatal dose of a barbiturate typically used for assisted suicide at Dignitas.

Thus, with these facts under consideration, the DPP’s decision centred upon whether the defendants’ behaviour satisfied the evidential element of the law, and if so, whether it was in the public interest to pursue a prosecution. Crucial to this decision is the Code for Crown

\textsuperscript{83} Decision on Prosecution (supra n.80) at para 10.
\textsuperscript{84} Ibid at para 17.
\textsuperscript{85} Ibid at para 11.
Prosecutors (the Code) which details a range of factors which may be considered when weighing up the arguments for and against prosecution in any given case.  

i) The Evidential Test

The Code provides that the evidential stage of the test determining whether a prosecution should go ahead will be satisfied when there is a realistic prospect of conviction.  

Having concluded beyond reasonable doubt that Daniel James died as a result of suicide, the DPP stated that the defendants’ actions indicated that they ‘intended’ to assist Daniel, thereby satisfying the mental element of the offence. The question of whether the defendants’ actions satisfied the actus reus of the offence unfortunately did not encourage the DPP to provide any analysis as to what the words ‘aid, abet, counsel or procure’ should mean. Treating Daniel’s parents’ activities as a joint enterprise, the DPP stated that in the absence of absolute clarity regarding who did what, there was sufficient evidence to show that both effectively aided and abetted their son’s suicide by assisting with correspondence, making payments to Dignitas, making travel arrangements and finally, accompanying Daniel to the clinic in Zurich.

With respect to the involvement of the family friend, it was concluded that while his actions were less significant than those of Daniel’s parents, in arranging and paying for the flights - whilst having knowledge of the purpose of the visit to Switzerland - his actions also amounted to aiding and abetting Daniel’s suicide. As discussed above, it is apparent that there is considerable juridical reluctance to convict those who provide only limited assistance in the absence of bad motive. As we saw illustrated in the case of Chard, where the defendant was found not guilty of assisting a suicide despite having supplied the deceased with a large quantity of paracetemol, the rhetoric from cases such as Able does not receive juridical support when actual convictions loom. In alleging that the family friend had breached the Suicide Act merely by arranging flights in circumstances where it was clear that Daniel would have gone to Dignitas irrespective of this assistance, the DPP was arguably being overzealous in his interpretation of the Suicide Act.

ii) The Public Interest Test

---

87 Ibid at para5.2.
88 See pp 109-114.
89 Supra n.14.
Having established that there was a realistic prospect of conviction, the DPP had to consider further whether it was in the public interest to bring such a prosecution against the defendants. The DPP noted the unusual nature of the offence in question compared to other aiding and abetting offences, saying, ‘the critical act – suicide – is not in itself unlawful’.\(^{90}\) For that reason a significant number of the factors identified in the Code were simply not relevant.\(^{91}\) Of relevance was the question of whether a conviction would be likely ‘to result in a significant sentence.’\(^{92}\) The DPP concluded that it would be ‘very unlikely’ that a court would be minded to impose a custodial sentence on Mr and Mrs James and their friend.

The DPP cited two cases by way of comparison, \(R \, v \, Wallis,\)\(^{93}\) which has been considered briefly above,\(^{94}\) and \(R \, v \, Hough.\)\(^{95}\) \(Hough\) involved more active assistance in suicide and resulted in a conviction for attempted murder. The defendant, Charlotte Hough, had agreed to help an 84 year old woman, Miss Harding, to commit suicide as a consequence of her great unhappiness, loneliness and suffering. Miss Harding, who was prone to describing herself as a ‘non-person’, was partially blind, partially deaf and suffering from arthritis. After failing over a year to dissuade her from her desire to commit suicide, the defendant agreed to supply a quantity of sodium amytal tablets to Miss Harding and to sit with her while she took them. Miss Harding prepared the drugs herself, together with some whisky with which to take them, while also obtaining plastic bags for the purpose of suffocation and apparently begging her friend to use them should the drugs prove insufficient. When the old lady fell unconscious, the defendant stayed with her and after several hours of observing Miss Harding’s continued breathing, the defendant placed a bag over her head and removed it when breathing ceased. The defendant’s appeal against her nine month sentence was unsuccessful.

These two cases provided the DPP with a useful comparison by which to judge the moral culpability of those assisting Daniel. Mr Wallis’s behaviour amounted to encouraging rather than discouraging the victim, and then actively assisting her by procuring the means of suicide. Although Charlotte Hough was not emotionally supportive of Miss Harding’s suicide

\(^{90}\) \textit{Decision on Prosecution} (n 5) para.28.

\(^{91}\) Factors regarded as not relevant to the case in hand were identified as 5.9 (b), (c),(d),(e),(j),,(k),(m),(n),(p) and 5.10(b),(c),(d),(e),(f),(g),(h) and (i) of the Code.

\(^{92}\) 5.9(a) of the Code

\(^{93}\) (1983) 5 Cr App R(S) 342

\(^{94}\) The accused appealed against a 12 month sentence for assisting in the death of a young, emotionally troubled friend. See above p.111.

\(^{95}\) (1984) 6 Cr App R(S) 406
bid - on the contrary, she tried in vain to discourage it - her actions nevertheless went far beyond merely assisting a suicide. As discussed above, when a case goes beyond complicity in suicide into the realms of homicide, the DPP is not confronted with an express instruction to consider whether there is any public interest in prosecuting and so a prosecution was bound to follow. With respect to motive, Charlotte Hough’s actions may be viewed as less morally reprehensible than those of Mr Wallis, but her actions in placing the bag over the old lady’s head were – notwithstanding the fact that causation was inconclusive – perceived as causative in a way that merely providing the means of suicide is not. Accordingly, in comparing the facts of Daniel’s assisted suicide to those in the cases of Wallis and Hough, the DPP drew a distinction between these cases and the behaviour of Mr and Mr James and their friend.

Also of relevance to the determination of whether the prosecution would be in the public interest was the question of whether the defendants were ringleaders or organisers of Daniel’s suicide.\textsuperscript{96} Despite evidence that all three defendants played a role in the organisation of the arrangements, the DPP’s interpretation of the Code led him to conclude this question in the negative. Clearly, Daniel was the ringleader in the orchestration of his own demise, but the interpretation of the word ‘organiser’ is interesting as it indicates that a suspect would have to play the primary or decisive role in organising the suicide, not merely taking part in some aspects of organising the suicide, in order to be seen as culpable in this respect. This interpretation might be seen to accord with the recent amendment to the Act, which updates the language to ‘encouraging or assisting’ in suicide, where ‘assisting’ will probably be overlooked but ‘encouraging’, as I consider later, seems more likely to lead to prosecution.

On the issue of premeditation,\textsuperscript{97} the DPP found no evidence that the defendants premeditated Daniel’s suicide, or that their actions comprised elements of a ‘group’ offence.\textsuperscript{98} The possibility that the offence might be repeated was similarly disregarded.\textsuperscript{99} The DPP considered whether the defendants were in a position of authority or trust, and whether there was a marked difference between the actual or mental ages of the defendant and the victim, or, if there was any element of corruption. On this point, the DPP found that despite the existence of a relationship of trust together with a considerable age gap between Daniel and

\textsuperscript{96} At para 5.9(f).
\textsuperscript{97} Para.5.9(g).
\textsuperscript{98} Para 5.9(h).
\textsuperscript{99} Para.5.9(o).
the defendants, he was satisfied that Daniel was by no means manipulated. Describing Daniel as a ‘mature, intelligent and fiercely independent young man’, it seems that the DPP was in no doubt as to the determination of Daniel to end his life with or without his parent’s assistance. The DPP stressed his conclusion that rather than his parents influencing Daniel to travel to Dignitas, he proceeded ‘in the teeth of them imploring him not to do so’. For the same reasons, the DPP rejected the question of vulnerability raised by 5.9(i) of the Code, stating that although Daniel was in some respects vulnerable, he was not vulnerable to manipulation or corruption by those under consideration. This approach accords with that of Hedley J in Re Z, in recognizing the autonomous right of competent adults to choose to travel abroad for an assisted suicide.

The next factor considered relevant, under 5.9(q) of the Code, was whether a prosecution would have a positive impact on maintaining community confidence, with the DPP concluding that given all the circumstances of the case, a significant positive impact would be unlikely. In some respects this might be viewed as one of the DPP’s more interesting conclusions, as it presents an opportunity to select one of two possible interpretations of what is positive in this context. Those who disapprove of relaxing the prohibition on assisted suicide might argue that the DPP missed the opportunity to send out a message that assisting disabled people to commit suicide will not be tolerated. Instead, the DPP chose to condone the actions of Mr and Mrs James. Whilst this decision might be – and in fact was – justified on the grounds that the defendants reluctantly respected and thus facilitated Daniel’s autonomous and determined desire to die, society is now instructed that provided one is reluctant it is excusable to help mentally competent, suicidal disabled people to die rather than helping them to live. Thus, in the face of a law that prohibits assisted dying even for the terminally ill, it is illuminating that the DPP did not construe a decision to prosecute in James as having a sufficiently significant positive impact on society with respect to both the prohibition against such acts, and societal attitudes to disability. Of course, it could equally be argued that to prosecute Mr and Mrs James would send out the message that the law lacked humanity and compassion, and furthermore, took insufficient account of the clear evidence of their reluctance and compassion. What is interesting therefore, is that the DPP opted to send out the message that assisting in suicide in such circumstances is not

---

100 Decision on Prosecution (supra n.80) para 32.
101 Ibid.
102 Discussed above at p.122-123.
sufficiently morally wrong – if it is *morally* wrong at all – to be deserving of censure. Whilst this decision might clearly have a positive impact on members of society who support the legitimization of assisted suicide,\(^{103}\) including, of course, Debbie Purdy - one of the key intended recipients of the information provided via the James decision - other will view the decision as having an entirely negative impact. It is also interesting to note that the post-*Purdy* Policy,\(^{104}\) which provides the focus for the next chapter, implies that the health of the victim is irrelevant to the prosecutorial decision. While the interim policy included a reference to the victim’s health,\(^ {105}\) this was removed from the final policy. I consider this at length in chapter 5, but it is interesting to note that the decision in *James* demonstrates that the health of the victim was indeed regarded as a relevant factor.

Having dismissed all factors in favour of prosecution, with the important exception of the offence itself being of a serious nature, the DPP considered that section of the Code identifying factors *against* prosecution. Paragraph 5.10(a) was seen as supportive of the argument against prosecution, as any penalty imposed following conviction is likely to be nominal. The DPP also viewed 5.10(c); whether the offence was committed as a result of a genuine mistake or misunderstanding, as being a factor, albeit one with little weight attached to it, against prosecution with respect to the family friend, as he was unaware that in booking the flights he was potentially legally culpable for assisting in Daniel’s suicide.

After providing a reminder that the factors in the Code, both in favour and against a prosecution, are not exhaustive of the public interest issues that may be relevant in any given case, the DPP highlighted Parliament’s decision to retain the assisting suicide offence in the Suicide Act 1961. Evidently keen to limit the significance of his decision, the DPP sought to emphasize that in spite of the decision not to prosecute in this particular case, even powerful mitigating circumstances in a case of assisted suicide should not automatically lead to a decision not to prosecute. In summing up the crucial determining factors in this case, the DPP cited as pivotal to his decision Daniel’s previous suicide attempts together with his fiercely independent spirit which would have undoubtedly led to further attempts to take his own life should his parents have refused to assist him. Also relevant, were the relentless

\(^{103}\) As I discussed in chapter 1, evidence suggests that a majority within society would support the legalisation of assisted suicide under certain circumstances, the main one being where the person wanting to die is terminally ill.

\(^{104}\) Available at [http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html)

\(^{105}\) It being a factor against prosecution if the victim was suffering from a serious health complaint.
efforts of Daniel’s parents to dissuade him from his chosen path. By comparing the actions of Mr and Mrs James and their friend to the actions of the defendants in Wallis and Hough, the DPP described them as being ‘towards the less culpable end of the spectrum.’ And finally, the fact that none of the defendants stood to gain any advantage, financial or otherwise, was cited as being important to the decision not to prosecute.

By combining a strict interpretation of the Suicide Act for the evidential test, with a liberal interpretation of the public interest test, the DPP’s decision conveyed two messages. Firstly, by highlighting the potential to pursue a prosecution for even quite inconsequential acts of assistance in a suicide where the motives of the defendant are perceived as less honourable than in the James case, the DPP sent out a warning that it remains an offence to assist in suicide and thus, potential offenders should tread carefully. But in his willingness to overlook the well intentioned assistor in suicide, the DPP also embraced the idea that compassionate and altruistic assisting in suicide should not be subject to criminal sanction. Moreover this decision also provided a template of sorts for the DPP’s subsequent interim policy, which, thanks to the efforts of Debbie Purdy preceded the final policy which, as I explore in the next chapter, now sets down clear guidelines to those who are considering their chances of prosecution under the Suicide Act.

4.8 The Purdy Appeals

i) The Court of Appeal

The DPP’s decision in the James case in December 2008 provided the Court of Appeal (just weeks later in February 2009) with an extremely useful example, which, notwithstanding that the appeal was dismissed, enabled them to provide Ms Purdy with what might be described as a comforting defeat.

Re-asserting the Divisional Court’s sentiments regarding the constitutional role of the court in relation to Parliament, the Court expressed great sympathy for Ms Purdy’s predicament but remained steadfast on the legal position. Although the Court of Appeal presented a more

---

106 Ibid at para. 35c.
108 "We cannot subject it (Suicide Act 1961) to judicial interpretation and produce a meaning which the statute does not bear. The statute does not admit of exceptions. We cannot suspend or dispense with the law."
encouraging view than the Divisional Court in relation to the significance of the ECtHR’s interpretation of human rights in *Pretty*, ultimately the appeal was dismissed on the basis that Ms Purdy’s rights under Article 8(1) are not engaged.\textsuperscript{109} Following an examination of both the House of Lords and the ECtHR’s rulings in *Pretty*, the Court determined that while the House of Lords clearly rejected any engagement of Article 8(1), the ECtHR did indeed find that Mrs Pretty’s rights under Article 8(1) were engaged, stating:

On the basis of this analysis everything in the judgement suggests that Article 8(1) is engaged. The only possible doubt arises from the choice of language in paragraph 67. This the Divisional Court found to be “curious” and “elliptical”... Be that as it may the House of Lords found that Mrs Pretty’s Article 8(1) rights were not engaged. The European Court of Human Rights found that they were. The decisions are clearly inconsistent.\textsuperscript{110}

In response to Ms Purdy’s contention that in view of the conflicting authorities, the Court should, under the circumstances and on policy grounds, consider themselves at liberty to follow the ruling of the Strasbourg Court, the Court of Appeal rejected this argument. Following their examination of *Kay v Lambeth LBC*, \textsuperscript{111} amongst other cases, \textsuperscript{112} where the principles of judicial precedent had come under analysis in this context, the Court of Appeal stated:

...there is nothing in these three decisions sufficient to indicate that lower courts should now be free to no longer consider themselves bound by the judgement of the House of Lords ... it follows that we must find that Ms Purdy’s Article 8(1) rights are not engaged.\textsuperscript{113}

Predictably the Court of Appeal also concluded that the DPP’s failure to promulgate a code does not render him in breach of any statutory duty.\textsuperscript{114} On this point the Court highlighted the significance of the decision of the DPP in the James case in providing guidance to those who,

\textsuperscript{109} The Court of Appeal held that there was insufficient case authority to indicate that the lower courts should now be free to consider themselves no longer bound by the House of Lords on this issue.
\textsuperscript{110} Paragraph 49.
\textsuperscript{111} Supra n. 65.
\textsuperscript{112} Paragraph 50 to 62.
\textsuperscript{113} Paragraph 62.
\textsuperscript{114} Under section 6(1) Human Rights Act 1998 in relation to Article 8(2) ECHR.
like Ms Purdy, seek some assurance regarding the application of the law in these circumstances, saying:

Although it is, like all such decisions, fact-specific, we believe that it is illustrative not only of the care with which the issues in these cases would be approached, but also an extremely helpful example of the kind of broad circumstances in which, notwithstanding that the evidential test has been passed, the ultimate decision would be that a prosecution should not be mounted.\textsuperscript{115}

And then later:

...with the example of the decision in the case of Daniel James available for analysis, there was ample material to enable Ms Purdy’s legal advisers to address the likelihood of a prosecution if her husband assisted her suicide.\textsuperscript{116}

\textbf{ii) The House of Lords}\textsuperscript{117}

Despite finding herself ‘...one step closer to the clarification I need’,\textsuperscript{118} Debbie Purdy took her case to its logical conclusion in the House of Lords. Perhaps gratified to have such an important (and newsworthy) case as their swan song, the House of Lords took the opportunity to resolve the conflict between their own ruling and that of the ECtHR in \textit{Pretty}. To the surprise of many, the House of Lords used their powers under the \textit{Practice Statement}\textsuperscript{119} to depart from their earlier decision in \textit{Pretty},\textsuperscript{120} in order to rule in favour of Ms Purdy. Before turning their attention to the implications of Article 8, their Lordships first ruminated upon the question of the territorial ambit of the Suicide Act. With the exception of Lord Phillips, who, rather alarmingly proposed that one suspected might instead be liable for murder,\textsuperscript{121} the Court agreed that any acts of complicity perpetrated within the jurisdiction would breach the

\begin{footnotesize}
\textsuperscript{115} Paragraph 19.
\textsuperscript{116} Para. 78.
\textsuperscript{117} [2009] UKHL 45.
\textsuperscript{118} ‘Woman with multiple sclerosis loses assisted suicide case’ \textit{The Guardian}, Thursday 19 February 2009.
\textsuperscript{119} \textit{The Practice Statement (Judicial Precedent)} [1966] 3 All ER 77. Lord Gardiner authorised the House of Lords to escape previously binding decisions made by itself in earlier cases in circumstances ‘when it appears to be right to do so.’
\textsuperscript{120} That Article 8(1) was not engaged upon the issue of a seriously ill person seeking an assisted suicide.
\textsuperscript{121} See para.12. Drawing upon the historical origins of the offence of murder – as an offence which transcends national boundaries – Lord Phillips concluded that the Suicide Act does not concern itself with acts which assist a suicide which occurs outside the jurisdiction, and thus, he looked to the pre 1961 Suicide Act legal position, whereby anyone assisting in suicide was guilty of murder.
\end{footnotesize}
Suicide Act no matter where the victim eventually died. However, as Lord Hope observed, the Court were not expressly charged with resolving the issue of the territorial ambit of the Suicide Act (as it was), and it may yet, according to Hirst and Buxton, fall to be resolved by a criminal court prosecuting a section 1(2) offence which occurred before the amendment by the Coroners and Justice Act 2009. As interesting as this might be, given that there have been no prosecutions to date, the likelihood of any pre-amendment cases of assistance in suicide tourism coming before the court is obviously very low.

On the crucial issue of whether Ms Purdy’s Article 8(1) rights were engaged, Lord Hope took the opportunity to refer to his own dicta in *Pretty*, where, despite not dissenting from the majority, he had said:

> Respect for a person’s ‘private life’, which is the only part of article 8(1) which is in play here, relates to the way a person lives. The way she chooses to pass the closing moments of her life is part of the act of the living, and she has the right to ask that this too must be respected. In that respect Mrs Pretty has a right of self-determination. In that sense, her private life is engaged even where in the face of a terminal illness she chooses death rather than life.124

Having established his theoretical support for the autonomous rights of the individual on this issue, Lord Hope went on to dispel any doubt over the ECtHR’s finding that Mrs Pretty’s Article 8(1) rights were engaged. Furthermore, he stated that even if there could be some doubt as to the ECtHR’s meaning over the engagement of Article 8(1) in *Pretty*, Ms Purdy’s case, being subtly different, is not open to any doubt on the question of whether her Article 8(1) rights are engaged. Interestingly, Lord Brown even suggested that the ECtHR implied that not only were Art.8(1) rights engaged on this issue, and accordingly that it may be appropriate not to prosecute in some cases, but it may even be ‘inappropriate’ or ‘wrong in principle’ to prosecute under section 2(1) of the Act, because to do so would deter people from assisting those who are unable to exercise their right of self-determination unaided.126

---

122 At para. 25.
124 Para. 36, *Purdy HL*.
125 At para.38.
126 At para.74 and 75.
With respect to the question of whether the requirements of Art. 8(2) were satisfied by the discretionary nature of the decision to prosecute pursuant to the general code for crown prosecutors, the Court were unanimous in concluding that:

...there is simply no sufficiently clear or relevant guidance available as to how the very widely expressed discretion accorded to the Director in section 2(4) of the 1961 Act will be exercised. The Code may well provide sufficient guidance for the purposes of most, even all, other crimes, but it is simply inadequate for the purposes of the crime created by section 2(1) of the 1961 Act.¹²⁷

Despite the DPP’s best efforts to provide guidance via his reasons for not prosecuting in James, the House of Lords agreed that in fact the ‘Director’s own analysis shows that, in a highly unusual and extremely sensitive case of this kind, the Code offers almost no guidance at all.’¹²⁸ Thus, guidance of a specific nature was required and Ms Purdy was victorious.

As Rogers observes,¹²⁹ their Lordships were not simply charging the DPP with the task of producing any such guidance he deemed appropriate. They were, as Baroness Hale expressly directed, most concerned with the promulgation of a policy with the object:

|to protect the right to exercise a genuinely autonomous choice. The factors which tell for and against such a genuine exercise of autonomy free from pressure will be the most important.¹³⁰|

Predictably, the House of Lords decision in Purdy has been subject to some criticism for promoting the autonomous rights of individuals at the expense of the criminal code.¹³¹ Equally, the nature of the office of the DPP has led to questions over whether, in placing the responsibility for formulating policy on such an important moral matter in the hands of an unelected official, constitutional traditions have been disregarded. For example, Williams has argued that ‘...ordering the DPP to publish a policy guidance document which effectively decriminalises assisted suicide, is not the way in which the law can or should be changed in

¹²⁷ Lord Neuberger, para.102.
¹²⁸ Lord Hope, para. 53.
¹³⁰ Para.65.
the UK’. Similarly Keown has observed that, the DPP was ‘[p]laced in this invidious position (by a ruling which was, with respect, unsound if not unconstitutional)’. While such criticisms might be expected given the both the unusual character and controversial implications of the decision, the nature of judicial obligation meant that the House of Lords had no option other than to make a decision in order to resolve the question of Article 8. Moreover, having correctly understood that Article 8 provides an obligation upon the state to articulate the nature of the interference with a competent adult’s right to choose death (and that current guidance was insufficient), the House of Lords were compelled to charge the task of clarifying policy to the DPP.

Before concluding this chapter in order to examine the implications of the DPP’s Policy in the next chapter, it is worth considering whether the implications of Purdy may yet be more far reaching. Whilst their Lordships were careful to reinforce the sovereignty of Parliament in order to deflect any allegations of changing the existing law, as well as being anxious to appear to remain neutral on the issue of whether the law should be changed, elsewhere the decision raised questions as to whether Article 8 rights might go further than merely providing a right to know how prosecutorial discretion is exercised. Lord Brown raised the possibility that in spite of the clear prohibition, there are circumstances in which it will be ‘inappropriate’ or ‘wrong in principle’ to prosecute. Furthermore, Lord Brown suggested that in some circumstances complicity in suicide might be regarded as commendable rather than worthy of condemnation, such that:

...it would be possible to regard the conduct of the aider and abettor as altruistic rather than criminal, conduct rather to be understood out of respect for an intending suicide’s rights under article 8 than discouraged so as to safeguard the right to life of others under article 2.

As Herring observes:

133 Keown, Supra, n.127.
134 For example, Lord Hope stressed that ‘this must be a matter for Parliament’ (Purdy HL at para. 26).
135 Ibid, for example, Lord Hope (para.26), Lord Brown (para.83).
136 Purdy HL at para. 74
137 Ibid at para. 83.
138 Ibid.
If assisting a person in committing suicide is respecting their Article 8 rights, as Lord Brown suggests, then as a person has a right to respect for their private life then he could be read as saying a person might have a right to assistance, and not just a right to have assisted suicide without interference from the state.\textsuperscript{139}

Furthermore, Herring considers how a person who is unable to travel to Switzerland for an appointment at Dignitas without assistance, and who does not have any friend or relative who is willing or able to assist, might now conceivably be able to press upon the state a duty to provide such assistance with travel etc in order to satisfy the Article 8 right to self-determination as confirmed in \textit{Purdy}.\textsuperscript{140} Whilst any further formal right to assisted suicide within the jurisdiction will almost certainly not be granted by the Supreme Court (as the House of Lords stated, this is a matter for Parliament), the incremental nature of jurisprudence means that in the event that Parliament continues to ignore this issue, we may see further strengthening of Article 8 rights of self-determination for those who choose death. For example, if the Court were to grant a right to be assisted to travel to Dignitas and subsequently, for whatever reason - e.g. assisted suicide for non-residents is outlawed in Switzerland\textsuperscript{141} – the option of a Swiss suicide expires, might a substantive right to be assisted \textit{at home} emerge? If people have a right to choose suicide, but are prevented by logistical obstacles from actually committing suicide, then should the State have a duty to facilitate such a right to self determination? As we know, the Courts in \textit{Pretty} said ‘no’ to this question, but \textit{Purdy} has changed the legal landscape. We might also view the availability of a Swiss suicide service as providing a safety valve which reduces pressure on UK authorities to legalise assisted dying. If the Swiss option were removed, then people would increasingly turn to options within the jurisdiction and societal pressure to legalise physician-assisted suicide would inevitably mount.

At the time of writing, a potentially interesting case is being pursued by an anonymous man who suffered complete paralysis following a devastating brain stem stroke.\textsuperscript{142} ‘Martin’, as he is known, has a wife who is unwilling to assist him in a journey to Dignitas. Martin has legal representation but his lawyer fears that prosecution policy may now place any professional

\begin{flushleft}

\textsuperscript{140} Ibid.

\textsuperscript{141} Such a development has been considered by Swiss authorities, who have, for the moment at least, decided to allow non residents to continue to receive assistance in suicide. See ‘Swiss vote to continue assisted suicide’, BBC 16 May 2011, available at http://www.bbc.co.uk/news/health-13410228.

\textsuperscript{142} See ‘Man in assisted suicide case spells out why he wants to be helped to die’, \textit{The Guardian}, August 18 2011.
\end{flushleft}
assisting a person such as Martin at risk of prosecution. Thus, his lawyer’s first task involves seeking a declaration that preparing a case on Martin’s behalf will not breach the Suicide Act. Subject to his lawyer’s ongoing assistance, Martin is reported as planning to fight for the right to receive palliative care to assist him to die by starvation/dehydration at home. This approach would be similar to that proposed (but then abandoned) by Kelly Taylor, as discussed in chapter 3. Martin’s case also bears resemblance to Tony Nicklinson’s case, which I discussed in chapter 2. It seems inevitable that these sorts of cases will continue to arise and so further developments arising from Article 8 rights may be difficult to resist.

4.9 Conclusion

In this chapter I have examined how the law on complicity in suicide has evolved since its inception in 1961. The controversial moral dilemma over when we should forgive complicity in suicide, and when we should condemn it has led to a range of seemingly inconsistent and conflicted court decisions. The discretion over the decision to prosecute has placed a series of DPPs in the position of moral arbiter with little or no guidance as to how such discretion should be exercised. The impact of Human Rights legislation, in the hands of a more progressively minded House of Lords, led to an important breakthrough for those pursuing a right to die. Although there remains no ‘right to die’, the right to know when prosecution might occur has, as I argue in the next chapter, led to clarification which has confirmed that certain modes of assisting a suicide will not be subject to the prohibition provided by the Suicide Act.

Following the decision in Purdy, the DPP produced an interim policy which directed Ms Purdy, prosecutors and the general public alike as to how prosecutorial discretion is exercised on the question of when one might be prosecuted for complicity in suicide. Thus, the interim policy bridged a gap whilst a public consultation exercise sought views on what the final policy should look like. As I will go on to explore in the next chapter, the final policy confirms what we arguably already knew; that one is almost certain not be prosecuted when

---

143 As I explore in the next chapter, according to the post-Purdy Policy, one of the factors in favour of prosecution refers to professional acts of assistance, thus rendering any lawyer at risk of prosecution and consequent professional sanction. Given that many lawyers have involved themselves in similar cases (e.g. Pretty, Purdy) prosecution for preparing a legal case seems unlikely.

144 See p.56.

the so-called victim dies abroad. But the factors which inform the prosecutorial decision are very interesting and in some instances, quite surprising, giving rise to a debate about whether certain modes of compassionate complicity in suicide are now beyond the reach of the criminal law.
CHAPTER 5

Overlooking the Criminally Compassionate?¹

5.1 Introduction

Following the successful endeavours of Debbie Purdy to compel the Director of Public Prosecutions (DPP) ‘to clarify what his position is as to the factors that he regards as relevant for and against prosecution in this very special and carefully defined class of case’, ² the ‘Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’³ (the Policy) now sets out determining factors for potential prosecution for encouraging or assisting suicide.⁴ As discussed in the previous chapter, to the surprise of many, and in their final decision before reconvening as the Supreme Court, the House of Lords departed from their earlier decision in the case of Pretty,⁵ by ruling that the ‘Article 8 rights of Ms Purdy entitle her to be provided with guidance from the Director as to how he proposes to exercise his discretion under section 2(4) of the 1961 (Suicide) Act.’⁶ Accordingly, the DPP published his interim guidelines in September 2009,⁷ at the same time as launching a public consultation exercise in order to gather views upon which to determine the final guidelines, which were then released in February 2010. The final guidelines present 16 factors in favour of prosecution and six against, as follows:

Public interest factors tending in favour of prosecution;

1 A version of this chapter was published in the Medical Law Review: See A Mullock ‘Overlooking the criminally compassionate: What are the implications of prosecutorial policy on encouraging or assisting suicide?’ Medical Law Review, (2010) 18(4),
³ Available at http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html
⁴ Where the potential offence under section 2 of the Suicide Act 1961 occurred on or after 1 February 2010, the amendment provided by section 59 and Schedule 12 of the Coroners and Justice Act 2009 applies.
⁵ R (On the Application of Dianne Pretty) v DPP (2001) WL 1171775 (HC); R (On the Application of Dianne Pretty) v DPP (2001) WL 1423045 (HL); Pretty v UK Application no.2346/02 (ECHR) (2002) 35 EHRR1, ECHR.
⁶ Purdy HL at para.106 (above n.2).
⁷ Interim Policy for Prosecutors in respect of Cases of Assisted Suicide, Issued by The Director of Public Prosecutions, September 2009. Available on www.cps.gov.uk
1. The victim was under 18 years of age;
2. The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
3. The victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
4. The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. The suspect pressured the victim to commit suicide;
8. The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. The suspect had a history of violence or abuse against the victim;
10. The victim was physically able to undertake the act that constituted the assistance him or herself;
11. The suspect was unknown to the victim and encouraged or assisted the victim to commit suicide by providing specific information via, for example, a website or publication;
12. The suspect gave encouragement or assistance to more than one victim who were not known to each other;
13. The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;
15. The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

Public interest factors tending against prosecution;

1. The victim had reached a voluntary, clear, settled and informed decision to commit 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.

Whilst the final Policy reflects the general tone of the interim policy - so that the message that it is not in the public interest to prosecute a person who has compassionately and reluctantly assisted in the suicide of a determined and competent adult endures - some changes have been made. Most notable amongst these changes is ‘the apparently heightened risk of prosecution’ now faced by healthcare professionals,\(^8\) together with the removal of the factor relating to illness or disability which featured in the interim policy, such that the final guidelines focus more on the motivations of the suspect than the health of the victim. Despite some clear differences between the interim and final policy, the DPP has stressed that the likelihood of prosecution remains unchanged. The DPP’s message, that it remains a criminal offence to encourage or assist in suicide,\(^9\) is also perhaps contradictory because, as it will be argued here, the Policy has precisely the effect of sanctioning compassionately motivated assisted suicide, with compassion as the key determining factor which potentially places an act which remains criminal beyond the reach of the criminal courts.

This chapter considers the implications of the Policy, both in relation to key specific factors and with respect to the wider implications such a policy might bring to bear on this area of law. Because these developments have stemmed from the phenomenon of suicide tourism, I begin with some consideration of aspects of the Policy which might influence where (at home or at Dignitas?) people seek assistance in suicide, in order to assess whether the location of the assisted suicide is not, as the DPP asserts, relevant to the prosecutorial decision.

Focus then shifts to the issue of compassion. Despite there being no presumptive weighting to any of the factors,\(^10\) it will be argued that aside from some of the more obviously harmful

---


\(^9\) At para. 6 of the policy (see n.4), the DPP states: ‘This policy does not in any way “decriminalise” the offence of encouraging or assisting suicide. Nothing in this policy can be taken to 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 person.’

\(^10\) John Coggon has observed that none of the factors “…is necessarily ‘heavier’ than others, and no one can find an answer simply by totting up factors for and against and seeing which list is longer.” See Coggon, ‘Prosecutorial Policy on encouraging and assisting suicide – how much clearer could it be?’, *JME* (2010), Vol.36(7);381-382.
factors,\textsuperscript{11} which might even call into question whether the victim’s death should be treated as a homicide rather than a suicide, the key issue is the motivation of the assistor and whether he or she was ‘wholly motivated by compassion’. With respect to the moral underpinnings of the Policy, the factor pertaining to autonomy might be seen as equally crucial, however, because it is assisting in suicide (and not mercy-killing) under scrutiny, compassionate assistance arguably depends on there being an autonomous desire for suicide. Moreover, I contend that the very concept of compassion, in this context, assumes autonomy on the part of the victim. Thus, assessing compassion will be the crucial issue in the vast majority of cases which fall under prosecutorial scrutiny. Leading on from this, I contend that the overt tolerance of compassionate assisted suicide will increasingly highlight the futility of continued prohibition in the face of a Policy which blatantly confronts the inadequacy of the criminal law in this area. With this in mind, this chapter will consider the implications of denying the relevance of the health of the victim whilst also seeking to deter any medical involvement, arguing that whilst recognising compassion as the key determining issue presents a sound basis upon which to found such a Policy, other aspects of the Policy are less sound.

In consideration of the factors which preceded the Policy, the DPP may be understandably anxious not to be seen as usurping the role of the legislature by legitimizing assisted suicide. However, as I discussed in the previous chapter, a number of factors have forced his hand. Consequently, the DPP was charged with the task of producing a policy which would remain consistent with existing practice,\textsuperscript{12} while simultaneously providing a sufficient degree of clarification as well as attempting not to tie the hands of the prosecution with respect to future cases. As discussed in the previous chapter, the circumstances which placed the DPP in this unenviable position are interesting. Most significantly, the availability of assisted suicide abroad has encouraged those in distress over a difficult and undignified end to view assisted suicide as a realistic option. In a climate of jurisdictional uncertainty, the current DPP’s predecessor initiated the prosecutorial approach to ‘suicide tourism’ with the decision that it

\textsuperscript{11} Such as the victim lacking capacity or being pressured into committing suicide.

\textsuperscript{12} Thereby rationalising why no prosecutions have followed on from suicides which have occurred abroad.
was not in the public interest to prosecute the widow of the first Briton to travel to Dignitas, Reginald Crew. 13

Thanks to the efforts of Debbie Purdy and the House of Lords, the policy which was promulgated in order to facilitate the rights of self-determination provided by Article 8 now confirms that prosecution is highly unlikely. With respect to the investigation of one suspected of assisting in suicide, evidence of compassion and the apparent absence of any selfish motivation will effectively place the suspect in the position of a legitimate assistor in suicide, provided of course that the so-called victim was a competent adult exercising his or her autonomous desire for suicide. Before considering the wider implications of the role of compassion in legitimising assisted suicide and how the practical implications of assessing compassion might be unravelled, it is interesting to consider whether the Policy genuinely takes no account of the location of the actual suicide, or whether, as previous policy might suggest, one is far less likely to be prosecuted when the victim dies abroad.

5.2 Complicity in England, suicide in...?

On the face of it, the Policy takes no account of the jurisdiction within which the victim’s suicide occurs, focusing only on where the act or acts of assistance or encouragement occurred. However, several of the factors which are clearly intended to deter (certain) people from providing more significant assistance in suicide will inevitably encourage travel to a permissive jurisdiction such as Switzerland. As Biggs comments, ‘... the Policy is likely to encourage people seeking assistance to travel abroad to more sympathetic jurisdictions.’ 14

This may not be entirely unexpected given that the Policy was essentially born as a consequence of the availability of assisted suicide abroad, which ignited Ms Purdy’s desire to understand how prosecutorial discretion is exercised in relation to suicide tourism. Nevertheless, it is worth considering whether the DPP’s assertion that the location of death is irrelevant withstands scrutiny.

13 Prior to the appointment of the current DPP (Keir Starmer) the office of his predecessor, Sir Ken McDonald, determined that in none of the cases involving an assisted suicide abroad was it in the public interest to pursue a prosecution, including that of Mr Crew.

14 H Biggs, ‘Legitimate Compassion or Compassionate Legitimation? Reflections on the Policy for Prosecutors in Respect of Cases or Encouraging or Assisting Suicide’ Feminist Legal Studies (2011) 19:83-91, p.89.
Consider the following factors tending in favour of prosecution: the victim was unknown to the suspect and provided assistance or encouragement via a publication or website; the suspect assisted more than one person; the suspect was acting in a medical capacity; and, the suspect was a person involved in an organisation or group whose purpose is to provide a physical environment for an assisted suicide.\footnote{See respectively; para.43(11), (12), (14), (16) of the Policy (see n.3).} Recall that if the actions of the suspect, although evidentially sufficient, might be regarded as constituting only minor encouragement or assistance,\footnote{Para.45(3) of the Policy (see n.4). We might assume that providing the method/means of suicide, for example, helping to collect pills or helping an incapacitated person to consume a fatal overdose, would not constitute ‘minor encouragement or assistance.’ Evidence suggests that the DPP has a strict approach to any form of determinative assistance in suicide. For example, as discussed in chapter 4, Kay Gilderdale was prosecuted for attempted murder for her role in her daughter’s suicide. See BBC news ‘CPS defends charging Gilderdale over ME daughter death’ 26 January 2010 available at www.news.bb.co.uk/1/hi/England/sussex/8481055.stm} it will count as a factor tending against prosecution. These factors are clearly aimed at deterring any individuals or organisations from providing any advice service or assisted suicide facility, in order to avoid the emergence of any Dignitas type organisation operating within the jurisdiction. Superficially, this may be viewed as a positive objective because it is indisputably desirable to discourage people from committing suicide. However, the Policy may merely succeed in encouraging people to seek help abroad because no meaningful help is available at home. This approach may also encourage people to seek an assisted suicide sooner than they might otherwise because of the need to travel abroad to Switzerland whilst they remain able to do so.\footnote{Indeed, this was one of the arguments put forward in Purdy. See HL decision, para.31 (supra n.2).} Although, as mentioned in the previous chapter,\footnote{See p.120.} there is some limited medical assessment of the person seeking an assisted suicide, there is no specific requirement that the person be terminally ill or even suffering unbearably. Unsurprisingly, this has invited criticism of Swiss law, particularly with respect to the activities of Dignitas.\footnote{See for example, ‘Murky truth behind Swiss suicide ‘clinic’ Dignitas’, Timesonline, Oct 25, 2008 available at www.thetimes.co.uk/tto/health/article1963892.ece .} As Seale has observed, ‘Swiss cases entail more women than men, and one in five has no fatal condition but rather, for example, arthritis, osteoporosis, “general weakness,” blindness, or mental disorders, usually depression.’\footnote{Clive Seale, ‘Do it properly or not at all’, BMJ 2010;340;c1719.} Although no validated statistics exist for assisted suicide in Switzerland, some of the cases involving UK citizens dying at Dignitas clearly support Seale’s observation and so it seems that we have good...
reason to be concerned.\textsuperscript{21} If the Policy succeeds in keeping down assisted suicide within the jurisdiction only at the cost of exporting suicidal UK citizens to a jurisdiction where assisted suicide is too easily available, this approach is less than satisfactory.

The factors mentioned above also raise interesting questions about the relationship between law and morality in this context. The question of which acts of assistance should or should not invite condemnation, or in fact which people should be more or less likely to be effectively exonerated,\textsuperscript{22} is also difficult to resolve. As Lord Lane CJ observed in \textit{Hough}, ‘in terms of gravity it could range from the borders of cold-blooded murder down to the shadowy area of mercy killing or common humanity.’\textsuperscript{23} Thus, one might question whether the location of the suicide and/or the extent of the degree of assistance, for example, \textit{should} determine the moral or legal character of an act? Two of the recent cases involving parental assistance in suicide provide an illuminating comparison. As previously mentioned, the parents of Daniel James escaped prosecution after they escorted their son to Zurich for an assisted suicide. By contrast, Kay Gilderdale was charged with attempted murder following her role in her daughter, Lyn’s, suicide. Clearly, Gilderdale’s role in her daughter’s death was more proactive than that of Mr and Mrs James, a fact which compelled the DPP to reject Gilderdale’s guilty plea for assisting in suicide and to instead pursue charges for attempted murder.\textsuperscript{24} Notwithstanding the DPP’s contention that Gilderdale’s actions had crossed the line from complicity in suicide to active killing (evidence of which was rejected by the jury), in reality both victims, being physically incapacitated, were equally reliant on the assistance provided by the defendants. Both victims had attempted suicide previously. Both victims demonstrated an equally clear, settled and competent wish to die. We might wonder, if Mr and Mrs James had obtained a fatal dose of barbiturates in order to help Daniel to die in England, would the DPP’s decision (not to prosecute) have been different? Or, does the

\textsuperscript{21} For example, Robert and Jennifer Stokes, who died at Dignitas in 2003, were both relatively young and neither suffered from a terminal or even serious illness. More recently, an 85-year-old man, Sir Edward Downes, who suffered from only age associated health problems, died at Dignitas together with his terminally ill wife, aged 74. While Mr and Mrs Stokes travelled unaided to Dignitas, the Downes’ son, Caractacus Downes, was investigated following his role in accompanying his parents to Dignitas. Despite being a beneficiary to his parents’ considerable estate, Caractacus was deemed by the DPP to have been ‘wholly motivated by compassion’. See ‘No assisted suicide charge for son of Sir Edward Downes’, BBC news, 19 March 2010 available at \url{www.news.bbc.co.uk/1/hi/england/london/8576218.stm}

\textsuperscript{22} For example, a person acting in their capacity as a healthcare worker is presumably more likely to be prosecuted than a relative who assists in suicide.

\textsuperscript{23} \textit{R v Hough} (1984) 6 Cr App Rep (S) 406 at 407.

\textsuperscript{24} Kay Gilderdale was alleged to have assisted her daughter by initially passing morphine to her and then, later after Lyn lost consciousness, to have continued administering morphine until Lyn died.
assistance of the Swiss volunteer nurse who would have overseen Daniel’s suicide at Dignitas mean that the assistance provided by Mr and Mrs James is morally different to the assistance provided by Kay Gilderdale?

Navigating this moral minefield is clearly going to be challenging, however, the first post-policy case involving an assisted suicide occurring within the jurisdiction suggests that the DPP’s assertion regarding location might be more convincing than expected. Michael Bateman was investigated after assisting in his wife’s suicide by assembling helium gas apparatus and placing a plastic bag over her head before she herself turned on the helium supply and tightened the bag.\(^{25}\) Clearly, Bateman’s actions could hardly be described as constituting ‘only minor assistance or encouragement’, but nevertheless the CPS concluded that Bateman had been wholly motivated by compassion and consequently it was not in the public interest to prosecute him. Evidently, this decision supports my earlier contention that assessing the suspect’s motivation is the overriding issue in such cases, but the Bateman decision is also interesting as an example of what might be a growing phenomenon of “Do-It-Yourself” assisted suicides. Whilst it seems that Mrs Bateman experienced a humane death following an autonomous decision to die, others may be less fortunate. As Seale opines, ‘[B]otched suicides assisted by amateurs and ill considered decisions to die by some of the most vulnerable people in society are the likely outcomes of the assisted dying policy of the DPP...’\(^{26}\) Although it seems unfair to lay the blame for botched suicides at the door of the DPP, it is not unreasonable to contend that a greater willingness to exonerate relatives and friends (over those who might offer more expert assistance)\(^ {27}\) might, in addition to compelling people to travel abroad to die, have the effect of encouraging more people to take matters into their own hands. Thus, an increase in botched suicides presided over by (hopefully) well-meaning but ill-informed relatives might be an unintended consequence of the Policy.\(^ {28}\) It is also apparent that although the organisation Dignitas operates with

\(^{25}\) Michael Bateman’s wife had been bedridden for years due to an undiagnosed condition. For details of the Bateman decision see; Assisted suicide charge not in the public interest, at http://www.cps.gov.uk/news/press_release/120_10/ See also, http://www.telegraph.co.uk/news/uknews/7760266/Man_who_helped_wife_commit_suicide_will_not_be_prosecuted.html

\(^{26}\) Supra n.20.

\(^{27}\) Referring to the factors mentioned above (see n.26), and the factor regarding healthcare workers, which is discussed further below.

\(^{28}\) For example, a terminally ill man, William Stanton, recently survived a suicide pact in which his wife, who was healthy, died. See; ‘I botched our suicide pact’, The Sunday Times, November 1 2009.
inadequate safeguards, it does at least provide that a third party is involved in the decision to
die and the consequent suicide. In addition to facilitating a humane death, a third party might
be seen as having an important role in seeking to ensure both that the victim has mental
capacity and is acting autonomously in order to escape suffering. At Dignitas, for example,
the so-called victim is repeatedly asked whether they ‘want to die today?’ before assistance is
forthcoming. The involvement of a third party may also encourage the victim to reconsider
and explore alternatives, a possibility which it seems the Policy has overlooked.

5.3 Wholly motivated by compassion?

At the basis of compassion lies an identification with the sufferer as a fellow human
being, a recognition that similar misfortunes may also befall one, insofar as one is human.30

The second public interest factor tending against prosecution invites an assessment of
whether ‘the suspect was wholly motivated by compassion.’ Similarly, the public interest
factors tending in favour of prosecution direct prosecutors to consider whether the suspect
was motivated by a prospective gain.31 The DPP advocates a ‘common sense approach’32 to
this issue, stating that the fact that a suspect has gained some benefit from the victim’s death
will not usually tend in favour of prosecution if it is shown that compassion was the only
driving force behind the suspect’s act. Naturally, this involves a retrospective assessment of
the motivations which prompted the suspect’s complicity in the suicide, and there are obvious
practical difficulties in investigating the motives of a suspect following the death of perhaps
the only person truly able to bear witness to the suspect’s motives in any meaningful sense.
Indeed, a complete lack of prosecutions following assisted suicides at Dignitas, some of
which have undoubtedly yielded significant benefits to people involved in assisting such
suicides, points to a trusting approach on this issue. Moreover, one might observe that in the

http://www.timesonline.co.uk/tol/news/uk/article6897964.ece Although note that this occurred prior to the
DPP’s policy.
29 As illustrated in the BBC programme featuring 2 British men who died at Dignitas. The programme,
‘Choosing to Die’, was presented by Terry Pratchett and aired on 13 June 2011.
31 See n.3, para.43(6) of the Policy.
32 Ibid, para.44 of the Policy.
absence of demonstrably evil motives, such as those displayed in the case of Mrs McShane33 - a woman in serious financial difficulty, who was convicted under the Suicide Act 1961 in the 1970s for attempting to persuade her mother to commit suicide - a prosecution is highly unlikely. The fact that Mrs McShane’s actions were captured on video assisted the prosecution in establishing a case against her, but such compelling evidence is extremely rare and evidence of bad motive in such cases is almost certain to be elusive even where it exists. Of course, it may be argued that it does not require a criminal mastermind to feign compassion and conceal self-interest, however as McShane illustrates, where there is bad motive there may also be pressure,34 or at the very least, the potential victim will be unlikely to have demonstrated that they ‘had reached a voluntary, clear, settled and informed decision to commit suicide’.35 Considering this point, factors tending against prosecution include: if there was evidence to suggest that the suspect had sought to dissuade the victim,36 and that 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.’37 Thus, when considered together, these factors arguably encourage a sensible assessment which seeks to ensure both that the victim was acting autonomously and that the suspect appeared to be motivated by nothing other than compassion.

Perhaps far more interesting than the practical implications of assessing compassion however, is the notion that compassion is the key determining factor which places an act which remains criminal beyond the reach of the criminal courts. The clear message is that, provided a person has acted only compassionately in providing assistance to a competent adult with a determined desire to commit suicide, then he or she will (almost certainly) not be prosecuted. Although it might be true that a suspect’s compassionate motivation has always been pertinent to the exercise of discretion in the decision to prosecute generally, the clear articulation of the crucial role of compassion provided by the Policy places compassion at the very core of not only current policy, but also identifies it as an impetus for potential legal change.

33 (1977) 66Cr App Rep 97. Discussed by R Huxtable in Euthansia, Ethics and the Law: From Conflict to Compromise, Routledge-Cavendish, 2007, p.60. McShane was recorded telling her mother to take an overdose and also not to tell anyone of her role in assisting the suicide for fear that she might lose her inheritance. In fact, the potential victim did not want to commit suicide and no attempt was made.
34 See n.4, para.43(7) of the Policy: “the suspect pressured the victim to commit suicide”.
35 Ibid, para.43(3).
36 Ibid, para.45(4).
37 Ibid, para.45(5).
With respect to the ethical underpinnings of the Policy, it is clear that autonomy is also an essential prerequisite to a decision not to prosecute. But in drawing a line between ethically acceptable and ethically unacceptable complicity in suicide, the Policy has primarily adopted a motive-centred approach. Of course, autonomy is vital, as are the other factors, but, as I will go on to discuss, the notion of compassion which the Policy seems to embrace encompasses consideration of the reasons why the victim chose death and also, arguably, the assumption that such choice was autonomous. It is difficult to conceive of a situation in which one’s act of assisting in suicide could be viewed as an act of compassion in the absence of there being ‘a voluntary, clear, settled and informed decision to commit suicide.’

If the victim was not completely certain that suicide presented the least worst option under the circumstances, how could it be recognised as objectively compassionate to assist or encourage such a person towards suicide? From a practical perspective, in the absence of clear evidence indicating a reluctance to die or a lack of capacity, it will be extremely difficult for investigators and prosecutors to assess whether the deceased had a clear, voluntary and capacituous desire to die. The test under the Mental Capacity Act 2005 encourages a presumption of autonomy which is relatively easy to satisfy. And, in the absence of hard evidence that the victim was relentlessly suicidal yet apparently competent (such as in the case of James), it will often be hard to determine the extent of voluntariness. Moreover, the victim will not be available for questioning whereas the suspect will. For this reason, I contend that in the majority of cases where there is no evidence to suggest obvious foul play, assessing compassion will be the most important prosecutorial task.

Such a motive based approach is unique. From a prosecutorial perspective it is possible that a suspect’s motive might sometimes be relevant to the decision to prosecute more generally, although it does not feature in the general code.\(^{38}\) Thus, formal recognition that motive is legally determinative presents an unusual and interesting development. Furthermore, compassion has not generally been regarded as legally important within common law jurisdictions. Traditionally, English law does not recognise any such motive as legally determinative, although, it would be inaccurate to describe motive as entirely irrelevant. For example, motive, or at least justification for the defendant’s action, is crucial in establishing certain justificatory defences such as self-defence, and motive may also be relevant to

---

sentencing. Generally however, proof of an act (actus reus) together with the requisite mental state (mens rea) indicates liability regardless of any motive which might be regarded as changing the moral nature of the act. Within the realm of assisted dying, however, one exception to this principle applies to doctors who hasten the death of patients suffering great pain and/or anxiety as death approaches. As discussed in chapter 3, the doctrine of double effect distinguishes medical killing, or at least hastening death, from murder in this context provided that the primary intention of the doctor was to relieve pain and not to kill. This is despite the fact that generally in English law, intention may be regarded as present when the defendant acted with the realisation that the consequence (death or very serious injury) was virtually certain to follow such act. The fact that the doctor might have realised only too well that death was virtually certain to follow the administration of a large dose of pain relieving and/or sedative medication does not amount to criminal intention, as it would in any other context, provided the doctor demonstrated only the desire to relieve suffering and not the desire to kill. Moreover, within the realm of assisted dying, the Law Commission has recommended that the issue of motive should be further considered, with the possibility of a partial defence to murder (in the context of euthanasia) on the grounds of mercy. Thus, the DPP’s recognition of a motive (compassion) as a key determining factor is novel but not entirely without precedent within the context of assisted dying.

In some civil law jurisdictions, however, the presence of compassion has long been recognised as legally determinative. For example, in Germany, compassionate killing, even in the absence of a request from the victim, reduces what would otherwise be murder to the

---

39 As Norrie remarked, “Having insisted upon a strict legal code so as to protect the liberty of the individual, it transpires that the individual’s liberty is ultimately dependant not upon the rule of law at all but on a group of men operating with a wide discretion at the sentencing stage.” See A Norrie, ‘From Criminal Law to Legal Theory: The Mysterious Case of the Reasonable Glue Sniffer’, Modern Law Review (2002), 65:538. Norrie also argues that when it is convenient, motive may be considered relevant, for example in permitting doctors to prescribe the contraceptive pill to girls under the age of 16 (see Gillick v West Norfolk AHA [1985] 3 All ER 402 (HL)). See also, A Ashworth, ‘The Treatment of Good Intentions’, in (eds) A Simester and A Smith, Harm and Culpability, (1996) Oxford University Press.

40 See for example, R v Adams [1957] Crim LR 365.

41 See R v Woollin [1998] 4 All ER103.

42 Also, in relation to a doctor withdrawing life-sustaining treatment, motive is central to a rather curious provision of the Mental Capacity Act 2005 relating to the withdrawal of life-sustaining treatment; Section 4(5) states; ‘Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.’ See J Coggon, ‘Ignoring the Moral and Intellectual Shape of the Law after Bland’, Legal Studies (2007) 27(1), 110.

crime of manslaughter. Similarly in Columbia, killing another in order to end intense
suffering stemming from a serious or incurable illness or a serious injury is recognised as
compassionate homicide rather than murder. As previously mentioned, Switzerland’s
position on assisted suicide prohibits only selfishly motivated assistance with suicide, which
will also obviously involve consideration of whether the suspect acted compassionately in the
interests of the deceased.

Penney Lewis has considered the role of compassion as the mechanism of legal change with
particular reference to a proposal put forward in France by the French National Bioethics
Advisory Committee (CCNE). In 2000, the CCNE reversed their former opposition to any
relaxation in the French prohibition against assisted dying, stating that euthanasia might be
permissible in exceptional circumstances. The CCNE did not advocate substantive legal
change but rather that a defence of euthanasia might halt the judicial investigation where the
defendant was shown to have acted compassionately. The proposal, which has not been
adopted, suggested that an interdisciplinary commission should evaluate the motivations of
the accused and provided that the suspect was evidently motivated by ‘concern to end
suffering, respect for a request made by a patient, compassion in the face of the inevitable,’ a
judge would then drop the charges. Clearly, within this proposal, the role of the
commission and the judge (in evaluating motivation in order to determine whether a
prosecution should be continued), is analogous to the quasi-judicial role of UK prosecutors in
assessing whether the suspect was wholly motivated by compassion prior to determining
whether it is in the public interest to prosecute. As Lewis notes, Pascale Boucard has
considered the CNNE’s proposals, observing that ‘the systematic character of the decision to
discontinue prosecution would shortly lead to the decriminalization of the act.’ While in
relation to France, this observation is purely hypothetical, we might now consider whether
the systematic character of the decision not to prosecute in England and Wales, because the

---

44 Articles 211-213 of the German Penal Code.
45 Article 106 of the Columbian Penal Code. For further consideration of the Columbian legal position see
Sabine Michlowski, ‘Legalisng Active Voluntary Euthansia Through the Courts: Some Lessons from Columbia’,
46 See P Lewis, Assisted Dying and Legal Change, Oxford University Press 2007. Also; P Lewis, ‘The evolution of
47 Comite Consultatif National d’Ethique (CNNE).
48 See Lewis (supra n.46) p.109.
49 Ibid, p110.
50 P Boucard, ‘Commentary on the opinion of the CNNE of 27 January 2000 entitled “end of life, ending life,
suspect was wholly motivated by compassion, will inevitably lead to the legalisation of compassionate assistance in suicide.

There are a number of reasons why Boucard’s view is compelling. First, as assisting in suicide is increasingly perceived as not being subject to criminal prosecution, society will come to expect exactly that. As Baroness Hale in *Purdy* stated, ‘[p]eople need and are entitled to be warned in advance so that, if they are of a law-abiding persuasion, they can behave accordingly.’ Thus, the DPP has informed people precisely how to ‘behave accordingly’ with respect to assisting suicide whilst remaining law-abiding. It is of course true that the law has not changed, but nevertheless, as Greasley has noted, ‘...a previously unofficial policy of non-prosecution in these cases has been ordered to be made official.’

Furthermore, in the event that some prosecutions do occur, sympathy for the defendant’s compassionately motivated predicament may increasingly call into question the nature and purpose of such an offence.

Consequently, with respect to any future parliamentary debates, the effective decriminalisation of certain modes of assisting suicide will inevitably affect how this issue is perceived by even those who are theoretically opposed to any relaxation of the prohibition. Although, as Lord Justice Brooke observed, ‘successive governments, and Parliaments, have set their face against euthanasia’, previous opposition to any form of assisted dying operated in a climate of considerably less overt tolerance of assisted suicide. It may be of some significance that by 2005, evidence of some shift in parliamentary attitude was arguably emerging, when the House of Lords Select Committee on Lord Joffe’s Assisted Dying for the Terminally Ill Bill adopted a more neutral stance than previous Committees on the issue of physician assisted suicide. Furthermore, at the time of the defeat of the last of the Joffe

---

51 *Purdy* HL (above n.2) at para.59.
53 See for example the case of *Gilderdale*, discussed above. Given that, as R Huxtable has observed, any ‘jury will be drawn from a population apparently in thrall to the idea of assisted suicide’ (supra n.33 at p.67) jury nullification is likely.
54 *Re A (Conjoined Twins)* [2001] Fam 147, 239, 211.
55 See the Assisted Dying for the Terminally Ill Bill – First Report, Sessions 2004-05, [www.parliament.uk](http://www.parliament.uk) Lord Joffe’s Bill began its journey embracing voluntary euthanasia but was considerably diluted to include only physician assisted suicide.
56 In 1994 a House of Lords Select Committee on medical ethics firmly opposed any relaxation in the law. (See ‘Report of the Select Committee on Medical Ethics’, HL Paper 21, London: Her Majesty’s Stationary Office.) Thus, the neutral stance adopted by the Committee convened to consider the Joffe Bill demonstrates some shift in parliamentary attitudes.
Bills (by 148 to 100 votes) suicide tourism was an altogether novel phenomenon, with little consequent need to legislate in order to control its practice. Five years later, the need for control has become more apparent. In consideration of the fact that a continuing legal prohibition offers only the opportunity to retrospectively determine whether the assistance fell within accepted boundaries, after the chance of preventing the victim’s death has passed,\(^\text{57}\) pre-emptive control through legalisation may seem increasingly attractive.

Of course, sceptics might argue that the fact that the state tolerates certain criminal acts does not inevitably lead to their legalisation,\(^\text{58}\) and there might even be some advantages to continuing a policy of tolerance within a regime of continued prohibition.\(^\text{59}\) Detailed consideration of these issues is beyond the scope of this thesis, but in partial consideration of the first argument, there are a number of reasons why assisted suicide may be distinguished from other tolerated (criminal) activities. First, it is a trite observation but as I discussed in chapter 1, people are naturally concerned with how they might die. In an increasingly aged society such concerns will inevitably preoccupy a greater proportion of the population. Evolving societal values also bring weight to bear upon this increasingly precarious area of criminal law. As Griffiths, Weyers and Adams have observed, there may be a link between a ‘post-materialistic value orientation’\(^\text{60}\) and the growing importance placed by individuals within society upon self-determination.\(^\text{61}\) In turn, the nature of the offence renders cases highly news-worthy and so the media repeatedly pushes this issue into the public consciousness. Protagonists in the debate seem to enjoy public sympathy,\(^\text{62}\) and the issue of

---

\(^\text{57}\) Or at least having ascertained, for example, that the person wanting to die is suffering unbearably from a terminal illness and that there are no other means of alleviating the suffering.

\(^\text{58}\) For example, a degree of tolerance in relation to the personal use/consumption of illegal drugs has not resulted in legalisation.

\(^\text{59}\) For example, Greasley (supra n.52) argues that in compelling the DPP to promulgate such a Policy, the House of Lords have taken a retrograde step. Greasley’s contention is that the previous practice of ‘wilful blindness’ to assisted suicide, in a climate of uncertainty as to what exactly constituted prosecutorial policy, was a preferable state of affairs.

\(^\text{60}\) Identified by R Inglehart (The Silent Revolution, (1977) Princtown, NJ, Princtown University Press), who argued that there is a connection between prosperity and value orientation, such that people living without threat to their livelihood move beyond concerns over safety and security, focusing instead on freedom, self-expression and quality of life. Discussed in J Griffiths, H Weyers and M Adams, Euthanasia and the Law in Europe, Hart Publishing 2008, p.15.

\(^\text{61}\) See Griffiths, Weyers and Adams (Ibid), p.525. In conclusion to their discussion of which countries are most likely to legalise some form of assisted dying, and notwithstanding that “prediction is very difficult”, Griffiths and Weyers predict that England is likely to be the next country to legalise some form of assisted dying.

\(^\text{62}\) For example, Debbie Purdy and, for very different reasons, Kay Gilderdale.
whether assisted suicide should be legalised is one which appears to garner public support.\textsuperscript{63} Finally, the organisation, Dignity in Dying, may also play a significant role in potential legalisation through their campaign to reform the law. Already their support of Debbie Purdy has led to the promulgation of the Policy which has confirmed that those motivated by compassion to assist in suicide are extremely unlikely to face prosecution. Thus, the Policy colludes with other influences and circumstances to render legalisation increasingly probable.

5.4 Assessing the victim

In his interim guidelines, the DPP identified the fact that if the victim had a terminal illness, a severe and incurable physical illness or a severe degenerative physical condition, it would count as one of the factors against prosecution. An overview of the cases in which a prosecution was not deemed to be in the public interest supports the idea that the physical condition of the victim has indeed been considered relevant to the question of whether or not to prosecute. Thus, it seemed sensible for the DPP to identify this issue as having some bearing upon the exercise of prosecutorial discretion. For example, as I explored in the previous chapter, the severe disability of Daniel James, which explained his decision to commit suicide, was regarded as a relevant factor. However, in response to representations yielded from the public consultation,\textsuperscript{64} the DPP has removed this factor, and so the current position invites the conclusion that the physical condition of the victim should have no presumptive bearing upon the decision to prosecute. It should perhaps be noted, however, that the DPP maintains that the factors listed are not exhaustive and so other unspecified factors might be pertinent to the decision. Accordingly, it may be that the health of the victim

\textsuperscript{63} For example, a recent BBC poll carried out for a ‘Panorama’ programme on the Gilderdale case, suggests that almost three-quarters of people support assisted suicide in cases where the person wanting to die has a terminal illness. Support falls to just below half if the illness is painful but not terminal. See Poll support for mercy killings, at http://news.bbc.co.uk/1/hi/uk/8489744.stm These results are similar to the results of other such polls. As the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill reported, following consideration of a number of polls, “It is evident that there is a great deal of sympathy, at least for the concept of euthanasia.” Supra n.55 at para.218.

\textsuperscript{64} Over 1500 respondents argued that it may be discriminatory to include factors relating to the health and disability status of the victim. See the ‘Public Consultation Exercise on the Interim Policy, Annex B – Equality and Diversity Impact Assessment’, para.25. Available at www.cps.gov.uk Perhaps also pertinent to this aspect of the final Policy is that following publication of the interim guidelines in September 2009, an Early Day Motion 302 was laid in the House of Commons calling for the policy to be withdrawn on the basis that it overrides the will of Parliament by indicating to would-be offenders how to avoid prosecution, and also puts vulnerable people at grave risk.
remains relevant as one of the other possible factors despite not featuring in the Policy, and we should not forget that the DPP has stated that the risk of prosecution remains unchanged. Nonetheless, it seems reasonable to contend that removing any reference to the victim’s health where previously it featured invites the presumption of a change in this aspect of the policy.

Clearly, by removing this factor the DPP has attempted to allay the fears of those for whom the inclusion of this factor implied that the lives of people with such conditions have less value. Indeed, perhaps one of the most compelling arguments put forward against the legalisation of any form of assisted dying is that there might be a disproportionate impact on vulnerable people. The idea that individuals with a serious or terminal illness or a serious disability, would ‘qualify’ for an assisted death, and thereby suffer discrimination because of the perception that their life has reduced value, links into slippery slope arguments; the contention being that any legal model of assisted dying would soon render the option of an assisted death an obligation for certain groups. On this issue, Greasley highlights the danger of employing objective thresholds, ‘...the law cannot impose value of life thresholds in assisted suicide without, by extension, engaging in value of life comparisons directed at not just individuals, but at whole groups of sufferers.’ While it may be difficult to refute the notion that differentiating between individuals on the grounds of health might necessitate a degree of ‘value of life’ appraisal, the evidence available suggests that such an appraisal does not invariably lead to negative consequences for certain groups. In jurisdictions where physician-assisted dying (PAD) has been legalised, notably the Netherlands and Oregon, there is little or no evidence that legalising PAD via a system which imposes objective health-based limitations upon access to PAD, leads to negative consequences for certain groups. The only possible exception concerns people with AIDS in Oregon, who are more

66 Greasley, n. 52, p.321.
likely to choose PAS than any other groups. The problem with this research, as I go onto discuss in the next chapter, is that people with terminal or unbearably hopeless illnesses are the only ones who will be permitted an assisted death. Thus, it is difficult to meaningfully engage with the question over negative consequences because it is inevitable that those with diseases such as cancer might consider the option of PAS or euthanasia (in the Netherlands). Whether a potential choice renders such people ‘at risk’ is open to dispute. Consequently, we must recognise that the concerns of those who may perceive themselves to be at risk from any such policy are valid. But equally valid are the concerns of those, such as Dianne Pretty and Debbie Purdy, who feel disadvantaged by a policy that prevents people wanting to escape the final throes of terminal illness from receiving assistance within the jurisdiction. Sheila McLean has considered this thorny issue, observing that:

People who want to facilitate autonomous choices at the end of life do not thereby disvalue disability...while impairments may be disabling as much because of society’s failure to accommodate them as for any other reason, nonetheless the fact of disability may be relevant to how people see their future. For example, the suffering associated with cancer is disabling, but it is also clearly relevant to the way in which people manage their healthcare decisions and their end-of-life choices.

Moving from consideration of the ethics of recognising certain conditions as relevant to prosecutorial Policy, to contemplation of how prosecutors will actually resolve this dilemma in practice, we might question whether it is even realistic to suppose that prosecutors will now cease to be influenced by the physical condition of the victim. As Biggs notes, ‘[I]f the suicidal person’s health status is not to be considered, the basis upon which the assistor is expected to feel compassion is unfathomable.’ Indeed, can any understanding of compassion exclude consideration of the victim’s health? In the context of prosecutorial tolerance of assisted suicide, one might ask how it could ever be viewed as ‘compassionate’ to assist a person in suicide unless the victim had some serious illness or condition from which death would provide a release. The very notion of compassion is, I would argue, inextricably linked to the idea that the subject of one’s emotions is suffering. For example,

---

68 See See M P Battin, ibid, and in response, I G Finlay, R George, ‘Legal physician-assisted suicide in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon’s data.’ (2011) 37 Journal of Medical Ethics, 171-174. This is examined in some detail in chapter 6.
70 H Biggs, supra n.14, p.86.
Nussbaum relates compassion to Aristotle’s account of pity, which rests on the premise that there is serious suffering. Consequently, any objective assessment of whether a person’s assistance in the suicide of another was motivated by compassion will naturally involve an assessment of whether the victim was suffering, and so the victim’s reason for wanting to die and the apparent rationality of the suicide wish will be crucial to any appraisal of the suspect’s involvement. The absence of any illness, injury or condition, which might be viewed as explaining the victim’s decision to die, will invariably cast one who assists in such a suicide in an unfavourable light. The factor in favour of prosecution where ‘the victim was physically able to undertake the act that constituted assistance him or herself’ will also, as Biggs comments, encourage some assessment of the victim’s health.

It should be noted, however, that misguided compassion is compassion nonetheless. If a person is ‘wholly motivated by compassion’ to assist in the suicide of a temporarily depressed (but otherwise healthy) friend, how will prosecutor’s resolve the prosecutorial dilemma? Even if the deceased could have acted unaided, it might seem that there is little or no public interest in prosecuting a person with poor judgement who nevertheless acted out of compassion.

While the possibility of misguided compassion should not be overlooked, it is probable that if one was to encourage or assist in the suicide of a person who did not have a sufficiently serious condition, from which death might (objectively) be viewed as providing an escape, there might be immediate doubts over the mental capacity of the victim. It is a disturbing fact that suicide and mental illness are often linked. Thus, it seems that the factor in favour of prosecution relating to a lack of capacity will also necessitate an appraisal of the victim’s physical and mental health.

---

72 Interestingly, this account of pity/compassion infers that compassion is to some degree a self-centred emotion because it is invoked partially because of fear that the same fate could befall the person feeling compassion.
73 H Biggs, supra n. 14, p.85.
74 Para. 43(2) of the Policy refers to capacity as defined by the Mental Capacity Act 2005. Section 3 provides that a person lacks capacity if he or she is unable to make decisions because of being unable to: (1)(a) understand the information relevant to the decision, (b) retain that information, (c) to use or weigh that information as part of the process of making that decision, or, (d) communicate that decision.
75 See the Mental Capacity Act 2005.
consequences of the decision, a conclusion that he/she was incompetent might be difficult to support.

From a comparative perspective, in other jurisdictions (except for Switzerland\textsuperscript{76}) where some form of assisted dying is permitted, there must be medical grounds supporting the desire to die. For example, in the Netherlands, assisted dying on request is permissible only where the ‘patient’s suffering was unbearable, and... there was no prospect of improvement’ and both doctor and patient were convinced that ‘there was no reasonable alternative in light of the patient’s situation.’\textsuperscript{77} Similarly, in Belgium, a doctor who performs euthanasia does not commit a crime if he or she ensures that ‘the patient is in a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious or incurable disorder caused by illness or accident.’\textsuperscript{78} Finally, in both Oregon and Washington, assisted suicide is available only to those with a terminal illness, which is defined as ‘an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months.’\textsuperscript{79}

In comparison to the jurisdictions mentioned above, a position which appears to disregard the health of the victim and the reasons behind the suicide wish clearly ignores the context within which assisted suicide is sought. The denial of the crucial reality behind this issue is also reflected in the Policy’s disapproval of medical involvement, which I go on to consider below. Moreover, it should be noted that whereas a majority within society appear to support assisted suicide for the terminally ill, support is far less forthcoming if the victim is not terminally ill. As noted by Baroness Hale of Richmond in Purdy:\textsuperscript{77}

\textsuperscript{76} In Switzerland non-selfish or altruistic assistance in suicide is not an offence irrespective of the health of the deceased, provided that the deceased had decisional capacity. Interestingly, unlike other jurisdictions in which assisted dying is permitted, Swiss law on assisted suicide (codified in 1918) was shaped upon motivations of ‘honour and romance’ rather than motives relating to health and suffering. See ‘Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians’, BMJ Vol. 326, 1 Feb 2003.

\textsuperscript{77} The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. See also J Griffiths, H Weyers and M Adams, Euthanasia and the Law in Europe, Hart Publishing 2008, p.84. The unbearable suffering must be attributable to a medically diagnosed physical or psychiatric condition.

\textsuperscript{78} Ibid, Griffiths et al, p.312.

\textsuperscript{79} The Oregon Death with Dignity Act and the Washington Death with Dignity Act.
...in attitudinal surveys the British public have consistently supported assisted dying for people with a painful or unbearable incurable disease from which they will die, if they request it, while rejecting it for people with other reasons for wanting to die.  

It seems that whether or not there is specific reference to the condition of the victim, some form of health focused assessment is unavoidable if compassion is the guiding principle. By adopting compassion as the central determining issue, the DPP has effectively retained the discretion to consider the physical condition of the victim, without subjecting the Policy to allegations of discrimination. But the main problem of such a non-discriminatory policy is the possible side-effect. Assuming it is a positive thing to limit assisted suicide to those who are clearly suffering from very serious or terminal illness, a policy which ignores the reasons for seeking death also ignores those who choose death for insufficiently serious reasons. In doing so the policy fails to protect the truly vulnerable. Despite the victim’s health being relevant to the assessment of the suspect’s motives, weighing compassion in the absence of a direct assessment of the victim’s health presents a vague and limited approach to an issue deserving greater scrutiny.

5.5 Medics Beware!

Significantly, in the final version of the Policy, the DPP added to the list of factors tending in favour of prosecution the fact that:

...the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such a prison officer, and the victim was in his or her care.  

In consideration of the DPP’s rationale for this addition, the summary of responses and commentary in relation to new factors in favour of prosecution is interesting. Concerns that the interim guidelines had presented an unfair bias against carers working in a care or nursing home environment in comparison to other healthcare workers clearly contributed to the
decision to widen the scope of healthcare workers regarded unfavourably by the Policy. 34 percent of respondents who commented in the public consultation exercise expressed the view that it is inappropriate to single out such care workers in the absence of any broader factor covering those working in a healthcare environment generally. At the same time, 83 percent of respondents agreed that it was desirable to regard the involvement of carers as a factor tending in favour of prosecution. Consequently, the DPP determined that it was desirable to extend this factor to include any healthcare professional or worker. In the absence of any further explanation as to why carers were initially singled out, and subsequently, why medical professionals and workers in general should now be at greater risk of prosecution, we might question the reasoning behind this factor. With respect to the consultation process more generally, Lewis has observed that:

The consultation document simply listed public interest factors for and against prosecution. No attempt was made to explain the reasons why these factors were chosen and why other factors were not. In order to be clear about ‘what was being proposed’, as required by the then government’s consultation criteria, some indications for the reasons for the proposals should have been provided.

In relation to physicians, other evidence suggests that there is greater public support for physician assisted suicide (PAS) than there is for family assisted suicide (FAS). A 2001 survey reported that 84 percent of respondents supported the legalisation of PAS, whereas just 54 percent supported the legalisation of FAS. Whilst this survey focused on opinions regarding legalisation rather than opinions regarding prosecution policy, the ethical considerations underpinning these issues are almost identical, aside from the fact that there might be a more obvious preference for expert over amateur assistance if legalisation were to occur. Thus, the opinions gathered by the DPP in the consultation exercise appear to be at odds with public opinion on this issue generally. If compassionate, reluctant assistance in suicide is now tolerated subject to the guidelines, we should ask why such tolerance is less likely to be extended to healthcare workers and professionals. Indeed, viewed comparatively, healthcare workers are far less likely to be motivated by factors other than compassion. The

---

83 The interim guidelines had included as a factor in favour of prosecution; (14) The suspect was paid to care for the victim in a care/nursing home environment.
potential ‘gain’ of a free hospital bed vacated by the deceased, for example, is a relatively insignificant benefit compared to the potential gains which a relative might reap, ranging from being freed from their role as primary carer to the financial gain enjoyed as a beneficiary to the victim’s estate.

The role of certain healthcare workers also puts them at greater risk of prosecution. For example, doctors and other healthcare professionals might now have concerns over criminal liability arising from difficult end-of-life conversations and whether they might be implicated merely by answering questions or providing information. In response to such concerns the Medical Defence Union (MDU) recently stated:

[T]he MDU’s advice to its members remains that doctors approached by patients for advice about suicide should not engage in discussion which assists the patient to that end. Members who are faced with requests from patients, including for example the provision of medical reports, should contact us for advice.86

In addition to the obvious role that a doctor could play in a patient’s suicide, by, for example, providing pills for an overdose, specific concerns focus upon a doctor’s duty towards a patient seeking an assisted suicide abroad. Dignitas, for instance, requires applicants to provide details of their medical records prior to an assisted suicide.87 As guardians of their patients’ medical records, doctors must therefore release this information in order for a patient to be considered by Dignitas. Thus, a doctor’s cooperation in the knowledge of the purpose of the provision of patient records might invoke potential criminal liability.88 In less controversial circumstances, section 7 of the Data Protection Act 1998 provides a patient with a clear right of access to such information. The purpose of the request for access in this context, however, creates a dilemma for doctors. The Data Protection (Subject Access Modification)(Health) Order 2000 creates an exception to the right of access so that data which would otherwise have to be disclosed can be withheld in the event that its disclosure

88 Evidentially, the doctor’s act in providing/releasing the information would be capable of assisting or encouraging a suicide or attempt, thereby satisfying the actus reus of the offence. Acting in the knowledge (with the foresight) that the attempt/suicide would be likely to follow would suffice to demonstrate that the doctor had the mens rea for the offence of assisting or encouraging suicide.
would be likely to cause serious harm to the physical or mental health of the data subject. Consequently, the conflicting duties of doctors faced with a request for access to medical records for the purposes of an assisted suicide may be difficult to resolve. The ‘serious harm’ exception to data release will be unacceptable to a patient who sees assisted suicide to be in her best interests, as an escape from harm rather than as harm in itself. Moreover, a doctor who refuses to release private data in an attempt to prevent a patient from exercising a competent and autonomous choice to travel abroad to avail themselves of a service which is legal within that jurisdiction, may be in breach of Article 8 ECHR.

In reality, the doctor who merely releases medical records in order for a patient to apply to an organisation such as Dignitas should not fear prosecution. Not a single doctor has been prosecuted for assisting in suicide in any capacity, and despite the apparently heightened risk now elucidated by the Policy, it seems that a policy which tolerates a relative pushing a wheel-chair bound victim onto the flight to Zurich and then on to the Dignitas premises could hardly sanction the prosecution of a GP who merely provided the victim’s medical notes.

While evidence suggests that healthcare professionals are less likely to be prosecuted than the Policy might lead us to believe, it is illustrative of a clear prosecutorial desire to deter healthcare workers from becoming embroiled in assisting in patient suicides. With little evidence of meaningful discourse on the subject, the Policy indicates that there are good reasons for regarding healthcare workers with greater suspicion than relatives who assist, for example. The inclusion of this factor accords with the overall message of the Policy by seeking to ensure that it remains extremely difficult to obtain meaningful or practical assistance in suicide within the jurisdiction. This might be justifiable if the Policy succeeded in reducing the number of suicides or even controlling who was able to access such assistance, but, as previously mentioned, given the availability of assisted suicide in Switzerland this seems unlikely. Moreover, in an increasingly aged society where ever larger numbers are surviving to endure the difficulties that great age can bring, the non-availability of expert information and advice about how to commit suicide, may lead to an increase in

---

89 For example, as discussed in chapter 4, Dr Michael Irwin escaped prosecution following his involvement in a number of cases.
90 Such an act being only of minor assistance (see para.45(3) of the Policy).
91 With only illicit advice being available, for example, an Australian doctor, Nitschke, has organised suicide workshops for the over 50s in English seaside retirement havens, as well as publishing advice on the internet and even offering for sale suicide drug testing kits. See “Dr Death’ Philip Nitschke reveals secrets of a peaceful exit’, *The Times*, May 6 2009. Also, despite the inclusion of a factor (para. 43(11)) designed to discourage
botched suicide attempts. As Seale states, ‘...it takes expertise to achieve a humane assisted
death. By ruling out medical involvement, the DPP’s policy ensures that no such expertise
will accumulate.’

Suzanne Ost has considered the relative merits of medicalised and de-medicalised assisted
dying and although there are clearly many benefits to a less medicalised approach in
comparison to a completely medicalised system, such as the Dutch model, a completely
amateur approach is extremely problematic. Moreover, the Policy is refusing to acknowledge
that the vast majority of people seeking assisted suicide are doing so because the medical
means of maintaining good health are proving inadequate, hence the issue is inherently
medical. Even if there is compelling evidence that doctors are opposed to PAS, there should
at least be some medical engagement with patients seeking an assisted suicide, if only in
order to explore the reasons why a person wants to die and whether there are any alternatives.
Furthermore, if one accepts that the tolerance of compassionate assisted suicide will
inevitably lead to the eventual legalisation of some form of assisted dying, it is inconceivable
that any legalisation would permit only amateur assistance in suicide. By seeking to prevent
any tentative medical involvement, might it be that the Policy is preventing society from
gathering experience and wisdom upon which an ethically acceptable path might be
navigated?

5.6 Conclusion

‘In England and Wales, we are now in unchartered territory, with a reluctant legislature,
little guidance from the courts and an opaque process of informal legal change by
prosecutors’

people from using the internet as a means of obtaining information/advice about suicide, it remains very
difficult to prevent such information from being made available.

92 Supra n.20.
93 S Ost, ‘The de-medicalisation of assisted dying: Is a less medicalised model the way forward?’ Medical Law
94 For example see C Seale, ‘Legalisation of euthanasia or physician-assisted suicide; survey of doctor’s
attitudes’ (2009) 23 Palliative Medicine 205, 209. The survey revealed that the majority of doctors were
opposed to any legalisation of PAS or voluntary euthanasia. Interestingly, in 2009 the Royal College of Nursing
dropped its opposition to assisted dying in favour of neutrality on the issue. See ‘RCN neutral on assisted
95 Lewis, supra n.84, p.134.
In their legislative capacity, the House of Lords rejected Lord Falconer’s attempted amendment to the Coroners and Justice Bill which would have legalised assisting someone to travel abroad for an assisted suicide subject to safeguards.\textsuperscript{96} It is, therefore, perhaps ironic that the indirect effect of the House of Lords decision in \textit{Purdy} is the confirmation that certain modes of compassionately assisting in suicide are effectively decriminalised \textit{without} any safeguards relating to the victim, other than age and mental capacity, and these are purely retrospective. In a democratic society, it should not fall to the DPP to resolve controversial moral dilemmas, but, in the absence of Parliamentary intervention, he has been forced to do just that. Charged with an unenviable task, the DPP sought to both rationalise and clarify the way in which prosecutorial discretion is exercised over complicity in suicide.

By adopting a motive-centred approach, in which compassion is identified as the key determining factor, thereby confirming that it is not appropriate to seek to punish the majority of those who assist in suicide in this context, the Policy treads a sensitive path. The clear recognition of compassion as being crucial to ethically acceptable complicity in suicide is an important development. Some elements of the Policy, however, demonstrate the difficulty in outlining a morally coherent approach in the face of a law which presents an evidently unsustainable prohibition, particularly with respect to some of the tension between assisted suicide at home and abroad. Born from the public consultation exercise, some of the factors also have a knee-jerk quality to them. The removal of the factor relating to the health of the victim, for example, seeks to address concerns over discrimination at the expense of plausibility and coherence. The reality of the context within which people seek to control the end of their life is similarly rejected by the inclusion of the factor relating to the involvement of healthcare professionals. Whilst the DPP had a duty to determine the final policy based on the public consultation findings, some of the consequences are disappointing.

Although Cartwright has observed that “regrettably it will take a legislature with considerably more courage than ours has demonstrated to broach this difficult area,\textsuperscript{97} in the face of mounting pressure, in addition to the other factors which I have identified as exerting an influence over this issue, it may soon become impossible for the current legal fudge to endure. Ultimately, if a practice judged by many to be undesirable is, in any case, occurring,\textsuperscript{96}The amendment to the Bill, which was defeated in 2009, required that two medical practitioners would assess that the person seeking suicide was both terminally ill and mentally competent. Additionally, the person would have to make a declaration of their intention to die in writing witnessed by an independent person.
\textsuperscript{97}Nick Cartwright, ‘48 years on; is the Suicide Act fit for purpose?’ \textit{Med Law Review} (2009), 17(3), 467.
even those opposed to it may recognise that rather than merely having the opportunity for retrospective appraisal and possible punishment, control through legalisation is a more satisfactory approach.
CHAPTER 6
LESSONS FROM ABROAD

6.1 Introduction

The dilemma over assisted dying is a dilemma to which certain other jurisdictions have responded with the legalisation of some form of assisted-dying. Having already considered some aspects of the Swiss experience of assisted suicide in chapters 4 and 5, this chapter focuses on the Netherlands and Oregon.

Notwithstanding that societal differences mean that there are fundamentally crucial reasons why one might argue that there is limited value in comparing, for example, how legal assisted dying has played out in the Netherlands and Oregon in order to explore the possibility in the UK, there are some aspects of the experiences of other jurisdictions which are comparatively valuable in the ongoing debate over assisted dying in this jurisdiction. In both Oregon and Netherlands, the experience of legal PAD provides the opportunity to explore concerns which are universally relevant to the debate, irrespective of geography and notwithstanding societal distinctions. For example, concerns over whether certain groups are put at risk by a system which permits PAD, or, questions over the assessment of patients in relation to both their physical and mental health, might be explored. Moreover, we have the opportunity to consider what effect legalisation might have on society. While there may be, for example, cultural differences in the doctor/patient relationship in both the Netherlands and Oregon, compared to England and Wales, which clearly impact on societal concerns over assisted dying, there are fundamental qualities within this relationship, particularly in liberal western democracies, which transcend cultural divergence.

While it is not possible within this chapter to undertake a comprehensive study of all aspects of assisted dying abroad which may be of some interest to our consideration of the UK position, I endeavour to focus on the issues which might be most illuminating to my study of assisted dying in the 21st century. Accordingly, this chapter will consider the legal regimes in both Oregon and the Netherlands and, briefly, how legal change occurred. More attention is devoted to the development of the law in the Netherlands than in Oregon, simply because the Dutch story presents a more gradual, complex (and interesting) discussion of legal
development. This chapter explores whether these models have adhered to the limitations imposed upon them, or whether, as many opponents predicted, these models have fallen victim to slippage down a dangerous slope. As discussed in chapter 1, one of the most common arguments put forward against the legalisation of assisted dying is the slippery slope argument. The opportunity that we now have to explore how these societies have responded to legal PAD, and particularly whether slippage has occurred in the Netherlands and Oregon might inform any legal changes which occur in this jurisdiction. For this reason, this chapter focuses on whether the systems in place in these jurisdictions have deviated from their original parameters; whether groups we might regard as 'vulnerable' have been placed at risk, and, whether the Netherlands in particular is now pushing the parameters of its highly medicalised legal model.

6.2 Oregon

The U.S. state of Oregon legalised Physician-assisted suicide (PAS) in 1998 following The Death with Dignity Act 1994. A decision of the Supreme Court in 1997 confirmed that although there could be no constitutional right to assisted suicide, the legalization of assisted suicide would not be unconstitutional. This followed two narrowly unsuccessful attempts to legalise assisted dying in both Washington and California. By contrast, Oregon voters passed the first Bill in November 1994 by a majority of 52 percent. Just as this controversial law was about to be enacted, an injunction was issued on the grounds that the statute violated the Equal Protection Clause of the Fourteenth Amendment. However, this injunction served only to delay matters as the court held that the plaintiffs lacked the necessary standing under the United States Constitution, and, following a further vote which affirmed the measure by a 60 percent majority, the Act was given a green light. As Pakes has discussed, the Oregon

---

1 See p.26.
3 The Death with Dignity ballot proposal would have legalized physician-assisted dying for terminally-ill competent patients. (See P Lewis, Assisted Dying and Legal Change, Oxford University Press 2007) PAS was, however, ultimately legalised in the state of Washington in 2008 by the Washington Death with Dignity Act.
4 In California Proposition 161 was defeated in November 1992. The proposition would have allowed terminally-ill adults with less than six months to live to request physician-assistance in dying. See Lewis, ibid.
6 Lee v Oregon (1997) 107 F.3d 1382, 1392 (9th Cir.).
law remains precarious;\textsuperscript{7} ‘[e]fforts to have it disabled or revoked continue until the present day.’\textsuperscript{8}

With respect to the parameters of the law, The Death with Dignity Act allows a physician to supply a prescription for lethal drugs under certain circumstances; these being upon the request of a competent adult who is suffering from a terminal illness from which they are expected to die within six months, and upon compliance with the following conditions:

- the patient must make an oral request followed by a formal written request;
- the patient must repeat their oral request at least 15 days after the written request, and then a further 48 hours must elapse before the prescription can be provided;
- the patient’s request must be witnessed by at least two other people besides the physician, at least one of whom must not be a relative, an heir or an employee of the medical institution in which the patient is receiving care;
- the patient must be asked to notify his/her family;
- a second doctor must confirm the patient’s diagnosis and that the patient is competent and acting voluntarily;
- the patient must have received full information about diagnosis, prognosis and any alternative treatments such as pain control and hospice care;
- if there is any indication that the patient is depressed or has a psychiatric disorder, he/she must be referred to a psychiatrist or psychologist.

Unlike in the Netherlands, there is no specific requirement that an applicant for PAS demonstrates unbearable or hopeless suffering, although the terminal illness (with death expected within six months) requirement is evidently an alternative way of assessing whether PAS is justified. This issue may then be assessed via a system for monitoring and collecting information on PAS which is maintained by the Oregon Department of Human Services. Information is collected, including physician and pharmacist compliance reports, death certificate reviews and follow-up interviews. The Department has adopted a neutral position and its role in monitoring PAS does not extend to any enforcement capacity. This service allows access to the data emerging from the experience in Oregon in order that we might assess how society has responded to the option of legal PAS. Thus, in the year following the

\textsuperscript{8} \textit{Ibid}, p.73.
enactment of the Death with Dignity Act, there were fifteen assisted suicides in Oregon, which accounted for 0.05 percent of all deaths. Subsequently, the number has risen although the annual numbers remain low. For example, in 2007, there were 49 assisted suicides, which accounted for 0.15 of all deaths, rising to 65 deaths in 2010. Whilst there may be some agreement as to the fact that these numbers remain on the low side - which might indicate that the Oregon experiment has not spiralled out of control - interpretation of the data is contentious. I return to consider some of the implications in the ongoing debate and, specifically, whether the Oregon experience has fallen victim to slippage or abuse, following my consideration of the Netherlands.

Before turning to a discussion of what has occurred in the Netherlands, another facet of the Oregon experience is worth our consideration. Unlike in the Netherlands, the final act of suicide, with respect to ingesting the drugs, is entirely in the hands of the patient. With this in mind, it is interesting to note that a significant number of those who receive a fatal prescription in Oregon choose not to ingest the drugs, instead allowing their terminal disease to run its course. For example, in 2010, 96 patients received a prescription for PAS, of whom only 65 chose to ingest the fatal drugs. Presumably the remaining 35 simply held on to the drugs with the knowledge that if things became intolerable, an escape route was available. The data from 2010, with respect to the proportion of patients who did not ingest their prescription, is reflective of previous years with approximately one third of those obtaining a prescription choosing not to die by PAS. Thus, it seems that a significant number of those who were sufficiently motivated by their predicament to go to the trouble of obtaining the option of PAS were, in the event, content to continue their lives until death came naturally. This suggests that for many people the option of PAS is sufficient, so that once the patient has the potential to control death, the final days, weeks or even months of life can be tolerated.

---

6.3 The Netherlands\textsuperscript{11}

1. How the law developed

Although the statute – The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 – which formally legalized euthanasia and assisted suicide, is a relatively recent development, the Dutch courts had, for three decades, been developing and interpreting the law in order to allow certain forms of assisted-dying. Before considering some specific aspects of the Dutch experience in more detail, it is useful to first explore the development of the law in the Netherlands.

A crucial factor in the development of Dutch law on euthanasia has been that the Dutch criminal code distinguishes between murder and mercy killing on request. Article 293 of the Dutch penal code provides that a ‘person who takes the life of another person at that other person’s express and earnest request’ is guilty of a serious offence, albeit an offence less serious than murder. With respect to assisted suicide, Article 294 provides that ‘a person who intentionally incites another to commit suicide, assists in the suicide of another, or procedures for that other person the means to commit suicide’ is guilty of a serious offence. Thus, a more nuanced legal position (compared to the English equivalent), which already took account of moral issues such as consent and mercy, was naturally more amenable to flexibility in this context. The first small steps on the long road to legalization were taken in 1973 with the case of Postma.\textsuperscript{12} Dr Postma was convicted of an Article 293 offence after giving her severely disabled (and suicidal) mother a fatal overdose of morphine. Despite the conviction, the court only imposed a suspended sentence of one week, and further took the opportunity to outline situations in which euthanasia could be acceptable when performed by a doctor.

In the early 1980s, in response to a number of cases coming before the courts involving doctors who had reported that they had performed euthanasia, Parliament established a State Commission on Euthanasia which was charged with the task of advising the government on the desirability of reforming the law. The State Commission consulted a number of organisations, one of whom being the main Dutch doctors’ organisation, the Royal Dutch

\textsuperscript{11} I am grateful to Professor John Griffiths and Professor Helen Weyers and the University of Groningen for their hospitality and kindness during the AHRC Project research trip to the Netherlands in 2010, which facilitated some of the research for this chapter.

\textsuperscript{12} Nederlandse Jurisprudentie 1973 No.183, District Court of Leeuwarden 21 Feb 1973.
Medical Association (KNMG). Subsequently, although the KNMG adopted a neutral position on the question of whether euthanasia should be legalised, they played an important role in formulating the basis upon which assisted dying became permissible. The KNMG advised that any relaxation in the law should permit only physician assisted dying (PAD), and a number of other requirements should be satisfied prior to any assisted death; in relation to the patient, there must be a voluntary and well-considered request and ‘unacceptable’ suffering. Procedurally, a second doctor must be consulted and the cause of death should be reported.

Subsequently, a significant development occurred in the case of Alkmaar or Schoonheim, when Dr Schoonheim was initially convicted for giving a lethal injection to his 95-year-old patient at her request. On appeal, the Dutch Supreme Court ruled that there had been inadequate investigation into the conflict of duties faced by the defendant, and following consideration of the facts, the court applied the ‘emergency’ defence (noodtoestand), which is broadly equivalent to the defence of necessity in English law. This is a justificatory defence which exculpates behaviour which would otherwise be criminal on the basis that a person is compelled to act in a situation of some emergency in order to avoid a greater evil. Once invoked, this enables a doctor to be excused from committing euthanasia only when the duty to preserve life comes into conflict with the duty to relieve unbearable suffering in the face of a patient’s request to die when there is no other means of alleviating the suffering (which is objectively extreme). Thus, the foundations upon which Dutch assisted dying law rests were established. Over this period a number of other cases were brought before the Dutch courts and, together with the influence of the KNMG, a set of criteria of ‘due care’ were incrementally set down, which served to excuse doctors from criminal liability in this context. The public prosecutor’s office then adopted the criteria as the guiding principles to determine whether to prosecute in cases involving euthanasia and assisted suicide. Interestingly, comparisons might be drawn between the role of the Dutch prosecutor in the assisted dying story, and the role of the DPP in England and Wales in recent developments at home, which I discussed in the previous chapter.

---

13 Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst.
14 Meaning ‘unbearable and hopeless’ in this context. ‘Hopeless’ means without prospect of improvement.
16 In relation to the conflict between preserving life on the one hand and relieving unbearable suffering.
17 Although, as I explored in chapter 3, the defence of necessity in England/Wales is not applied in the same way.
Although the State Commission on Euthanasia, which reported back in 1985, returned a majority view in favour of legalising assisted dying, political factors kept statutory legalisation at bay during the late 1980s and 1990s. The Christian-democratic party, which opposed legalisation, was, at the time, an important part of the Dutch coalition government and thus used its position to block any legislative reform. But nevertheless, other developments continued to bolster the legitimacy of euthanasia. During this period, and following a court decision in 1987, which confirmed that a doctor who follows the due care requirements may assume that he or she will not be prosecuted, focus shifted from the legality of euthanasia to the issue of control. Steps were taken to attempt to encourage appropriate reporting following the first national research in 1990 which showed that only 18% of cases were being correctly reported. By 1995, reporting rates had increased to 38%, and although this presented an improvement, the Government were anxious to increase reporting rates and so they established the Regional Review Committees (RRC) in order to create a buffer between doctors and prosecutors.

During the 1990s, important questions regarding the extent of a doctor’s duty to relieve suffering, depending on the nature of such suffering, were also considered. In the case of *Chabot*, a psychiatrist complied with a woman’s repeated requests for assistance in committing suicide, after terrible grief and unhappiness following the death of both her children, had left her irretrievably determined to end her life. The Court accepted that there may be circumstances in which the necessity (noodtoestand) defence could apply in the absence of terminal illness or unbearable physical suffering, provided of course that there was serious psychological suffering which could not be alleviated through other means. Nevertheless, Dr Chabot was convicted because there was insufficient evidence to show that he had adhered to the due care requirements with respect to consulting another physician in order to ensure that the patient’s condition was sufficiently grave. Despite Chabot’s

---

19 Ibid, p.32.
20 Comprising a lawyer, a physician and an ethicist, the Committees’ role is to review all reported cases and determine whether the doctor had complied with the due care requirements. Based on their determination of whether the doctor was ‘careful’ or ‘not careful’, the Committee then advises the prosecutorial authority whether to prosecute. The Committees commenced work in 1998.
21 Nederlandse Jurisprudentie 1994 No.656, Supreme Court.
conviction, no punishment was imposed, a decision which is reflective of Dutch Courts’ reluctance to punish doctors convicted of breaching the law in this way.\textsuperscript{22}

The question of whether PAD might also be an appropriate means of relieving existential suffering was considered in the case of Sutorius.\textsuperscript{23} Existential suffering is not a concept that has been clearly defined, but might be understood as suffering which derives from social rather than clinical factors, such that the subject feels tired or weary of life, in an increasingly dependent, socially isolated and generally ‘hopeless’ situation. The Dijkhuis Committee,\textsuperscript{24} who use the term ‘Suffering from life’, describe people who suffer:

\ldots at the prospect of having to continue living in a manner in which there is no, or only a deficient, perceived quality of life, giving rise to a persisting desire to die, even though the absence or deficiency in quality of life cannot be explained in any or significant measure by an identifiable somatic or psychiatric condition.\textsuperscript{25}

In 1998 Dr Sutorius assisted in the suicide of an 86-year-old man, Brongersma, on the grounds that he was suffering existentially as a consequence of a number of the side-effects of old age,\textsuperscript{26} which had rendered him feeling increasingly undignified and socially isolated. Sutorius had two independent consultants examine and talk to Brongersma, both of whom confirmed the view that in the absence of depression the ex-senator was experiencing his life as unbearable due to his physical deterioration. Following Brongersma’s death Sutorius reported what had happened and the prosecutorial authorities decided to prosecute.\textsuperscript{27}

\textsuperscript{22} For example, in the case of Van Oijen (Court of Appeals, Amsterdam, AF9392 no 23-000166-02.) the defendant physician was convicted of murder after he gave a lethal injection to a dying woman in the absence of any request. The woman, who was in a coma and therefore not suffering, had been left in a terrible state because of nurses’ reluctance to interfere with the patient because she was imminently expected to die. The woman’s daughter asked Van Oijen to put an end to this degrading situation, which he did by administering a muscle relaxant. Van Oijen was sentenced to a one week conditional (suspended) sentence with two years probation.


\textsuperscript{24} The Committee established to formulate a response to the questions raised by the case of Brongersma.


\textsuperscript{26} Ex-senator Brongersma apparently suffered from a number of conditions sometimes associated with great age, such as balance problems and incontinence.

\textsuperscript{27} Griffiths and Weyers (see n.18, p.36) point out that Sutorius had expected the case to be dismissed because he was aware of other ‘tired of life’ cases in which the prosecutorial authority had decided not to prosecute. Had he realised what would transpire, Sutorius would apparently have founded the decision to assist in Brongersma’s death on his physical problems, of which there were many.
At first instance\textsuperscript{28} the court accepted the proposition that the suffering of the deceased could not have been alleviated by other means, and so acquitted Sutorius on the grounds that necessity could be invoked for suffering of this nature. The prosecution appealed on the basis that the decision would invite an expectation of an unqualified right to patient self-determination, whilst also expressing their doubt as to the ‘unbearable’ nature of Brongersma’s suffering. After considering whether it should be part of a doctor’s professional duty to relieve such non-medical existential suffering, the Dutch Court of Appeals concluded that although doctors should be concerned about such suffering, and should seek to relieve it, this concern should not extend to providing PAD. Thus, Sutorius was found guilty although no punishment was imposed. Sutorius appealed his conviction and in December 2002 the Supreme Court upheld Sutorius’s conviction,\textsuperscript{29} reiterating that:

A doctor who assists in suicide in a case in which the patient’s suffering is not predominantly due to a ‘medically classified disease or disorder’, but stems from the fact that life has become meaningless for him, acts outside the scope of his professional competence.\textsuperscript{30}

At around the same time that the Brongersma case was unravelling, changes in the Dutch political landscape following the 1998 elections\textsuperscript{31} resulted in the adoption of a bill which became The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, thereby completing the process of legalisation of PAD in the Netherlands. As Griffiths, Weyers and Adams observed:

As far as the legality of euthanasia is concerned, the law of 2002 does little more than ratify what the State Commission, the Medical Association, the courts and the prosecutors had already accomplished. The only genuinely new provisions concern the

\textsuperscript{28} District Court Haarlem, 30 October 2001, no 15/035127-99; \textit{Tidjdschrift voor Gezondheidsrecht} 2001/21.
\textsuperscript{29} \textit{Nederlandse Jurisprudentie} 2003, no 167.
\textsuperscript{30} Griffiths et al, n.18, p.37.
\textsuperscript{31} Dutch elections are on the basis of proportional representation. Since universal suffrage was achieved in 1917, a large number of parties have engaged in the political scene, none of whom have ever enjoyed a majority in the Dutch Parliament. Thus, coalition government is the norm and following the 1998 elections, three parties (PvDA, VVD and D66), formed the coalition responsible for supporting the bill which formally legalised PAD.
legality of euthanasia pursuant to a prior written request by a person who has become incompetent, and the position of minors.\textsuperscript{32}

Thus, the law of 2002 amended Articles 293 and 294 of the Criminal Code and came into force on 1 April 2002. Euthanasia and assisted suicide remain (potentially) unlawful\textsuperscript{33} but exceptions are introduced such that:

‘The act...shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in Section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist of this act in accordance with the provisions of section 7, subsection 2 of the Burial and Cremation Act,’\textsuperscript{34}

Under section 2 of the 2002 law, the requirements of due care are that a physician:

(a) holds the conviction that the request by the patient was voluntary and well-considered;

(b) holds the conviction that the patient’s suffering was lasting and unbearable;

(c) has informed the patient about the situation he was in and about his prospects;

(d) and the patient holds the conviction that there was no other reasonable solution for the situation he was in;

(e) has consulted at least one other independent doctor who has seen the patient and has given his written opinion on the requirements of due care referred to in parts (a)-(d); and

(f) has terminated a life or assisted in a suicide with due care.

\textsuperscript{32} See Griffiths et al, n.18, p.33. With respect to the new provisions, the law of 2002 permits advance requests for euthanasia; section 2(2) provides that a doctor may comply with a written request/declaration provided that the patient was competent at the time the declaration was made. Evidence shows that compliance with such advance directives is extremely rare (see ML Rurup et al ‘Physicians’ Experiences with Demented Patients with Advance Euthanasia Directives in the Netherlands’ (2005) 53 Journal of the American Geriatric Society 1138-44). With respect to minors, children over the age of 12 may be entitled to request euthanasia or assisted suicide. For children under the age of 16, no doctor may comply with a request unless the child’s parents have consented. Evidence shows that less than 1 percent of child deaths in the Netherlands are the result of euthanasia and none are the result of assisted suicide (see M P Battin, A van der Heide, L Ganzini, G van der Wal and B D Onwuteaka-Phillipsen, ‘Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable Groups”’ (2007) 33 Journal of Medical Ethics 591-7).

\textsuperscript{33} Under Articles 293(1) and 294(1).

\textsuperscript{34} Articles 293(2) and 294(2).
2. Assisted dying in practice

Evidence collected in the national studies of assisted dying in practice in the Netherlands provides the following information.35

**Estimated frequency of euthanasia and PAS as a percentage of all deaths**36

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthanasia</td>
<td>1.7</td>
<td>2.4</td>
<td>2.6</td>
<td>1.7</td>
</tr>
<tr>
<td>PAS</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
</tr>
</tbody>
</table>

At the time of writing (November 2011), the data from the 5 yearly reviews for the period up to 2010 is still not available, although the data which has emerged from this period suggests that numbers are rising. Some reports suggest that 2009 saw an increase of 13% following a 10% increase in 2008,37 with the speculation that the rise is attributable to taboos fading and a rise in doctors reporting euthanasia and PAS.

Interestingly, the evidence shows that in the vast majority of cases, the extent of estimated life shortening is less than one month, with 46 percent of cases thought to have been shortened by less than one week and 46 percent of cases involving shortening of between one week and a month.38 In just 8 percent of cases is life estimated to have been shortened by more than a month. No doubt this is at least in part because the majority of cases (84 percent) concerned patients suffering from cancer who wanted to escape the final ravages of the disease.39 A general reluctance to comply with requests for PAD amongst the medical profession is indicative of a cautious approach which also affects this issue, with only 44 percent of explicit requests for PAD being carried out.40

---


36 Annual Reports, Regional Review Committees, reproduced in Griffiths and Weyers et al. (See n.18), p.154.

37 See DutchNews.nl, 16 June 2010, and, ‘Euthanasia cases in Holland rise by 13 per cent in a year’ The telegraph, 20 June 2010. This represents a rise from 1,933 deaths in 2005 to 2636 deaths in 2009.


39 Ibid.

40 See M C Jansen-van der Weide, B D Onwuteaka-Philipsen, G van der Wal, ‘Granted, Undecided, Withdrawn and Refused Requests for Euthanasia and Physician-Assisted Suicide’, Arch Intern Med. Vol. 165, August 8/22,
The drop in cases of euthanasia, from 2.6 percent in 2000 to 1.7 percent in 2005 was perhaps surprising. However, this dip seems to correspond with a rise in the number of deaths following terminal or palliative sedation.\(^1\) Of course, this may be coincidental, and it is only possible to estimate the proportion of cases involving continuous deep sedation which actually hasten death.\(^2\) It is also interesting because in a society where PAD is legal, one might have presumed that other (more covert) clinical practices which hasten death would be less prevalent. Evidence from the Netherlands however, indicates that the doctrine of double effect in the context of possible death-hastening palliative care remains important, and, perhaps surprisingly, there has actually been a small rise in recorded deaths attributable to DE since the legalisation of PAD occurred. Data collected in 2005, showed that 25 percent of all deaths in the Netherlands were attributable to the administering of pain relief with life-shortening effect.\(^3\) This presented a rise of 6 percent since 1995 and 1990, when recorded data showed that deaths following pain relief with double effect accounted for 19 percent of all deaths.

3. Euthanasia vs Physician Assisted Suicide

Legally speaking, the Dutch regard euthanasia and PAS as equivalent acts. Both are permitted on identical grounds and are subject to identical requirements of due care, although in practice, as evidenced in the table above, there is a clear preference for euthanasia over PAS. It is perhaps surprising that ‘...despite the indifference of the law, and everything that can otherwise be said in favour of assisted suicide as the more eligible choice, Dutch doctors perform euthanasia far more often than assisted suicide.’\(^4\) The reasons for this preference are not entirely clear. Griffiths \textit{et al} consider this issue and cite a number of factors as having some effect. First, as Dutch law was born from the empowerment of the medical profession rather than as a (patient) rights-driven vehicle, might it be that doctors regard themselves as having a duty to perform euthanasia in response to a request, and so it is somehow ‘natural’ that this task is solely theirs. This preference was, in the early days (until 1984) of the

---

\(^1\) Discussed in chapter 3, see p.97.
\(^2\) See Griffiths and Weyers \textit{et al}, n.18.
\(^3\) Ibid, p.154.
\(^4\) Ibid, p.178.
assisted dying experience, supported by organisations such as the Medical Association, although since this is now purely historic, it is perhaps surprising that the professional preference has endured.

The negative label of ‘suicide’ might also determine perceptions of assisted dying options, with a possible patient preference for a death which might be viewed as a final ‘treatment’ by the doctor, rather than as a suicide. This links back to the origins of Dutch law and the role of the Voluntary Euthanasia Association (NVVE) in seeking to distance their movement from possible negative associations with psychiatric illness and suicide. But practical issues are also important and, given the nature of the options in terms of the doctor’s role, it may be an issue of convenience which has partly determined the preference for euthanasia. A doctor who performs PAS must (except in rare circumstances) remain with the patient until death arrives, a process which may take several hours. By contrast, the drugs used for euthanasia cause death quickly, and so the busy doctor can return to her other duties. The fact that the doctor is in complete control, with almost no chance of the patient surviving is also relevant. With this in mind, it is interesting to note that in Oregon, where only PAS is permitted, a small number of patients do survive PAS. For example, in 2010, two patients who ingested the fatal medication regurgitated the drugs and survived.\(^{45}\) Clearly therefore, the comparative practical ease of euthanasia over PAS is determinative in the Dutch preference.

It also seems likely that patients generally prefer euthanasia over PAS. Having made the decision to die, the burden of killing rests in the hands of the doctor and so there is a less stressful, easier death for the patient. In comparing the proportionally higher rates of PAD in the Netherlands to PAS in Oregon, and notwithstanding that there may be a multitude of reasons why more Dutch people (than Oregonians) seek an assisted death, it seems reasonable to contend that euthanasia is more appealing to people than PAS. It is interesting to note that the House of Lords Select Committee on Lord Joffe’s Bill considered the evidence from the Netherlands and Oregon to predict that the legalisation of euthanasia (rather than just PAS), in the UK would result in a significantly greater number of deaths.\(^{46}\) The Committee estimated that replication of the Dutch system in the UK would lead to approximately 13,000 deaths per year. By contrast, replication of the Oregon law would result in approximately 650 deaths per year in the UK. While such predictions are of course


\(^{46}\) *House of Lords - Assisted Dying for the Terminally Ill Bill - first report*, para. 243.
speculative, it seems evident that euthanasia is easier (and thus more attractive) for the patient. Consequently, it is probable that legal euthanasia is more likely to prompt people to choose death than a system which allows only PAS in the form of a prescription which is then left with the patient.

6.4 Assessing the slippery slope in Oregon and the Netherlands

Because slippage can only really be assessed once legalisation has occurred, the experiences in the Netherlands and Oregon clearly have some potential to provide evidence over slippery slope concerns. Before focusing on the specific elements of the slippery slope debate which are most relevant here, it is useful to first outline the various theories of the slippery slope. As I outlined in chapter 1, broadly speaking slippery slope arguments rest upon the assumption that people are unable to abide by distinctions between morally acceptable behaviour and related, but morally unacceptable, behaviour. Thus, slippery slope arguments have a particular resonance in the debate on assisted dying with the key proposition being that if voluntary euthanasia is legalised it will become impossible to make a distinction between voluntary euthanasia and non voluntary or even involuntary euthanasia. Slippery slope arguments may be broadly categorised as either empirical or logical, with further possible sub-divisions of the logical strand of the argument. The empirical strand of the argument contends that legalisation will defy effective regulation, and so morally acceptable and permissible PAD will inevitably open the door to morally unacceptable and impermissible PAD. For example, doctors might fail to adequately ensure that requests for PAD are genuine and well-considered, or equally, a doctor might overlook alternative ways to relieve suffering. Moreover, the argument runs, any number of mistakes, or simply a lack of care, regarding diagnosis or prognosis will result in PAD being performed inappropriately.

In addition to this inadvertent slippage, a further slide may occur because attitudes (of doctors, the general public or both) will change because of the relaxation of the law. Previous abhorrence of killing will melt away and doctors or society may come to regard

48 Also sometimes referred to as the ‘practical’ slippery slope.
49 For example, Wilbrun van der Burg has distinguished two versions: the first being one from consistency or precedent; the second being a ‘sorites-type argument’. See ‘The Slippery-Slope Argument’ (1991) 102 Ethics 42, pp 42-43.
50 Assuming of course that other objections to PAD, such as the sanctity of life argument, are put to one side.
euthanasia as a solution to social problems in an increasingly aged society, or even as a means to rid society of severely disabled individuals, and so the only way we can avoid such slippage from the acceptable to the unacceptable is to continue to prohibit assisted dying.

The logical aspect of the slippery slope argument proposes that the ethical justifications for allowing PAD, namely beneficence and autonomy, will naturally invite at least one of two morally problematic conclusions. The first conclusion, resting on the presumption that PAD may only be permitted when it is in the interests of the patient in order to end suffering and is therefore beneficent, is that voluntary euthanasia is only acceptable if non-voluntary euthanasia is acceptable. Keown illustrates this contention with imaginary terminally ill twins, X and Y, under the care of Dr A, who, having agreed that the competent twin’s request for euthanasia should be complied with, feels duty-bound to terminate the life of the incompetent twin who is suffering in silence.51

The second conclusion, resting on the justification of patient autonomy, is that if we allow those suffering unbearably from a terminal illness to have an assisted death based on their autonomous request, what is to prevent us from respecting the requests of healthy individuals who have other - equally autonomous - reasons for preferring death?

As one might expect, the various strands of the slippery slope debate have been the subject of some scrutiny. Stephen Smith, for example, has considered both the empirical and logical arguments, providing a comprehensive and compelling response to Keown’s treatise.52 Also, Lillehammer has addressed aspects of the debate, with a persuasive rebuttal of Keown’s central argument over the logical slippery slope.53 As Lillehammer shows, Keown’s appraisal treats the separate requirements (of autonomy and beneficence) as individually sufficient rather than jointly necessary. More generally, others have considered the merits of slippery slope arguments,54 providing a useful basis upon which to further consider the slippery slope in relation to the extension of PAD for those suffering existentially.

---

53 H Lillehammer, ‘Voluntary euthanasia and the logical slippery slope argument’, Cambridge Law Journal 2002, 61(3), 545-550. Lillehammer rejects Keown’s theory that the two central justifications for PAD will inevitably result in PAD on the basis of only beneficence or autonomy. Lillehammer argues that both ethical grounds are individually necessary but only sufficient when jointly present.
Although opinions divide on exactly how the empirical evidence should be construed, the evidence that exists arguably does not support the proposition that either the Netherlands or Oregon has departed from their tightly controlled systems. With respect to the worst case scenario over non-voluntary or involuntary euthanasia, it is clear that the examples utilized by opponents such as Keown, to purportedly demonstrate how voluntary euthanasia has degenerated into its less acceptable counterpart are objectively unconvincing. As Lewis argues, these arguments present ‘flawed logic’. Furthermore, ‘the Dutch data does not precisely address the issue of legalization, as there is no evidence of the rate of non voluntary euthanasia prior to legalization with which to compare the steady post-legalization rate.’ Keown cites evidence of death-hastening through analgesia in the Netherlands as evidence of abuse, but these practices occur in all jurisdictions irrespective of whether there is any legal option of PAD. For example, as I examined in chapter 3, there are higher levels of terminal sedation in the UK than in the Netherlands. However, whilst the evidence does not prove the slippery slope, neither does it disprove it. So does the empirical evidence tell us anything useful about slippery slopes?

As mentioned above, Dutch physicians on the whole are evidently reluctant to comply with patient requests for PAD. Given that the data in both jurisdictions indicates that the number of people dying via PAD remains relatively stable, both models seem to have withstood any pressure to slide down a dangerous slope. For example, in research which addresses some possible aspects of the empirical strand of the slippery slope debate (in relation to how slippage might have occurred via the failure to protect the vulnerable), Battin et al have

55 It should be noted that the information emerging from the Netherlands from the five-yearly national research, which has been subject to scrutiny in relation to assessing slippage, has been interpreted very differently by different commentators. Contrast the conclusions of Griffiths, Weyers et al (n.18) with those of John Keown (see Euthanasia, Ethics and Public Policy: An Argument Against Legalisation, Cambridge University Press, 2002). See also, J A C Rietjens, P J van der Maas, B D Onwuteaka-Phillipsen, J J M van Delden, A van der Heide, ‘Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?’ Bioethical Inquiry (2009) 6:271-283, which presents convincing evidence to suggest that, ‘no slippery slope seems to have occurred. Physicians seem to adhere to the criteria in the large majority of cases.’ See also, M P Battin, A van der Heide, L Ganzini, G van der Wal and B D Onwuteaka-Phillipsen, ‘Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable Groups”’ (2007) 33 Journal of Medical Ethics 591-7.


58 Ibid, p.199.


60 Supra n.40.
considered the impact on patients in so-called ‘vulnerable’ groups in both the Netherlands and Oregon.\textsuperscript{61} The key question addressed by this research was whether there is evidence that people in these vulnerable groups are at heightened risk from a legal position which sanctions PAD. People identified as ‘vulnerable’ in the study are: the over 85s, women, people without health insurance, people with AIDS, people with low educational status, the poor, racial and ethnic minorities, people with non-terminal physical disabilities or chronic non-terminal illnesses, minors and mature minors, and finally, patients with psychiatric illness. Of these groups, the only people identified by the study as being at heightened risk were those with AIDS in Oregon, where, in nine years, six people with AIDS were found to have died via PAS. Although this is clearly not a high number, and in fact represents just two percent of the total number of people having PAS during that period, the data shows that people with AIDS are 30 times more likely to have an assisted death in comparison to those who died of chronic respiratory disorders in the interview portions of the nationwide studies in the Netherlands. Although evidence from the Netherlands generally demonstrates no heightened risk for those with AIDS, in an Amsterdam cohort of 131 homosexual men with AIDS who died before 1995, 22 percent died from PAD, which is obviously a very high percentage. These findings seem to accord with Magnusson’s research, which highlighted the phenomenon of ‘underground’ assisted dying within the AIDS community.\textsuperscript{62} Moreover, it may be that there are reasons beyond the scope of Battin et al’s research as to why people with AIDS are at greater risk from both covert and overt assisted dying, although, as treatment for HIV and AIDS continues to advance we might expect (and hope) to see less evidence of heightened risk within this group.

In response to the study carried out by Battin et al, Finlay and George have questioned the conclusions drawn from the research which relates specifically to Oregon, suggesting that:

‘Vulnerability to PAS cannot be categorised simply by reference to race, gender or other socio-economic status and that the impetus to seek PAS derives from factors, including emotional state, reactions to loss, personality type and situation and possibly to PAS contagion, all factors that apply across the social spectrum.’\textsuperscript{63}

\textsuperscript{61} Battin et al, supra n.55.


\textsuperscript{63} I G Finlay, R George, ‘Legal physician-assisted suicide in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon’s data.’ JME, Dec 2010, doi 10.1136/jme2010.037044.
A valid point is made with respect to elderly residents of Oregon. As Finlay and George opine, 85 is very elderly and thus arguably an inappropriate age at which to begin any categorisation of the elderly. Instead, Finlay and George suggest that 65 is an appropriate start for any categorisation of the elderly. But just as 85 is a rather advanced age at which to begin such a categorisation, 65 seems too young. Arguably, a reasonable compromise position might suggest 70 or 75 as a more appropriate starting age. Nevertheless, because the data from Oregon concerning those aged 65 to 84 (an age group not considered by Battin et al), does indicate a much higher rate of PAS, it is apparent that it may be misleading to state that there is no heightened risk to the elderly based on data which concerned only those over the age of 85. That said, we must not ignore the fact that people over the age of 65 are clearly more likely to suffer from a terminal illness than younger people, rendering this age group more likely to be eligible for PAS under the legislation in Oregon, which means that this age group are arguably more likely to avail themselves of PAS because of illness and disease rather than because of age.

Other concerns are raised over depression and prognostication. With respect to depression, Finlay and George refer to research carried out by Gazzini on patients with possible depression requesting PAS. Gazzini’s conclusion was that Oregon’s Death with Dignity Act ‘may not adequately protect all mentally ill patients’. This possibility is recognised by Battin et al in their acknowledgment that ‘not all patients who requested assistance were specifically evaluated by mental health professionals.’ Evidently, despite there being no concrete data to show that mentally ill people are at greater risk in Oregon, it is clear that there is limited and insufficient attention given to this issue. The clinical limitations of prognostication are also troubling. Battin et al cite examples of patients provided with fatal prescriptions who choose to continue their natural life and subsequently outlive their six month prognosis, while Finlay and George cite an example of a man who lived for three years following his diagnosis and consequent prescription for PAS. Clearly, the distinction between chronic and terminal illness can be a difficult one. As with the previous point on depression, greater clinical engagement with this issue seems to be necessary if such concerns are to be put aside.

64 60% of PAS in Oregon is amongst this age group.
Overall however, given Baroness Finlay’s well-publicised views on assisted dying it is not surprising that objectivity in the rebuttal of Battin et al’s findings remains elusive. Whilst there may well be imperfections with the Battin research, Finlay and Georges’ response offers only limited consideration of any failings and instead resorts to predictable assertions. The main problem with their response is that if one is fundamentally opposed to any form of assisted dying, the temptation to view any person who takes this option as an unfortunate victim of a liberal policy is clearly overwhelming. Thus, these unfortunate victims are, almost entirely by virtue of what has befallen them, cast as ‘vulnerable’ in the eyes of opponents to any legal model of assisted dying. In the absence of any evidence to show that groups traditionally thought of as being vulnerable, such as the poor, are actually at heightened risk from the law, Finlay and Georges’ response is to counter, for example, that Battin et al ‘do not reflect on the vulnerabilities that wealth may bring, for example, perceptions of suffering, dignity, control, or the stigmatisation of illness and disability.’ Similarly, the educated become ‘vulnerable’ to PAS simply because more educated people have opted for PAS, irrespective of any meaningful investigation of why the educated are more likely to die in this way.

Although it might be of only limited value to consider women, ethnic minorities or certain socio-economic groups as potentially vulnerable in the context of PAS, these are at least groups which have traditionally been cast as potentially vulnerable in sociological research into other broadly comparable issues. There can be little doubt that any research that failed to consider such groups in this context would equally be criticised for such a failing. Thus, Finlay and Georges’ attempt to re-appraise what vulnerability might mean in this context becomes a largely meaningless exercise. The question more generally of which mentally competent adults should be considered vulnerable is an extremely vexed question and vulnerability is a slippery concept. As Dunn et al argue, constructing the vulnerable adult in order to justify welfare interventions is highly problematic as there is a very fine line between protecting and disempowering those labelled as vulnerable. Clearly however, a position which achieves the goal of protecting competent adults even at the cost of disempowering

---

66 For example, Baroness Finlay is Co-chair of ‘Living and Dying Well’, a group opposed to assisted dying whose aim is to ‘keep the law safe for sick and disabled people’. See http://www.livinganddyingwell.org.uk/
67 Supra, n.63.
them is exactly what those opposed to the legalisation of PAD are seeking to uphold. Conversely, it might be argued that those seeking to legalise PAD are empowering people at the cost of failing to protect the vulnerable. Moreover, we should not be surprised to find that objectivity on the issue of what constitutes ‘vulnerability’ is extremely difficult if not impossible in this context.

6.5 A closer look at the Dutch experience

As one might expect, both Oregon and the Netherlands are understandably anxious to refute the notion that their highly regulated model of PAD has fallen victim to slippage, and, as the data suggests, the worst fears of opponents have not come to pass. However, some recent developments in the Netherlands suggest that, at least for some, the existing limits of assisted dying are too restrictive. The strictly medical model, which permits only PAD might be seen to be under some strain as a consequence of a number of cases involving lay assistance. For example, in the case of Schellekens, in May 2009, the District Court in Almelo found Gerard Schellekens, the president of a Dutch right-to-die organisation, guilty of the offence of assisted suicide. Unlike physician offenders, who seem almost certain to escape a custodial sentence, Schellekens was sentenced to a 10 month sentence. But even more significant in the ongoing Dutch debate is the fact that the (strictly medical) grounds upon which a person might access PAD are being called into question, with a movement to open the door to PAD for elderly people suffering existentially. Because this movement may represent a precursor to a shift in Dutch policy, which might be viewed as slippage down the slope, it is worth considering in some detail.

Following the case of Brongersma, the KNMG established a Committee, presided over by J Dijkhuis, an Emeritus Professor in clinical psychology and psychotherapy, to consider norms surrounding assisted dying requests in cases of existential suffering. The Committee’s report, which was published in 2004, recommended that providing PAD for patients experiencing terrible existential suffering might fall within the realm of a physician’s duty because such


71 For example, Chabot and Van Oijen, discussed above.


73 Discussed above at p.179.
suffering may be regarded as unbearable and hopeless. The Dijkhuis Committee’s report has elicited a cautious response from the KNMG, who, in response, have formulated a policy on ‘[T]he role of the physician in the voluntary termination of life’. The KNMG position rejects the idea that assisted dying should be available for elderly people suffering existentially, advocating continuing the policy of providing assisted dying as a ‘last resort’ only when the suffering emanates from a medical condition. But despite medical reluctance to expand the existing boundaries, the pressure to broaden the concept of suffering has been mounting.

The case of Moek is illustrative of this dilemma. Moek was a 99-year-old woman residing in a nursing home. As a consequence of her failing health, Moek had experienced a decrease in her quality of life and was rendered unable to participate in activities, such as reading, which she had previously found pleasurable. Increasingly dependent and fearful of further degeneration, Moek consulted a doctor about the possibility of PAD, however the doctor in question found that she did not meet the due care criteria with respect to suffering unbearably from a medical condition, and so her request was refused. Subsequently, Moek took matters into her own hands by collecting pills which she intended to use to take her own life. Moek confided in her Stepson, Alberta Heringa, who realised that these pills would not cause death and so agreed to help in his Step-mother’s suicide bid. Subsequently, Heringa provided her with a fatal dose of anti-malaria medication which he had collected on his travels abroad, together with sleeping pills and an anti-vomiting drug. After consulting a criminal lawyer, Heringa took the precaution of making a video-recording of Moek’s final hours in order that her autonomy and clear determination to die could not be questioned. Together with his daughters, Heringa then stayed with Moek until she fell asleep, leaving the nursing home whilst Moek was still alive in order to avoid arousing suspicion. Following Moek’s death, which occurred during the night, the doctor who was summoned recorded Moek’s death as a natural one. Despite this, Heringa sought to challenge the legal status quo by releasing his recording of his Mother’s suicide to the NVVE, a prominent Dutch right-to-die

---

74 The KNMG position paper, supra n.25.
75 ‘Moek’ means ‘Mother’ in Dutch.
76 Nederlandse Vereniging Voor Een Vrijwillig Levenseinde. The NVVE is the largest right-to-die organisation in the Netherlands. The NVVE’s objective is to ‘contribute to an open debate that will lead to the realization of a solution for this difficult and highly emotional problem for people who consider their life completed, and, therefore, prefer death over life.’
organisation, who then broadcast a documentary on Moek’s death during their ‘Completed Life’ campaign during February 2010. Heringa was then questioned by the police.\textsuperscript{77} The NVVE’s ‘Completed Life’ campaign coincided with Citizen’s Initiative founded by a citizen’s action group, ‘UIT Vrije Wil’ (By Free Choice). This initiative demands that people over the age of 70 (seniors) who are tired of life should have a right to an assisted death without having to satisfy the existing medical criteria in the Netherlands. Over 120,000 Dutch citizens signed the initiative, invoking the Dutch constitutional requirement for Parliament to consider the proposal.\textsuperscript{78} The pressure which is being exerted in an attempt to stretch current boundaries may thus be seen as demonstrating some shift in Dutch attitudes towards assisted dying, which, assuming that any expansion to the existing rules is undesirable, might be indicative of slippage down a slope towards a more autonomy-focused justification for PAD. The tension between the decision in Brongersma (which is supported by the KNMG), and the position of the Dijkhuis Committee demonstrates how Dutch society may be torn between extending the autonomous rights of individuals who are genuinely suffering on the one hand, whilst at the same time maintaining the appropriate level of medical engagement within a highly-medicalised model of assisted-dying. This section of the chapter seeks to explore the implications of these developments in light of the ongoing assessment of the Dutch slippery slope.

\textbf{6.6 Physician-assisted Dying for the Terminally Old?}

In consideration of slippery slope concerns pertaining to the developments discussed here, it seems that elements of both the empirical and logical strands of the argument are relevant to the pressure to extend the grounds for PAD to encompass existential suffering. Empirically speaking, assuming there was once a broad consensus that it was justifiable to provide PAD only to those suffering unbearably from some medically diagnosed disease or condition, recent developments invite the presumption that attitudes have shifted. Of course, this is not an entirely novel development with respect to the idea that great age brings burdens. The recent developments reflect previous discussions in the Netherlands over the possibility of a

\textsuperscript{77} Discussed in Ost, Mullock, supra n.72.
\textsuperscript{78} On 16 February 2011 the Safety and Justice Committee of the Lower Chamber of Dutch Parliament evaluated the Assisted Death for the Elderly (Review Procedures) Act.
suicide pill for the elderly. Moreover, on the question of suffering, there may inevitably be some tension between subjective and objective perceptions of suffering and whether the patient’s or doctor’s assessment should be most crucial. As Rietjens et al have observed:

..it is likely that physicians may have different opinions about which suffering can count as a legitimate ground for euthanasia. They may also have a different judgement than their patients, which is illustrated by the fact that a frequently mentioned reason for rejecting a patient’s euthanasia request is that the physician did not consider the patient’s suffering to be unbearable.

However, although there may be little political will to extend the suffering criteria, and despite evidence that doctors are generally reluctant to provide PAD, it seems that the emergence of cases such as Brongersma and ‘Moek’, together with the Citizens’ Initiative and the conclusions of the Dijkhuis Committee, provide some evidence that attitudes have indeed changed. Volokh refers to such shifts as ‘attitude-altering slippery slopes’, and questions whether such changes in attitude are necessarily bad, suggesting that some changes in attitude resulting from legal change might be described as ‘good learning’ rather than ‘bad desensitization’. Whilst this is undoubtedly true in general - for example, the decriminalisation of homosexuality in the late 1960s clearly encouraged less homophobic and accordingly more positive attitudes within society - highly contentious issues such as assisted dying are understandably more controversial. Moreover, it may be inevitable that those opposed to the Dutch law on PAD will see the ongoing debate on existential suffering as evidence of exactly the type of slippage envisaged. If the subject under consideration was a slide from voluntary euthanasia to non-voluntary or even involuntary euthanasia it would be easy to reach a consensus that a terrible slide had occurred, but with an altogether different kind of shift; namely, with (Dutch) opinions divided on the question of whether PAD should be available to those suffering existentially, how should these developments be viewed?

---

79 The ‘Drion pill’. Huib Drion, the then vice-president of the Dutch Supreme Court, and professor of law, put forward the idea of a suicide pill for the elderly who were tired of life. See ‘Suicide Pill for the Elderly’, Radio Netherlands World Wide, available at [http://www.rnw.nl/english/article/suicide-pill-elderly](http://www.rnw.nl/english/article/suicide-pill-elderly)

80 Rietjens et al (supra n.55).


82 See Volokh (supra n.54) p.1104.

83 Ibid.
At the heart of this debate lies the issue of autonomy. Because the current dilemma focuses on whether to extend PAD to those suffering existentially, it is clear that Keown’s argument in relation to the logical slippery slope has not transpired; both the suffering (beneficence) and the request (autonomy) remain crucial. However, this debate does demonstrate that the founding principle of the Dutch law - that PAD is justified only when requested by a patient who is suffering unbearably from a medical condition84 - is under some stress. Autonomy remains crucial, but with the nature of the suffering necessary in order to invoke physician-participation under dispute, the founding principle of beneficence seems less stable. Opponents of PAD would argue that the first slide down the slope occurred with the case of Chabot,85 which confirmed that patients suffering psychologically might lawfully receive help in dying. The provision of PAD to patients with dementia is also controversial, inviting concerns over what might be viewed as a form of non voluntary euthanasia.86 Where existential suffering is concerned, while the Supreme Court’s decision in Brongersma maintained the existing parameters of physician involvement, the actions of Dr Sutorius clearly illustrated a problem which now seems to be growing.

Perhaps a useful analogy may be drawn between assisted dying and abortion with respect to the issue of autonomy. The Abortion Act 196787 was enacted in order to protect women from the perils of backstreet abortionists, and so the key ethical justification for the Abortion Act was non-maleficence with respect to avoiding dangerous, unhygienic practices and the enhancement of public health. Although female autonomy was clearly promoted by the Abortion Act, this was essentially a side-effect and not the primary purpose of the legislation. Nevertheless, autonomy and a woman’s right to choose has become the key ethical justification in the ongoing abortion debate, and so parallels might be drawn between the post legalisation primacy of autonomy relating to abortion and the growing primacy of autonomy in the assisted dying debate. This, of course, accords with the increasingly strong commitment to patient autonomy generally.

84 The medical condition may be physical or psychological in nature, and both the doctor and the patient, together with another independent doctor, must agree that such suffering cannot be alleviated through any other means.
85 Nederlandse Jurisprudentie 1994 No.656, Supreme Court.
86 For example, reports show that increasing numbers of people with dementia are being allowed to die via PAD, rising from 3 people in 2006 to 21 in 2010, although doctors are extremely reluctant to act in such circumstances. See ‘Dutch doctors wary of euthanasia for dementia’ Radio Netherlands Worldwide, available at http://www.rnw.nl/english/bulletin/dutch-doctors-wary-euthanasia-dementia
87 Essentially, the Abortion Act provides a limited criminal defence to sections 58 and 59 of the Offences Against the Person Act 1861, both of which concern the unlawful procurement of a miscarriage.
Whilst there are some important differences in the respective ethical dilemmas posed by the two issues, the legitimacy of both abortion and PAD (in the Netherlands) depends upon the cooperation of two physicians who must approve the patient’s decision on the grounds of there being sufficient health-related evidence. On the issue of abortion, the ‘health’ grounds outlined by the Abortion Act under section 1(1) provide that it shall not be an offence for a physician to terminate a pregnancy on the following grounds:

(a) that the pregnancy has not exceeded its twenty fourth week and that the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical and mental health of the pregnant woman or any existing children of her family; or
(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated.

Thus, section 1(1)(a), with respect to the ‘physical and mental health’ element of the provision relating to terminations before 24 weeks, has allowed a degree of flexibility which in turn has promoted the idea that there is a ‘right’ to choose not to continue an unwanted pregnancy. Again, the question of what constitutes ‘health’ is a key determining factor. The Royal College of Obstetricians and Gynaecologists suggest that its reference to health is generally assumed to adopt the wider understanding provided by the World Health Organisation’s definition. Thus, with respect to a woman’s physical health, a termination is generally less risky than pregnancy and so a termination will usually pose less risk to a woman’s physical health. Similarly, the mental well-being of a woman who does not want to be pregnant will almost always be enhanced by a termination.

88 For example, whilst both abortion and assisted-dying are opposed by pro-life groups - based on sanctity of life principles – because the issue of abortion engages the conflicting interests of the woman and fetus, the abortion debate is also subject to pressure from those concerned with fetal rights. For example, see J Finnis, ‘The Rights and Wrongs of Abortion: A Reply to Judith Thomson’ (1973) 2 *Philosophy and Public Affairs*, 117-45.
90 The definition of health provided by WHO is, ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. See also, E Jackson, *Medical Law: Text, Cases and Material*, Oxford University Press 2010, p.677.
Unsurprisingly, this has been the subject of some debate. For example, Keown has opined:

Even ardent pro-choicers would have to concede that, although the Abortion Act 1967 permits abortion for medical not social reasons, abortion for social reasons has become the norm, or at least commonplace.\(^{91}\)

Consequently, those opposed to abortion have seized upon the escalation in so called ‘social’ abortion as evidence to confirm the power of slippery slope arguments in relation to not only abortion but also assisted dying. For example, Keown states, ‘If VAE\(^{92}\) were to follow in the footsteps of abortion, would it not frequently be performed with inadequate examination of the quality of the request and little if any exploration of alternatives?’\(^{93}\) Keown’s argument assumes that a proper system of examination and assessment must inevitably yield to the autonomous demands of the patient, so that it is impossible to maintain proper checks etc whilst also respecting patient autonomy. With respect, there is no reason why patient autonomy and having a proper system of assessment and examination should be mutually exclusive, although it may be conceded that if autonomy is afforded more importance than other concerns, such as whether the patient is suffering from a disease or condition, then the assessments relating to the other concerns will obviously be less crucial.

Ultimately, whether it is morally acceptable to afford greater importance to autonomy than to a strictly medical assessment of health or suffering is highly subjective, being entirely dependent upon not only one’s view of the morality of abortion and PAD generally, but also upon one’s opinion regarding the importance of autonomy in connection to these issues. Emily Jackson has considered the tension between autonomy and the health grounds for abortion,\(^{94}\) in a debate which has some relevance to the current tension over the grounds for PAD in the Netherlands. Jackson argues that the requirement under the Abortion Act that two medical practitioners approve ‘a woman’s reasons for seeking to terminate a pregnancy may be inconsistent with the priority currently granted to the common law principle of self-determination.’\(^{95}\) Clearly, determining the appropriate levels of medical engagement in both abortion decisions and decisions on assisted dying\(^{96}\) is morally problematic. Jackson’s

---

\(^{91}\) See Keown (supra n.55) p.71.

\(^{92}\) Voluntary Active Euthanasia

\(^{93}\) See Keown (n.55) p.74.


\(^{95}\) Ibid, p.468.

‘consistency’ argument also resonates in the assisted-dying debate. For example, with respect to the inviolable right of a competent adult to refuse even life-saving treatment, it is evident that self-determination already extends to decisions of dubious moral quality, although clearly this rests on active/passive distinctions which are accorded legal significance.

Naturally, those opposed to the very concept of assisted dying will seize upon these developments as further proof that slippage is occurring. Arguably, however, whilst the Dutch model of PAD may be under some stress, the stress is very much focused on the nature of suffering, inviting questions about the possible re-drawing of clinical concepts of suffering. There will always be those who call for greater emphasis upon self-determination in this context, but in reality the Dutch model of PAD is unlikely to be re-defined because of autonomy. Rather, if there is to be any re-drawing of boundaries, it will be with reference to the concept of suffering and ultimately, in view of political concerns and medical antipathy changes seem unlikely. The following statement provided by the KNMG illustrates the all important medical view; ‘[S]uffering that has no medical basis falls outside the domain of medicine and therefore outside the domain of the physician’s professional expertise and outside the Euthanasia law.’

6.7 Any detriment to palliative care?

One of the many arguments raised in opposition to the legalisation of PAD is that the provision of good palliative care is incompatible with any legal PAD. Indeed the very ethos of palliative care seems to centre on the understanding that, if we allow PAD, either palliation will somehow be rendered obsolete, or that palliation will be seen as a costly and burdensome alternative to PAD. This links into slippery slope arguments with respect to wider concerns that PAD may be seen as a cost-effective alternative to treatment generally, particularly where patients might been as being on their ‘last legs’ in any case. It might be

97 Generally ‘consistency’ is put forward as an argument in favour of legalising assisted dying on the basis that doctors already hasten death via the double effect doctrine and also with respect to withdrawing life-sustaining treatment. However, Smith argues that some aspects of Keown’s slippery slope argument against legalisation should be more accurately described as a ‘consistency’ argument. See Smith, ‘Fallacies of the logical slippery slope in the debate on physician-assisted suicide and euthanasia’, (Supra n.52).
98 Lord Donaldson MR in Re T (Adult:Refusal of Treatment) [1993] Fam 95, said ‘This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.’
99 See Airedale NHS Trust v Bland [1993] AC 789 HL.
100 P. 41 of the KNMG position paper (supra n.25).
101 This was discussed in chapter 1, see p.28.
argued that some evidence of this has indeed emerged in Oregon, with reports that some patients have had requests for costly life-lengthening drugs refused by their health insurers, who instead took the opportunity to offer to cover the cost of PAS.\textsuperscript{102} Clearly, if such reports are accurate, they do not directly concern palliative care but rather treatment for the patient’s specific terminal condition. Nevertheless, such reports seem to add ammunition to the arguments against legalisation. However, notwithstanding the dubious ethics of US health insurers appearing to tempt patients to opt for PAS, such companies would doubtless argue that certain treatments may not be available on demand irrespective of the availability of PAS, and that by offering to cover the cost of PAS they are merely setting out the end-of-life options available.

Returning to the specific issue of palliative care, whilst consideration of any effects on palliative care within a private health care system, such as the one in Oregon, is not perhaps comparatively useful to us, we might assess this theory by reference to the Dutch experience. Compulsory health care insurance,\textsuperscript{103} which facilitates almost universal coverage for the population, puts Dutch citizens in a similar (although some might argue, better) position to UK citizens with respect to health care provision. Conscious of the potential for criticism over neglecting palliative care, the Dutch government sought to prevent euthanasia through palliative care contemporaneously to ratifying the legal position which confirmed the legality of PAD.\textsuperscript{104} Thus, the development of palliative care became part of the national health care policy. Consequently, the hospice movement, which began in the Netherlands in 1988, has grown to number over 200 specialised institutions for terminal palliative care,\textsuperscript{105} with the quality and availability of palliative care in the Netherlands considered to be ‘very advanced’ in comparison to other countries.\textsuperscript{106} As Gordijn and Janssens report:

\begin{quote}
Looking back on the last decade,\textsuperscript{107} it is safe to conclude that the development of palliative care (in the Netherlands) has been immense. Small regional networks are now being constructed within which a variety of palliative care services such as nursing
\end{quote}

\textsuperscript{102} See for example, S Gutmann ‘Do not go gentle... into legalised assisted suicide’, The Telegraph, 8 April 2010.
\textsuperscript{103} In 2006 a universal system of health insurance replaced the previous system which combined public and private provision. Every citizen is required to take up compulsory insurance with a fixed premium for all and then an income dependant supplement. See Griffiths, Weyers and Adams, (supra n.18, p.16).
\textsuperscript{105} See Griffiths, Weyers and Adams, supra n.18, p.18.
\textsuperscript{106} \textit{Ibid.}
\textsuperscript{107} They refer to the period from 1994 to 2004.
homes, home care services, GP’s and hospitals work closely together. On a higher level, 9 palliative care centres, attached to the so-called integral cancer centres in the Netherlands provide specialist consultation services while a national organisation, Agora, supports initiatives with a national and international function.108

Another interesting facet to this issue is that the tension between palliative care and PAD, which features in the UK and other jurisdictions, is not present in the Netherlands. The ‘Network Palliative Care for Terminal Patients of the Netherlands’ has a neutral stance on the question of euthanasia. Accordingly, the idea which is so prevalent amongst opponents of legalisation in the UK; that PAD and palliative care are somehow mutually exclusive, does not inform the debate in the Netherlands from a palliative perspective.

Interestingly, there is some evidence from the Netherlands that rather than having a negative effect on overall end-of-life care, the option of PAD even enhances some facets of end-of-life care for patients, by increasing dialogue about patient concerns. Frances Norwood, an American medical anthropologist, studied the phenomenon of ‘euthanasia talk’,109 looking at the experiences of twenty-five terminally-ill patients. Of these patients, fourteen requested euthanasia, and, during the course of the study, three patients received PAD.110 Norwood concludes that the option of legal PAD in the Netherlands has facilitated a cultural practice in which euthanasia is more often a discussion than an actual life-ending act, with such discussion serving to affirm social bonds and to enhance the doctor/patient relationship. Because the doctor must be sure that there is unbearable suffering before a patient’s request for PAD can be considered, greater attention is focused on the patient in order to assess suffering and whether such suffering could be alleviated by other means. This provides the patient with a level of care that serves to enhance the end-of-life experience. Accordingly, we should remain open to the possibility that discussions about PAD are not necessarily a route to death, but an aspect of end-of-life care which not only prioritises patient choice, and consequently empowers the patient, but also serves to provide the patient with a level of attention that might otherwise be lacking.

110 Five patients died from their illness during the course of the study and six remained alive as the study concluded.
6.8 The effect on the medical profession

We can also look to the Dutch experience in order to assess the effects of legal assisted dying on the medical profession. Far from becoming hardened from the legitimisation of euthanasia, evidence shows that the reality of legal PAD is emotionally and psychologically burdensome to doctors. For example, the KNMG report that:

A request for euthanasia is one of the most intrusive and onerous demands that a patient can make of a physician. Most physicians find it difficult to perform euthanasia or assisted suicide.\(^\text{111}\)

This seems to be reflected in the general reluctance and caution demonstrated by the number of requests which are refused or not carried out by physicians.\(^\text{112}\) A study by Kimsma shows that while patients and families generally respond positively to PAD - for example, families report feelings of relief that their loved one is no longer suffering - it can be very difficult for doctors.\(^\text{113}\) ‘Euthanasia hurts’ for many of the doctors involved, with evidence of a range of sometimes conflicting emotions from, ‘extreme shock to anxieties, leading to sleeplessness and deep struggles to come to a final conclusion’ but also sometimes ‘deep satisfaction after the act’.\(^\text{114}\) Perhaps perversely, some doctors reported suffering more negative emotions following performing PAD on request compared with actions which end life without an explicit request. The authors suggest that this might be because the latter (generally unconscious) patient group were so severely ill that ending life seemed less controversial, being perhaps comparable to palliative care rather than to euthanasia.

6.9 A postscript - Belgium

Following in the footsteps of their Dutch neighbours, Belgium legalised euthanasia in 2002 whilst maintaining a legally uncertain stance on assisted suicide.\(^\text{115}\) Article 3.1 of the Law on

---

\(^\text{111}\) KNMG position paper (supra n.25) p.40.
\(^\text{112}\) Discussed above, see p.182, supra n.40
\(^\text{114}\) Ibid, p.358.
\(^\text{115}\) The legal model of assisted dying permits only euthanasia. An absence of case law on either euthanasia (which, prior to the law of 2002 was regarded as murder) or assisted suicide has perpetuated the uncertainty over assisted suicide.
Euthanasia provides that a doctor who performs euthanasia does not commit a crime if he or she ensures that:

‘the patient is in a medically hopeless situation of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.’116

Consequently, the Belgian Law on Euthanasia permits a doctor to provide euthanasia subject to certain conditions; the patient must be over the age of 18, competent, conscious and in a ‘medically hopeless’ situation with persistent and unbearable physical or mental suffering - as a result of a serious and incurable disorder caused by illness or accident – that cannot be alleviated. There must be a voluntary, well-considered and repeated request to die in the absence of any external pressure. In response, the physician must inform the patient about his condition, discuss his request for euthanasia, discuss possible therapeutic and palliative options, and, provided the physician agrees with the patient regarding the nature of his suffering, and that the request is durable, so that there are no reasonable alternatives for the patient, the doctor must consult another doctor. The second doctor must be qualified to provide an opinion on the disorder in question and independent of both the first doctor and the patient. The second doctor must then review the medical record and examine the patient to ascertain the patient’s persistent and unbearable suffering that cannot be alleviated through other means, before writing a report for the patient’s doctor who must then inform the patient about the results of the consultation. Extra measures must be taken if the patient is not expected to die in the near future (whatever that means). Accordingly, for such not imminently terminal patients the second doctor must be a psychiatrist or specialist in whichever disorder afflicts the patient, and there must be a period of at least one month between the patient’s request and the euthanasia. There are also provisions for patients to draw up advance requests for euthanasia in case they should lose capacity.117

The fact that Belgium has adopted a similar approach to the Netherlands is unsurprising given the closeness of the two nations and the influence of the Dutch speaking population. More interesting perhaps is the fact that unlike the Netherlands Belgium did not have any pre-statutory examples of legitimate euthanasia to build upon. Prior to 2002 euthanasia was illegal. Thus, the change in the law which occurred borrowed heavily from the Dutch model

---

117 For a full description of the legal requirements in Belgium see Griffiths et al, Ibid, p.306-309.
of PAD but, unlike in the Netherlands, such change was prompted entirely by political will
with little or no involvement of the medical profession. In this respect the emergence of a
legal model of PAD in Belgium has similarities with the Oregon experience.

It is also interesting to consider how far the legalisation of assisted dying in one jurisdiction is
influential upon neighbouring countries. The relationship between the Netherlands and
Belgium provides an obvious example of one society adapting its law according to shifts in
morality influenced at least in part by the legalisation and moral acceptance of assisted dying
in a neighbouring – and culturally close – jurisdiction. The fact that Luxembourg has also
legalised euthanasia provides further evidence of this contagion, and in the US we see a
similar phenomenon with Washington following Oregon, and other states looking likely to
legislate. While the UK does not share close cultural ties with any other European country,
it seems that the increasing importance placed upon the right to self-determine issues of life
and death is a phenomenon shared by a number of countries. As Biggs has observed,
‘[T]hroughout Europe public support for assisted dying has been growing for many years in
response to humanitarian concerns about the indignities associated with protracted dying.’
Moreover, the way that the drive to self-determine has developed in Switzerland, giving rise
to the emergence of assisted suicide organisations such as Dignitas and Exit (whose doors are
open to non Swiss residents), as I explored in chapters 4 and 5, has had repercussions beyond
the Swiss border.

6.10 Conclusion

I started this chapter by looking at how legal change occurred in Oregon and the Netherlands.
Whilst any legalisation in the UK is unlikely to emerge in quite the same way as it did in
Oregon, the fact that the most recent attempts to legalise PAS borrowed heavily from the
Death with Dignity Act demonstrates the likelihood of any legal model in the UK being

118 The coalition that formed in Belgium following the elections of 1999, which for the first time in 40 years did
not feature the Christian Democrats, unanimously agreed (after some initial differences) upon the Bill which
then became law.
119 For example a recent legal challenge in the state of Montana raised the question of the legality of PAS. See
120 H Biggs, ‘The Assisted Dying for the Terminally Ill Bill 2004: Will English Law soon allow Patients the Choice
similar to the Oregon law.\textsuperscript{121} With respect to any comparison with the Netherlands, while recent developments at home conflict sharply with the Dutch medicalised approach,\textsuperscript{122} the way in which the courts and prosecutors are shaping the legal landscape in spite of the statutory prohibition bears some resemblance to the development of Dutch law prior to codification. Of course, following the Dutch path is highly unlikely given that UK physicians, unlike their Dutch counterparts, seem opposed to PAD generally, with even stronger opposition to euthanasia, but in spite of the differences, some lessons from abroad are valuable. Questions about whether either jurisdiction has slipped into bad practices, abuse or ideological diversion \textit{are} pertinent to the debate at home. By observing the experiences of our overseas neighbours, we can better determine what, if anything, should be done at home. Having considered the slippery slope, it appears that although there is nothing to indicate actual slippage from the original limitations of the law in either Oregon or the Netherlands, there are issues that require some attention in both jurisdictions.

Notwithstanding that some of the evidence purportedly relating to ‘vulnerable’ people defies objective appraisal, some of the evidence from Oregon indicates that legal PAS requires better gate-keeping. Although the actual number of AIDS sufferers dying via PAS are low (6 in 9 years), the implication, that a particular group is more susceptible to PAS, requires attention. Similarly, tentative evidence over people who might be suffering from depression, as well as issues over prognostication, suggest that both concerns require greater levels of medical assessment prior to a request for PAS being granted. Thus, any legal model of PAS in the UK should contain safeguards which seek to address these concerns more effectively than the Oregon legislation. The Oregon phenomenon has also revealed that a significant proportion (approximately one third) of those who obtain the prescription in order to die, actually go on to live out their natural life. This demonstrates that for many people it is enough to have the option of PAS, with the peace of mind and potential to control one’s destiny that this provides, without actually dying via PAS.

In the Netherlands, an entirely different system, with far more prevalent PAD has presented other issues, such as the dilemma over existential suffering which continues to tax Dutch parliamentarians. Whilst opponents might seize upon the ongoing debate in the Netherlands

\textsuperscript{121} Lord Joffe’s Assisted Dying for the Terminally Ill Bill.

\textsuperscript{122} I refer to prosecutorial policy on assisted suicide which renders doctors more likely to be prosecuted than lay people.
as evidence that legal PAD leads to an increasing societal desire to expand the parameters to facilitate greater rights of autonomy, in reality, further legal change is highly improbable and crucially, Dutch doctors are particularly reluctant. Nevertheless, we might view the Dutch debate with interest as it arguably shows that when certain taboos melt away, there seems an almost inevitable increasing societal demand for greater rights over what was previously impossible (or at least unlawful). Consequently, if any form of legal PAD arrives in the UK, we might expect that eventually whatever it is that has been legalised will not be enough for certain people in society. ‘Wanting more’ is clearly part of the human condition. Thus, at the point of legalisation, assuming that there are important reasons why a certain form of legal PAD, available only on limited grounds has been sanctioned, any legislation should seek to resist pressure to expand the boundaries.
Chapter 7

Time for Cautious Revolution?

7.1 Introduction

‘There are dangers both in legalizing and refusing to legalize; the rival dangers must be balanced, and neither should be ignored.’

It seems that the legal landscape, with respect to both end-of-life law and assisted dying – in so far as the law allows or overlooks what might be thought of as assisted dying – has been sculpted by a process of evolution. This thesis has explored how various factors have compelled the law to consider its response to end-of-life issues. Where health care professionals are concerned, medical advances have created dilemmas over whether we should always prolong life artificially just because we can, or, whether we should let some patients die. Similarly, pharmaceutical advances have enabled doctors to alleviate the suffering of dying patients, but with the risk or possible side-effect of hastening death. In response to such dilemmas the law has evolved, whilst remaining (in the formal sense) fundamentally unchanged, in order to legitimise solutions to controversial moral questions. Beyond the medical context and where complicity in suicide is concerned, society’s march towards greater rights of self-determination, together with human rights advances and the increasingly liberal attitude towards assisted dying in some other European countries, has forced further evolution upon English law.

The previous chapters have considered the various challenges that have confronted both the law of homicide and the Suicide Act 1961. Developments, where they have occurred, have essentially presented a de facto compromise, either turning a blind eye to assisted dying or enabling legal justifications to circumvent the law. And so while the law remains steadfast in its formally prohibitive stance, the reality of the law in action has offered more flexibility and thus more compassion than the letter of the law would indicate. Whether the law has

2 As discussed in chapter 2.
3 As discussed in chapter 3.
successfully accommodated the changing values of society whilst also remaining rational, morally coherent and tenable in the 21st century is far from clear. In the medical context, a range of justificatory devices are employed to obscure the fact that doctors sometimes do things (hopefully) in the patient’s best interests, that kill or at least hasten death. As we saw in chapters 2 and 3, a range of inconsistencies, muddled morals and medical practices which are potentially open to abuse might lead one to conclude that reform of our homicide law is necessary. On the question of assisted suicide, alongside some questionable aspects of prosecutorial policy which might be seen to turn a blind eye to all but the most heinous examples of complicity, the nature of legal developments has led to concerns that unconstitutional legal change is endorsing a permissive approach that has not been approved by Parliament. 4

This final chapter draws upon my preceding analysis in order to determine whether, in the 21st century, continuing a policy of allowing the law to evolve within its existing (supposedly) prohibitory parameters remains an adequate response to the various challenges which confront society, or whether a fundamental re-appraisal is required. Given the conflicting ethical arguments, finding an answer which reflects some sort of consensus view seems impossible, but, as Battin has observed:

A more mature phase of the intellectual discussion may also seem to be beginning. Some works advance the discussion towards resolution by reserving judgement on the theoretical and policy issues while exploring the realities of concrete application, whether the practices in question are legalized or remain underground. 5

Such is my objective in this final chapter. Accordingly, I seek to balance the conflicting arguments and evidence in order to conclude my analysis with a proposal for legal change that would present what might be described as a cautious revolution in end-of-life law.

---

4 See for example, J Laing, ‘On the Wrong Track’ (2010) 154(2) Solicitors Journal, 8.
7.2 Competing concerns and the spectre of abuse

While there are many unsatisfactory elements within the current legal position, finding a solution that is broadly regarded as acceptable is extremely difficult. As Price has observed, ‘it is a truism that it is easier to justify a specific instance of euthanasia than a social and legal policy of permitting such a practice.’ Thus, even if one concludes that the conflicting arguments over euthanasia and assisted suicide point, on balance, to the legalisation of some form of assisted dying being morally justified, concerns that any legal model may result in bad consequences might prevent us from going down the route of legalisation. Of all the reasons why assisted dying has remained illegal (notwithstanding the general political lack of will), an important factor is that in the face of moral confusion, the preferred approach is to err on the side of caution. Moreover, the theoretical potential for any legal model of assisted dying to lead to harmful consequences has engendered a restrictive approach to this issue.

Battin has argued that, whatever conclusion (to legalise or not) our moral compass might direct us to, we should only legalise voluntary euthanasia if we are confident that we are able to prevent abuse via the policy which we intend to put in place. Interestingly, she identifies three conceptually distinct types of abuse which might occur following legalisation: interpersonal abuse (where relatives or partners encourage the patient to choose death), professional abuse (where health care professionals promote death), and institutional abuse (less direct abuse via the narrowing of health care options). Of the final category, Battin sees three primary mechanisms which limit patient choice: direct policy stipulations, indirect policy agendas and the use of policies that control preference. Although Battin considers such abuse from a US perspective, her fears over institutional abuse seem particularly, and perhaps increasingly, relevant to the UK. Moreover, whilst it might be possible to provide measures which would guard against professional abuse and even interpersonal abuse, wider policy limitations which might affect decisions to live or die are harder to avoid.

---

8 Ibid. Battin observes that the particular problem with respect to a privately funded system, and caring for those without health insurance in the US, will inevitably lead to a lack of choice which will lead to patients asking for euthanasia to avoid the other (worse) options available.
9 For example, in the Netherlands there is no evidence that either health professionals or relatives encourage people either towards assisted death, in fact the reverse seems true particularly with respect to physicians.
As our health system hobbles along under the weight of budget constraints and an ever larger old-age population, and with concerns about our ability to provide even adequate care within the NHS, the constriction (or at least the continuing inadequacy) of end-of-life and palliative choices seems unavoidable. Unless we are able to provide better palliative, hospital and out-patient care for those members of society who need it, it is clear that some people will choose death as the least worst option. Choosing death might be objectively understandable and ethically acceptable in certain circumstances. But choosing death because the alternative care options are so objectively appalling (when satisfactory care is theoretically possible) would be a terrible indictment of our health care system and thus, of society. Does it mean therefore, that because our health care system is inadequate, sometimes subjecting people to substandard care or even neglect, we should force them to put up with it because otherwise they might choose death? Clearly neither option is satisfactory. Furthermore, such concerns seem to indicate that Battin’s observations over institutional abuse might be hard to avoid if certain forms of assisted dying within the medical context were to be legalised. As we know, options within the NHS are already narrow and often less than ideal.

7.3 Concluding lessons from abroad

As I discussed in the previous chapter, and despite some of the allegations of anti-euthanasia commentators, the evidence from the Netherlands does not demonstrate that legal assisted dying on request leads inevitably to abuse and consequent non voluntary or involuntary euthanasia, or even widespread voluntary euthanasia and PAS. What legalisation might lead to, however, is pressure to expand access to assisted dying. Thus it seems reasonable to observe that any legal model might invite pressure to extend its limitations in much the same way that the current prohibition is under pressure. I do not suggest that this prediction

---

See for example the evidence discussed in chapter 6 (p.182) about professional reluctant to provide assisted dying.


necessarily speaks to the question of legalisation. But it is interesting nonetheless and invites the conclusion that any legal model should seek in so far as it is possible, to achieve a consensus, via a cautious and carefully constructed law that will withstand such pressure, unless, of course, there is a general consensus that the law needs reviewing.

While there may be a number of shared or common elements between Dutch society’s approach to health care and our own – both being secular, relatively wealthy and well-developed Western democracies – other factors diverge, particularly with respect to society’s view of the doctor/patient relationship, creating subtle but important reasons for being cautious over which lessons can be learnt from other jurisdictions. For example, in relation to Battin’s fears over abuse, it is possible that the nature of the relationship between health care professionals and patients in the Netherlands, involving greater continuity of care and thus perhaps being more trusting, might invite less concern over professional abuse than in the UK.12 Similarly, given that the Dutch health care system, being funded by almost universal insurance, is also perhaps better resourced than our own system, there is reason to suppose that the Dutch system would be less at risk of both professional abuse and institutional abuse via the narrowing of options.13

The Dutch experience also presents an entirely medicalised model of assisted dying. This contrasts sharply with the present approach regarding complicity in suicide in the UK and although, as I have discussed,14 any legal model of assisted dying would almost certainly comprise at least some medical involvement, the Dutch model requires a level of medicalisation that many (especially many doctors) would find undesirable. As Ost has argued, there are some clear advantages to a less medicalised model.15 Not least of these advantages, is the fact that a more hands off approach might be seen to reinforce the voluntariness of the decision. Involuntary or non voluntary assisted suicide is more difficult to carry out than involuntary or non-voluntary euthanasia. With reference to the Oregon


13 With evidence of neglect, for example at Stafford Hospital, (see ‘Analysis: why can some care be so bad?’ at, http://www.bbc.co.uk/news/health-15288154 ), or even that certain institutions, such as Gosport Memorial hospital, operate a culture of euthanasia (see ‘No manslaughter charges for misconduct GP Jane Barton’ at, http://www.bbc.co.uk/news/uk-england-hampshire-11008943 ).

14 In chapter 5.

model, the less medicalised form of PAS available there is also more flexible, which enables the patient to die at a time and place of their choosing. Furthermore, it is interesting to note that once equipped with the means to die at home, approximately one third of PAS candidates in Oregon choose not to die by their own hand. Therefore, it seems reasonable to contend that for many people the availability of PAS might enhance their final months, via the potential to control one’s death, without actually necessitating an assisted death.

In Oregon we have seen how some of the concerns over the legalisation of PAS centred on the fact that poor uneducated people without health insurance might choose PAS as the only affordable option, and yet, the reverse has proved true. On this issue, the phenomenon of suicide tourism from the UK, with citizens travelling to Dignitas in Switzerland, seems to reflect what has occurred in Oregon, with more middle class people opting for assisted suicide. But while the UK experience might be driven at least in part by financial factors – it is very expensive to die at Dignitas – in Oregon the choice made by a greater number of wealthy and educated Americans compared to poorer less educated Americans appears not to be fiscally driven. In Oregon it seems that middle class people, having generally enjoyed greater levels of choice and self-determination during their lives, are less willing to surrender to the death that fate has in store for them. If it is true that people who have enjoyed greater levels of control of their life are more likely to seek to control death, and I would argue that this is indeed the case, then the phenomenon of comparably more middle class people seeking access to assisted dying would be likely to continue in the UK even if the current financial barrier to a professionally assisted suicide (in Switzerland) was removed. While I do not suggest that this is necessarily an argument either way in the debate about legalisation, it presents an interesting perspective, inviting speculation that if assisted dying was to be legalised, we would be more likely to see greater numbers of middle class (than less privileged) people seeking to die via PAS. This prediction accords with other sociological observations over assisted dying. For example, as Griffiths, Weyers and Adams have observed by reference to Inglehart’s work, in a post-materialist society (such as the

---

16 As I discussed in chapter 6, more educated middle class people in Oregon have died by PAS. See also Finlay and George (supra n.11).
17 There are of course other reasons, such as religion, and it may be that middle class Americans are less likely to be religious.
19 R Inglehart (The Silent Revolution, (1977) Princtown, NJ, Princtown University Press), who argued that there is a connection between prosperity and value orientation, such that people living without threat to their
Netherlands), individuals place increasing importance upon self-determination. While not all citizens in the UK are able to enjoy the benefits of post-materialism, the middle class are certainly in this position and are thus more likely to seek to control death. This observation might also be seen to reinforce the perspective that many people seeking PAS are empowered rather than vulnerable, although, as I discussed in chapter 6, such observations are subjective.

With respect to numbers, the evidence (discussed in chapter 6) adduced from the Netherlands and Oregon by the House of Lords Committee on the Assisted Dying for the Terminally Ill Bill is also very interesting.\(^{20}\) I suggest that such predictions, whilst speculative, provide compelling reason for caution over which forms of assisted dying might be legalised. Presuming that less is better in this context, the legalisation of PAS on a similar basis to Oregon would clearly therefore provide a solution with less impact than the legalisation of euthanasia.

### 7.4 The medical perspective

We should also consider the issue through the eyes of the medical profession. As I examined in chapter 1,\(^{21}\) many doctors reject the idea that assisted dying falls within the remit or scope of their professional function. While, as Jackson has discussed,\(^{22}\) there are aspects of this stance which are clearly anachronistic, other factors combine to support a cautious approach on this issue. With respect to the evidence that indicates that doctors are not generally supportive of legalising assisted dying, research from the Netherlands suggests that there are good reasons for such opposition. As we have seen, the burden placed upon doctors is onerous. Although any law which permitted assisted dying might easily provide a clause to shield the conscientious objector, for those who fall outside the realms of what might be thought of or described as ‘conscientiously objecting’, and even for those doctors who might support a patient’s right to die in this way, the effects of performing euthanasia can be

\(^{20}\) Recall that the HL predicted that replication of the Dutch model would lead to 13,000 deaths per year, in comparison to 650 if the Oregon model was replicated here.

\(^{21}\) I also raised this point in chapter 2, in relation to the opposition that many doctors might feel about actively ending the lives of patients in PVS.

psychologically difficult. Recall that assisted dying in the Netherlands is a very ‘hands-on’ matter for physicians. Even where PAS is chosen over euthanasia, the doctor is required to remain with the patient in case he or she needs a fatal injection to complete the dying process. It is possible that doctors prescribing a fatal dose for a patient to go home with the means to commit suicide (as they may in Switzerland and Oregon) might equally feel the weight of responsibility for the patient’s death. However, providing the means for a suicide in a more ‘hands-off’ sense must surely weigh less heavily than physically ending a life. With euthanasia, the responsibility for the patient’s death (as a causative agent) rests entirely with the doctor. With PAS, the responsibility is shared between doctor and patient and so while the doctor is burdened by the decision of whether to prescribe or not, the burden is less onerous and thus, one which doctors might more reasonably be asked – but not compelled – to carry. As the House of Lords have reported, evidence gathered from the medical profession suggests, ‘there would be rather less unhappiness about a law which is limited in its scope to assisted suicide.’ Moreover, in his evidence to the House of Lords Dr Wilks proposed that more doctors would support the legalisation of only PAS, saying that ‘there was a feeling of comfort that there is a partnership involved between the doctor and the patient as opposed to the doctor being the agent.’ This corresponds to my discussion in chapter 3, which showed that doctors are generally less opposed to PAS than to euthanasia.

7.5 A compromise in end-of-life care?

We have also seen that despite the evidence over inadequate care generally, as discussed above, many doctors would argue that advances in medicine have equipped health care professionals with the means to alleviate suffering without resorting to assisted dying or even

---

23 Evidence shows that the prescription given in the Netherlands for PAS is generally less potent than in other jurisdictions (Oregon, Switzerland) where it is legal. For example, in the Netherlands 9g of pentobarbital is generally prescribed for PAS, compared to 10-12g in Switzerland (see P Admiraal, B Chabot, RD Ogden, A Rietveld, J Glerum, Guide to a Humane Self-Chosen Death, (2006), The Wozz Foundation, Printed in the Netherlands by Macdonald/SSN.BV). Thus, whilst there is always the possibility that the patient will vomit up the drugs and survive, the possibility that an intervention will be necessary to end the life of the patient seems more probable in the Netherlands.

24 See House of Lords - Assisted Dying for the Terminally Ill Bill - first report, para.245.

25 Ibid.

26 Notwithstanding that they are generally opposed to all forms of PAD.
possible palliative death hastening. Chapter 3 explored the evidence, discussing how, despite the palliative evidence, a number of factors direct us to the conclusion that interventions such as the use of large doses of analgesic drugs to prevent suffering and the use of continuous deep sedation (CDS), occupy a realm somewhere in between PAD and palliation. Notwithstanding this tension, it seems clear that certain palliative interventions share some characteristics with euthanasia, so that patients seeking an early death to escape suffering might instead ask to be deeply sedated or heavily drugged with opioids, thus facilitating a compromise in the ongoing ‘power struggle’. As I discussed in chapter 3, although a hastened death via CDS does not necessarily accord with the need for dignity and control over one’s closing moments, for some people the option of a sedated death might provide an acceptable alternative to euthanasia. Equally, the knowledge that as death draws nearer one’s doctor might - subject to it being clinically indicated and intended only as a means of relieving pain - increase analgesia even at the risk of abbreviating life, may provide some comfort to those who fear the end. As Huxtable argues:

The compromiser should also be inclined to support a policy that sanctions the use of opioids and their like in terminal care, even when the drugs look likely to hasten death.28

Concerns over inappropriate death hastening at the hands of doctors like Bodkin Adams or Howard Martin should be addressed by an approach that prioritises consent in end-of-life care. Consequently, I suggest that some compromise and greater dialogue might pave the way for a solution that stops short of legalising euthanasia but nevertheless empowers patients to take greater control over the manner in which they die, albeit within the parameters of clinically indicated options. Such an approach would enhance autonomy despite not allowing patients to ‘demand’ an assisted death. Following the suggestions of Battin,29 I propose that people should be invited via their GP to compose a ‘personal end of life policy’. This would accord with recent attempts to enhance patient involvement in end-of-life decision making.30 Similarly, a recommendation made by the National Audit Office, following their investigation into end-of-life care, proposed that ‘PCTs should encourage

28 Supra, n.5, p.162.
29 MP Battin, supra n.5, p.40.
30 See for example, Recent GMC guidance refers to the advantages of advance care planning (see Treatment and Care Towards the End of Life: Good Practice in Decision making, (2010))
providers to develop care plans, including advance care plans, for those that wish to have one”.

For those unable to participate in decision making, questions over life and death decision making are particularly vexed. Chapter 2 explored the legal position in respect of patients such as Anthony Bland. On the one hand such patients seem to have the least to lose through death because there is an almost overwhelming consensus that such an existence is devoid of experience and incompatible with widely held perceptions of dignity. On the other hand, one of the most powerful arguments in favour of permitting euthanasia – the patient’s autonomous desire to escape terrible suffering – is not applicable to incompetent patients. In chapter 2 I suggested alternative approaches to the Bland legacy, with respect to adopting a rebuttable presumption that no one would consent to being maintained in PVS, or even, employing the doctrine of necessity as a better way through the moral maze. While both proposals have their own shortcomings, we cannot expect any answer to completely alleviate our ‘moral discomfort’ in ending a life, whether by act or omission. Such decisions are incredibly difficult and it is a moral imperative to seek to determine a more coherent approach.

7.6 Drawing a coherent legal line

As Mason and Laurie comment:

The greater part of the existing legislation – or the opposition to its adoption – is founded on attempts to legalise euthanasia or, put another way, to separate therapeutic killing from the offence of homicide. It would, surely, be easier to concentrate on the reverse possibility – that is to reconsider the offence of assisting suicide. In doing so, the authorities would not only be removing the goal-posts from the morally suspect ground of homicide but would also be respecting the principle of self-determination.

---

My analysis has led to the conclusion that Mason and Laurie are correct and furthermore, that there are sound reasons for advocating the legalisation of assisted suicide but not euthanasia. Of course, any moral or ethical difference between the two is subject to debate, but, there are nevertheless sound reasons for making a distinction. It also seems possible to accommodate the demands (for autonomy, the alleviation of suffering) of those arguing for legalisation by legalising PAS but not euthanasia. Even those, such as Dianne Pretty, with extremely restricted physical capability would be able, with assistance, to ingest the necessary drugs. While the Dutch perspective effectively advocates euthanasia as the easier route for the patient,34 there are arguably advantages in making such an irrevocable choice one which is not too easy. Moreover, if there is to be any legal assisted dying, a line needs to be drawn somewhere to delineate justifiable action from that which is unjustifiable. Thus, I contend that the present legal distinction between murder and assisted suicide presents a useful starting point for such a line. This is not simply drawing an arbitrary ‘line in the sand’.35 Admittedly, any line that is drawn might not be able to provide a boundary between the (morally) acceptable and unacceptable in a way that pleases everyone. Unlike the present legal position, however, it would at least determine a coherent, compassionate and rational stance that provides a clear legal position.

My suggested reform would involve the legalisation of PAS with a similar, yet more restrictive, approach than that which has been adopted in Oregon.36 Whilst there may be a number of routes to decriminalisation,37 I suggest that legislative reform would provide the most suitable and effective response as any legal change on such an important matter requires meticulous, precise and comprehensive provision. Briefly, I propose that PAS should be

36 My proposal would reflect the concerns of the HL First Report on the Assisted Dying for the Terminally Ill Bill (paras. 234-269), which suggested that Lord Joffe’s Bill required clauses regarding the nature of suffering (intractable or unrelievable) as well as a requirement for clinically defined ‘terminal’ illness, a waiting period between application and provision, proper psychiatric assessment and a provision regarding palliative care.
37 For example, simply amending the Suicide Act 1961 in order to provide an exception, as suggested by Mason and Laurie (see supra n.33, p.608, See also JK Mason and D Mulligan ‘Euthanasia by stages’ (1996) 347 Lancet 810). Or, retaining the general prohibition subject to a prospective prosecutorial grant of immunity, as proposed by P Lewis, R Brownsword and G Richardson in their submission to the commission on assisted dying, available at http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/07/Brownsword-Lewis-Richardson-Prospective-Legal-Immunity-and-Assistance-with-Dying.pdf Interestingly, Williams has considered the various options (see G Williams, Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide (2007) Routledge-Cavendish, p. 180-182).
permitted only for terminally ill, mentally competent adults who are suffering intractably, with no other satisfactory means of alleviating such suffering, and who are expected to die within 6 months. The question over what constitutes a ‘terminal’ illness would require careful consideration in order to agree a definition which avoids ambiguity. I suggest that any legal PAS should involve greater assessment than the Oregon model, with specialist psychiatric evaluation, as well as a second specialist opinion regarding prognosis and a provision for exploring the palliative alternatives. In the event that the clinical requirement conflicted with a professional’s religious or ethical beliefs, any law should contain a conscientious objection clause which would enable a doctor, nurse or pharmacist, for example, to decline to provide assistance.

As a non-essential, non-therapeutic and potentially costly option, PAS should arguably not be available within the NHS, although GPs should provide the starting point for the necessary referrals. Thus, patients would have to self-fund the requisite medical assessments and prescription, which would be accessible only after a period of reflection and a final medical assessment in order to assess mental capacity. This model would present a less medicalised model than, for example, that which is in operation in the Netherlands, and, by enabling access but not provision, the NHS would be distanced from legal PAS. This would alleviate or even resolve Battin’s concerns over institutional abuse. While legal PAS would clearly present a choice for those patients qualifying, it would not become a mainstream medical option and thus, I contend, would not burden patients with an ongoing choice over whether to live or die.  

Admittedly, this approach would present some inequity with regard to those without funds seeking PAS, but I anticipate that the cost of legal PAS within the jurisdiction would be far more affordable than a Swiss assisted suicide. It is also likely that groups such as Dignity in Dying, who currently campaign for legal change, might shift their focus to providing charitable support for those seeking PAS. Moreover, the cost would present a further obstacle which would serve to ensure that those applying for PAS were sufficiently determined to die. Finally, from a practical and political perspective, advocating a model which minimises the cost of legal PAS to the state would also perhaps enhance the chances of any such Bill being passed during a period of intense economic difficulty.

---

38 For a feminist perspective of the burden of such a choice see for example, K George, ‘A woman’s choice? The gendered risks of voluntary euthanasia and physician assisted suicide’ (2007), Medical Law Review, 15(1), 1-33.
With respect to questions over monitoring and reporting, a number of options are possible. I suggest that a system of prospective and retrospective formalities might be devised to monitor PAS. Interestingly, the idea of a tribunal to assess the patient’s application has been suggested. I would argue, however, that determining suitability for PAS via a tribunal is neither necessary nor appropriate. Clinical assessments should be left to physicians and the moral or ethical question, provided of course that the patient had satisfied the psychiatric assessment, should be left to the patient.

7.7 The advantages of legal PAS over current policy

One crucial advantage of legal PAS compared to current policy is that we might gain greater control over the phenomenon of assisted suicide. This links into concerns that people with insufficiently serious health problems or with mental health problems might not be protected by current policy. There are, as I discussed in chapter 5, conflicting arguments over who should be permitted to die. A potential problem with creating health-based limitations upon access to assisted suicide lies in the message it sends out to certain potentially vulnerable groups. By not identifying certain groups as potentially eligible, or at least less worthy of protection, current policy does not discriminate. However, despite providing legal equality, current policy is actually more likely to fail the truly vulnerable, such as those who choose death for objectively trivial health troubles. Moreover, without dismissing concerns that some terminally-ill people might feel disadvantaged by legalisation, we might question whether promoting theoretical equality is more important than devising a morally coherent approach to the question of when assisted suicide is justifiable. Permitting PAS only for the terminally ill at the end-of-life would not disadvantage the disabled or the seriously ill, and only those in the closing months of life would be eligible.

Currently, we have only the retrospective opportunity to assess the appropriateness of the suspect’s actions following the so-called victim’s death. Clearly, this fails to provide any pre-emptive system of control and scrutiny which might appraise the reasons for suicide and seek to limit access to assisted suicide. An inevitable consequence of turning a blind eye is a lack

39 See for example, my discussion of the systems in place in Oregon and the Netherlands in chapter 6.
of opportunity to offer possible alternatives or ensure, for example, proper psychiatric assessment and possible counselling. Evidently, legal PAS would provide opportunities to assess and protect potential victims and we might speculate that a significant number of those seeking an assisted suicide might be provided with alternative treatments which would deter them from seeking help in dying. What legalisation could not necessarily do is prevent people from taking matters into their own hands or travelling to Switzerland in order to obtain what is unavailable at home due to any legal model being restrictive. Moreover, if those unable to have legal PAS within the jurisdiction simply turn to other means to get what they want, a key argument of legalisation (gaining control and offering protection) is defeated. However, whereas the current approach offers little moral coherence by failing to determine exactly when assisting in suicide is acceptable, a legal model would at least differentiate between legally justified PAS and complicity which is not justified. For example, under my suggested reform, assisting in the suicide of a disabled person who is not terminally ill would not be justified. Thus, whereas Dianne Pretty would receive the help she wanted, Daniel James would not. This would reinforce a moral line even if after the event such complicity might be excused (but not justified), because there is no public interest in prosecuting.41

On the issue of prosecution policy following the legalisation of PAS, a more robust policy might be pursued on the grounds that ‘turning a blind eye’ is not an appropriate response in a jurisdiction where legal PAS is permissible. I am not suggesting that well-meaning relatives of people travelling to Dignitas to die (perhaps after being refused PAS within the jurisdiction) should necessarily face prosecution, but at least some prosecutions should be pursued in order for the question of liability to be determined by the courts. Moreover, in order to promote a more rational and coherent legal position, post-legalisation prosecutorial policy should reflect the fact that legal PAS is available within the jurisdiction for individuals for whom the law has allowed an exception to the general prohibition.

Returning to one of Debbie Purdy’s main arguments, with respect to the need to travel to Switzerland sooner than ideally desired because proper assistance is unavailable within the jurisdiction; legalisation would address this concern. Similarly, because ‘professional’

41 See for example Huxtable (supra n.5, pp.158-160), who has considered the distinction between justification and excuse, and J Coggon, ‘Prospective immunity for assisting a suicide? Legal technicalities, moralistic policies and real politics’, (in progress).
assistance is unavailable within the jurisdiction, the current law discriminates against those who are unable to make their own arrangements to travel abroad independently or obtain the means to commit suicide unaided. Moreover, those who do not have a friend or relative willing to assist, or who cannot afford the high cost are currently, depending on one’s view, either disadvantaged or protected. Accordingly, legal PAS within the jurisdiction would have a dual effect of allowing people to live longer with greater equality of access. Inevitably, legalisation would lead to more people gaining access to PAS than under the current policy, which, for some, is a key reason not to legalise. Without dismissing this concern, we should recognise that a legal model that restricted PAS to the terminally ill would not increase (total) deaths in all but the very short term. If only those who are imminently about to die are permitted PAS, these people would be almost certain to die anyway within days, weeks or, at the most, months of the date upon which they ended their lives via PAS. Clearly this observation might not satisfy those for whom the sanctity of life is a crucial reason not to legalise, but it should be recognised that the current legal position fails to say anything about the value of life other than that prosecution is highly unlikely where the assistor has acted compassionately. By contrast, in advocating a restrictive legal model that allows PAS only for the imminently terminal, some recognition that life has an intrinsic worth is reflected. Moreover, quality of life concerns would only supplant concerns over the intrinsic worth of life within a limited period, when the quantity of life remaining is in any case very limited.

It is thus argued that such legal reform would present a compromise which is far more satisfactory than the compromise currently provided by the policy of prohibition coupled with non-prosecution. While those in favour of legal assisted dying would gain some ground, restricted access to PAS would facilitate only a very limited ‘right to die’ for only those who are suffering unbearably in the later stages of terminal illness and so Harris, for example, would have to accept that autonomy does not rule on the issue of assisted dying. Those, such as Keown, who are set against legal change, should acknowledge that the current prohibition does not prevent assisted dying and so legislating in order to permit a restrictive

---

42 This was one of Dianne Pretty’s arguments, see chapter 4.
43 I referred to the work of John Harris, one of the most well known advocates of assisted dying, in chapter 1 (p.23) (e.g. The Value of Life (1985) London Routledge and Kegan Paul), in contrast to the work of John Keown, one of the most well known opponents of assisted dying (e.g. Euthanasia, Ethics and Public Policy: An Argument Against Legalisation (2002) Cambridge University Press).
44 Ibid.
form of PAS would serve to exert control and protect the vulnerable rather than simply turning a blind eye.

### 7.8 Reforming Homicide law

While I have argued that it is neither necessary nor desirable to legalise euthanasia, I agree with the numerous commentators who have suggested that the common law offence of murder is too blunt an instrument to provide an appropriate means of dealing with those who have killed for only merciful reasons. The current position, as I discussed in chapters 2 and 3, invites obfuscation and distortion. There is insufficient space here to consider the nature and scope of legal reform necessary except to say that a proposal considered by the Law Commission, advocating a possible partial defence to murder, would provide a useful starting point. People who kill for entirely merciful reasons, whether they are doctors (such as Dr Cox), mothers (such as Francis Inglis), or husbands (such as George Webb), should not be regarded in the same light as violent murderers. At the very least a partial defence to murder (other than diminished responsibility), which would reduce the offence to one of voluntary manslaughter, should distinguish between those who, albeit misguidedly, kill in compassion. Alternatively, a new offence might provide a more appropriate response. For example, in his consideration of the middle ground, Huxtable has suggested:

> In short, the compromiser should recognise euthanasia as a particular type of killing, which can be governed by a distinct offence of ‘mercy killing’ (or some other suitable synonym like ‘compassionate killing’) that will also operate as a partial defence to other homicide charges.

---

45 See for example, Williams’ discussion (supra n.37).
46 See, ‘Murder, Manslaughter and Infanticide, Project 6 of the Ninth Programme of Law Reform: Homicide’, (2006) Law Com No.304, London: Law Commission, in which the Commission suggested that those motivated by mercy should perhaps be treated more leniently than the current law allows. The Commission suggested that the government should undertake a consultation process to determine whether there should be a new offence of ‘mercy killing’, or whether ‘mercy’ should present a new partial defence to murder.
50 R Huxtable, supra n.5, p.165.
Reform to sentencing policy in order to remove the compulsory life sentence which murder carries might also provide a means to ameliorate the harshness of the current law.\textsuperscript{51} The possibility of such reform has been proffered on numerous occasions, and enjoys judicial support.\textsuperscript{52} However, political response to public concern that judicial discretion over sentencing would be inappropriately exercised seems to thwart any such reform. Consequently, the proposal to create a new offence or a partial defence to murder would seem to provide a more suitable solution by separating mercy killers from their malicious counterparts. As I discussed in chapters 4 and 5, compassion on the part of a person complicit in suicide is legally decisive, deterring any prosecution. Thus, it seems extremely unjust that the compassionate mercy-killer who is unable to demonstrate diminished responsibility will currently be prosecuted as a murderer with no account taken of either the victim’s request or the defendant’s motive.

7.9 Conclusion

A range of diverse legal, medical, ethical and circumstantial factors in this context have combined to present a legal position which might generally produce the desired (or least worst) consequence, but will rarely do so in a rational, coherent or transparent way. While a degree of fudging in the medical context will occasionally be what the patient wants, the majority of patients would rather participate in medical decision making. In view of the societal developments I have discussed, the growing need to self-direct death seems likely to continue. Thus, end-of-life care and life and death decision making, whether or not it abbreviates life, should better reflect what the patient wants and not what the doctor - or even the doctor and the judge - think the patient deserves. The approach I have advocated would enhance patient autonomy but not at the expense of legitimate competing concerns.

The most crucial arguments in favour of reforming the law, self-determination and mercy/compassion, have, via the House of Lords decision in Purdy and the resulting prosecutorial policy been recognised as legally determinative on the issue of assisted suicide.

\textsuperscript{51} For example, a recent group of lawyers, judges and academics formed the ‘Homicide Review Advisory Group’, in order to review the law and sentencing policy. They have recommended discretionary sentencing powers particularly where mercy killers are concerned. See http://www.bbc.co.uk/news/uk-16044145
\textsuperscript{52} For example, see ‘Lord Chief Justice urges free vote on murder reform’, at http://www.bbc.co.uk/news/uk-16048082
Those calling for formal legal change may, for the time being at least, have to satisfy themselves with the knowledge that some of their demands have been met. Those opposed to legal change should recognise that the prohibition has become largely illusory and achieves little in the way of either upholding sanctity principles or protecting the vulnerable. Ultimately, the ongoing tide of suicide tourists together with legal challenges seeking to establish greater rights of self-determination under Article 8 of the ECHR, are likely to compel Parliament to reconsider its position. Other seemingly intractable moral dilemmas, such as abortion or embryo research, have been resolved, or at least moved forward by legal change,53 and it can only be a matter of time before we can say the same about physician-assisted suicide.

Bibliography

Books and Articles


BENJAMIN, M, Splitting the Difference:Compromise and Integrity in Ethics and Politics, University Press of Kansas 1990.


GARBUJT, G, DAVIES, P, ‘Should the practice of medicine be a deontological or utilitarian enterprise?’ (2011) 37 Journal of Medical Ethics, 267.


OTLOWSKI, M, Voluntary Euthanasia and the Common Law (1997), Oxford University Press.


PRICE, D, ‘Euthanasia, pain relief and double effect’ (1997) 17(2) Legal Studies, 323-342,


SMITH, S, ‘Evidence for the practical slippery slope in the debate on physician-assisted suicide and euthanasia’, Medical Law Review (2005), 13(1), 17-44,


Reports, Guidance, Policies and Consultation Documents


House of Commons; the Adjournment debate in the House of Commons on January 29, 1951 (Hansard, HC vol.483, col. 679, paras 681-682).

House of Lords Select Committee on Medical Ethics, Report, HL Paper 21-I (Session 1993-1994) [20].

House of Lords, Assisted Dying for the Terminally Ill Committee, Assisted Dying for the Terminally Ill Bill – First Report (2005), 42.


National Audit Office report, End of Life Care, 2008. Ordered by the House of Commons, HC 1043


Policy for Prosecutors in respect of cases of encouraging or assisting suicide, available at http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

‘Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide Issued by the Director of Public Prosecutions Summary of Responses’, at section 3 (New Factors Identified in favour of Prosecution). Available at www.cps.gov.uk


*The Practice Statement (Judicial Precedent)* [1966] 3 All ER 77.

*Treatment and Care Towards the End of Life: Good Practice in Decision-Making* (GMC: London, Aug 2010)


**Newspaper and Online Reports**

1. **BBC Reports**


‘CPS defends charging Gilderdale over ME daughter death’, at www.news.bbc.co.uk/1/hi/England/sussex/8481055.stm

‘Euthanasia doctor is struck off’, at http://news.bbc.co.uk/1/hi/health/4286470.stm
‘Fatal overdose GP is struck off’, at http://news.bbc.co.uk/1/hi/england/cumbria/8256145.stm

‘Fighting for the right to die’, at http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/332464.stm

‘Legal battle over ‘right to die’’, at http://news.bbc.co.uk/1/hi/health/6353339.stm

‘No assisted suicide charge for son of Sir Edward Downes’, at www.news.bbc.co.uk/1/hi/englan/london/8576218.stm


‘Poll support for mercy killings’, at http://news.bbc.co.uk/1/hi/uk/8489744.stm

‘RCN neutral on assisted suicide’, at www.news.bbc.co.uk/1/hi/health/8167455.stm

‘Surrey right to die campaigner seeks day in court’, at http://news.bbc.co.uk/1/hi/england/8648703.stm

‘Swiss vote to continue assisted suicide’, at http://www.bbc.co.uk/news/health-13410228

‘Why baby boomers want the ultimate freedom’, at http://www.bbc.co.uk/news/magazine-11550760
2. Newspaper Reports

‘British woman takes own life at Dignitas because she did not want to die of old age’ *The Telegraph*, 3 April 2011.


‘Do not go gentle... into legalised assisted suicide’, *The Telegraph*, 8 April 2010.


‘‘Dr Death’ Philip Nitschke reveals secrets of a peaceful exit’, *The Times*, May 6 2009.

‘Dr Death’ sells euthanasia kits in UK for £35’ *The Observer*, March 29 2009.

‘‘Dr Death’ escapes prosecution over Dignitas suicide because of his age’ *The Telegraph*, June 26, 2010.

‘‘Dr Death’ Philip Nitschke reveals secrets of a peaceful exit’, *The Times*, May 6 2009.

‘Euthanasia cases in Holland rise by 13 per cent in a year’ *The telegraph*, 20 June 2010.

‘I botched our suicide pact’, *The Sunday Times*, November 1 2009, at http://www.timesonline.co.uk/tol/news/uk/article6897964.ece

‘Judge rejects family’s right to die case’, *The Telegraph*, 29 September 2011, at http://www.telegraph.co.uk/health/healthnews/8794013/Judge-rejects-familys-right-to-die


‘Man in assisted suicide case spells out why he wants to be helped to die’, *The Guardian*, August 18 2011.


‘No miracle as brain-damaged patient proved unable to communicate’, *The Guardian*, available at [www.guardian.co.uk/world/2010/feb/19/miracle-patient-facilitated-communication](http://www.guardian.co.uk/world/2010/feb/19/miracle-patient-facilitated-communication)


‘Suicide woman allowed to die because doctors feared saving her would be an assault’, *The Telegraph*, 30 September 2009, at [http://www.telegraph.co.uk/health/6248646/Suicide-woman-allowed-to-die-because-doctors-feared-saving-her-would-be-assault.html](http://www.telegraph.co.uk/health/6248646/Suicide-woman-allowed-to-die-because-doctors-feared-saving-her-would-be-assault.html)


3. **Other Reports**


CASES


A Local Authority v Z (An Adult: Capacity) [2004] E.W.H.C. 2817 (fam), [2005] 3All E.R. 280

An NHS Trust A v M; An NHS Trust B v H [2001] 1 All ER 801.

Attorney General v Able and others [1984] All ER 277, [1984] QB 795 (QBD)


B v NHS Hospital Trust [2002] 2 All ER 449

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Bolitho v City and Hackney HA [1997] 4 All ER 771

Chabot, Nederlandse Jurisprudentie 1994 No.656, Supreme Court.

F v West Berkshire Area Health Authority, [1990] 2 AC 1


Herczegfalvy v Austria (1992) 15 EHRR 437 at para.89


London Borough of Southwark v Williams [1971] CH 734


R v Adams [1957] Crim LR 365

R v Adomako [1995] 1 AC 1

R v Bourne [1939] 1 KB 687

R v Brown [1994] 1 AC 212


R v Dudley and Stephens (1884) 14 Q.B.D. 273

R v Gibbins and Proctor (1918) 13 Cr App Rep 134.

R v Gilderdale, unreported

R v Hancock, [1986] Crim L R 180

R v Hough (1984) 6 Cr App R(S) 406

R v Howe [1987] AC 417

R v Inglis, unreported

R v Irwin (1977) 66 Cr App Rep 97, Court of Appeal, Criminal Division.

R v Lawson, The Times, 9 June 2007

R v Mcshane (1977) 66 Cr App Rep 97, Court of Appeal, Criminal Division.


R v Nedrick [1986] 3 All ER 1

R v Prentice [1993] 4 All ER 935, CA

R v Stone and Dobinson [1977] 2 All ER 341, CA.


R v Watts [1998] Crim LR 833


R (Burke) v General Medical Council [2005] 3 FCR 169.
Re C [1994] 1 All ER 819

Re G [1995] 2 FLR 528

Re Jobes 529 A.2d 434, 456.

R (On the Application of Dianne Pretty) v DPP (2001) WL 1171775 (HC); WL 1423045 (HL); Pretty v UK (ECtHR)(2002) 35 EHRR 1


Re Quinlan (1976) NJ 355 A 2d 647

Re S (Adult Patient: Sterilisation) [2000] 3 WLR 1288

Re T (Adult: Refusal of Treatment) [1993] Fam 95

Re Y (Mental Patient: Bone Marrow Donation), [1997]Fam 110

R v Shaylor [2001] 1 WLR 2206 (CA Crim.div.)

Re Wyatt (A Child) (Medical Treatment: Parent’s Consent), [2004] EWHC 2247 (Fam).

Schellekens, LJN: B15890, Rechtbank Almelo, 08/750709-07.


Sutorius, Nederlandse Jurisprudentie 2003, no 167.

Vacco v Quill 117 SCt 2293 (1997).

Van Oijen (Court of Appeals, Amsterdam, AF9392 no 23-000166-02.)

Washington et al. v Glucksberg 117 SCt 2258 (1997)

Wilsher v Essex Area Health Authority [1986] 3 All ER 801, CA.
LEGISLATION

Abortion Act 1967
Coroners and Justice Act 2009
Criminal Justice Act 2003
Homicide Act 1957
Human Fertilisation and Embryology Act 1990
Human Rights Act 1998
Hunting Act 2004
Mental Capacity Act 2005
Offences Against the Person Act 1861
Prosecution of Offences Act 1985
Suicide Act 1961
The Oregon Death with Dignity Act 1994
The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (translated from Dutch)
Appendix 1

Mullock, A, ‘Prosecutors Making (Bad) Law?’

*Medical Law Review*, 17, Summer 2009, 290-299.
Appendix 2

Mullock, A ‘Overlooking the Criminally Compassionate: What are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?’ Medical Law Review, 18, Winter 2010, 442-470
Appendix 3