Assisted suicide

Under the *Suicide Act 1961* it is an offence for one person to assist encourage or assist the suicide (or attempted suicide) of another. Suicide or attempted suicide are not in themselves criminal offences.

There have been several legal cases regarding the offence of assisted suicide, particularly in the context of disabled or terminally ill people who are unable to end their lives without assistance from family or friends.

Of particular importance is the case of Debbie Purdy, who in July 2009 obtained a House of Lords ruling ordering the Director of Public Prosecutions to formulate an offence-specific policy setting out the public interest factors the Crown Prosecution Service will consider when deciding whether to prosecute assisted suicide offences. The DPP’s policy was published in February 2010 following a public consultation.

In June 2014 the Supreme Court revisited the issue in the cases of Tony Nicklinson, Paul Lamb and AM, who were seeking a declaration that the current law on assisted suicide was incompatible with their right to a private life under Article 8 of the European Convention on Human Rights. The Supreme Court decided against making such a declaration by a majority of seven to two. It took the view that Parliament was the most appropriate forum for considering changes to the law on this particular issue.

The House of Lords is currently considering the *Assisted Dying Bill*, a Private Member’s Bill introduced by Lord Falconer of Thoroton. The Bill aims to enable competent adults who are terminally ill to be allowed assistance with ending their life if they request it. There was general consensus among those who spoke in the Second Reading debate – whether for or against the Bill – that Parliament needed to properly address the issue following the Supreme Court’s judgment in Nicklinson and that the Bill should proceed to Committee for detailed consideration. The Bill was therefore given its Second Reading without division.

The Government has indicated that it considers this issue to be a matter of individual conscience.

This information is provided to Members of Parliament in support of their parliamentary duties and is not intended to address the specific circumstances of any particular individual. It should not be relied upon as being up to date; the law or policies may have changed since it was last updated; and it should not be relied upon as legal or professional advice or as a substitute for it. A suitably qualified professional should be consulted if specific advice or information is required.

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1 The Suicide Act 1961

Until 1961 it was a criminal offence to commit, or attempt to commit suicide; however, section 1 of the Suicide Act 1961 provided that “the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated”. Accordingly, committing suicide ceased to be a crime, as did attempting to commit suicide.

However, section 2(1) of the 1961 Act, which is still on the statute book (as amended by the Coroners and Justice Act 2009), provides:

2 Criminal liability for complicity in another’s suicide

(1) A person (“D”) commits an offence if –

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D’s act was intended to encourage or assist suicide or an attempt at suicide.¹

Although suicide (or attempted suicide) itself is no longer an offence, it therefore remains an offence for a third party to encourage or assist a suicide or attempted suicide. Any proceedings under section 2(1) can only be brought by or with the consent of the Director of Public Prosecutions (DPP).²

In March 2014 the Crown Prosecution Service (CPS) published details of the number of assisted suicide cases it had considered since 2009:

From 1 April 2009 up to 13 February 2014, there have been 91 cases referred to the CPS by the police that have been recorded as assisted suicide or euthanasia.

Of these 91 cases, 65 were not proceeded with by the CPS. 13 cases were withdrawn by the police.

There are currently 8 ongoing cases. 1 case of assisted attempted suicide was successfully prosecuted in October 2013 and 4 cases were referred onwards for prosecution for murder or serious assault.³

An overview of the legal position in other selected jurisdictions (Switzerland, Oregon and Scotland) is set out in the Appendix to this note.

2 Cases on assisted suicide

2.1 Dianne Pretty (2002)

Dianne Pretty suffered from motor neurone disease; she wished to end her own life but was unable to do so without help. She unsuccessfully sought an undertaking from the DPP that,

¹ For background on the changes made to the original wording of the 1961 Act by the Coroners and Justice Act 2009, see Ministry of Justice Circular 2010/03, Encouraging or Assisting Suicide: Implementation of Section 59 of the Coroners and Justice Act 2009, and Library Research Papers 09/06, Coroners and Justice Bill: Crime and Data Protection, and 09/27 Coroners and Justice Bill: Committee Stage Report.
² s2(4) Suicide Act 1961
³ CPS website, Assisted suicide: latest assisted suicide figures, 1 March 2014. For details of the one successful prosecution, please see CPS news release, Kevin Howe convicted of assisted attempted suicide, 12 September 2013
if her husband aided her, he would not be prosecuted. She made the following claims relating to the European Convention on Human Rights (the ECHR):

- article 2 protected a right to self-determination, entitling her to commit suicide with assistance;
- failure to alleviate her suffering by refusal of the undertaking amounted to inhuman and degrading treatment proscribed by article 3;
- her rights to privacy and freedom of conscience under articles 8 and 9 were being infringed without justification; and
- she had suffered discrimination in breach of article 14, since an able-bodied person might exercise the right to suicide whereas her incapacities prevented her doing so without assistance.

The House of Lords unanimously dismissed her appeal, finding that article 2 could not be interpreted as conferring a right to self-determination in relation to life and death and assistance in choosing death. The DPP also had no power to undertake that a crime yet to be committed should be immune from prosecution, as the executive was unable to dispense with or suspend laws without parliamentary consent.4

Five months later, the European Court of Human Rights ruled unanimously that neither the blanket ban on assisted suicide nor the DPP’s refusal to give an advance undertaking that no prosecution would be brought against Mrs Pretty’s husband violated the ECHR.5 Less than two weeks after that, in May 2002, Mrs Pretty died in a hospice.6

2.2 Daniel James (2008)

As a result of injury during rugby training, 23 year old Daniel James lost the use of his body from the chest down. He ended his life at the Dignitas clinic in September 2008. His parents had assisted him to send documentation to Dignitas, made payments to Dignitas from their joint bank account, made travel arrangements to take him to Switzerland and accompanied him on the flight. In December 2008, the DPP announced that, while there was sufficient evidence for a realistic prospect of conviction of the parents (and a family friend who had assisted with travel arrangements), such a prosecution was not in the public interest and no further action should be taken against them.7

The DPP published his full decision on the CPS website. This was the first time that the full reasoning behind a decision not to prosecute an assisted suicide offence had been made public.8

2.3 Debbie Purdy (2009)

Debbie Purdy suffers from multiple sclerosis, for which there is no known cure, and she is confined to a wheelchair. She has said that when her condition becomes unbearable, she hopes to end her own life. Her husband has said he is willing to help her and, if necessary,

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4 Pretty v DPP and Secretary of State for the Home Department [2001] UKHL 61
5 Pretty v United Kingdom 2346/02 [2002] ECHR 427
6 “Diane Pretty dies”, BBC News website, 12 May 2002
7 CPS press release, No charges following death by suicide of Daniel James, 9 December 2008
8 CPS/DPP, Decision On Prosecution - The Death By Suicide Of Daniel James, 9 December 2008
face a prison sentence; however, she has said that she is not prepared to put him in that position.

In contrast to Diane Pretty, she did not bring legal action to seek immunity from prosecution for her husband. Instead, she sought a declaration that the DPP should be required to publish an offence-specific policy outlining the circumstances in which a prosecution under s2(1) of the 1961 Act would or would not be appropriate.

Judgment was delivered on 29 October 2008. Lord Justice Scott Baker emphasized that the case was not about whether it should continue to be a criminal offence in this country to help another person, whatever the circumstances, to take their own life: that was a matter for Parliament and not the courts. Nor was it about whether someone could obtain in advance immunity from prosecution for helping another person to travel to another country where assisted suicide is lawful, for the purpose of an assisted suicide: that question had already been decided in the negative by the House of Lords in the case of Diane Pretty.

The court held that Article 8(1) of the ECHR (the right to private and family life) was not engaged. The Article 8(1) guarantee only prohibited interference in the way a person lived their life, not on how they wished to die. However, even if it had been engaged, any interference with the right by the operation of s2 of the 1961 Act would be lawful, as the combination of the Code for Crown Prosecutors and the administrative law principles and remedies developed under the common law satisfied the ECHR’s standards of clarity and foreseeability. There were special reasons why the DPP had produced specific codes for other types of offences, such as domestic and football-related crime, which concerned a particularly prevalent social problem and were more easily identifiable, whereas the number of cases of assisting suicide was not large.

Ms Purdy appealed to the Court of Appeal, but on 19 February 2009 her appeal was dismissed. In a sympathetic judgment, the Lord Chief Justice referred to her “terrible predicament”, the “distressingly stark” facts of her case and the “impossible dilemma” facing the couple.

A further appeal to the House of Lords followed. On 30 July 2009, the House of Lords allowed Ms Purdy’s appeal. Departing from its previous decision in the Diane Pretty case, the House of Lords considered that the right to respect for private life under article 8(1) was engaged in Ms Purdy’s case. In the lead judgment, Lord Hope went on to consider article 8(2), and the requirement that any interference with the right to respect for private life be “in accordance with the law”:

40. The Convention principle of legality requires the court to address itself to three distinct questions. The first is whether there is a legal basis in domestic law for the restriction. The second is whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his actions so that he can regulate his conduct without breaking the law. The third is whether, assuming those two requirements are satisfied, it is nevertheless open to the criticism that it is being applied in a way that is arbitrary because, for example, it has been resorted to in bad faith or in a way that is not proportionate. (…)

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9 R v DPP ex p Purdy [2008] EWHC 2565 (Admin)
10 R v DPP ex p Purdy [2009] EWCA Civ 92
41. (...) So far as it goes, section 2(1) of the 1961 Act satisfies all these requirements. It is plain from its wording that a person who aid, abets, counsels or procures the suicide of another is guilty of criminal conduct. It does not provide for any exceptions. It is not difficult to see that the actions which Mr Puente will need to take in this jurisdiction in support of Ms Purdy’s desire to travel to another country where assisted suicide is lawful will be likely to fall into the proscribed category.

42. The issue that Ms Purdy raises however is directed not to section 2(1) of the Act, but to section 2(4) and to the way in which the Director can be expected to exercise the discretion which he is given by that subsection whether or not to consent to her husband’s prosecution if he assists her.

43. This is where the requirement that the law should be formulated with sufficient precision to enable the individual, if need be with appropriate advice, to regulate his conduct is brought into focus in this case.11

Lord Hope set out the steps that the DPP had already taken “to provide a measure of consistency” when deciding whether to prosecute assisted suicide offences. One of these was the Code for Crown Prosecutors, issued under section 10 of the Prosecution of Offences Act 1985, which sets out the general principles to be applied by the CPS in determining whether to institute proceedings for an offence. However, the Code applies to criminal offences in general, rather than assisted suicide cases in particular. Lord Hope drew attention to the fact that in the Daniel James case the DPP himself had decided that “many of the factors identified in the Code in favour or against a prosecution do not really apply in this case”. Other steps were also highlighted, for example the creation of a “Special Crimes Division” within the CPS and the publication of the DPP’s decision in the Daniel James case. Counsel for the DPP submitted that, taking these steps together, there was now sufficient guidance available as to how decisions were likely to be taken in assisted suicide cases.

The House of Lords, however, stated that “these developments fall short of what is needed to satisfy the Convention tests of accessibility and foreseeability”.12 It therefore ordered the DPP to:

...promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy’s case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.13

It is worth emphasising that the judgment did not legalise assisted suicide, nor did the Law Lords express any views on whether Parliament should do so.14

2.4 Tony Nicklinson, Paul Lamb and AM (2014)

Tony Nicklinson suffered a stroke in 2005 which left him suffering with ‘locked in’ syndrome. His condition was not life threatening and he had a reasonable expectation of living for many years. In 2007 he expressed a desire to end his own life but would only have been able to do so by refusing all food and liquids. He wanted a doctor to help him end his life by giving him a lethal injection, but if necessary he was prepared to kill himself using a machine invented by a Dr Nitschke (which would have been loaded with a lethal drug and activated by Mr Nicklinson via an eye blink computer). However, any doctor actively injecting Mr

11 Ibid, at paras 40-43
12 Ibid, at para 53
13 R v DPP ex p Purdy [2009] UKHL 45 at para 56
14 Ibid, at para 26
Nicklinson would have been open to a charge of murder, and anyone assisting him to commit suicide would have been liable to charges under s2(1) of the Suicide Act 1961.

Mr Nicklinson applied to the High Court for a declaration that a doctor who injected him with a lethal drug or who assisted him in terminating his own life would be able to make use of the defence of “necessity” and so would not be liable to criminal charges. The defence of necessity says that an act which would otherwise be a crime may (in very limited circumstances) be excused where it was done to avoid a greater evil: “the evil represented by committing the offence is outweighed by the greater evil which would ensue if the offence were not to be committed”.  

If the first declaration was refused, Mr Nicklinson sought an alternative declaration that the current state of the law on murder and assisted suicide was incompatible with his right to a private life under Article 8 of the ECHR.

Alongside Mr Nicklinson’s case the court also considered the case of another man, referred to as Martin, who is virtually unable to move following a brain stem stroke. He would be capable of physically assisted suicide and wishes to travel to Dignitas to undertake this. His wife, a nurse, is not prepared to help him achieve this, although she would wish to be with him to provide comfort if he were to succeed in his purpose with the help of others. Martin therefore sought a declaration that the DPP should clarify his policy on prosecuting cases of assisted suicide so that other people with no personal connection to him who might be willing to help on compassionate grounds – for example members of the public, health professionals or solicitors – would know whether they were more likely to face prosecution than not.

The High Court refused Mr Nicklinson both forms of relief. He died six days later from pneumonia, having refused food following the judgment. It also refused Martin’s application. Lord Justice Toulson said:

To do as Tony wants, the court would be making a major change in the law. To do as Martin wants, the court would be compelling the DPP to go beyond his established legal role. These are not things which the court should do. It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. Under our system of government these are matters for Parliament to decide, representing society as a whole, after Parliamentary scrutiny, and not for the court on the facts of an individual case or cases. For those reasons I would refuse these applications for judicial review.

Mr Nicklinson’s widow was added as a party to the proceedings and pursued an appeal to the Court of Appeal. Paul Lamb, another man with locked in syndrome, was added as a claimant in the Court of Appeal. Martin also appealed.

The Court of Appeal dismissed the Nicklinson/Lamb appeal but Martin’s appeal was partially successful. In relation to the first appeal, it reiterated the views of the High Court:

The repeated mantra that, if the law is to be changed, it must be changed by Parliament, does not demonstrate judicial abnegation of our responsibilities, but rather highlights fundamental constitutional principles.

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15 Blackstone’s Criminal Practice, 2014 edition, para A3.47
16 R on the application of Tony Nicklinson v Ministry of Justice [2012] EWHC 2381
17 The Guardian, Tony Nicklinson dies six days after losing ‘right to die’ case, 22 August 2012
18 R on the application of Tony Nicklinson v Ministry of Justice [2012] EWHC 2381, at para 150
19 R on the application of Nicklinson and Lamb v Ministry of Justice [2013] EWCA Civ 961
In relation to Martin’s appeal, the Court of Appeal ruled (by a majority of two to one) that the DPP’s policy was insufficiently clear regarding what it referred to as “class 2” helpers, being persons with no close or emotional connection to the person seeking assistance with suicide.21 The Master of the Rolls and Lord Justice Elias said:

In our view, the Policy should give some indication of the weight that the DPP accords to the fact that the helper was acting in his or her capacity as a healthcare professional and the victim was in his or her care. In short, we accept the submission of Mr Havers [counsel for Martin] that the Policy does not provide medical doctors and other professionals with the kind of steer in class 2 cases that it provides to relatives and close friends acting out of compassion in class 1 cases.22

In a dissenting judgment, the Lord Chief Justice said he would have dismissed Martin’s appeal in its entirety. He said that there was a “clear demarcation” between responsibility for the processes leading to the decision to prosecute, which lies with the DPP alone, and the process of the court, to which the DPP is subject, and that this should not be blurred. He added:

With great respect, we cannot keep ordering and re-ordering the DPP to issue fresh guidelines to cover each new situation. Prosecutorial Policy decisions must remain fact specific and certainty about the Policy which can be no more than indicative of the eventual decision if a crime is committed is not to be equated with the certainty required of provisions which create or identify criminal offences.23

Mrs Nicklinson and Mr Lamb appealed to the Supreme Court. The DPP appealed against the Court of Appeal’s majority ruling in Martin’s case, and Martin cross-appealed against the Court of Appeal’s dismissal of the remainder of his application.

The cases were heard together in December 2013 by nine Justices and judgment was handed down on 25 June 2014.24 A press summary is also available.25 The Supreme Court dismissed the Nicklinson/Lamb appeal by a majority of seven to two. The Justices were divided as to whether the Supreme Court had the constitutional authority to make a declaration that the current law on assisted suicide is incompatible with Article 8, or whether this should be left to Parliament. The Justices were also divided as to whether such a declaration should in fact be made.

Three Justices (Lord Neuberger, Lord Mance and Lord Wilson) held that the Supreme Court had the constitutional authority to make a declaration of incompatibility, but should not do so in this particular case. In relation to authority, Lord Neuberger said:

The interference with Applicants’ article 8 rights is grave, the arguments in favour of the current law are by no means overwhelming, the present official attitude to assisted suicide seems in practice to come close to tolerating it in certain situations, the appeal raises issues similar to those which the courts have determined under the common law, the rational connection between the aim and effect of section 2 is fairly weak, and

21 Ibid, at para 154
22 As compared to “class 1” helpers, being friends or family with emotional ties to the person seeking assistance who act in good faith out of compassion
23 Ibid, at para 179
24 R on the application of Nicklinson and Lamb v Ministry of Justice [2014] UKSC 38
25 Supreme Court, Press Summary: R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant) [2014] UKSC 38 On appeal from [2013] EWCA Civ 961, 25 June 2014
In relation to whether such a declaration ought to in fact be made, all three Justices considered that Parliament should instead be given the opportunity to consider the issue first. Lord Neuberger said there were four reasons why it would be “institutionally inappropriate at this juncture” for the Supreme Court to issue a declaration of incompatibility before giving Parliament the opportunity to consider the position:

First, the question whether the provisions of section 2 should be modified raises a difficult, controversial and sensitive issue, with moral and religious dimensions, which undoubtedly justifies a relatively cautious approach from the courts. Secondly, this is not a case where the incompatibility is simple to identify and simple to cure: whether, and if so how, to amend section 2 would require much anxious consideration from the legislature; this also suggests that the courts should, as it were, take matters relatively slowly. Thirdly, section 2 has, as mentioned above, been considered on a number of occasions in Parliament, and it is currently due to be debated in the House of Lords in the near future; so this is a case where the legislature is and has been actively considering the issue. Fourthly, less than thirteen years ago, the House of Lords in Pretty v DPP gave Parliament to understand that a declaration of incompatibility in relation to section 2 would be inappropriate, a view reinforced by the conclusions reached by the Divisional Court and the Court of Appeal in this case: a declaration of incompatibility on this appeal would represent an unheralded volte-face.27

Four Justices (Lord Sumption, Lord Hughes, Lord Reed and Lord Clarke) held that the Supreme Court should defer to Parliament on this matter given the issues involved. It would therefore be inappropriate to consider the question of whether to grant a declaration of incompatibility. Lord Sumption said:

…the social and moral dimensions of the issue, its inherent difficulty, and the fact that there is much to be said on both sides make Parliament the proper organ for deciding it. If it were possible to say that Parliament had abdicated the task of addressing the question at all, so that none of the constitutional organs of the state had determined where the United Kingdom stood on the question, other considerations might at least arguably arise. As matters stand, I think it is clear that Parliament has determined for the time being the law should remain as it is.

(...) In my opinion, the issue is an inherently legislative issue for Parliament, as the representative body in our constitution, to decide. The question what procedures might be available for mitigating the indirect consequences of legalising assisted suicide, what risks such procedures would entail, and whether those risks are acceptable, are not matters which under our constitution a court should decide.28

Only Lady Hale and Lord Kerr concluded that the Supreme Court both had the authority to make a declaration of incompatibility and should in fact do so in this case. Lady Hale said:

...I have reached the firm conclusion that our law is not compatible with the Convention rights. Having reached that conclusion, I see little to be gained, and much to be lost, by refraining from making a declaration of incompatibility. Parliament is then free to cure

26 Ibid, at para 111
27 Ibid, at para 116
28 Ibid, at paras 233-4
that incompatibility, either by a remedial order under section 10 of the Act or (more probably in a case of this importance and sensitivity) by Act of Parliament, or to do nothing. It may do nothing, either because it does not share our view that the present law is incompatible, or because, as a sovereign Parliament, it considers an incompatible law preferable to any alternative.

Why then is the present law incompatible? Not because it contains a general prohibition on assisting or encouraging suicide, but because it fails to admit of any exceptions.”

In Martin’s case, the nine Justices unanimously allowed the DPP’s appeal and dismissed Martin’s cross-appeal:

It is one thing for the court to decide that the DPP must publish a policy, and quite another for the court to dictate what should be in that policy. The exercise of judgment by the DPP, the variety of relevant factors, and the need to vary the weight to be attached to them according to the circumstances of each individual case, are all proper and constitutionally necessary features of the system of prosecution in the public interest.

3 The DPP’s policy for prosecuting cases of assisted suicide

Following the House of Lords judgment in the Debbie Purdy case, the DPP indicated that an interim policy would be published by the end of September 2009. Given the sensitivity of the subject, and in the absence of a legislative framework, he also said that the CPS would undertake a full public consultation before publishing a final policy in spring 2010.

3.1 The interim policy and public consultation

On 23 September 2009, the DPP published an interim policy setting out the factors he would take into account when deciding whether to prosecute assisted suicide cases. He emphasised that the interim policy did not provide any guarantees against prosecution, nor did it legalise assisted suicide or euthanasia. The interim policy took immediate effect and applied to all cases of assisted suicide that were ongoing between 23 September 2009 and the publication of the final policy on 25 February 2010.

On the same day that the interim policy was issued, the CPS also launched a public consultation seeking views on the public interest factors for and against prosecuting assisted suicide offences. Consultation respondents were asked to indicate whether they agreed with the factors identified in the interim policy, whether any additional factors should be included and whether the weighting of factors was appropriate.

The consultation closed on 16 December 2009. A summary of responses was published on 25 February 2010, together with the final policy. The consultation received a total of 4,710 responses, of which nearly 4,000 came from individual members of the public. Other

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29 Ibid, at paras 300-1
30 Supreme Court, Press Summary: R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant) [2014] UKSC 38  On appeal from [2013] EWCA Civ 961, 25 June 2014
31 CPS press release, CPS statement on Debbie Purdy, 30 July 2009
32 CPS, Interim Policy for Prosecutors in respect of Cases of Assisted Suicide, September 2009
33 CPS press release, DPP publishes interim policy on prosecuting assisted suicide, 23 September 2009
34 CPS website, A public consultation on the DPP’s interim policy for prosecutors on assisted suicide [accessed 20 August 2014]
35 CPS, Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide: Summary of Responses, February 2010
respondents included healthcare professionals, faith representatives, academics, lawyers, politicians and over 100 organisations.\textsuperscript{36}

For an overview of the changes that were made to the interim policy as a result of the consultation, please see CPS, \textit{DPP's Introductory Remarks on Assisted Suicide Policy}, 25 February 2010.

3.2 The final policy

The final policy was published (and took effect) on 25 February 2010. It emphasises that the act of suicide requires the victim to take his or her own life: it is murder or manslaughter for a person to do an act that ends the life of another, even if this is at the latter's express wish.\textsuperscript{37}

The public interest factors tending \textbf{in favour} of a prosecution are as follows:

(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 or attempt 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

\textsuperscript{36} CPS, \textit{DPP's Introductory Remarks on Assisted Suicide Policy}, 25 February 2010

\textsuperscript{37} CPS, \textit{Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide}, February 2010, p4
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.  

The public interest factors tending against prosecution are as follows:

(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.  

None of these factors is weighted, and assessing the public interest will not simply be a “tick box” exercise of adding up the factors on either side and seeing which has the greater number.  

The DPP again emphasised that the policy does not change the law on assisted suicide, nor does it open the door for euthanasia:

It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not.  

3.3 Parliamentary debate on the policy

In March 2012, the Commons debated a motion tabled by Conservative Member Richard Ottaway which asked the House to “welcome” the DPP’s policy in respect of assisting or encouraging suicides.  

Dame Joan Ruddock MP moved an amendment to the motion to invite the Government to consult as to whether to put the guidance on a statutory basis:

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38 Ibid, pp5-6
39 Ibid, p7
40 Ibid, p6
41 CPS press release, DPP publishes assisted suicide policy, 25 February 2010
42 HC Deb 27 March 2012 cc1363-1440
As it stands, the policy could be changed by the DPP, who is after all an individual who holds the role of DPP for a term of five years. It is unlikely that a future DPP would make significant changes to the policy, but it is always possible. That is why placing the DPP’s policy on a statutory footing would mean that this sensible, humane and popular policy could be changed only by Parliament. In conclusion, I welcome the DPP’s policy and this debate. The policy is sensible, humane and provides clarity on how the law is applied in assisted suicide cases. The public strongly support that approach, which is why I believe the Government should consult on whether they want the clarity provided by the policy to be placed on a statutory footing. I have always known that in compelling circumstances I would assist a loved one to die. That is why I think it is so important that the DPP’s policy should be placed in statute. I urge hon. Members to support this amendment and the motion.43

In response, the then Solicitor General Edward Garnier said:

Guidelines or a policy statement are not required in every criminal case, but I invite the House to consider that such guidelines are best issued by prosecutors and for prosecutors, although available for public inspection and comment. Quite apart from the propriety of guidelines for prosecutors being a matter for prosecutors, there are some practical considerations to guidelines remaining on a non-statutory basis. Surely to place them in statute would be to attempt to confine the infinite. Policies and guidance are there to provide practical assistance to prosecutors on how particular categories of cases should be approached and the internal processes that should be followed. Therefore, there needs to be a certain amount of flexibility, not least because, as case law develops and public opinion and our collective moral view alter, the law changes and these guidelines and the policies will need to change in response, often quickly.44

Dame Ruddock’s amendment was negatived without division.

The House of Lords considered the policy and some of the broader legal issues in March 2014, when Baroness Jay of Paddington tabled a question asking whether the Government “continued to be satisfied” with the DPP’s guidelines. She took the view that the current law – including the DPP’s guidelines – did not provide overall coherence on the issue, did not offer adequate legal protection, and did not do enough to prevent unnecessary suffering at the end of life.45 She called for Parliament to legislate on the matter, rather than leaving the issue in the hands of the courts and lawyers.

Justice Minister Lord Faulks responded to the debate for the Government. He said that the DPP’s policy did not change the law and could only act as guidance for prosecutors. He also confirmed that any change on the law in this area would be a matter for Parliament to determine as an issue of individual conscience.46

4 Previous attempts to change the law

4.1 The Assisted Dying for the Terminally Ill Bill [HL]

In 2004, Lord Joffe introduced the Assisted Dying for the Terminally Ill Bill [HL], which aimed “to enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make

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43 HC Deb 27 March 2012 c1374
44 HC Deb 27 March 2012 c1377
45 HL Deb 5 March 2014 c1410
46 HL Deb 5 March 2014 c1429
provision for a person suffering from such a condition to receive pain relief medication”. The Bill was remitted to a select committee under the chairmanship of Lord Mackay of Clashfern.

The take note debate was on 10 October 2005. The Bill lapsed at the end of the 2004/05 session, but was re-introduced on 9 November 2005. The final second reading debate was on 12 May 2006; however, on division the Lords voted by 148 to 100 against second reading. Writing in the Times, Lord Joffe commented that the last thing the opponents of assisted dying seem to want is a debate, … shown by their conduct at the last hearing of my Bill when they broke a longstanding tradition in the Lords of never opposing a Private Member's Bill at second reading. They succeeding in summarily bringing the debate to an end before a detailed examination of its provisions could even take place.

**4.2 The Coroners and Justice Bill 2008-09**

During the passage of the Coroners and Justice Bill (now the Coroners and Justice Act 2009), two amendments that sought to amend the law on assisted suicide were tabled. Neither was successful.

Patricia Hewitt tabled an amendment for the Bill’s report stage in the Commons. The amendment would have added the following provision to the 1961 Act:

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2ZA Acts not capable of encouraging or assisting

An act by D is not to be treated as capable of encouraging or assisting the suicide or attempted suicide of another person (“T”) if the act is done solely or principally for the purpose of enabling or assisting T to travel to a country or territory in which assisted dying is lawful.
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The amendment was not called. A number of members expressed dissatisfaction that the programme motion had made it virtually certain that the amendment would not be reached, commenting that assisted suicide was a topical and urgent matter that required parliamentary debate.

During the Bill’s committee stage in the Lords, Lord Falconer of Thoroton proposed an amendment that would have provided:

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"Acts not capable of encouraging or assisting suicide

(1) An act by an individual ("D") is not to be treated as capable of encouraging or assisting the suicide or attempted suicide of another adult ("T") if—

(a) the act is done solely or principally for the purpose of enabling or assisting T to travel to a country or territory in which assisted dying is lawful;

(b) prior to the act, two registered medical practitioners, independent of each other, have certified that they are of the opinion in good faith that T is
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47 This Bill followed a similar one (the Patient (Assisted Dying) Bill) introduced by Lord Joffe in 2003, which had its second reading in June 2003 but did not proceed any further (HL Deb 6 June 2003 cc1585-1690).
48 HL Deb 10 October 2005 c12-32, 45-150
49 HL Deb 9 November 2005 c619
50 HL Deb 12 May 2006 c1184-1296
51 “Debbie Purdy deserves a less terrible choice”, 30 October 2008, The Times [subscription only]
52 HC Deb 23 March 2009 cc52-61
terminally ill and has the capacity to make the declaration under subsection (2); and

(c) prior to the act, T has made a declaration under subsection (2).

(2) A declaration by T is made under this subsection if the declaration—

(a) is made freely in writing and is signed by T (or is otherwise recorded and authenticated if T is incapable of signing it),

(b) states that T—

(i) has read or been informed of the contents of the certificates under subsection (1)(b), and

(ii) has decided to travel to a country or territory falling within subsection (1)(a) for the purpose of obtaining assistance in dying, and

(c) is witnessed by an independent witness chosen by T.

(3) "Independent witness" means a person who is not—

(a) likely to obtain any benefit from the death of T; or

(b) a close relative or friend of T; or

(c) involved in caring for T.

(4) D is not to be treated as having done an act capable of encouraging or assisting the suicide or attempted suicide of T by virtue of being with T when, in a country or territory falling within subsection (1)(a), T takes steps (including steps taken with the assistance of D) to commit suicide by lawful means."

Introducing the amendment, Lord Falconer said:

The reason that I proposed this amendment, along with my noble friend Lady Jay of Paddington and the noble Lords, Lord Low and Lord Lester of Herne Hill, is that it is absolutely plain that the law is being marginalised. The law is not being applied by the Director of Public Prosecutions because it plainly no longer fits the current situation. The result of the law not being applied is that we have the horror of people going earlier to clinics abroad, without their loved ones being there on the day that they die. Equally, the law provides no protection or safeguard against abusive people, or for those under a mistaken impression of what illness they have. The only current safeguard is the fear of prosecution. That is not removed because the declaration must be made freely.53

Baroness Campbell, a leading campaigner for disabled people’s rights who herself has the degenerative condition spinal muscular atrophy, spoke strongly against the amendment:

…but if these amendments were to succeed, despair would be endorsed as a reasonable expectation for which early state-sanctioned death is an effective remedy. Is this really the message that we wish to give disabled and terminally ill people? Is this really the future that we wish to offer those who become terminally ill? Those of us who know what it is to live with a terminal condition are fearful that the tide has already turned against us. If I should ever seek death - there have been times when my progressive condition challenges me - I want a guarantee that you are there supporting my

53 HL Deb 7 July 2009 c598
continued life and its value. The last thing that I want is for you to give up on me, especially when I need you most. I urge your Lordships to reassure us by rejecting this amendment.54

On a free vote, the amendment was defeated by 194 votes to 141.55

5 Current attempts to change the law

5.1 The Assisted Dying Bill [HL]

The Assisted Dying Bill [HL] is a Private Member’s Bill first introduced by Lord Falconer in May 2013. It did not proceed beyond First Reading in the 2013-14 session, but was reintroduced by Lord Falconer in the 2014-15 session. First Reading was on 5 June 2014 and Second Reading was on 18 July 2014.

The Bill aims to enable competent adults who are terminally ill to be allowed assistance with ending their life if they request it. In brief:

- The Bill outlines how competence and terminal illness will be determined. It states that a person must have a diagnosis from a qualified medical practitioner of a terminal illness and be reasonably expected to have a life expectancy of up to six months. A person’s capacity will be assessed in line with the Mental Capacity Act 2005.

- Two doctors must be involved in the assessment of the patient for both extent and diagnosis of illness and competence to make a declaration of wanting assistance to end their life.

- The Bill goes on to set out the practical arrangements for the prescribing of medication. The Bill requires a ‘cooling off period’ of 14 days (or six days in certain situations) before the medication is delivered and a health professional at that time re-assesses whether the person wishes to revoke their declaration.

- The medication would have to be self-administered but the Bill makes provision for those who cannot swallow by allowing a tube or syringe driver to be loaded with the medication. The patient must take the final act that ends their own life: for example, activating the syringe driver.

- The Bill includes a conscientious objection clause, and a clause that explains that a coroner may, but is not required to, hold an inquest in respect of an assisted death.

- Clause 8 enables the Secretary of State to issue codes of practice regarding matters relating to the operating of the Bill: for example, assessments of capacity, the effect psychological disorders on decision making.

The explanatory notes to the Bill provide full details, as does the Lords Library briefing In Focus: Assisted Dying Bill [HL].56

The content of the Bill was shaped by the findings of the Commission on Assisted Dying, which was chaired by Lord Falconer. The Commission was established following a tender from two private individuals, Terry Pratchett and Bernard Lewis (both advocates of assisted dying), with support provided by think-tank Demos.

54 HL Deb 7 July 2009 c614
55 HL Deb 7 July 2009 c634
56 LIF 2014/006, 14 July 2014
The Commission published its final report in January 2012.\(^57\) It described the current legal status of assisted suicide as “inadequate and incoherent” and proposed that Parliament should consider developing a new legal framework. This conclusion was supported by all of the Commissioners other than the Reverend Canon Dr James Woodward, who considered that greater ethical, moral and social consensus needed to be generated on this issue before legal change should be considered.

The Bill’s Second Reading debate took place on 18 July 2014.\(^58\) Opinion on the Bill was evenly split. To give one example in support of the Bill, Lord Falconer said:

Some say that the courts should be involved as an additional safeguard before an assisted death occurs. We should constructively consider that issue in Committee. Others say that the change in the law will place pressure to take that option on those who are dying. I disagree. The numbers will be small—that is the experience in Oregon. The safeguards make clear the exceptional nature of the course. Some say that the current law should just be allowed to continue. They are wrong. Without intending to be, and despite the very best efforts of those who seek to enforce it, the current law provides the option of an assisted death to those rich enough to go abroad; for the rest, it provides despair and often a lonely, cruel death—and no adequate safeguards.\(^59\)

To give one example in opposition to it, Baroness Campbell of Surbiton said:

First, I must declare a very important interest. This Bill is about me. I did not ask for it and I do not want it but it is about me nevertheless. Before anyone disputes this, imagine that it is already law and that I ask for assistance to die. Do your Lordships think that I would be refused? No; you can be sure that there would be doctors and lawyers willing to support my right to die. Sadly, many would put their energies into that rather than improving my situation or helping me to change my mind. The Bill offers no comfort to me. It frightens me because, in periods of greatest difficulty, I know that I might be tempted to use it. It only adds to the burdens and challenges which life holds for me.\(^60\)

For the Government, Justice Minister Lord Faulks said:

…the Government believe that any change in the law in this emotive area is an issue of individual conscience. In our view, it is rightly a matter for Parliament to decide rather than government policy. Taking a neutral position on an issue of conscience, though, is not the same as doing nothing. The Government must of course be concerned with the fitness for purpose of any legislation that may reach the statute book. That is not to suggest that the Government will seek to block the Bill at a later stage if the consensus of this House is that it should proceed; rather, we should seek to correct any drafting deficiencies and to ensure that the law would operate in the way that Parliament intended.\(^61\)

There was general consensus among those who spoke in the debate – whether for or against the Bill – that Parliament needed to properly address the issue following the Supreme Court’s judgment in Nicklinson and that the Bill should proceed to Committee for detailed consideration. The Bill was therefore given its Second Reading without division.

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\(^57\) The Commission on Assisted Dying, “The current legal status of assisted dying is inadequate and incoherent...”, 2012

\(^58\) HL Deb 18 July 2014 c775

\(^59\) HL Deb 18 July 2014 c777

\(^60\) HL Deb 18 July 2014 c809

\(^61\) HL Deb 18 July 2014 c919
5.2 Reaction to the Bill

Reaction to the Bill has (unsurprisingly) been mixed. A number of opinions from stakeholders representing both sides of the debate are set out below.

The charity Dignity in Dying, which supports a terminally ill person’s choice for assisted dying, says that the Bill “would not lead to more deaths, rather it would lead to less suffering for those dying people who want the choice to control how and when they die”. It argues that the Bill would do the following if enacted:

- Result in fewer dying adults – and their families – facing unnecessary suffering at the end of their lives, subject to strict upfront safeguards, as assessed by two doctors.
- Bring clarity to an area of the law that is currently opaque and thereby provide safety and security for the terminally ill and for medical professionals.
- Neither legalise voluntary euthanasia, where a doctor directly administers life-ending medication nor act as a slippery slope to do so.
- Protects anyone who doesn’t have a terminal illness, including elderly and disabled people, by not in any way affecting the law that makes it a criminal offence to assist ending their lives.
- Above all it will give dying adults peace of mind that the choice of assisted dying is available if their suffering becomes too great for them in their final months of life.

Living and Dying Well, a public policy research organisation that was formed in 2010 to explore issues surrounding terminal illness and dying, has made a number of criticisms of the Bill. Its main criticism is what it describes as a lack of safeguards to govern the assessment of requests for assisted suicide:

The bill contains no safeguards, beyond stating eligibility criteria, to govern the assessment of requests for assisted suicide. It relegates important questions such as how mental capacity and clear and settled intent are to be established to codes of practice to be drawn up after an assisted suicide law has been approved by Parliament. This is wholly inadequate for a bill, such as this, with life-or-death consequences. Parliament cannot responsibly be asked to approve such a radical piece of legislation without seeing the nature of the safeguards that would accompany it. On this measure alone the bill is not fit for purpose.

Like its predecessors, the bill places responsibility for assessing applicants for assisted suicide and supplying them with lethal drugs on the shoulders of the medical profession. Only a minority of doctors would be willing to participate in such acts if they were to be made lawful. An inevitable consequence, as evidence from the US State of Oregon has shown, is that many of those seeking physician-assisted suicide would find themselves being assessed by doctors to whom they had only recently been introduced and who could know little of them beyond their case notes. The implications of such 'doctor shopping' for thorough and proper assessment are obvious.

The bill also ignores expert medical evidence given to Parliament in recent years regarding the unreliability of prognoses of terminal illness at the range it envisages.

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62 Dignity in Dying website, *Lord Falconer’s Assisted Dying Bill* [accessed 20 August 2014]
63 Dignity in Dying website, *Lord Falconer’s Assisted Dying Bill* [accessed 20 August 2014]
64 Living and Dying Well, *Another Assisted Dying Bill: does it pass the public safety test?*, 2013
A cross-party group of Members of the House of Lords, writing for Living and Dying Well, has described the Bill as a “blank cheque” given that it would leave detailed provisions on the assessment of mental capacity to secondary legislation:

The Peers find that, in relegating the question of safeguards to codes of practice, the Bill is “asking Parliament to sign a blank cheque” and is “the equivalent of putting up notices on a railway embankment to warn the public against trespassing but not putting any fencing in place to discourage or prevent people from wandering onto the tracks”.

“As legislators,” they state, “we have to think carefully about the consequences as well as the intentions of legislation” and that “the criminal law exists, not to offer options to individuals, but to protect us, all of us, from harm, irrespective of our age, gender, race - and state of health”.

The authors conclude that “compassion may prompt us to empathise with a strong-willed individual who is completely clear about wanting to hasten death in preference to living with a terminal illness” but that “compassion for all terminally people requires that they receive the protection of the law and are not exposed to the unintended consequences of legislation designed to oblige a minority”.65

The leaders of the major faith communities in Britain have issued a joint statement opposing the Bill, arguing that it will “only add to the pressures that many vulnerable, terminally ill people will feel, placing them at increased risk of distress and coercion at a time when they most require love and support”.66 The Archbishop of Canterbury has described the system the Bill would introduce as a “sword of Damocles to hang over the head of every vulnerable, terminally ill person in the country”.67

However, two high-profile religious figures have indicated their support for the Bill. Desmond Tutu said that he revered the sanctity of life, “but not at any cost”.68 Former Archbishop of Canterbury George Carey said:

Until recently, I would have fiercely opposed Lord Falconer’s Bill. My background in the Christian Church could hardly allow me to do otherwise.

I would have used the time-honoured argument that we should be devoting ourselves to care, not killing. I would have paraded all the usual concerns about the risks of ‘slippery slopes’ and ‘state-sponsored euthanasia’.

But those arguments that persuaded me in the past seem to lack power and authority now when confronted with the experiences of those suffering a painful death.

(…)

The current law fails to address the fundamental question of why we should force terminally ill patients to go on in unbearable pain and with little quality of life.

It is the magnitude of their suffering that has been preying on my mind as the discussion over the right to die has intensified.

The fact is that I have changed my mind. The old philosophical certainties have collapsed in the face of the reality of needless suffering.69

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67 “Helping people to die is not truly compassionate”, Times, 12 July 2014 [subscription only]
68 “Desmond Tutu: a dignified death is our right – I am in favour of assisted dying”, Observer, 13 July 2014
The *Guardian* reported that a group of 27 senior medical figures (writing in a personal capacity rather than a representative capacity) had written to every Member of the House of Lords calling on them to back Lord Falconer’s Bill:

The letter has been organised by Sir Terence English, a former president of the Royal College of Surgeons, who is also a patron of Dignity in Dying. The signatories ask peers to recognise "that the narrow scope of the bill does not allow for assisted suicide when the patient is not terminally ill, as is practised in Switzerland, nor for voluntary euthanasia, as in Belgium and Switzerland, where a doctor administers the lethal medication".

(…)

Assisted dying would empower patients, the doctors write. "We hope that assisted dying or, as some would have it, physician-assisted suicide for the terminally ill, will become legal and thereby allow dying patients who meet the criteria to have this degree of control over the final days of their life. The alternative is for them to have to consider a number of unpalatable options, including help from friends or relatives or travelling abroad to die without the advice and support of a sympathetic physician."70

Not Dead Yet UK, a network of disabled people opposed to assisted dying, has made the following comments on the Bill:

- We are deeply concerned that a change in the law will lead to disabled people – and other vulnerable people, including older people - feeling under pressure to end their lives.

- The issue tells us a lot about public attitudes towards disabled people.

- Why is it that when people who are not disabled want to commit suicide, we try to talk them out of it, but when a disabled person wants to commit suicide, we focus on how we can make that possible?

- We believe that the campaign to legalise assisted suicide reinforces deep-seated beliefs that the lives of sick and disabled people are not worth as much as other people’s. That if you are disabled or terminally ill, it's not worth being alive.

- Disabled people want help to live – not to die.71

In July 2014, the British Medical Journal set out its support for the Bill in an editorial entitled “It’s the right thing to do, and most people want it”.72

6 Stakeholders

There are many stakeholders on both sides of the debate, including campaign groups and medical bodies. Brief details of some of these organisations are set out below; this is not a comprehensive list of all bodies that have an expressed interest in or position on this issue.

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69 "Lord Carey: why I’ve changed my mind on assisted dying", *Daily Mail*, 12 July 2014
70 "Assisted dying: leading doctors call on Lords to back legalisation", *Guardian*, 15 July 2014
71 Not Dead Yet UK news release, *Support Not Dead Yet UK Demonstration against Lord Falconer’s Bill 18th July 2014*, 24 June 2014
72 “It’s the right thing to do, and most people want it”, *British Medical Journal*, 2014, 349: g4349
6.1 Campaign groups

**Dignity in Dying**

*Dignity in Dying*, formerly known as the Voluntary Euthanasia Society, campaigns for "greater choice and control at the end of life". This would include giving mentally competent, terminally adults the choice of an assisted death within a strict legal framework. Further details of Dignity in Dying’s aims are set out on its website:

We believe that everyone has the right to a dignified death. This means:

- **Choice** over where we die, who is present and our treatment options.
- **Access** to expert information on our options, good quality end-of-life care, and support for loved ones and carers.
- **Control** over how we die, our symptoms and pain relief, and planning our own death.  

*Dignity in Dying* has an ongoing campaign in support of the Assisted Dying Bill.  

**Care Not Killing**

*Care Not Killing* is an alliance of groups opposing euthanasia and assisted suicide formed in 2005. Its members include religious groups, disability rights groups and palliative care doctors. An overview of its aims is provided on its website:

1. promoting more and better palliative care;
2. ensuring that existing laws against euthanasia and assisted suicide are not weakened or repealed;
3. influencing the balance of public opinion against any further weakening of the law. 

A section of its website suggests ways in which members of the public can express their opposition to the Assisted Dying Bill. 

**Not Dead Yet UK**

*Not Dead Yet UK* was founded in 2006 by Jane Campbell, a campaigner and adviser for disability reforms who was made a life peer in 2007. It is a network of disabled people who oppose what the organisation describes as “the legalised killing of disabled people”. Its website sets out its position on assisted suicide:

If we give in to the demand to assist in a suicide we are reinforcing attitudes that say that the lives of disabled people are not worth living – that they are a particular burden to themselves, their relatives and friends, and the state. These negative attitudes are faced by disabled people all the time. This discrimination does not just happen at moments of crisis or imminent death, they are the underlying reason why society is so inaccessible to disabled people and excludes and isolates us systematically. NDYUK’s position links with that of the Disability Rights Commission. In their policy statement on assisted suicide they say there are a number of steps that need to be taken before we contemplate assisted dying legislation:

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73 Dignity in Dying, *About us* [accessed 20 August 2014]
74 Dignity in Dying, *Lord Falconer’s Assisted Dying Bill* [accessed 20 August 2014]
75 Care Not Killing website, *About Care Not Killing* [accessed 20 August 2014]
76 Care Not Killing website, *Falconer: final weeks* [accessed 20 August 2014]
• Abolishing discriminatory guidelines and practice on withholding and/or withdrawing life-saving treatment for disabled people;

• Producing demonstrable reductions in discrimination and inequalities in health services;

• Improving the quality and capacity of palliative care provision equally across the country and ensuring supply does not lag behind demand (as is currently the case);

• Implementing effective rights to independent advocacy and communication support; and

• Implementing rights to independent living to create a society where all disabled people are able to participate fully as equal citizens.77

6.2 Medical bodies

The British Medical Association

The British Medical Association (BMA), the trade union and professional association of doctors, formulates policies at its Annual Representative Meeting (ARM) where motions submitted by the BMA membership are debated. If approved, they become BMA policy.

The BMA’s Ethics Department published a policy paper in August 2009 setting out the BMA’s views on “end-of-life” issues, including its opposition to all forms of assisted dying.78 The BMA last debated its policy opposing assisted dying at its 2012 ARM, when members voted against a motion that the BMA should move from a position of opposition to neutrality.79 A summary of the BMA’s current policy is set out on its website.80

BMA guidance to doctors issued in 2010 states:

The BMA advises doctors to avoid all actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt. This means that doctors should not:

• advise patients on what constitutes a fatal dose;

• advise patients on anti-emetics in relation to a planned overdose;

• suggest the option of suicide abroad;

• write medical reports specifically to facilitate assisted suicide abroad; nor

• facilitate any other aspects of planning a suicide.81

Royal College of Nursing

In July 2009 the Royal College of Nursing (RCN) moved to a “neutral” position on assisted suicide, having previously opposed it.82 The decision, voted on by the RCN Council, followed

77 Not Dead Yet UK website, About Not Dead Yet UK [accessed 20 August 2014]
78 BMA, End-of-life decisions: Views of the BMA, August 2009
79 BMA, BMA continues to oppose legalising assisted dying, 27 June 2012. Earlier that month the editor in chief of the British Medical Journal had called on the BMA to maintain its neutrality, arguing “doctors hold the means but the decision rests with society and its representatives in parliament”: see “Legalisation is a decision for society not doctors”, British Medical Journal, 2012, 344:e4075
80 BMA website, What is current BMA policy on assisted dying? [accessed 20 August 2014]
81 BMA, Responding to patient requests relating to assisted suicide: guidance for doctors in England, Wales and Northern Ireland, July 2010, p2
82 RCN news release, RCN moves to neutral position on assisted suicide, 24 July 2009
a three month consultation by the RCN with its members. Over 1,200 individual responses were received; 49 per cent. of individuals supported assisted suicide, although a substantial minority of 40 per cent. opposed it. The remaining submissions were either neutral on the issue (nine per cent.) or failed to record a position (one per cent.).

The decision provoked some controversy among nurses; some argued that the consultation process was inadequate and that 1,200 responses out of around 400,000 members was not a sufficient mandate for change.83

In a letter to the *Times*, Dr Peter Carter, Chief Executive of the RCN, emphasised that its shift to a neutral position did not represent “implicit support” for assisted suicide, nor was it advising nurses to engage in dialogue with patients “on this contentious issue”.84

In October 2011 the RCN issued guidance to nurses on how to respond to requests to hasten death.85

**Royal College of General Practitioners**

The Royal College of General Practitioners (RCGP) held a consultation on its position on assisted dying in 2013.86 On 21 February 2014 it announced that the majority of respondents had agreed with maintaining a position of opposition to a change in the law on assisted dying:

> Although a minority of respondents put forward cases to shift the College’s collective position to ‘neutral’ or ‘in favour’ of a change in law on assisted dying, most respondents were against a change in the law for a range of reasons, including that a change in the legislation would:

- be detrimental to the doctor-patient relationship
- put the most vulnerable groups in society at risk
- be impossible to implement without eliminating the possibility that patients may be in some way coerced into the decision to die
- shift the focus away from investing in palliative care and treatments for terminal illnesses
- instigate a ‘slippery slope’ whereby it would only be a matter of time before assisted dying was extended to those who could not consent due to reasons of incapacity and the severely disabled.87

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83 See, for example, “Nurses need to speak up against euthanasia”, *Telegraph*, 29 July 2009, “Christian nurses speak against assisted suicide”, *Observer*, 26 July 2009

84 “Nurses, undertakers and duty to die”, *Times*, 30 July 2009 [subscription only]

85 Royal College of Nursing, *When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death*, October 2011. See also RCN press release, *RCN launches guidance for nurses on assisted suicide*, 20 October 2011.

86 RCGP, *Assisted Dying Consultation Analysis*, January 2014

87 RCGP, *RCGP announces continued opposition to change in law on assisted dying*, 21 February 2014
Appendix: the position in other selected jurisdictions

This appendix provides an overview of the legal position in Switzerland, Oregon and Scotland. Switzerland has been selected as it is home to the Dignitas clinic, which a number of Britons have used to end their lives. Oregon has been selected as Lord Falconer has used its legislation on assisted suicide as the basis for his Assisted Dying Bill. Scotland has been selected to provide a domestic comparison with the law in England and Wales.

Switzerland

In Switzerland, there is very little explicit legal regulation on assisted suicide. Under Article 115 of the Swiss Criminal Code assisted suicide is only a crime if done for selfish reasons:

Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.

In October 2009, the Swiss cabinet sent two proposals into the legislative process for consultation, one for tighter regulation of assisted suicide and the other for an outright ban:

The Swiss parliament is said to prefer the less drastic route, which would set down strict guidelines for assisted dying groups to follow. The new rules would include requiring patients to obtain two medical opinions proving their illness was incurable and probably fatal within months. These doctors must state that the dying person had the mental capacity to assert their wish to die, and prove they had held this wish for some time. The new proposal would also require assisted dying groups to provide better written records to stop organisations profiting from patients wanting to die – and to help in case of any subsequent investigation and prosecution.  

However, the Federal Council ultimately decided against introducing any specific criminal provisions targeting assisted suicide.

In May 2011 Zurich-based voters took part in a referendum on assisted suicide. A proposal to ban assisted suicide was rejected by 85 per cent., while a second proposal to limit assisted suicide to Zurich residents was rejected by 78 per cent.

In recent years some concern has been expressed that in Switzerland there is no legal requirement for a person to be suffering from a terminal illness in order to undergo assisted suicide. For example, in 2009 the Guardian reported that it had obtained a document from the Dignitas clinic showing that a number of Britons with non-terminal conditions had used it to commit suicide:

The document shows that while many had terminal illnesses such as cancer and motor neurone disease, others had non-fatal conditions which doctors say some people can live with for decades.

It covers the medical history of all but one of the 115 Britons who have died with Dignitas's help since the first did so in 2002. It identifies 22 conditions in all. Thirty-six

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88 “Death tourism' leads Swiss to consider ban on assisted suicide”, Guardian, 28 October 2009
89 Swiss Federal Department of Justice and Police press release, Assisted suicide: strengthening the right of self-determination, 29 June 2011
of the 114 unnamed Britons had various forms of cancer, 27 had motor neurone
disease and 17 had multiple sclerosis.

But two had Crohn's disease, an inflammatory bowel disease; two were tetraplegics;
three had kidney disease, which can be usually treated by dialysis or a transplant; and
one had rheumatoid arthritis – all conditions which doctors say are not terminal.

The details have prompted deep concern among senior doctors, calls for the NHS to
provide much better end-of-life care and a renewed debate over demands for a new
legal right of assisted death to render the growing British use of Dignitas
unnecessary.91

**Oregon**
The relevant legislation in Oregon is the *Death with Dignity Act*, which was enacted in
October 1997.

Detailed information on the Act is available on the Oregon Health Authority’s website: see
*Public Health: Death with Dignity Act* [accessed 20 August 2014].

According to the Authority's website, the Act “…allows terminally-ill Oregonians to end their
lives through the voluntary self-administration of lethal medications, expressly prescribed by
a physician for that purpose”. A list of frequently asked questions provides more detailed
background: see *FAQs about the Death with Dignity Act*.

The FAQs set out the criteria that an individual must fulfil in order to make use of the Act:

> The law states that, in order to participate, a patient must be: 1) 18 years of age or
> older, 2) a resident of Oregon, 3) capable of making and communicating health care
decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death
within six (6) months. It is up to the attending physician to determine whether these
criteria have been met.

The patient must be able to prove residency in Oregon at the time they approach a physician
for a prescription (e.g. by producing an Oregon Driver Licence or voter registration, or a
lease agreement or property ownership document), but there is no minimum residency
requirement.

The FAQs explain that prescriptions of lethal medications under the Act can only be made by
qualified physicians who are willing to do so:

> Patients who meet certain criteria can request a prescription for lethal medication from
a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or
Doctor of Osteopathy (D.O.) licensed to practice medicine by the Board of Medical
Examiners for the State of Oregon. The physician must also be willing to participate in
the Act. Physicians are not required to provide prescriptions to patients and
participation is voluntary. Additionally, some health care systems (for example, a
Catholic hospital or the Veteran’s Administration) have prohibitions against practicing
the Act that physicians must abide by as terms of their employment.

They also set out the procedure for obtaining a prescription:

> The patient must meet certain criteria to be able to request to participate in the Act.
Then, the following steps must be fulfilled: 1) the patient must make two oral requests
to the attending physician, separated by at least 15 days; 2) the patient must provide a

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91 “Suicide clinic challenged over patients who could have lived 'for decades’”, *Guardian*, 22 June 2009
written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient; 3) the attending physician and a consulting physician must confirm the patient’s diagnosis and prognosis; 4) the attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself; 5) if either physician believes the patient’s judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination; 6) the attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control; 7) the attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician will also offer the patient an opportunity to rescind his/her request at the end of the 15-day waiting period following the initial request to participate.

Physicians must report all prescriptions for lethal medications to the Oregon Health Authority, Vital Records. As of 1999, pharmacists must be informed of the prescribed medication’s ultimate use.

The FAQs also stress that euthanasia is illegal in Oregon (and in every other US state): the patient, not the doctor, must administer any lethal medication prescribed under the Act.

Scotland
In Scotland there is no specific statutory offence of assisting suicide. However, those who do assist suicide could potentially find themselves liable for more general offences such as murder, culpable homicide, reckless endangerment, assault, breach of the peace, or various offences under the Misuse of Drugs Act 1971.92

In January 2010, the *End of Life Assistance (Scotland) Bill* was introduced in the Scottish Parliament by Margo MacDonald MSP. The Bill sought to permit assistance to be given to persons who wish their lives to be ended, under certain conditions. Further details can be found in *Scottish Parliament Information Centre Briefing 10/51* (2 September 2010). The Scottish Parliament disagreed to the general principles of the Bill on 1 December 2010 and the Bill therefore fell.93

In January 2012 Ms MacDonald launched a fresh proposal for a Bill on assisted suicide. Her *Proposed Assisted Suicide (Scotland) Bill* was subject to consultation until 2012. The *Assisted Suicide (Scotland) Bill* was introduced in November 2013. The Health and Sport Committee is the lead committee for scrutiny of the Bill and the Inquiry is ongoing; evidence sessions are expected to start in November/December 2014.94

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92 *Scottish Parliament Information Centre Briefing 10/51*, 2 September 2010, p10. This Briefing suggests that there is currently no reported case law on the application of the criminal law to cases of assisted suicide in Scotland.

93 *SP OR 1 December 2010, cc31042-31087 and 31094-31096*

94 The Scottish Parliament, *Stage 1 consideration of the Assisted Suicide (Scotland) Bill*