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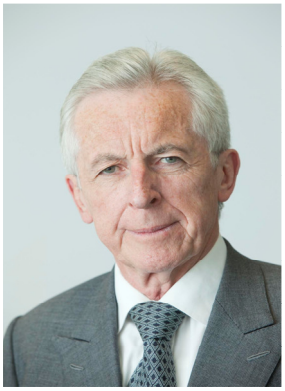
'ASSISTED DYING' AND THE LAW



An analysis of the Suicide Act 1961 and of how it works in practice

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Living and Dying Well is a public policy research organisation established in 2010 to promote clear thinking on the end-of-life debate and to explore the complexities surrounding 'assisted dying' and other end-of-life issues.
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Introduction

1. Parliament is being asked[1] yet again to legalise what is being called 'assisted dying'. It is important to be clear what is the question here. It is not whether 'assisted dying' is moral or immoral or whether it is compassionate or not or whether it promotes personal autonomy. The question before Parliament is whether it should be made lawful - more specifically, whether doctors should be licensed by law to involve themselves in assisting the suicide of some of their patients by supplying them with lethal drugs. To answer this question it is necessary to understand what the law is and how it works. There is widespread misunderstanding and misinformation on this subject. This paper explains what the law says and how it works and examines some of the claims that have been made by advocates of legal change.

Definitions

2. It is necessary to begin by saying something about the language being used. The term 'assisted dying' has no meaning in English law: it is a euphemism devised by campaigners for legal change. The 'assisted dying' that Lord Falconer's Bill seeks to legalise is, in fact, physician-assisted suicide. Those who use the term 'assisted dying' claim that it is not the same thing as assisted suicide on the grounds that under their proposals assistance with suicide would be available only to people diagnosed as terminally ill. As these people are expected to die anyway, so the argument runs, assisting them to end their lives is not assisting a suicide but assisting a dying process.

3. The logic here is beguiling but flawed. In law, and in plain English, if you end your own life, whatever your state of health, that is suicide; and a doctor, or anyone else, who assists you to do so is assisting suicide. It may perhaps make the licensing of assisted suicide more palatable to call it 'assisted dying' but good law-making requires that words are used with clarity and with the meanings they have, not those that some of us might like them to have.

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[1] Lord Falconer's Private Member's 'Assisted Dying Bill' (HL Bill 24, Session 2013-14)

The Law

4. The law in this case is the Suicide Act 1961, under which acts of suicide or attempted suicide were given immunity from prosecution. Under Section 2 of the Act, however, encouraging or assisting the suicide of another person is a criminal offence. This distinction, between suicide itself and its encouragement or assistance, is important. It reflects a widely-held view in society that, while individuals who attempt to take their own lives should not be prosecuted for doing so, suicide is not something another person should encourage or assist. All the emergency responses to attempted suicides, the 'suicide watches' that are maintained in places where individuals are considered to be at risk of self-harm and the suicide prevention strategies that successive governments have introduced provide ample testimony that society's view of suicide is essentially no different today from what it was 50 years ago.

5. Conviction by a court of encouraging or assisting another's suicide carries a penalty of up to 14 years imprisonment. It is important to understand, however, that this is a maximum penalty designed to punish very serious cases with no mitigating factors and that, for reasons explained below, it is seldom if ever invoked. Moreover, the 1961 Act requires that no prosecution for an offence of encouraging or assisting suicide be undertaken without the consent of the Director of Public Prosecutions (DPP). In making this provision the law recognises that an individual act of assisting suicide may cover a wide spectrum of circumstances, from malicious assistance with suicide designed to secure personal gain to reluctant assistance given after much soul-searching and with genuinely compassionate intent and that, as with other criminal laws, prosecutorial discretion is necessary in order to differentiate between different types of case.

6. The 1961 Act is supported by a policy for prosecutors published in 2010 in response to a Judgment of the House of Lords (now the Supreme Court). The policy explains that, as with other criminal offences, decisions on whether or not to bring a prosecution for encouraging or assisting suicide follow a two-stage process. The first

stage is a police investigation to establish whether there is evidence that the offence has taken place and, if so, in what circumstances. If the result of this investigative process is that there is sufficient evidence for prosecution to be considered, the case is passed to the DPP, who considers whether there is sufficient evidence to support a conviction and, if so, whether a prosecution is in the public interest.

7. The DPP's assessment of the public interest is guided by a range of factors, and the published policy for prosecutors lists a number of aggravating and mitigating circumstances which may argue either for or against prosecution in any particular case. As examples, evidence that the deceased person had not reached a voluntary and settled wish to commit suicide or that the assister had been in a position of trust or had stood to gain from his or her actions or had in some way pressured the deceased to end his or her life would be regarded as arguments favouring prosecution. On the other hand, evidence that the assister had been wholly motivated by compassion or had given assistance of a minor nature or had sought to dissuade the deceased from suicide would tend towards a decision not to prosecute.

8. The policy states clearly, however, that "*assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number*". It explains that "e*ach case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction*"[2].

The Law in Practice

9. On average less than 20 cases of encouraging or assisting suicide throughout England and Wales cross the desk of the DPP in any year and very few of them result in prosecution. It is sometimes argued by

[2] "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide", Crown Prosecution Service, February 2010, Paragraph 39

those who want to license 'assisted dying' that the absence of prosecutions means that the law is not working. On the contrary, it indicates that it is working as it should. The effectiveness of a law is not measured by the number of prosecutions brought under it. An important consideration is its effectiveness in deterring the offence in question from happening at all. With the penalties it holds in reserve to deter malicious acts of assistance and with the discretion it allows to temper justice with mercy where prosecution is not appropriate, we see the law working to good effect. This is not to say that prosecutions do not happen. They do, but they are rare; and they are rare because the law has the clarity and the 'teeth' to make anyone minded to encourage or assist another person's suicide think very carefully indeed before doing so. As a result the handful of cases that pass the evidential test and reach the DPP's desk tend to be those where the assistance given has been of a minor nature or there is evidence of genuinely compassionate motivation and of serious soul-searching.

10. It is sometimes claimed[3] that prosecutions for assisted suicide are rare because the Director of Public Prosecutions 'does not have the stomach' to prosecute in cases involving compassion. This is not so. The exercise of prosecutorial discretion can be observed in relation to other criminal laws and there are published policies for prosecutors covering other offences than encouraging or assisting suicide. Given the deterrent effect of the present law it is not surprising that breaches of it are rare and that the cases which do occur are often those where prosecution is considered unnecessary.

The Counter-Claims

11. We turn now to some of the claims which have been made by campaigners for legal change about the law and we subject them to careful examination.

Claim 1: The law isn't being enforced

12. It is sometimes claimed that acts of assisted suicide are taking place but are not being investigated. For example, it has been

[3] See, for example, Lords Hansard, 7 July 2009, Col. 597

suggested[4] that in some cases where a Briton has been assisted in one way or another to travel to Switzerland to seek the services of assisted suicide organisations there, there has been no referral of the case to the Crown Prosecution Service (CPS). This claim rests on a statement on the CPS's website that in the four years from April 2009 to March 2013 68 cases of either assisted suicide or euthanasia had been referred by the police to the CPS[5]. This number of referrals has been set alongside a figure of 108 British people who were assisted in one way or another to travel to Switzerland in order to seek assisted suicide there and the deduction has been drawn from this that in many cases "*there has been no oversight by the authorities*", that instances of assisted suicide "*are not being reported*" and that "*therefore the practice is not safe*".

13. This deduction rests on a misunderstanding of the criminal law. As we have observed above, the CPS assesses cases of assisted suicide where there is sufficient evidence to support a prosecution and where a decision is required as to whether a prosecution is needed in the public interest. That in some cases there has been no referral to the CPS does not mean that there is no oversight of what is happening but rather that the cases in question have not passed the threshold of evidence to justify referral by the police to the CPS.

Claim 2: Seriously-ill people are already being helped to end their lives outside the law

14. It has been claimed[6] that "*an estimated 2% of suicides are by people with terminal illness, which equates to 97 cases per year*". This estimate is derived from a study based on extrapolation of data from a limited number of primary care trusts. It relates, moreover, to acts of suicide, not assisted suicide - which is the issue under discussion here. Nor has any evidence been adduced to support the inference that terminal illness was the cause of the suicides in question - suicides occur for all kinds of reasons.

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[4] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013
[5] www.cps.gov.uk/publications/prosecution/assisted_suicide.html
[6] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013

15. Similarly, it has been claimed[7] that "*0.21% of deaths attended by a medical practitioner in the UK are as a result of voluntary euthanasia at the patient's explicit request*" and that "*this equates to around 1,000 illegal cases of assistance to die each year*". This claim rests on data derived from research drawing on anonymous responses to questionnaires. While anonymity is obviously helpful in encouraging candour, it precludes the opportunity to dig deeper to establish to what extent the responses given can be substantiated. In fact, the research in question[8] concluded that illegal action by doctors in the UK to hasten patient deaths was "*rare or non-existent*". Indeed, its author, Professor Clive Seale, told Lord Falconer's 'commission on assisted dying' in 2011 that "*there is a kind of joint quality to decision-making in UK medical practice that is very marked compared to other countries*" and that "*with that situation decisions don't go unscrutinised*".

16. These issues aside, there is the wider picture to be considered. As a society we have suicide prevention strategies, and in day-to-day life we go to considerable lengths to prevent suicides taking place. What the advocates of 'assisted dying' are saying, in effect, is that for some people we should put this process into reverse and facilitate their suicide. That suicides occur and that some of these involve seriously ill people who are suffering is tragic, but that is no reason why we should change the law to facilitate assistance with suicide for one group of people. To do so is, in effect, to say that their lives are considered to be of less value than the lives of others. The law exists not only, or even primarily, to punish offenders but also to indicate those actions of which, as a society, we disapprove. One of those actions is aiding and abetting other people's suicides.

Claim 3: Investigation of assisted suicide comes too late

17. It is sometimes argued[9] by 'assisted dying' campaigners that "*even where there is an investigation, this happens after the person has died, when it is too late to prevent any potential abuse*". Those who

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[7] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013
[8] Seale, C "End-of-Life Decisions in the UK involving Medical Practitioners", Palliative Medicine 2009; 00:1-7
[9] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013

advance this argument are not comparing like with like. They are comparing an evidence-based police investigation of what has actually happened, and in what circumstances, with a series of subjective assessments (about, for example, mental capacity or family influence) by doctors who may have little or no first-hand knowledge of the patients concerned or of their personal and family situations. A police investigation may not invariably uncover the full facts surrounding a criminal offence, but it is an evidence-based process focusing on facts rather than a series of subjective assessments. In today's clinical world of the multi-partner GP practice home visits are relatively rare and many doctors have limited knowledge of their patients beyond the consulting room - for example, about what motivates them or what influences are operating in the background of their lives. The doctors whom patients encounter in hospitals know even less about them. The plain fact is that the cosy world of the 'family doctor' who knows his or her patients and their families well is a vanishing phenomenon.

18. Surveys of medical opinion in Britain show that the majority of practising doctors are opposed to 'assisted dying' and would be unwilling to participate in aiding their patients' suicides if it were to be legalised. A consequence of this is that patients seeking physician-assisted suicide under the law that Lord Falconer is proposing could well find themselves being assessed by doctors to whom they had only recently been introduced. Oregon's experience in this respect is salutary. Oregon legalised physician-assisted suicide for terminally-ill people in a law which came into force in 1997. The latest official annual report on the working of that law shows that the median length of the doctor-patient relationship for all those who have died by physician-assisted suicide since 1998 was just 12 weeks, and it is clear that many of those who die in this way receive lethal drugs from doctors to whom they have been introduced specifically for that purpose and whom they have known for only a very short time.

19. Moreover, the system of subjective assessments which is advocated by the campaigners for 'assisted dying' contains no deterrent factor. Under the law in England and Wales as it stands anyone minded to assist another person's suicide knows that his or her

actions and motivation will have a spotlight shone on them and that any malicious or manipulative behaviour could well come to light as a result. Under the proposals in Lord Falconer's bill, on the other hand, there is little to deter anyone from exerting improper influence on an applicant for assisted suicide: the only risk being run is that the application might be rejected. The law as it stands may not be perfect, but it is safer than the creation of an advance licensing system.

Claim 4: The law inhibits doctor-patient dialogue

20. It has been claimed[10] that "*people considering assisted dying cannot talk openly to healthcare professionals about their reasons for wanting an assisted death or the alternatives available to them*". This is nonsense. There is nothing in the law to prevent a patient raising this subject with his or her doctor or to prevent the doctor exploring the reasons for the request. What the doctor cannot do is to assist or encourage the patient to commit suicide. The situation was set out by the General Medical Council in guidance published earlier this year:

"*Where patients raise the issue of assisting suicide, or ask for information that might encourage or assist them in ending their lives, doctors should be prepared to listen and to discuss the reasons for the patient's request but they must not actively encourage or assist the patient as this would be a contravention of the law*"[11].

21. It is perhaps worth adding that doctors themselves do not regard the law as preventing them from engaging in dialogue with their patients about assisted suicide. Lord Falconer's 'commission on assisted dying' was told by the GMC that "*we don't get asked about this very often*", while the Medical Protection Society described it as "*a small issue in terms of numbers for our members*" and a consultant in old age psychiatry had "*not heard any colleagues mention it to me*". In short, there is no evidence whatever to suggest that the law is inhibiting doctor-patient dialogue.

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[10] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013

[11] "Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide", GMC, January 2013

Claim 5: The law encourages amateur assistance with suicide

22. The CPS's published prosecution policy lists, as an aggravating circumstance, a situation where assistance with suicide had been provided by a doctor or a nurse and the deceased person had been under his or her care. The advocates of legalised 'assisted dying' claim that this encourages 'amateur' assistance with suicide. This is not the case. The policy does not encourage any kind of assistance with suicide. Its inclusion of medical assistance as an aggravating factor reflects advice given to the DPP by the Royal College of Physicians, during the public consultation on the policy, that a doctor's duty of care for patients "*does not include being in any way part of their suicide*" and that *"any clinician who has been part in any way of assisting a suicide death should be subject to prosecution*"[12].

Claim 6: Oregon's physician-assisted suicide law is working well

23. There has been a steady and continuing rise in the incidence of physician-assisted suicide in Oregon since the practice was legalised there. The latest official report shows that there were nearly five times as many suicide deaths of this nature in 2012 as in 1998. Those campaigning for legalised 'assisted dying' in this country deny that there has been such an increase in deaths from physician-assisted suicide in Oregon and that "*the figure has stayed constant over the past five years at around 0.2% of all deaths in the State per year*"[13]. The word 'around' is the important word here. The official annual reports from Oregon for the last five years show that deaths from physician-assisted suicide as a proportion of all deaths in the State rose by 21 per cent between 2008 and 2012. Oregon's death rate from this source in 2012, if replicated in England and Wales, would result in between 1,100 and 1,200 assisted suicide deaths here.

Conclusion

24. Licensing doctors to supply lethal drugs to some of their patients to facilitate their suicides would represent a major change to the

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[12] Letter from Royal College of Physicians to Director of Public Prosecutions, dated 14 December 2009

[13] "Briefing on the Assisted Dying Bill", circulated by Lord Falconer et al, 16 July 2013

criminal law. If Parliament is to be asked to give serious consideration to such proposals, it needs clear evidence that the law as it stands is not fit for purpose. No such evidence has been produced.

25. The law accurately and conscientiously reflects the perceptions which, as a society, we have of suicide - that, while those who attempt to take their own lives should not be punished, suicide itself should not be encouraged or assisted. The law's combination of deterrence with discretion means that the incidence of illegal action is small and generally of a nature where prosecution is not necessary. It is not an oppressive law: it is a law with a stern face but an understanding heart. Claims that the law is not being enforced or that it inhibits doctor-patient dialogue or that it encourages amateur assistance with suicide do not stand up to serious scrutiny.

26. Lord Falconer's bill proposes no mere amendment of the law but a fundamental change to it. It is asking Parliament to agree that it should be lawful for some people to involve themselves in deliberately bringing about the deaths of others. The advocates of such legislation claim that there would be safeguards to prevent abuse. But Lord Falconer's bill contains no safeguards governing the assessment of requests for assisted suicide. While it contains criteria of eligibility for 'assisted dying', it makes no provision as to how these criteria are to be met. The bill leaves the real safeguards to be decided by others *after* Parliament has approved the bill. But knowing what the proposed safeguards are and assessing their effectiveness is an integral part of Parliament's consideration of the bill. As it stands, the bill is asking Parliament to sign a blank cheque.

27. Lord Falconer has suggested[14] that the debate on his bill in the House of Lords should be limited to establishing whether the House supports it in principle. But as legislators we have a duty to satisfy ourselves that any laws we enact will work in practice and will not put vulnerable people at risk of harm. Of course the House must consider the principle of the Bill. But we should not forget that public safety is itself a key principle of legislation: it cannot be offloaded onto others.

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[14] Interview, ITV News, 31 July 2013