The Committee will meet at 10.00 am in Committee Room 1.

1. **End of Life Assistance (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—

   Dr Georg Bosshard, Lecturer in Medical Ethics at the University of Zurich and at the Fachhochschule Gesundheit WE’G;

   Professor Martin Buijsen, Professor of Health Law, Institute of Health Policy and Management, Erasmus Universiteit Rotterdam;

   Dr Rob Jonquière, former Chief Executive of the NVVE (Dutch Right-to-Die Association) and Communications Director, World Federation of Right to Die Societies;

   Professor Penney Lewis, Professor of Law, School of Law and Centre of Medical Law and Ethics, Kings College London;

   and then from—

   Lord Mackay of Clashfern;

   Adrian Ward, Convener, Mental Health and Disability Committee, Law Society of Scotland;

   and then, not before 5.00 pm, by video conference from—

   Professor Linda Ganzini, Professor of Psychiatry and Medicine Senior Scholar, Center for Ethics in Health Care at Oregon Health and Science University;

   Deborah Whiting Jaques, Executive Director/CEO, Oregon Hospice Association.
Douglas Thornton
Clerk to the End of Life Assistance (Scotland) Bill Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5247
Email: Douglas.Thornton@scottish.parliament.uk
The papers for this meeting are as follows—

**Agenda Item 1**

PRIVATE PAPER ELA/S3/10/4/1 (P)

Submission from Dr Georg Bosshard ELA/S3/10/4/2

Submission from Dr Rob Jonquière ELA/S3/10/4/3

Supplementary submission from Dr Rob Jonquière ELA/S3/10/4/4

Submission from Prof Penney Lewis ELA/S3/10/4/5

Submission from Lord Mackay of Clashfern ELA/S3/10/4/6

Supplementary submission from Lord Mackay of Clashfern (Part 1) ELA/S3/10/4/7

Supplementary submission from Lord Mackay of Clashfern (Part 2) ELA/S3/10/4/8

Report by the House of Lords Assisted Dying for the Terminally Ill Committee (Session 2004-05) ELA/S3/10/4/9

SPICe Briefing ELA/S3/10/4/10
Content

A. General / comparative data on EAS from various European countries (including Switzerland), and the United States

1. Attitudes                     p. 2
2. Legal situation              p. 2
3. Practices                    p. 4

B. Specific information on Switzerland                                   p. 5
A. General / comparative data on EAS from various European countries (including Switzerland), and the United States

1. Attitudes

1.1 Attitudes of the general public

- A clear majority of the general public in most European countries is in favour of legal assisted suicide or voluntary active euthanasia (EAS).\(^1\)

- The acceptance of EAS among the general public in most European countries has further increased over the last decades.\(^2\)

1.2 Attitudes of doctors

- The acceptance of EAS among doctors is generally lower than among the general public.\(^3\)

- Amongst doctors, the acceptance of EAS is lowest amongst those specialists who have most experience in caring for the dying and who are the most likely to be asked for EAS in case it should be legal.\(^4\)

2. Legal situation

2.1 Countries / states with explicit legalisation of EAS

<table>
<thead>
<tr>
<th>Country / State</th>
<th>Legalised practice</th>
<th>Year of legalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Territory (AUS)</td>
<td>E</td>
<td>1996 - 1997</td>
</tr>
<tr>
<td>Oregon (USA)</td>
<td>AS</td>
<td>1997</td>
</tr>
<tr>
<td>Netherlands (EU)</td>
<td>AS / E</td>
<td>2002</td>
</tr>
<tr>
<td>Belgium (EU)</td>
<td>(AS) / E</td>
<td>2002</td>
</tr>
<tr>
<td>Washington State (USA)</td>
<td>AS</td>
<td>2008</td>
</tr>
<tr>
<td>Luxemburg (EU)</td>
<td>E</td>
<td>2009</td>
</tr>
<tr>
<td>Montana (USA)</td>
<td>AS</td>
<td>2010</td>
</tr>
</tbody>
</table>

AS=assisted suicide; E= voluntary active euthanasia

2.2 Overview of legislations governing open assisted dying

<table>
<thead>
<tr>
<th>Year when legal regulation entered into force</th>
<th>Netherlands</th>
<th>Belgium</th>
<th>Oregon</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002¹</td>
<td>2002</td>
<td>1997</td>
<td></td>
<td>AS condoned according to Art. 115 Swiss Penal Code³</td>
</tr>
<tr>
<td>Regulated end-of-life practice</td>
<td>AS and E</td>
<td>(AS and) E</td>
<td>AS</td>
<td>AS</td>
</tr>
<tr>
<td>Restriction to terminal illness</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Role for non-doctors allowed</td>
<td>no</td>
<td>no</td>
<td>(yes)²</td>
<td>yes</td>
</tr>
</tbody>
</table>

AS = assisted suicide, E = euthanasia
¹ assisted dying tolerated by Dutch courts from 1973
² in practice – no explicit legal role
³ dating back to the first half of 20th century

2.3 Services and responsibilities of doctors, right-to-die organizations, and others in assisted dying in the Netherlands, Belgium, Oregon, and Switzerland

<table>
<thead>
<tr>
<th>First contacted - discusses general eligibility</th>
<th>Netherlands, Belgium</th>
<th>Oregon</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinates and supervises overall process</td>
<td>Doctor</td>
<td>Doctor or Organization</td>
<td>Doctor or Organization</td>
</tr>
<tr>
<td>Provides information on diagnosis, prognosis, and treatment options</td>
<td>Doctor</td>
<td>Doctor</td>
<td>Doctor</td>
</tr>
<tr>
<td>Refers to counselling or provides in-formation on alternatives (e.g. hospice)</td>
<td>Doctor</td>
<td>Doctor and Organization</td>
<td>Doctor and Organization</td>
</tr>
<tr>
<td>Assesses decisional capacity and confirms absence of coercion</td>
<td>Doctor</td>
<td>Doctor</td>
<td>Doctor and Organization</td>
</tr>
<tr>
<td>Prescribes lethal drug</td>
<td>Doctor</td>
<td>Doctor</td>
<td>Doctor</td>
</tr>
<tr>
<td>Dispenses lethal drug</td>
<td>Pharmacist</td>
<td>Pharmacist</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Is present and offers support during self-administration of lethal drug (ass. suicide)</td>
<td>Doctor</td>
<td>(Doctor or) Organization$</td>
<td>(Doctor or) Organization$</td>
</tr>
<tr>
<td>Administers lethal drug (euthanasia)</td>
<td>Doctor</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Reports death to authorities</td>
<td>Doctor</td>
<td>Doctor</td>
<td>Organization</td>
</tr>
</tbody>
</table>

$ Doctor is not excluded from being present, but is unlikely to do so

3. Practices

3.1 Frequency of assisted dying and other end-of-life practices investigated according to the Remmelink study design and questionnaire

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NTD</td>
<td>18</td>
<td>20</td>
<td>20</td>
<td>16</td>
<td>29</td>
<td>16</td>
<td>15</td>
<td>14</td>
<td>4</td>
<td>14</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>APS</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>25</td>
<td>31</td>
<td>19</td>
<td>22</td>
<td>26</td>
<td>19</td>
<td>21</td>
<td>22</td>
<td>33</td>
</tr>
<tr>
<td>PS-DC</td>
<td>??</td>
<td>??</td>
<td>6</td>
<td>8</td>
<td>?</td>
<td>?</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>?</td>
</tr>
<tr>
<td>Assisted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>&lt;0.1</td>
<td>&lt;0.1</td>
<td>0</td>
</tr>
<tr>
<td>suicide</td>
<td>1.7</td>
<td>2.4</td>
<td>2.6</td>
<td>1.7</td>
<td>1.8</td>
<td>1.1</td>
<td>0.3</td>
<td>&lt;0.1</td>
<td>&lt;0.1</td>
<td>0</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Euthanasia</td>
<td>0.8</td>
<td>0.7</td>
<td>0.6</td>
<td>0.4</td>
<td>3.5</td>
<td>3.2</td>
<td>1.5</td>
<td>0.7</td>
<td>&lt;0.1</td>
<td>0.2</td>
<td>0.4</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Numbers in italics relate to decisions that were illegal in the country concerned at the time
NTD = non-treatment decision
APS = alleviation of pain and symptoms with possible, non-intended life-shortening (double effect)
PS-DC = palliative sedation, deep and continuous
NOR = active ending of life through injection of drugs, without an explicit request from the patient
NL=Netherlands, AU=Australia, BE=Belgium, DK=Denmark, IT=Italy, SE=Sweden, CH=Switzerland, UK=United Kingdom
° original Remmelink study + different wording of the questionnaire (->limited comparability)
* different study design § no data available for these years (no question on PS-DC asked)

3.2 Medical diagnoses in EAS in the Netherlands, Switzerland, and Oregon

<table>
<thead>
<tr>
<th></th>
<th>EAS in the Netherlands 1984 - 1993 (n=1707)⁷</th>
<th>AS in Switzerland 1990-2000 (n=331)⁸</th>
<th>AS in Oregon 1998-2008 (n=401)⁹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>78%</td>
<td>47%</td>
<td>82%</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>4%</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases of the</td>
<td>2%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>nervous system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV / AIDS</td>
<td>9%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>21%</td>
<td>3%</td>
</tr>
</tbody>
</table>

⁷ Van der Maas G et al. Cases of euthanasia and assisted suicide reported to the public prosecutor in North Holland over 10 years. BMJ 1996;312:612-613
⁸ Bosshard G et al. 748 cases of suicide assisted by a Swiss right-to-die society. Swiss Med Wkly 2003;133:310-317
B Specific information on Switzerland

1. Social and political features of Switzerland
   • Direct Democracy, federalism, principle of subsidiarity
   • Liberalism; belief in the self-organisational power of civil society
   • Pragmatism, “harm reducing approach” (cf. for instance medical supply of heroine for critically ill drug-addicts)

2. Legal regulation of assisted suicide in Switzerland\(^{10}\)
   • Art 114: Killing on request
     A person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and insistent request, will be sentenced to a term of imprisonment (Gefängnis).
   • Art 115: Inciting and assisting someone to commit suicide
     A person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of imprisonment (Zuchthaus) of up to 5 years or a term of imprisonment (Gefängnis).
   • Civil Code, Art 16: Legal capacity
     A person is presumed to have capacity to act reasonably, unless he or she is deemed not to have such capacity because he or she is a child, suffers from a mental illness, mental infirmity, drunkenness or a similar condition.
   • Law on Pharmaceutical Products, Art 26 Basic principle relating to prescribing and dispensing
     The prescribing and dispensing of pharmaceutical products must be carried out in accordance with the acknowledged rules of medical and pharmaceutical science.
   • Narcotics Law, Art 11
     Medical doctors and veterinarians are obliged to use, dispense and prescribe drugs only to the extent that is necessary according to the acknowledged rules of medical science.

3. Preconditions of the guidelines of the Swiss Academy of Medical Science for assisted suicide to be checked by the doctor
   • The patient’s disease justifies the assumption the patient is approaching the end of life
   • Alternative possibilities for providing support have been discussed and, if desired, have been implemented
   • The patient is capable of making the decision, his wish has been thought out, without external pressure, and he persists in this wish. This has been checked by a third person, who is not necessarily a doctor.

4. Number of assisted suicide cases in Switzerland according to right-to-die society

*most of the deceased individuals involved coming from outside Switzerland ("suicide tourism")

5. Reasons for assisted suicide, Switzerland 2001-2004

<table>
<thead>
<tr>
<th>Reason</th>
<th>Physicians</th>
<th>Deceased</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical reasons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pain</td>
<td>56%</td>
<td>58%</td>
<td>0.74</td>
</tr>
<tr>
<td>dyspnoea</td>
<td>23%</td>
<td>23%</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Social reasons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>need of long-term care</td>
<td>37%</td>
<td>39%</td>
<td>0.65</td>
</tr>
<tr>
<td>immobility</td>
<td>23%</td>
<td>30%</td>
<td>0.17</td>
</tr>
<tr>
<td><strong>Psycho-existential reasons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>control on circumstances of death</td>
<td>12%</td>
<td>39%</td>
<td>0.000</td>
</tr>
<tr>
<td>loss of dignity</td>
<td>6%</td>
<td>38%</td>
<td>0.000</td>
</tr>
</tbody>
</table>

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End of Life Assistance (Scotland) Bill

Rob Jonquière MD

As former CEO of the Dutch Right to Die Society NVVE (retired) and now Communications Director for the World Federation of Right to Die Societies WFRtDS, I consider myself as having extensive experience in the field of legalization of assisted dying by physicians. I have been involved in the discussions around the Dutch Euthanasia Bill, right from the moment it was introduced in the Dutch Parliament in 1999, up to its endorsement by the Senate in 2001 and its implementation in 2002 and later evaluations.

I have been in the position to explain to great extents the ins and outs of our law in many countries in the world in general and Europe in particular. My thus built experience has learnt me to understand on one side the impossibility to export Dutch Law to other countries one-in-one (how much our sister societies would like to) because of different cultural and juridical/legal systems, but also on the other side it has taught me that “our” experience (now some 37 years of tolerated and legalized practice) forms a sound basis and even may provide valuable concrete contributions for other jurisdictions to design their own law; to design a system in which – this turned out in The Netherlands to offer the most important effect – the quality of end of life care could be improved, also because the patient had a real choice at the end of his/her life.

One of the ever returning discussion points when in debate with “opponents” of this choice possibility was the (deliberate?) misuse of the figures on the end-of-life practice in The Netherlands, presented by The Netherlands self. Since 1995 we have produced regular scientifically sound (world renowned statistics!) figures about our practice, repeated more or less every five years, in 2005 for the last time. These figures include amongst others also figures on doctors actions at the end of life of persons, which are against our law then as now (the number of euthanasia case without request, happily misused by opponents); but, these figures have decreased by some 50% since our law was put into force.

In many countries now Palliative Care (PC) in general and Palliative (terminal) Sedation (PS) in particular is brought forward as alternative to Euthanasia or Physician Assisted Dying. Euthanasia and PS are two possibilities at the end of a process of dying guidance / palliative care; each has its own properties, the one never can be replaced by the other as if they are full alternatives.

**Euthanasia** is termination of life *on request by the person involved*; if the doctor performs the euthanasia and he complies with the criteria of the law, he will be free of prosecution. One of those criteria says there should be a situation of unbearable and hopeless suffering.

**Palliative sedation** is possible when there is a terminal situation (dying is to be expected within 1 - 2 weeks) and there are refractory (untreatable)
symptoms (pain, shortness of breath for example). The sedation is given to have the patient in a deep sleep in order for him not to notice the refractory symptoms. It is a medical decision and seen as a normal medical treatment for which no reporting is required.

Yes of course there is a grey area between the two methods, but that area is not bigger because euthanasia is legalised; both proponents of euthanasia and of palliative sedation wants this area to be as small as possible. The existence of both law and guideline gives more guarantee for transparent treatments by doctors in order for patients to have the right to co-decide with the doctor which way they prefer.

To summarize:

1. People in The Netherlands (as in Scotland) rather live then die, but want to have (and in The Netherlands now are lucky to have) the possibility to ask for medical support when they find the end of their life is inhumane because of futile suffering. The Dutch have since seen no increase in numbers, no increase in misuse (if at all in substantial numbers), no decrease in trust in doctors and all that despite internationally recognized high level of Dutch palliative care! A human being does not ask easily for help to die; the legal possibility to do so facilitates the asking, facilitates the civilized conversation about this last phase of someone’s life and – in my experience – sooner prolongs life than shortens it; prevents ill-considered decisions from desperate humans and leads to better end-of-life care for all, palliative care included!

2. In no country in the world there is so much openness on medical decisions around the end of life as in the Netherlands. The scientifically well renowned reports of 1990, 1995, 2001 and 2005 (Remmelink, Van der Wal, Onwuteaka) are statistically sound and show no signs of a slope downwards, let alone a slippery slope:

   a. the absolute numbers of euthanasia and physician assisted suicide have shown to be rather stable, being about 2% of all death cases per year;
   b. the percentage of reported euthanasia cases has grown from 18% in 1990 to 80% in 2005;
   c. the same reports even showed the decisions without requests (also in our eyes to be incorrect!) also to dramatically go down from 0,8% in 1990 to 0,4% in 2005 (some of them being termination of the life of severely multi-handicapped new-borns)
   d. since 2001 there was a significant rise in percentage of Palliative Sedation (PS), a development in the opposite direction of that of Euthanasia.

3. Even the best of Palliative Care (PC) will never be able to take away all requests for euthanasia. The best PC offers a free choice to patients as to how and when they die. One of those should be Euthanasia, another
PS. Good communication between the dying patient (and his/her family) on the one side and the acting doctor on the other side, long before the final moments turn out to be crucial for a humane death for the patient and a soothing bereavement for the relatives.

4. The lessons from the Netherlands can be that legalisation of Euthanasia turned into a better quality of all end-of-life care, a higher level of Palliative Care and a continued high level of trust between doctors and patients.

Now, as WF Communications Director and as webmaster of its website www.worldrtd.net, I regularly see those false arguments reappear, and my big fear is that wrongly used statistics from The Netherlands might be the reason for NOT accepting Margo McDonald’s Bill. It is in the interest of patients to have real choices and those are only there where and if a legalized possibility is in existence.

Knowing the complexities in this and realizing the limitations of written evidence, I will be happy to give oral evidence on the matter in a discussion with your Committee if they see the benefits of such evidence.

I wish you wisdom in your decisions.

Rob Jonquière MD
WF Communications Director
11 May 2010
Agenda Item 1  
7 September 2010  
Dr Rob Jonquières – supplementary written evidence

<table>
<thead>
<tr>
<th>Category</th>
<th>1990</th>
<th>1995</th>
<th>2001</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>nr of death’s</td>
<td>128.800</td>
<td>135.700</td>
<td>140.000</td>
<td>136.400</td>
</tr>
<tr>
<td>% Euthanasia</td>
<td>1.8</td>
<td>2.4</td>
<td>2.5</td>
<td>1.7</td>
</tr>
<tr>
<td>% Physician Assisted Suicide</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>% without request</td>
<td>0.8</td>
<td>0.7</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>% terminal sedation side eff.</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>% non treatment</td>
<td>18</td>
<td>20</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

**COMPARISON by countries** -- van der Wal, Kuhse, Deliens

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>% euthanasia</td>
<td>2.7</td>
<td>1.9</td>
<td>1.5</td>
</tr>
<tr>
<td>% non voluntary</td>
<td>0.7</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>% end-of-life decision</td>
<td>24.8</td>
<td>64.9</td>
<td>38.9</td>
</tr>
</tbody>
</table>

**PERMISSIVENESS of Doctors in NL** -- van der Wal

<table>
<thead>
<tr>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
</tr>
<tr>
<td>1995</td>
</tr>
<tr>
<td>2001</td>
</tr>
</tbody>
</table>

**PALLIATIVE CARE in NL**
The European Association for Palliative Care (EAPC) commissioned a Taskforce on The Development of Palliative Care in Europe (head prof. Carlos Centeno). This taskforce presented a ranking (of European countries as to resources in which ranking NL came out in the top 6 of Europe.


Another recent study on the Quality of Dying (Economist Intelligence Unit – EIU) put The Netherlands on 7th place; the existing possibility of euthanasia and other sort like end-of-life decisions was not one of the ranking criteria. The report can be downloaded at


**DEFINITIONS in NL**

**EUTHANASIA = deliberate termination of life by someone else, on the explicit request of the person involved.**

- The medication is applied by the doctor: \(\rightarrow\) euthanasia
  - The medication is prescribed by the doctor and taken by the person self: \(\rightarrow\) (physician) assisted suicide

**Deliberate:** intentional
**Someone else:** in Dutch definition no medical person is mentioned
**Implicit request:** only on request one speaks of euthanasia
**Person involved:** only the person himself can ask for this – not someone else

**PALLIATIVE SEDATION = intentionally lowering someone’s consciousness to such a degree that this person is no longer suffering from (otherwise) intractable symptoms and complaints.**

- The medication is applied by medical personnel at a doctor’s responsibility

**Intentionally:** intention is to take away intractable symptoms
**Consciousness:** no life termination
**Intractable:** all treatment possibilities have been futile

**PRINCIPLES of Dutch Euthanasia Law**

Euthanasia is still a crime, but......

- when it is a *doctor* who acts
  - and
- he follows the *criteria of due care* ......

Such a doctor is not punishable and free of prosecution
Agenda Item 1  ELA/S3/10/4/4
7 September 2010
Dr Rob Jonquière – supplementary written evidence

Other then doctor: commits a crime with a max. 12 year imprisonment crucial in the juridical assessment of due care:
- request: voluntary and well considered
- unbearable and hopeless suffering
- consultation 2nd independent doctor (SCEN)
- good medical practice
- reporting to Review Committee

REPORTING: year numbers – and rate

Source: Annual reports of the Review Committee’s to be found at

http://www.euthanasiecommissie.nl/en/review-committees/annualreport/

Amsterdam, August 2010

Rob Jonquière, MD
WF Communications Director

robjonquiere@kpnplanet.nl
www.worldrtd.net
Assisted dying regimes

Introduction
A small number of jurisdictions now permit euthanasia and/or assisted suicide. This briefing note discusses how the law was changed in those jurisdictions, outlines the regulatory regimes, and summarises the empirical evidence of the practice of euthanasia and assisted suicide (defined in box 1).

How the law was changed to permit assisted dying

The Netherlands
In the Netherlands, euthanasia and assisted suicide were effectively legalised through the use of the defence of necessity in prosecutions of (primarily) doctors. The defence is available when the doctor faced a conflict between his or her duties to preserve life and relieve suffering. The courts held that only doctors can face such a conflict of duties because only doctors have a professional duty to relieve suffering: lay-persons (who include relatives) and nurses do not. Over some thirty years, the courts developed this duty-based defence of necessity in euthanasia cases, placing conditions on the defence, including: an express and earnest request; unbearable and hopeless suffering; consultation; careful termination of life; record-keeping; and reporting. These conditions became known as requirements of due care or careful practice. The Dutch legislature eventually codified the parameters of the defence in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, which lists six due care criteria which must be met in cases of euthanasia and assisted suicide (see box 2). The judicially-developed necessity defence is still applied to cases involving incompetent persons, particularly neonates.

Belgium
Unlike in the Netherlands, there had been few criminal prosecutions in euthanasia cases prior to its legalisation in Belgium, so legal change had to come from outside the judiciary. The 1980s and 1990s witnessed a series of unsuccessful legislative moves to allow euthanasia. After a change of government and intense legislative debate, the Law on Euthanasia was passed in 2002. It allows only doctors to perform euthanasia. Assisted suicide is not explicitly covered, although Belgium’s oversight body, the Federal Control and Evaluation Commission (FCEC) has accepted cases of assisted suicide as falling under the law.

Luxembourg
The Law on Euthanasia and Assisted Suicide came into force in Luxembourg in 2009 after a heated political and public debate. The law is closely based on the Belgian law, although it does specifically permit assisted suicide as well as euthanasia.

Box 1. Definitions

• Euthanasia: an intervention undertaken with the intention of ending a life to relieve suffering. In the Dutch and Belgian contexts, the term euthanasia refers only to the termination of life upon request.

• Assisted suicide: any act which intentionally helps another person to commit suicide, for example by providing him or her with the means to do so. In the Netherlands, assisted suicide is often included in the term euthanasia. Legal regimes often permit only physician-assisted suicide which is commonly referred to as PAS.

• Assisted dying: (voluntary active) euthanasia and assisted suicide. (Though sometimes used as a synonym only for assisted suicide.)

Switzerland
In Switzerland, it is a criminal offence to assist a suicide only where the assister has a selfish motive. This provision in the Penal Code has not changed since 1942. When it was originally drafted in 1928, “the attitudes of the Swiss public were shaped by suicides motivated by honour and romance, which were considered to be valid motives. Motives related to health were not an important concern, and the involvement of a physician was not needed.” Euthanasia is not permitted in Switzerland, although as in many other European jurisdictions, the separate offence of murder at the victim’s request carries a lower minimum sentence than murder.

Oregon and Washington
Many US states allow legislation to be enacted if a majority votes for an initiative placed on the ballot following a petition signed by a minimum number of voters. Following two narrowly unsuccessful attempts to permit physician-assisted suicide by ballot initiative in Washington and California, Oregon voters passed the first Death with Dignity Act in 1994, by a majority of 52%. The Act permits the provision of a prescription for lethal medication to be self-administered by the patient. The Act was controversial from the moment the ballot measure was passed, and there were a number of ultimately unsuccessful legal
challenges to it. Washington voters passed an almost identical Act in 2008 by a majority of 58%.

Features of assisted dying regimes
This section outlines the most important legal regimes permitting assisted dying: those in the Netherlands, Belgium and Oregon.

The requesting person's condition and experience of suffering
The legal requirements relating to the requesting person's condition and experience of suffering vary widely across these jurisdictions. It is notable that despite this variation, over 80% of all reported cases of euthanasia or physician-assisted suicide in the Netherlands, Belgium and Oregon involve cancer patients.

In the Netherlands, the "attending physician . . . must have been satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement". The patient's suffering need not be related to a terminal illness and is not limited to physical suffering such as pain. It can include, for example, the prospect of loss of personal dignity or increasing personal deterioration, or the fear of suffocation. A related due care criterion (see box 2) is that there must be "no reasonable alternative in light of the patient's situation". In cases where the source of the suffering is a physiological disorder, the patient's reasonable decision to refuse a realistic treatment possibility (whether curative or palliative) which might ease his or her suffering does not stand in the way of a request for euthanasia based on that suffering.

In Belgium, the "patient must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident". As in the Netherlands, there is no requirement that the patient be suffering from a terminal illness, although additional procedural requirements are imposed if the patient is "clearly not expected to die in the near future". Again there must be "no reasonable alternative" to euthanasia. However, euthanasia is permissible only if the disorder is incurable, so a patient's reasonable refusal of potentially curative treatment will prevent access to euthanasia. The reasonable refusal of a palliative treatment possibility will not have this effect.

The Netherlands permits assisted suicide in cases where the source of the patient's suffering is a psychiatric rather than a physiological disorder. In such cases, the patient may not reject "a realistic alternative to relieve the suffering". In Belgium, the permissibility of euthanasia or assisted suicide in psychiatric cases was initially unclear. Since legalisation, the Federal Control and Evaluation Commission (FCEC) has accepted six psychiatric cases (which constitute less than 1% of all reported cases). Of these, five patients suffered from serious and incurable depression and one from psychosis with repeated suicide attempts.

In Oregon, the patient must be suffering from a terminal disease, defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months". There is no additional requirement relating to the patient's experience of the disease or any minimum level of suffering.

The request
In the Netherlands, the patient's request must be "voluntary and carefully considered". The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent. The request must also be well-informed.

In Belgium, the patient must be "legally competent". The request must be both "completely voluntary" and "not the result of any external pressure". The doctor must inform the patient about "his health condition and life expectancy" and "the possible therapeutic and palliative courses of action and their consequences".

In Oregon, the competence, voluntariness and information requirements are set out in some detail. The patient must have "the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available." Two witnesses must attest that the patient is acting voluntarily and is not being coerced to sign the request. The patient must make an "informed decision . . . that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control."

The requesting person's age
The Dutch law applies also to patients under the age of majority (18). A patient between the ages of 16 and 18 who is "capable of making a reasonable appraisal of his own interests" may request euthanasia or assisted suicide. The parent(s) or guardian does not have a veto, but must be consulted. Patients aged between 12 and 16 must pass the same test of capacity. In addition, the consent of the parent(s) or guardian is required.

In Belgium, euthanasia is legal only for patients over the age of 18 and for minors over the age of 15 who have been legally emancipated by a judicial decision. No cases involving minors have been reported. The Oregon and Luxembourg laws apply only to patients over the age of 18.

Box 2. The Dutch due care criteria
The due care criteria are set out in section 2(1) of the 2001 Act.

“The attending physician must:

a. be satisfied that the patient has made a voluntary and carefully considered request;

b. be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;

c. have informed the patient about his situation and his prospects;

d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;

e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and

f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.”

Consultation and referral
All of the regimes require another physician to confirm the fulfilment of the legal requirements. A number of additional functions may be served by a consultation requirement, including
quality control; avoidance of idiosyncratic judgments; provision of information to the attending physician; and enabling effective retrospective scrutiny of actions and decisions.\textsuperscript{13}

In the Netherlands, the independent physician must see the patient and give a written opinion on the extent to which the due care criteria are met (see box 2). The consultation requirements are more stringent if the patient’s suffering is due to a psychiatric disorder. The state-funded programme Support and Consultation on Euthanasia in the Netherlands (SCEN) trains physicians to be consultants and to provide support and advice for doctors treating patients at the end of life. Most reported euthanasia cases involve a SCEN consultant.

In Belgium, the consulting physician must examine the patient and the medical record and ensure that the suffering requirement has been met. Moreover, if the patient “is clearly not expected to die in the near future”, there is a mandatory additional consultation with either a psychiatrist or relevant specialist (and a waiting period of at least one month). Although a consultation with a palliative care expert is not legally required, many Catholic hospitals in Flanders impose such a palliative filter in addition to the statutory criteria.\textsuperscript{15}

In Oregon, the attending physician must refer the patient to “a consulting physician for medical confirmation of the diagnosis, and for determination that the patient is capable and acting voluntarily.” Further, a counselling referral must be made if either the attending or consulting physician suspects that the patient “may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment”. Physician-assisted suicide (PAS) is allowed only if the counsellor determines that the patient is not suffering from such a condition.

The person providing assistance

In the Netherlands, the courts originally required that the person who providing euthanasia was the patient’s treating physician.\textsuperscript{16}

The current requirement focuses more closely on its purpose: the doctor must know the patient sufficiently well to be able to assess whether the due care criteria are met (see box 2). Cases in which there is no pre-existing doctor-patient relationship are likely to be closely investigated.

The Belgian Act requires that the physician have “several conversations with the patient spread out over a reasonable period of time” in order to be certain of the persistence of the patient’s suffering and the enduring character of his or her request. The Dutch purpose-focused argument (that in order to assess whether the due care criteria are met, the doctor must have some familiarity with the patient) might also be applied in Belgian euthanasia cases. However, the legislative history makes clear that the patient should be able to bypass his or her attending physician if so desired – from which one might infer that there is no requirement for a pre-existing physician-patient relationship.\textsuperscript{17}

In Oregon, the attending physician is defined as “the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease”. The evidence suggests that many patients who sought assisted suicide had to ask more than one physician before finding one who was willing to provide a prescription. Over the first three years of operation of the Oregon law, only 41\% of patients received their prescription from the first physician asked.\textsuperscript{18} This suggests that in many cases there was no longstanding or pre-existing physician-patient relationship.\textsuperscript{19} The median duration of that relationship in Oregon over the first ten years was 11 weeks. The range was between 0 and 1440 weeks.\textsuperscript{20} Commentators opposed to the Oregon law have raised the possibility that a patient refused PAS by one physician on the grounds of failing to meet one of the statutory criteria may obtain the prescription from a more accommodating physician.\textsuperscript{21}

The laws in Belgium and Oregon contain conscientious objection provisions. Although there is no such provision in the Dutch law, it is nonetheless clear that “no doctor has any obligation to accede to a request [for euthanasia], however well-founded.”\textsuperscript{22}

Reporting and scrutiny

Termination of life on request and assisted suicide remain criminal offences in the Netherlands. The defences inserted into the Penal Code by the Act require the doctor to report the case as euthanasia or assisted suicide to the municipal pathologist, who then passes the file to the relevant Regional Review Committee (RRC). If the RRC finds that the doctor did not act in accordance with the due care criteria (see box 2), the case is referred to the Public Prosecution Service. Thirty eight cases were referred between 1999 and 2008 (0.19\% of reported cases). No prosecutions have been brought following these referrals.\textsuperscript{3,4,20}

Compliance with the Belgian law is monitored by the Federal Control and Evaluation Committee (FCEC), to which all cases of euthanasia must be reported. No cases have been reported to the prosecutorial authorities by the FCEC. In Oregon, the physician must report each prescription written under the Act to the Oregon Department of Human Services (ODHS), and report each death resulting from the ingestion of the prescribed medication. At least 18 physicians have been referred by the ODHS to the state Board of Medical Examiners; most of these cases involved incorrectly completed forms.\textsuperscript{21}

Empirical evidence

Most of the evidence is either of the frequency of particular end of life decisions (obtained from surveys completed anonymously by doctors) or of cases reported to the relevant authority. This section summarises key evidence, much of which is about the Dutch experience. Many of the empirical claims made about the practice of assisted dying under existing legal regimes misrepresent the data, take it out of context or neglect important comparisons with jurisdictions where assisted dying is prohibited.\textsuperscript{22}

What is known about the frequency of end of life decisions

Chart 1. Rates of euthanasia, PAS and termination of life without request

Chart 1 shows the percentage of all deaths in specific years that were cases of euthanasia (EUT), PAS or termination of life without request (TLWR). It combines data from a number of different anonymous prevalence surveys of doctors.\textsuperscript{23,24,25,26} All surveys were based on one originally designed by Dutch researchers.\textsuperscript{27} The relatively broad and overlapping confidence intervals suggest that fine comparisons should not be made between countries with the lowest percentages.
Chart 2: End of life decisions (ELDs) in the Netherlands & the UK

Chart 2 compares the types of ELDs in the Netherlands in 2005 and the UK in 2007-8. Each country’s chart on the left represents approximately 60% of deaths. (In the remaining deaths no ELD was made.) In addition to euthanasia (EUT), PAS and termination of life without request (TLWR), two much larger categories are included: abstention (withdrawing or withholding life-sustaining treatment) and alleviation of symptoms taking into account possible or probable hastening of death. In both countries, EUT, PAS and TLWR were relatively rare, all together comprising 2.2% of all Dutch deaths and 0.24% of all UK deaths.

Netherlands

The latest Dutch reporting rate (from 2005) is 80%. “The major reason for failure to report [a case as euthanasia] is that the physician does not regard the course of action as a life-terminating act”. These unreported cases frequently involve the use of non-typical drugs to cause death (morphine rather than barbiturates and/or muscle relaxants which are typically used in euthanasia cases) and/or a very short life expectancy. The number of estimated deaths from euthanasia includes such cases, as it does not rely on doctors’ labelling of their own practice. As 99% of cases involving typical euthanasia drugs are reported, this inconsistent labelling now likely accounts for most unreported cases. Doctors need more clarity on when to report.

What is known about reporting

Chart 3. Estimated & reported deaths from euthanasia in the Netherlands

Chart 3 shows that more and more deaths from euthanasia came to be reported as the Dutch control system became established, and that the Dutch reporting rate has improved significantly over time.22,20,24

Penney Lewis
Endnotes

5 College van procureurs-generaal (2007) Aanwijzing vervolgingsbeslissing inzake levensbeëindiging op verzoek ( euthanasie en hulp bij zelfdoding) [5.3].
7 Chabot, Hoog Raad, Nederlandse Jurisprudentie 1994, no. 656.
9 Smets et al. Legal euthanasia in Belgium: characteristics of all reported euthanasia cases. Medical Care 2010;48:187-192, Table 2.
Introduction

1. Margo MacDonald’s Bill is seeking to legalise assisted suicide and voluntary euthanasia for persons who are terminally ill or are “permanently physically incapacitated to such an extent as not to be able to live independently”\(^1\) and who also find life intolerable.

2. In 2004-05 I chaired a select committee of the House of Lords of the Westminster Parliament which examined a similar bill tabled by Lord Joffe\(^2\). This bill was similar in many respects to that recently tabled by Margo MacDonald in the Scottish Parliament, the main difference being its narrower ambit – Lord Joffe’s bill was limited to persons who were terminally ill. In the hope that it will assist the deliberations of the committee examining Margo MacDonald’s bill, I offer below a summary of expert evidence received and conclusions reached by the Westminster select committee in respect of certain parts Lord Joffe’s bill that closely resemble aspects of Margo MacDonald’s. As it is not my intention to comment on the suitability or otherwise of the latter bill, I submit this evidence as a factual account rather than in the form of responses to the questions posed in the call for evidence.

The Westminster Select Committee

3. The select committee spent some six months examining both the underlying principles and the detail of Lord Joffe’s bill. During this time, in addition to taking evidence in London, the committee visited the US State of Oregon, where physician-assisted suicide was legalised in 1997; The Netherlands, where physician-assisted suicide and physician-administered euthanasia were legalised in 2001; and Switzerland, where assisted suicide was legalised in 1942, though not specifically as a medical procedure. The committee received over 60 written submissions from interested organisations and took oral evidence from over 140 expert witnesses in the UK and the three other legislatures. In addition, it received over 14,000 letters or emails from members of the public.

4. The committee did not finish its work in time to enable the bill to make progress in that Session and agreed that its report should summarise the evidence received and draw attention to those respects in which any subsequent bill should seek to correct what were seen as deficiencies in Lord Joffe’s bill. The committee’s report was published on 4 April 2005 as HL Paper 86 of Session 2004-05. It is available online at the Parliament website\(^3\) and provides the basis of the comments that follow.

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\(^1\) Section 4(2)(b)
\(^2\) Assisted Dying for the Terminally Ill Bill 2004
\(^3\) http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.
Evidence and Conclusions

Terminal Illness

5. Margo MacDonald’s bill defines a person who is terminally ill as someone who “suffers from a progressive condition and if death within six months in consequence of that condition can reasonably be expected”\(^4\). This definition is similar to that which appeared in Lord Joffe’s bill\(^5\), so it may be instructive to look at what expert witnesses had to say about it.

6. Diagnosis and prognosis are expert processes, and perhaps for that reason many of us tend to regard them as exact sciences. The select committee was told, however, that they were far from being that. The Royal College of Pathologists pointed to a consistent 5% error rate, revealed in post mortems, in diagnosis of terminal illness. They wrote that “almost all histopathologists (doctors who perform post-mortem examinations) have experience of cases deemed to have died from an untreatable terminal illness, but post mortem examination discloses another condition – that would have been treatable – for the patient’s death”\(^6\).

7. The difficulties of making an accurate prognosis – ie predicting the course of a diagnosed terminal illness – were, the select committee was told, even greater. Medicine was described as “a probabilistic art” and there was a general consensus that, while reasonably accurate prognoses could be made when a patient was within days or a few weeks of death, the scope for error at six months was considerable. Indeed, it was not uncommon for patients given six months’ life expectancy to live for two or three times as long or even longer.

8. The select committee’s conclusion was that “there is clearly a difference between the popular view of terminal illness, which employs phrases like ‘three months to live’, and the reality of clinical practice, in which prognosis is far from being an exact science and in which there can be wide variations from an overall norm”\(^7\). We recommended that, “if a future bill should include terminal illness as a qualifying condition, this should be defined in such a way as to reflect the realities of clinical practice as regards accurate prognosis”\(^8\).

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\(^4\) Section 4(4)
\(^5\) “terminal illness means an illness which in the opinion of the consulting physician is inevitably progressive, the effects of which cannot be reversed by treatment (although treatment may be successful in relieving symptoms temporarily) and which will be likely to result in the patient’s death within a few months at most”
\(^6\) HL Paper 86, Volume II, Page 730
\(^7\) HL Paper 86, Volume I, Paragraph 250
\(^8\) HL Paper 86, Paragraph 269(c)(iii)
Mental Capacity

9. Margo MacDonald’s bill requires that a person requesting assisted suicide or voluntary euthanasia should have “capacity” to make the request. It defines capacity as “not suffering from any mental disorder which might affect the making of such a request”. Lord Joffe’s bill required an applicant to be “competent”, which it defined as “having the capacity to make an informed decision”. The two requirements are therefore broadly similar.

10. The select committee’s expert witnesses warned that “the desire to die covers a spectrum of intent” and that “far more people express a desire to die than actually make an attempt to kill themselves”. Our attention was drawn to the presence of “episodes of reactive depression as a result of a diagnosis of life-limiting illness” and to “a significant incidence of moderate to severe depression and anxiety at various stages throughout the course of many diseases”, measurement of which could be confounded by the symptoms of the diseases themselves. We were told of research that indicated that “the will to live and the desire for death fluctuate throughout the course of terminal illness for all except a very small number of patients”.

11. We were also advised that, in the case of patients with neurological conditions, there was a significant risk of “cognitive impairment”, which could be difficult to detect. All were agreed that any applicant for assisted suicide or voluntary euthanasia should be referred for thorough psychiatric evaluation, with other professionals – eg neuropsychologists or palliative care physicians – involved as necessary. The select committee endorsed these conclusions, adding that, where evidence of mental disorder was apparent, treatment should be offered.

Finding Life Intolerable

12. Margo MacDonald’s bill requires, as a condition for approval of assisted suicide or voluntary euthanasia, that an applicant “finds life intolerable”. In this respect it resembles closely Lord Joffe’s requirement that an applicant for what the bill called ‘assisted dying’ must be “suffering unbearably”.

13. There was consensus among our witnesses that “unbearable suffering” was necessarily a subjective term and that, if it were to provide any sort of effective filter for assisted suicide or voluntary euthanasia, a patient’s statement that he or she was “suffering unbearably” needed to be confirmed as a reasonable and permanent state of mind. This would require, in the opinion of the National Council for Hospice and Specialist Care.

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9 Section 9(3)(a)
10 Sections 1(2), 2(2)(b) and 3(b)
11 HL Paper 86, Volume I, Paragraph 124
12 HL Paper 86, Volume I, Paragraph 125
13 HL Paper 86t, Volume I, Paragraph 126
14 HL Paper 86, Volume I, Paragraph 254
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Palliative Care Services\textsuperscript{15}, a longer relationship between doctor and patient than was required under Lord Joffe’s bill. In other words, for this condition to be at all effective, the physician’s assessment would have to be based on personal knowledge of the patient over a period of time. Other witnesses pointed out that unbearable suffering, while real enough, might not derive from the presence of terminal illness but from concomitant circumstances (for example, the loss of a loved one) and, moreover, that many people who are not terminally ill – or even ill at all - feel they are suffering unbearably.

14. The select committee considered that the definition of an applicant’s suffering needed more objectivity than was provided for in Lord Joffe’s bill. It recommended “unrelievable” or “intractable” suffering as a more satisfactory criterion. In our report we offered the view that “a test of ‘unrelievable suffering’ might ensure than an application would not be taken at face value but that action would be taken to attempt to relieve any suffering and that only in those cases where this was unsuccessful would assisted suicide or voluntary euthanasia be considered further”\textsuperscript{16}.

Implementation

15. The select committee was concerned that Lord Joffe’s bill did not specify clearly what actions a physician might and might not legally take to give effect to an approved application for assisted suicide or voluntary euthanasia. The bill spoke simply of a doctor “assisting a patient to die”. The committee recommended therefore that any future bill “should spell out what a doctor may and may not do in circumstances where an applicant has met all the specified criteria and made a formal declaration”. It should “set out the procedures under which a prescription for lethal medication may be given and the necessary drugs obtained, along with the responsibilities, rights and immunities of the persons involved, such as doctors and pharmacists”. Similarly, “we would expect to see a detailed procedure for establishing whether a request fell within tightly-defined criteria for voluntary euthanasia rather than assisted suicide and, in the event that it did, for putting the necessary action into effect”\textsuperscript{17}.

16. Margo MacDonald’s bill appears to present similar difficulties in this respect to Lord Joffe’s. Though a general definition of ‘end of life assistance’ is given in Section 1(2)\textsuperscript{18}, nowhere is it stated what form “the provision or administration of appropriate means” may or may not take or what other forms of ‘assistance’ might be legal. Though a registered medical practitioner is placed at the centre of the assessment and approval process, his or her precise responsibilities after the approval of an application are not made clear.

\textsuperscript{15} Now the National Council for Palliative Care (NCPC)
\textsuperscript{16} HL Paper 86, Volume I, Paragraph 256
\textsuperscript{17} HL Paper 86, Volume I, Paragraph 248
\textsuperscript{18} “In this Act “end of life assistance” means assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress”
17. It would also appear that under Mrs MacDonald’s bill the choice between assisted suicide and voluntary euthanasia is to be left for agreement between the applicant and the registered practitioner, whereas Lord Joffe’s bill provided for voluntary euthanasia only where the applicant was unable to end his or her own life via assisted suicide. Given the much higher death rate from voluntary euthanasia than from assisted suicide where these practices have been legalised, the committee may wish to consider whether Margo MacDonald should be invited to introduce a similar limitation into her bill.

Conscientious Objection

18. Margo MacDonald’s bill, unlike Lord Joffe’s, does not appear to make any provision for doctors who may have a conscientious objection to assisting a suicide or administering voluntary euthanasia. This is a surprising omission and Mrs MacDonald will no doubt wish to consider what amendment should be made to her bill to cater for those doctors, possibly the majority, who would be unwilling to implement its provisions.

19. In doing so, she may wish to take note of the select committee’s observations on Lord Joffe’s bill as regards conscientious objection. The select committee had noted an observation by the Joint Committee on Human Rights that requiring a doctor with a conscientious objection to refer a patient seeking ‘assisted dying’ to another physician, as Lord Joffe’s bill required, could itself constitute an infringement of conscience. Recognising this difficulty, Lord Joffe undertook to include a more satisfactory conscience clause in any successor bill.

20. However, the select committee made two further observations in its report. The first was that other health care professionals than physicians, including nurses and pharmacists, could find themselves caught up in one way or another in implementing assisted suicide or voluntary euthanasia. Any conscience clause would need to protect their positions as well as that of doctors. The second was that care of the terminally ill is often a matter of multidisciplinary teamwork, with doctors of different specialities working together as equals. The select committee recommended therefore that the drafting of any conscience clause would need to cater satisfactorily for situations such as, for example, where a doctor with primary responsibility for a patient wished to respond to a request for assisted suicide or voluntary euthanasia but other members of the care team had reservations.

Waiting Time

21. Margo MacDonald’s bill requires that, following final approval of a request for ‘end of life assistance’, the applicant and the designated

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19 See HL Paper 86, Volume I, Paragraph 243
20 HL Paper 86, Volume I, Paragraph 262
21 HL Paper 86, Volume I, Paragraph 263
22 Section 10(3)
practitioner must agree on how that approval is to be implemented and it stipulates that “the agreement does not become effective until the expiry of at least two clear days from the date of its conclusion”. Lord Joffe’s bill required a ‘cooling off’ period of 14 days, though this was to be counted from the date when the application was lodged rather than approved.

22. The select committee had reservations about the shortness of Lord Joffe’s proposed ‘cooling off’ period. Though it was recognised that an approved application need not be acted on at once, the committee considered “that, in the patient’s own best interests, he or she should be prevented from acting without reflection – or even from feeling subconsciously that, having proceeded as far as the signing of a declaration and having put a number of people to a lot of trouble, he or she should not draw back”\(^{23}\). Witnesses had drawn attention to the need for a pause so that a patient could stand back from focusing on the process of applying for ‘assisted dying’ and reflect on the decision itself.

23. This reservation is particularly relevant to Margo MacDonald’s bill, which prescribes both a minimum and a maximum waiting period between the two stages of the application process – the second application for ‘end of life assistance’ may be made only if “a period of at least 15 and not more than 30 days has elapsed from the date when the requesting person was informed of the approval” [of the first application]\(^{24}\). The committee examining the bill will wish to consider whether the setting of a maximum time limit could have the unintended effect of pressuring applicants to press ahead with a project on which they have embarked but on which they may have flickering reservations.

**Conclusion**

24. There are many similarities between the MacDonald and the Joffe bills, the main difference between the two being the wider scope of the former. In the preceding paragraphs I have drawn attention to what the 2004-05 Westminster select committee heard from expert witnesses and concluded about some of the features that the two bills have in common. I hope this perspective will be of assistance to the committee in its deliberations on Margo MacDonald’s bill.

Lord Mackay of Clashfern
22 April 2010

\(^{23}\) HL Paper 86, Volume I, Paragraph 260
\(^{24}\) Section 8(1)(c)
ASSISTED DYING FOR THE TERMINALLY ILL BILL

THE SELECT COMMITTEE

1. I have agreed to provide assistance to the Committee on the current legal position in relation to assisted suicide and euthanasia, and the meaning and effect of the proposed legislation, in accordance with my role of giving legal advice to Parliament. My evidence will be limited to advice on the legal questions and will not include any views on the merits of the proposal and will not give any indication of government policy in this regard.

2. The clerk to the Select Committee has made it clear that the Committee would welcome assistance on the following matters:

(i) The current statutory position in the UK in respect of attempted suicide, assisted suicide and voluntary euthanasia.

(ii) The current practice in relation to the prosecution of people who are believed to have participated in any of the above, including the position of people who go abroad in order to procure assisted suicide or euthanasia.

(iii) The current state of the law in respect of a patient's right to refuse life-prolonging treatment and to the withholding or withdrawal of life-prolonging treatment without a patient's consent, and the status in law of current medical guidelines on these acts.

(iv) Interpretation of recent judgements, under both national and international law, on cases involving assisted suicide or euthanasia.

(v) Whether the enactment of legislation allowing assistance with suicide for terminally ill people who are suffering unbearably would be likely to have any implications in law for the obligations placed on authorities, such as (for example) prisons, to protect those in their charge (some of whom might be deemed to be suffering unbearably) from self-harm.
(vi) The Bill before the committee provides, inter alia, that a doctor who carries out assisted suicide or euthanasia "shall be deemed not to be in breach of any professional oath or affirmation" (Section 10(3)). The Committee seeks assistance on whether a change in the law could affect professional oaths or affirmations in this way.

I will respond to these questions at the Select Committee, but provide this background paper on the current law in advance for the assistance of Committee members.

THE CURRENT LAW OF HOMICIDE

3. There are three relevant offences: murder, manslaughter and complicity in suicide.

Murder

4. Murder is defined as "unlawful killing with malice aforethought". This is to be contrasted with those forms of manslaughter which consist of killing without "malice aforethought". The principal distinguishing feature between murder and manslaughter is that murder requires an intention to kill or to cause grievous bodily harm. The penalty for murder is life imprisonment. In summary, deliberately taking the life of another person, whether that person is dying or not, constitutes the crime of murder. Accordingly, any doctor who practises mercy killing can be charged with murder if the facts can be clearly established.

5. The only exception is where the doctor acts to do all that is proper and necessary to relieve pain with the incidental effect that this will shorten the patient's life. This was explained by Devlin J. in R v Adams [1957] Crim L R 773. Doctor Adams was charged with the murder of a patient. It was alleged that he had prescribed and administered such large quantities of drugs that he must have known that death would result. In his summing up to the jury, Devlin J. stated:

"If her life was cut short by weeks or months it was just as much murder as if it was cut short by years. There has been much discussion as to when doctors might be justified in administering drugs which would shorten life. Cases of severe pain were suggested and also cases of helpless misery. The law knows no special defence in this category . . . ."

However he went on to say:

". . . but that does not mean that a doctor who was aiding the sick and dying had to calculate in minutes, or even hours, perhaps, not in days or weeks, the effect on a patient's life of the medicines which he could administer. If the first purpose of medicine—the restoration of health—could no longer be achieved there was still much for the doctor to do and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer. The doctor who decided whether or not to administer the drugs could not do his job, if he were thinking in terms of hours or months of life. Dr Adams's defence was that the treatment was designed to promote comfort and if it was
the right and proper treatment the fact that it shortened life did not convict him of murder."

This introduced into English law the "double-effect" principle, that is if an act has two consequences, one good and one bad, the bad consequence may nevertheless be acceptable depending upon the circumstances.

**Manslaughter**

6. Manslaughter is usually classified as either voluntary or involuntary. Voluntary manslaughter consists of those killings that would be murder, because the accused has the relevant mens rea, but which are reduced to manslaughter because of one of the three special defences provided for by the Homicide Act 1957. These special defences are diminished responsibility (section 2 of the Homicide Act 1957), provocation (section 3 of the Homicide Act 1957), and killing in pursuance of a suicide pact (section 4 of the Homicide Act 1957). Involuntary manslaughter refers to those types of manslaughter where the accused lacks the mens rea for murder. It encompasses killing by an unlawful act likely to cause bodily harm and killing by gross negligence.

**Killing in pursuance of a suicide pact**

7. Section 4(1) of the Homicide Act 1957 provides: "it shall be manslaughter, and shall not be murder, for a person acting in pursuance of a suicide pact between him and another to kill the other or be a party to the other being killed by a third person."

8. A suicide pact is defined in section 4(3) as: "a common agreement between two or more persons having for its object the death of all of them, whether or not each is to take his own life, but nothing done by a person who enters into a suicide pact shall be treated as done by him in pursuance of the pact unless it is done while he has the settled intention of dying in pursuance of the pact."

9. The burden of proving that he was acting in pursuance of a suicide pact is placed on the accused. He must prove not only that there was in fact a suicide pact, but also that at the time of the killing he had the intention of dying himself.

10. Killing in pursuance of a suicide pact is closely related to the offence of aiding and abetting suicide under the Suicide Act 1961 (see below).

**Abetting suicide**

11. The traditional attitude of the common law was to condemn suicide and it was regarded as a criminal offence until the law was changed by the Suicide Act 1961 ("the 1961 Act"). The 1961 Act provided: "the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated." One result of the 1961 Act is that it is no longer a crime to attempt suicide. However, the 1961 Act continues to impose a considerable measure of responsibility upon persons other than the suicide or would be suicide. The
1961 Act makes it a statutory crime to aid, abet, counsel or procure a suicide or attempted suicide and the offence carries a penalty of up to 14 years’ imprisonment.

12. The consent of the Director of Public Prosecutions ("the DPP") is required to initiate proceedings for the offence (Suicide Act 1961, section 2(4)). In R v Hough (1984) 6 Cr. App. R. (S) 406, Lord Lane C.J. commented that the crime of abetting suicide could range "from the borders of cold blooded murder down to the shadowy area of mercy killing or common humanity." In that case a 60 year old woman was sentenced to nine months' imprisonment for aiding and abetting the suicide of an eighty four year old woman who was partly blind, partly deaf and suffered from arthritis. The accused had provided the woman with tablets and, when the 84 year old woman became unconscious, placed a plastic bag over her head.

13. In Wallace (1983) 5 Cr. App. R. (S) 342, a sentence of 12 months' imprisonment was described by the Court of Appeal as "at the extreme of leniency" in a case where the offender pleaded guilty to aiding the suicide of a 17 year old by buying her tablets and alcohol.

**Elements of the offence**

14. The offence is governed by the ordinary rules which apply to aiding and abetting crime. "Aid" and "abet" are generally considered to cover assistance and encouragement given at the time of the offence, whereas "counsel" and "procure" are more aptly used to describe advice and assistance at an earlier stage. To procure is generally taken to mean to produce by endeavour and the word covers the provision of help to a person who wishes to commit suicide: R v Reed (1982) Crim L R 189. In Reed the accused was convicted of a conspiracy to aid and abet suicide and the Court of Appeal stated that a person procures a thing by setting out to see that it happens and taking the appropriate steps to produce that happening.

15. As a general rule aiding and abetting requires proof of mens rea, and this is usually taken to mean an intention to aid as well as a knowledge of the relevant circumstances. For the purposes of the section 2 offence, the accused must intend that someone commit or attempt to commit suicide. This is made clear by the decision in Attorney-General v Able [1984] 1 QB 795. In that case the accused, who were members of the voluntary euthanasia society, published a booklet entitled "a guide to self deliverance" for distribution to members of the society. The booklet set out both the purpose of the society, namely that it was to overcome the fear of the process of dying and five separate methods of suicide. On the Attorney-General's application for a declaration that the supply of the booklet involved the commission of the offence, Woolf J. held that before an offence can be established to have been committed, it must at least have been proved:

"(a) that the alleged offender had the necessary intent, that is, he intended the booklet to be used by someone contemplating suicide and intended that person would be
assisted by the booklet's contents, or otherwise encouraged to attempt to take or to take his own life;

(b) that while he still had that intention he distributed the booklet to such a person who read it; and,

(c) in addition . . . that such a person was assisted or encouraged by so reading the booklet to attempt to take or to take his own life."

Jurisdiction

16. The general rule is that the English courts do not accept jurisdiction over offences committed outside England and Wales, even if the accused is a British subject. In Treacy v Director of Public Prosecution [1971] AC 537, Lord Morris stated: "the general rule as expressed by Lord Halsbury L. C. in MacLeod v Attorney-General for New South Wales [1891] AC 455 at 458, is that "all crime is local" and that jurisdiction over a crime belongs to the country where it is committed. Unless, therefore, there is some provision pointing to a different conclusion, a statute which makes some act (or omission) an offence will relate to some act (or omission) in the United Kingdom."

17. In Re Z [2004] EWHC 2817 (Fam), Headley J. expressed the view that the making of arrangements in England to assist a person to commit suicide abroad fell within section 2(1) of the 1961 Act. This was clearly correct. In that case Mrs Z was suffering from an incurable and irreversible illness. She had become increasing disabled by her condition and would in due course die as a result of it. In late 2003 she began to express strong views about seeking assistance to commit suicide. She knew that this could be arranged in Switzerland, where it is not unlawful to assist suicide. Mr Z proposed to make all the necessary arrangements and to accompany his wife for the assisted suicide. The Local Authority sought to restrain Mr Z from removing Mrs Z from England and Wales. The critical issue in the case was the extent of the duty owed by a Local Authority when the welfare of a vulnerable person in their area was threatened by the criminal or other wrongful act of another. It was held that although the Local Authority was under an obligation to investigate the position of a vulnerable adult and to consider whether she was legally competent to make and to carry out her decision and her intention, there was no obligation to seek the continuation of an injunction to prevent Mr and Mrs Z from travelling to Switzerland. Although the acts of Mr Z could amount to an offence of aiding and abetting suicide this was a matter for the police and the DPP to consider once they had been informed of the facts. Headley J. noted that Parliament "has committed to the DPP the discretion as to whether to permit a prosecution" and that this militated strongly against the intervention of the civil remedy of an injunction. He went on to state: "This case affords no basis for trying to ascertain the court's views about the rights and wrongs of suicide assisted or otherwise. This case simply illustrates that a competent person is entitled to take their own decisions on these matters and that that person alone bears responsibility for any decision so taken. That is the essence of what some will regard as God-given free will and what others will describe as the innate right of self-autonomy. It illustrates too that the civil court, and in this context, especially the Family court will be slow to restrain behaviour consistent with the rights of others
simply because it is unlawful where adequate powers are vested in the criminal justice agencies."

The Pretty Case

18. In R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800, it was held that a terminally ill Claimant could not require the DPP to undertake not to consent to the prosecution of her husband for assisting her proposed suicide. It was further held that section 2(1) of the Suicide Act 1961 was compatible with Articles 2, 3, 8, 9 and 14 of the European Convention for the Protection of Human Rights and Fundamental Freedoms ("the European Convention").

19. In Pretty v United Kingdom 29 April 2002, the Strasbourg Court held that there had been no violation of the Convention in Mrs Pretty's case. The Court did not consider that the blanket nature of the ban on assisted suicide was disproportionate. It accepted the Government's argument that flexibility is provided for by the fact that consent is needed from the DPP to bring a prosecution and by the fact that a maximum sentence is provided allowing lesser penalties to be imposed as appropriate.

Refusing Treatment

20. In Re T (Adult: Refusal of Treatment) [1993] Fam 95, the Court of Appeal made it clear that an adult, mentally competent patient enjoys an absolute right to refuse medical treatment even where refusing treatment means certain death. The legal position in England and Wales is often stated adopting the words of Cardozo J. in Schloendorff v Society of New York Hospital (1914) 211 NY 125: "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

21. This principle was recognised by the Strasbourg Court in Pretty v United Kingdom: in the sphere of medical treatment, the refusal to accept a particular medical treatment might, inevitably, lead to a fatal outcome, but the imposition of medical treatment, without the consent of a medically competent adult, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8(1) of the Convention.

22. The essential principle in English law is that a doctor may only carry out a medical treatment or procedure which involves contact with a patient if there exists a valid consent by the patient or another person authorised by law to consent on his behalf.

23. The exceptions to the general principle are:

(a) children, where a parent or the court may override the patient's refusal if that is in his best interests;
(b) here the treatment is for the mental disorder of a patient detained under the Mental Health Act 1983;

(c) here the treatment is justified to the extent that it is reasonable in the circumstances and where the competence of the individual is unknown. For example, faced with a patient in a casualty department who has taken a drugs overdose a doctor would be entitled to entertain doubts as to the patient's competence and so act out of necessity to save his or her life;

(d) as a matter of public policy the common law may justify interventions against a competent person's wishes in wholly exceptional circumstances. For example a patient may not refuse measures designed to maintain basic hygiene in a hospital ward where those measures are considered necessary in the interests of other patients.

24. Consistent with the principle that a competent adult patient has an absolute right to refuse consent to any medical treatment, a patient's anticipatory refusal of consent (a so called "advance directive" or "living will") remains binding and effective notwithstanding that the patient has subsequently become and remains incompetent.

25. In Miss B v An NHS Hospital Trust [2002] EWHC 429 (Fam), a tetraplegic patient was found competent to refuse life sustaining treatment (artificial ventilation) and the court made a declaration that continued treatment was unlawful. Dame Elizabeth Butler Sloss P, stated "The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity."

The Bland Case

26. In Airedale NHS Trust v Bland [1993] AC 789, it was held that where a patient was incapable of deciding for himself whether to continue treatment, what could lawfully be done to him depended upon whether the treatment was in his best interests. The patient, aged seventeen was in a persistent vegetative state. The medical opinion was that there was no hope of any improvement in his condition or recovery. With the concurrence of the patient's family, the authority responsible for the hospital where he was being treated sought a declaration that they might lawfully discontinue all life sustaining treatment and all medical support measures designed to keep the patient alive. The House of Lords held that the object of medical treatment and care was to benefit the patient. Since a large body of informed and responsible medical opinion was of the view that existence in the persistent vegetative state was not to the benefit of the patient, the principle of the sanctity of life was not violated by the ceasing of giving medical treatment and, therefore, withdrawing the treatment was lawful. The House of Lords went on to advise that before treatment was discontinued in any other case, a declaration should be sought from the Family Division to the effect that continued treatment and care no longer conferred any benefit upon the patient. Details of the procedure to be adopted in applications to the court are set out in the Official Solicitors Practice Note [2001] 2 FLR 158. Where a patient is diagnosed as being in a persistent
vegetative state, the court, after careful consideration of the patient's best interests, may authorise the withdrawal of artificial nutrition and hydration on the basis that this constitutes medical treatment and that such treatment is futile: the patient has no further interest in being kept alive. The function of the court is to verify the diagnosis of the patient as being in a persistent vegetative state. The views of the patient's relatives or of others close to the patient will be taken into account by the court but cannot act as a veto. The question of the withdrawal of artificial nutrition and hydration from a patient whose condition falls significantly short of the persistent vegetative state has been left open for future decision. The courts are unlikely to grant declarations to permit or to sanction the withdrawal of treatment where there is any real possibility of meaningful life continuing to exist (Re D (Medical Treatment) [1998] 1 FLR 411).

The Burke Case

27. In R (on the application of Oliver Leslie Burke) v The General Medical Council [2004] EWHC 1879, the Claimant suffered from cerebellar ataxia. He wished to establish that he would receive food and water by artificial means when the need arose. He contended that the relevant guidance issued by the General Medical Council ("the GMC") on the withholding and withdrawing of life prolonging treatments was incompatible with his rights under Articles 2, 3, 6, 8 and 14 of the European Convention. In the course of his judgement Munby J. stated at paragraph 213: "A failure to provide life prolonging treatment in circumstances exposing the patient to inhumane or degrading treatment will in principle involve a breach of Article 3. Where the NHS has assumed responsibility for treating a terminally ill patient's condition and he has become reliant on the medical care he is receiving, there will prima facie be a breach of Article 3 if that care is removed in circumstances where this will reduce him to acute mental and physical suffering and lead to him dying in avoidably distressing circumstances. Moreover, even if the patient's suffering does not reach the severity required to breach Article 3, a withdrawal of treatment in such circumstances may nonetheless breach Article 8 if there are sufficiently adverse effects on his physical or moral integrity or mental stability."

28. If the patient is competent, his decision as to where his best interests lie and what life prolonging treatment he should have is, in principle, determinative. If the patient is incompetent, the test is whether the treatment is in the patient's best interests. If the patient is competent or where incompetent, and has made a valid advance directive, his decision to require artificial nutrition and hydration is in principle determinative and the withdrawal of such treatment before the patient finally lapses into a coma would involve a breach of both Articles 3 and 8. Once the patient has finally lapsed into a coma there will no breach of Articles 2, 3 or 8 if artificial nutrition or hydration is withdrawn in circumstances where it is serving absolutely no purpose other than the very short prolongation of the life of a dying patient who lacks all awareness of what is happening. In these circumstances it can properly be said that the continuation of the treatment would be bereft of any benefit and would be futile.
29. Where it is proposed to withhold or withdraw artificial nutrition and hydration and there is an issue as to the capacity of the patient or the patient's best interests, the prior authorisation of the court is required as a matter of law.

30. This case is subject to appeal and the Department of Health has now applied to join that appeal. There is therefore a question mark over its effect on the right of patients to demand any life prolonging treatment they wish, no matter how untested, expensive or inappropriate. However, that does not affect the issue before this Committee.

Medical Guidelines

31. The GMC has issued guidance entitled "Withholding and Withdrawing Life Prolonging Treatments: Good Practice In Decision Making." It was published in August 2002. The GMC believes that the guidance reflects, as so far established, the broad consensus within the council, the professions and the public as to what can be regarded as good practice in this area of decision making. The status of this guidance was considered by Mumby J. in the Burke case, who stated "the guidance is not a legal textbook or statement of legal principles. It consists primarily of professional and ethical guidance for doctors provided for them by the professional body which is responsible for such matters."

The Position of Detained Persons

32. In Reeves v The Commissioner of Police for the Metropolis [2000] 1 AC 360, the House of Lords held that where police officers were aware that a prisoner was a suicide risk they had a duty to take reasonable care not to allow a prisoner to kill himself. Respect for personal autonomy did not preclude the taking of steps to "control a prisoner's environment in non-invasive ways calculated to make suicide more difficult".

33. In Keenan v The United Kingdom (3 April 2001) 33 EHRR 38, the applicant's mentally ill son committed suicide in Exeter prison where he was serving a sentence of four months' imprisonment for assaulting his girlfriend. Nine days before his expected release date he had been given a disciplinary punishment consisting of seven days in segregation in the punishment block and an additional 28 days' imprisonment. Relying on Articles 2, 3 and 13 of the Convention, the applicant complained that the prison authorities had failed to protect her son's right to life and that he had been subjected to inhuman and/or degrading treatment in the period before his death. The Court found that there had been no violation of Article 2 but that there had been a violation of Articles 3 and 13. In relation to Article 3, the Court held that the lack of effective monitoring of Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclosed significant defects in the medical care provided to a mentally ill person known to be a suicide risk.

34. An adult prisoner of sound mind and capacity has a specific right of self-determination which entitles him to refuse nutrition and hydration: Secretary of State for
the Home Department v Robb [1995] Fam 127. In that case an adult prisoner began to refuse all nutrition. Medical experts agreed that he was of sound mind and fully understood the consequences of his decision to refuse food and that death would result. The Home Secretary sought a declaration that the physicians and nursing staff responsible for the prisoners might lawfully observe and abide by the prisoner’s refusal to receive nutrition and might lawfully abstain from providing him with hydration and nutrition for as long as he retained capacity to continue to maintain his refusal. In the course of his judgement Thorpe J. stated that the state interest in preventing suicide had no application in such a case where the refusal of nutrition and medical treatment in the exercise of the right of self-determination did not constitute an act of suicide.
Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide

Issued by The Director of Public Prosecutions

February 2010

Introduction

1. A person commits an offence under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide. This offence is referred to in this policy as "encouraging or assisting suicide". The consent of the Director of Public Prosecutions (DPP) is required before an individual may be prosecuted.

2. The offence of encouraging or assisting suicide carries a maximum penalty of 14 years' imprisonment. This reflects the seriousness of the offence.

3. Committing or attempting to commit suicide is not, however, of itself, a criminal offence.

4. This policy is issued as a result of the decision of the Appellate Committee of the House of Lords in R (on the application of Purdy) v Director of Public Prosecutions reported at [2009] UKHL45, which required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" (paragraph 55) in cases of encouraging and assisting suicide.

5. The case of Purdy did not change the law: only Parliament can change the law on encouraging or assisting suicide.

6. This policy does not in any way "decriminalise" the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person.

7. For the purposes of this policy, the term "victim" is used to describe the person who commits or attempts to commit suicide. Not everyone may agree that this is an appropriate description but, in the context of the criminal law, it is the most suitable term to use.

8. This policy applies when the act that constitutes the encouragement or assistance is committed in England and Wales; any suicide or attempted suicide as a result of that encouragement or assistance may take place anywhere in the world, including in England and Wales.

The Investigation

9. The police are responsible for investigating all cases of encouraging or assisting suicide. The Association of Chief Police Officers (ACPO) intends to provide all
Police Forces with guidance on dealing with cases of encouraging or assisting suicide soon after the publication of this policy. Prosecutors who are involved in such cases should ensure that they familiarise themselves fully with the ACPO guidance when it is available.

10. The ACPO guidance will specifically recommend that police officers liaise with the reviewing prosecutor to seek his or her advice at an early stage and throughout their enquiries so that all appropriate lines of investigation, in the context of the individual case, are discussed and agreed by the Prosecution Team. This is to ensure that all relevant evidence and information is obtained to allow a fully informed decision on prosecution to be taken.

11. The reviewing prosecutor must ensure that he or she has sufficient evidence and information in order to reach a fully informed decision about the evidential and public interest stages of the Full Code Test (see paragraph 13 below). The reviewing prosecutor will need detailed information about the mental capacity of the person who committed or attempted to commit suicide and about any relevant public interest factor.

12. The reviewing prosecutor should only make a decision when he or she has all the relevant material that is reasonably capable of being obtained after a full and thorough investigation. The reviewing prosecutor should tell the police if any further evidence or information is required before a decision can be taken.

The decision-making process

13. Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide. The Full Code Test has two stages: (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

14. The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met.

The evidential stage

15. Section 2 of the Suicide Act 1961 was amended with effect from 1 February 2010. It is therefore essential that prosecutors identify the timing of any act of encouragement or assistance that it is alleged supports the bringing of a criminal charge relating to the suicide or attempted suicide of the victim.

16. Where the act of encouragement or assistance occurred on or after 1 February 2010, section 2 of the Suicide Act 1961 as amended by section 59 and Schedule 12 of the Coroners and Justice Act 2009 applies.

17. In these cases, for the evidential stage of the Full Code Test to be satisfied, the prosecution must prove that:
the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and

- the suspect’s act was intended to encourage or assist suicide or an attempt at suicide.

18. “Another person” referred to in section 2 need not be a specific person and the suspect does not have to know or even be able to identify that other person. The offence of encouraging or assisting suicide can be committed even where a suicide or an attempt at suicide does not take place.

19. It is no longer possible to bring a charge under the Criminal Attempts Act 1981 in respect of a section 2 Suicide Act 1961 offence by virtue of paragraph 58 of Schedule 21 of the Coroners and Justice Act 2009. Attempts to encourage or assist suicide are now captured by the language of section 2, as amended.

20. In the context of websites which promote suicide, the suspect may commit the offence of encouraging or assisting suicide if he or she intends that one or more of his or her readers will commit or attempt to commit suicide.


22. Section 2A provides that a person who arranges for someone else to do an act capable of encouraging or assisting the suicide or attempted suicide of another person will also be liable alongside that second person for the encouragement or assistance.

23. Section 2A also makes it clear that a person may encourage or assist another person even where it is impossible for the actual act undertaken by the suspect to provide encouragement or assistance - for example, where the suspect believes he or she is supplying the victim with a lethal drug which proves to be harmless.

24. Finally, section 2A also makes it clear that a suspect who threatens or puts pressure on the victim comes within the scope of the offence under section 2.

25. The amendments to section 2 of the Suicide Act 1961 are designed to bring the language of the section up-to-date and to make it clear that section 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.

26. Prosecutors should consult the Ministry of Justice Circular 2010/03 which provides further detail about the changes made to section 2 of the Suicide Act.

27. Where the act in question occurred on or before 31 January 2010, the former offence of aiding, abetting, counselling or procuring the suicide of another, or an attempt by another to commit suicide, contrary to the then section 2 of the Suicide Act 1961, applies.

28. In these cases, for the evidential stage to be satisfied, the prosecution must prove that:

- the victim committed or attempted to commit suicide; and

- the suspect aided, abetted, counselled or procured the suicide or the attempt.

29. The prosecution also has to prove that the suspect intended to assist the victim to commit or attempt to commit suicide and that the suspect knew that those acts were capable of assisting the victim to commit suicide.
30. In relation to an act done prior to 1 February 2010, it is possible in law to attempt to assist a suicide. Such an offence should be charged under the Criminal Attempts Act 1981.

31. This enables an individual to be prosecuted even where the victim does not go on to commit or attempt to commit suicide. Whether there is sufficient evidence of an attempt to assist suicide will depend on the factual circumstances of the case.

**Encouraging or assisting suicide and murder or manslaughter distinguished**

32. The act of suicide requires the victim to take his or her own life.

33. It is murder or manslaughter for a person to do an act that ends the life of another, even if he or she does so on the basis that he or she is simply complying with the wishes of the other person concerned.

34. So, for example, if a victim attempts to commit suicide but succeeds only in making him or herself unconscious, a person commits murder or manslaughter if he or she then does an act that causes the death of the victim, even if he or she believes that he or she is simply carrying out the victim's express wish.

**Explaining the law**

35. For the avoidance of doubt, a person who does not do anything other than provide information to another which sets out or explains the legal position in respect of the offence of encouraging or assisting suicide under section 2 of the Suicide Act 1961 does not commit an offence under that section.

**The public interest stage**

36. It has never been the rule that a prosecution will automatically follow where the evidential stage of the Full Code Test is satisfied. This was recognised by the House of Lords in the *Purdy* case where Lord Hope stated that: "[i]t has long been recognised that a prosecution does not follow automatically whenever an offence is believed to have been committed" (paragraph 44). He went on to endorse the approach adopted by Sir Hartley Shawcross, the Attorney General in 1951, when he stated in the House of Commons that: "[i]t has never been the rule... that criminal offences must automatically be the subject of prosecution".

37. Accordingly, where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

38. In cases of encouraging or assisting suicide, prosecutors must apply the public interest factors set out in the Code for Crown Prosecutors and the factors set out in this policy in making their decisions. A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which outweigh those tending in favour.
39. 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. Each 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. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether nonetheless a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.

40. The absence of a factor does not necessarily mean that it should be taken as a factor tending in the opposite direction. For example, just because the victim was not "under 18 years of age" does not transform the "factor tending in favour of prosecution" into a "factor tending against prosecution".

41. It may sometimes be the case that the only source of information about the circumstances of the suicide and the state of mind of the victim is the suspect. Prosecutors and investigators should make sure that they pursue all reasonable lines of further enquiry in order to obtain, wherever possible, independent verification of the suspect's account.

42. Once all reasonable enquiries are completed, if the reviewing prosecutor is doubtful about the suspect's account of the circumstances of the suicide or the state of mind of the victim which may be relevant to any factor set out below, he or she should conclude that there is insufficient information to support that factor.

Public interest factors tending in favour of prosecution

43. A prosecution is more likely to be required if:
   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 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.

44. On the question of whether a person stood to gain, (paragraph 43(6) see above), the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

Public interest factors tending against prosecution

45. A prosecution is less likely to be required if:
   0. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
   1. the suspect was wholly motivated by compassion;
   2. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
   3. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
   4. 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;
   5. 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.
46. The evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.

47. These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.

48. If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim, the public interest factors tending in favour of or against prosecution may have to be evaluated differently in the light of the overall criminal conduct.

**Handling arrangements**

49. Cases of encouraging or assisting suicide are dealt with in Special Crime Division in CPS Headquarters. The Head of that Division reports directly to the DPP.

50. Any prosecutor outside Special Crime Division of Headquarters who receives any enquiry or case involving an allegation of encouraging or assisting suicide should ensure that the Head of Special Crime Division is notified.

51. This policy comes into effect on 25 February 2010 and supersedes the Interim Policy issued on 23 September 2009