ARTICLE

Crossing the Rubicon? Legal developments in assisted suicide†

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SUMMARY

UK law on assisted suicide and euthanasia is very clear: it is unlawful. However, there have been successive proposals for changes to legislation in this area (in England and Scotland) and a series of individual challenges to current legislation in the courts. This article does not seek to debate the profound ethical arguments that surround this emotive subject, but instead to portray how the law, through court judgment and legislative proposals, has wrestled with opposing views, particularly over the past decade or so, as the impact of the Human Rights Act has presented unique challenges. Some of our closest European neighbours have diverse legislation that could influence our own legislature, and, from across the Atlantic, the Oregon Death with Dignity Act is being mirrored in proposals to change the law in the UK.

LEARNING OBJECTIVES

- Be able to recognise the impact of the Human Rights Act on challenges to legislation relating to assisted suicide.
- Understand proposals for statute.
- Appreciate how certain other countries legislate in this area.

DECLARATION OF INTEREST

None.

Nowhere are opinions more polarised in contemporary medical law and ethics than in the debates about voluntary euthanasia (Box 1) and assisted suicide. Recent challenges in the English courts, and a Private Member's Bill tabled in the House of Lords in May last year by Lord Falconer (House of Lords 2013), ensure that the subject retains centre stage in the public arena. Lord Goff confirmed in *Airedale NHS Trust v Bland* [1993] AC 789 that:

> 'it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering might be […]. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and the other hand euthanasia […]'.

Current law and assisted suicide

In England and Wales, at common law, suicide used to be a criminal offence. Although a person who actually died by suicide would be beyond the reach of the criminal justice system, this was not true for those who survived a suicidal act: they risked being prosecuted, as under common law it was an offence to *attempt* to commit a crime.

The Suicide Act 1961 changed this situation:

> 'the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated' (section 1).

However, section 2 of the Act as originally enacted states:

> 'a person who aids, abets, counsels, or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding 14 years'.

Section 2 has since been amended by the Coroners and Justice Act 2009 in response to legal challenge (see below). This Act, together with guidance for the prosecutors (Director of Public Prosecutions 2010) setting out factors favouring and against prosecution, clarifies the law. There have been high-profile media reports (both before and after these clarifications were made) of individuals being accompanied to the Dignitas clinic in Switzerland for the purpose of assisted

BOX 1 Euthanasia

- Euthanasia and assisted suicide are illegal under English law. Euthanasia is regarded as manslaughter or murder, punishable by law with a maximum penalty of life imprisonment
- Voluntary euthanasia is where a person makes a conscious decision to die and asks for help in this
- Non-voluntary euthanasia is where a person is unable to give consent
- Active euthanasia is deliberately intervening to end someone's life
- Passive euthanasia is where a person causes death by withholding or withdrawing treatment that is necessary to maintain life

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†For a commentary on this article, see pp. 378–379.

BOX 2 The European Convention on Human Rights

The UK was one of the first countries to sign up to the European Convention on Human Rights (ECHR) in 1951, after it was drawn up by the Council of Europe in 1950. It came into force in 1953. It has been ratified by all 47 member states of the Council of Europe. It is a requirement for any member state of the European Union (EU), therefore all 28 EU member states are signatories.

suicide (Crown Prosecution Service 2008; Powell 2009), and of such acts occurring closer to home (Burns 2010) without any prosecutions taking place. Earlier this year the media reported on the case of a woman who helped her elderly parents in England to take lethal drugs that she had ordered over the internet, at their request. Her parents had been rejected by Dignitas because of her mother's dementia. The mother's psychiatrist gave evidence at the inquest into their deaths that her patient did not have capacity and was susceptible to coercion. The Crown Prosecution Service (CPS) decided it was not in the public interest to prosecute the daughter (Urquhart 2014).

The law on assisted suicide in Northern Ireland is the same as the law in England and Wales. In Scotland there is no specific crime of assisted suicide, but people who assist in the suicide of another may be liable for prosecution for the crime of culpable homicide.

Case law challenges

The Human Rights Act 1998, which incorporated the European Convention on Human Rights (ECHR) (Box 2) into UK law in 2000, has led to a series of legal challenges to the Suicide Act 1961, the first by Dianne Pretty in 2001.

The case of Dianne Pretty

Ms Pretty was suffering from motor neuron disease, and took civil proceedings in the English courts by means of judicial review (Box 3) of a decision by the Director of Public Prosecutions (DPP) on the criminal law matter of complicity in suicide and its compatibility with the ECHR.

BOX 3 Judicial review

A mandatory order, prohibiting order and quashing order are remedies for individuals who successfully challenge acts of public officials or public authorities in the Administrative Court of the High Court in England and Wales.

The Court decided, however, that she was unable to show that the DPP's refusal to guarantee that her husband would not face prosecution (if he helped her to take her own life) under section 2 of the Suicide Act 1961 amounted to a breach of her rights under the ECHR, concluding (*R (on the application of Pretty) v Director of Public Prosecutions* [2001] UKHL 61) that:

- under article 2 (the right to life), there is no negative aspect, i.e. it does not include a right to die
- under article 3 (the prohibition of torture and inhumane treatment), the State is under no obligation to sanction acts that lead to death
- under article 9 (freedom of conscience), there was no interference with this freedom
- under article 14 (the prevention of discrimination), the law was justified in failing to distinguish between those who were capable of ending their own life and those who were not.

Article 8, however, was more complex, with article 8(1) stating that 'everyone has the right to respect for his private and family life, his home and his correspondence', which means that people have a right to self-determination. Article 8(1) is not an absolute right, but a qualified right. Article 8(2) further specifies that:

> 'there shall be no interference by a public authority with the exercise of this [article 8(1)] right except such as is *in accordance with the law* and is *necessary in a democratic society* in the interest of national security, public safety, or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the *protection of the rights and freedoms of others*' (emphasis added as pertinent to later discussion),

thus limiting article 8(1) in certain clearly specified circumstances, and any limitation must be proportionate, i.e. must not go beyond what is absolutely necessary to achieve the aim under article 8(2).

In the case of *Pretty* [2001] Lord Bingham stated:

> 'I would for my part accept the Secretary of State's submission that Mrs Pretty's rights under article 8 are not engaged at all. If, however, that conclusion is wrong, and the prohibition of assisted suicide in section 2 of the 1961 Act infringes her convention right under article 8, it is necessary to consider whether the infringement is shown by the Secretary of State to be justifiable under the terms of article 8(2)'.

And furthermore (in referring to the Suicide Act 1961),

> 'the power to dispense with and suspend laws and the execution of laws without the consent of Parliament was denied to the Crown and its servants by the Bill of Rights 1689'.

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BOX 4 Law in the UK

The doctrine of parliamentary supremacy (or sovereignty) is a core doctrine of the UK (unwritten) constitution. It is a fundamental principle of the UK constitution that Parliament has the power to enact, repeal or amend any law it wishes. No one (including the judiciary) has the right to override or set aside the legislation of Parliament. There are four main sources of law in England and Wales: legislation (statute and delegated legislation), case law, European Union law and Human Rights law. Despite the volume of legislation, judicial decisions remain an important source of law through judicial precedent, which depends on the hierarchy of the courts. In general, courts are bound by the legal principle contained in decisions of higher courts and courts of equal status. Judges make law by interpreting statute and, where there is no statute, by declaring what the law is.

The Court upheld the DPP's refusal to give the undertaking that Ms Pretty requested (Box 4). Ms Pretty took her case to the European Court of Human Rights in Strasbourg (in *Pretty v UK* (2002) 35 EHRR 1). The European Court agreed with the House of Lords opinion that there was no violation of article 8, but disagreed that article 8 was not engaged, stating that: 'the very essence of the Convention is respect for human dignity and human freedom […] the Court considers that it is under article 8 that notions of the quality of life take on significance'.

However, in assessing the requirements of article 8(2) in determining whether an interference with this right is 'necessary in a democratic society', the Court 'will take into account that a margin of appreciation is left to national authorities', and that a blanket ban on assisted suicide was not therefore disproportionate. Dianne Pretty died of her illness in a hospice in 2002.

The case of Debbie Purdy

In 2008 Debbie Purdy, who suffered from multiple sclerosis, sought judicial review under the Human Rights Act against the DPP in similar circumstances. She sought clarification of prosecution policy (compare with Ms Pretty's case, which sought an undertaking not to prosecute her husband). The High Court dismissed her case and she lost her appeal to the Court of Appeal in February 2009 (*R (Purdy) v DPP* [2009] EWCA Civ 92), but was successful in a further appeal to the House of Lords in July 2009 (*R (Purdy) v DPP* [2009] UKHL 45).

All five members of the Committee of the House of Lords ruled that there was interference with her rights under article 8(1). This decision was a departure from its own previous ruling in the Dianne Pretty case, concluding that its prior decision that the right to die does not engage article 8 could not stand, following the decision of the European Court of Human Rights.

The discretion to prosecute afforded to the DPP was not 'in accordance with the law' (as demanded by article 8(2) – see above), as this phrase means that there are certain clear provisos that should enable others, including ordinary citizens, to know when a person would or would not be likely to be prosecuted, i.e.,

> 'whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his action so that he can regulate his conduct without breaking the law' (*R (Purdy) v DPP* [2009] UKHL 45).

Thus, at the time, the approach of the DPP to assisted suicide cases fell short of what was required to satisfy the Convention tests of accessibility and foreseeability, and the DPP was ordered to formulate a specific policy for cases of assisted suicide.

To ensure that any interference with article 8(1) rights to self-determination (by an article 8(2) exception) was justifiable in law, the House of Lords made a mandatory order requiring the DPP to 'promulgate [his] policy identifying facts and circumstances which he will take into account in deciding whether to consent to prosecution under section 2(1) of the Suicide Act 1961', with Lord Brown saying:

> 'Strasbourg clearly appears to have recognised, that in certain circumstances it will be wrong in principle to prosecute A for assisting B to commit suicide, because to do so would unjustifiably deter those in A's position from enabling those in B's position to exercise their article 8(1) right to self-determination' (*R (Purdy) v DPP* [2009] UKHL 45).

The DPP issued an interim policy in September 2009 (Director of Public Prosecutions 2009) in which he confirmed that the law would not change and that every case where assisted suicide was suspected should continue to be investigated. He explained:

> 'There are no guarantees against prosecution and it is my job to ensure that the most vulnerable people are protected while at the same time giving enough information to those people like Ms Purdy who want to be able to make informed decisions about what actions they choose to take' (Topping 2009).

The final *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* was published in February 2010 (Director of Public Prosecutions 2010).

Coroners and Justice Act 2009

The wording of section 2 of the Suicide Act 1961 was substantially amended in February 2010 by the coming into force of section 59 of the Coroners and Justice Act 2009. Section 59 inserted sections 2A and 2B into the 1961 Act. The offence now consists of encouraging or assisting suicide or attempted suicide, with the two parts of criminal liability, i.e. the *actus reus* (guilty act) being the act of encouraging or assisting suicide or attempted suicide, and the *mens rea* (guilty mind) in the intention to encourage or assist suicide or attempted suicide. The purpose of the amendments was to clarify, rather than change, the law on assisted suicide.

Section 2(4) provides that no proceedings shall be instituted except by, or with, the consent of the DPP. Prosecutors must apply the public interest factors set out in the Code for Crown Prosecutors. The DPP set out public interest factors favouring prosecution (including that 'the suspect was acting in his or her capacity as a medical doctor, nurse, or other healthcare professional'). Factors tending against prosecution include that the victim had reached a voluntary, clear, settled and informed decision to commit suicide (Director of Public Prosecutions 2010). Just prior to the judgment in Purdy, Lord Falconer lodged amendments to the 2009 Coroners and Justice Bill in the House of Lords that would have exempted from prosecution individuals giving assistance to those who travel abroad for the purpose of suicide, but this gave rise to criticism that it sanctioned making use of other jurisdictions, and was defeated by 194 votes to 141 (HL Deb 7 July 2009, col 634). To date, no one who has accompanied any Britons abroad has been prosecuted, however (Roxby 2012).

The cases of Martin and of Tony Nicklinson

In August 2012, the High Court also rejected challenges to the legal ban on voluntary euthanasia, and to the policy of the DPP in a case of assisted suicide, brought jointly by two men, each severely disabled by a stroke. The Court judged that any change in the law must be a matter for Parliament to decide.

The primary relief sought by one of the men (known as Martin) was an order that the DPP should:

> 'clarify his published policy so that other people, who may on compassionate grounds be willing to assist Martin to commit suicide (e.g., solicitors or health or social care professionals), through the use of Dignitas, would know, one way or another, whether they would be more likely or not to face prosecution in England' (*R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin)).

He additionally sought a declaration that the General Medical Council (GMC) and Solicitors Regulation Authority would not expose a doctor or solicitor (respectively) to the risk of professional disciplinary proceedings. If these claims against the DPP were to fail (i.e., the challenge to current guidance), he would seek a declaration that section 2 of the Suicide Act is incompatible with article 8 of the ECHR. Martin's wife was unwilling to help him to end his life herself, but was supportive of his attempt to facilitate others able to do so. She would not travel to Switzerland with him, but if she had been in agreement to help him herself, she would have been unlikely to face prosecution, and the case would therefore never have been brought.

The other man, Tony Nicklinson, would not be able to have an assisted suicide at the Dignitas clinic in Switzerland because he would be unable to swallow the medication. He sought judicial review for a declaration that it would not be unlawful, on the grounds of necessity, for his GP or another health professional to terminate or to assist the termination of his life (*Nicklinson* 2012).

This defence was unsuccessful in the famed case of *R v Dudley and Stephens* (1884) 14 QBD 273 DC, the so-called lifeboat case, which established a precedent throughout the common law that necessity is not a defence to a charge of murder. After a shipwreck, both defendants had killed and eaten a cabin boy to keep themselves alive.

Counsel for Tony Nicklinson, Mr Bowen QC, submitted that the Rubicon referred to by Lord Goff in *Bland* was crossed in *Re A (children) (conjoined twins: surgical separation)* [2001] Fam 147, in which the Court of Appeal held that it was permitted to allow the death of one of the twins, Mary, to save the other, Jodie:

> 'I can see no difference in essence between [the] resort to legitimate self-defence and the doctors coming to Jodie's defence and removing the threat of fatal harm to her presented by Mary's draining her life-blood. The availability of such a plea of quasi self-defence, modified to meet the quite exceptional circumstances nature has inflicted on the twins, makes intervention by the doctors lawful.'

Mr Nicklinson also sought a declaration that the current law of murder and/or assisted suicide was incompatible with his right to respect for private life under article 8, but this was rejected by the Court as the need for compatibility of law with the Human Rights Act applies to statute, whereas murder is a common law offence, although there are statutory defences:

> 'the question whether voluntary active euthanasia may give rise to a defence of necessity to a charge of murder is governed by the common law. The Human Rights Act does not make provision for the courts

to declare that the common law is incompatible with a Convention right' (*Nicklinson* 2012).

Lord Justice Toulson concluded that it would be wrong for the court to hold that article 8 requires voluntary euthanasia as a possible defence to murder and that to do so would go beyond anything that the Strasbourg Court had said, and would be to usurp the proper role of Parliament.

Additionally, it would not be right to require the DPP to formulate a policy in such a way as to meet the test advocated by Martin (*Nicklinson* 2012), and therefore it followed that the claims against the GMC and Solicitors Regulation Authority failed.

However, two Court of Appeal judges last year agreed that it is unclear whether doctors or others would be brought before the courts for assisting suicide, with Lord Dyson, Master of the Rolls, and Lord Justice Elias upholding Martin's complaint that the policy of the DPP does not provide sufficient clarity. Lord Judge, the Lord Chief Justice, disagreed, as he believed it is clear that someone acting out of compassion would not be prosecuted. All three, however, rejected the challenge to the legal ban on voluntary euthanasia brought by Mr Nicklinson's widow and a paralysed road traffic accident victim, Paul Lamb, who was added as an applicant at the Court of Appeal stage (Silverman 2013). Leave was granted to appeal to the Supreme Court, which has now delivered its ruling. By a majority of seven to two it dismissed the appeal brought by Mr Nicklinson and Mr Lamb. It dismissed the cross-appeal brought by Martin and unanimously allowed the appeal brought by the DPP (*R (on the application of Nicklinson and another) v Ministry of Justice* [2014] UKSC 38).

Proposals for UK statute

There have been a number of parliamentary attempts to alter the law in this area. Lord Joffe introduced bills in the House of Lords without success in 2003, 2004 and 2005, but last year Lord Falconer read to the House of Lords his Private Member's Bill (Box 5) on assisted dying to 'enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life; and for connected purposes' (House of Lords 2013).

> **BOX 5** Acts of Parliament
>
> Acts of Parliament can be the result of a Government Bill or a Private Member's Bill. Most legislative proposals come from the Executive, i.e. the government. Notable Private Member's Bill successes have been the Hunting Act 2004 and the Abortion Act 1967, introduced by Michael Foster and David Steel respectively.

The Assisted Dying Bill

The Bill, which relates to England and Wales only, passed its second reading in the House of Lords on 18 July without a vote (BBC News 2014). It will be examined by peers as it passes to Committee stage. It proposes that a person who is terminally ill may request and be lawfully provided with assistance to end their own life if:

- they have made a clear and settled intention to do so (subject to certain conditions), and
- they have made a declaration to that effect, and
- on the day the declaration is made they are aged 18 and over and have been ordinarily resident in England or Wales for at least 1 year.

The declaration

The conditions include that the person has made and signed the declaration in the format specified (see below) in the presence of a witness (who must not be a relative or directly involved in the person's care and treatment). The declaration must be countersigned by two doctors: the registered medical practitioner from whom the person has requested assistance to end their life (the 'attending doctor') and another registered medical practitioner (the 'independent doctor'), who would not be a relative, partner or colleague of the attending doctor. It is proposed that the attending doctor may, but need not be, the registered medical practitioner who diagnosed the person as terminally ill or first informed them of the diagnosis.

Before countersigning, both doctors must independently be satisfied that the person is terminally ill, has the capacity to make the decision to end their own life, has a clear and settled intention to end their life which has been reached voluntarily, on an informed basis and without coercion or duress, and has been fully informed of palliative, hospice and other available care.

The patient would be able to revoke the declaration at any time and this need not be in writing, and the declaration is valid and takes effect on the day that it is countersigned by the independent doctor.

Other proposals include that the patient must wait for at least 14 days after the declaration takes effect before they can ask the attending doctor (or another attending doctor or nurse) to pick up the prescription and deliver it to their home. The waiting period can be reduced to 6 days if the patient is expected to die within a month.

Delivering and administering the medication

The doctor or nurse only delivers the medication after confirming that the person has not revoked and does not wish to revoke their declaration, and returns the medication to the pharmacy if the patient decides not to do so. The patient takes the medication themselves.

Doctors and nurses may assist with setting up devices to enable the patient to self-administer the medication, but cannot end the patient's life directly. The doctor or nurse remains on the premises, but does not have to be in the same room. The cause of death will be recorded as 'assisted suicide'.

Further safeguards

The proposed conditions/safeguards specified are aimed at limiting the application of the law in order to protect the vulnerable. Conscientious objections clauses would ensure that no health or social care professional would be under any duty to participate in the assisted dying process.

Only the patient themselves would be able to raise the issue of assisted dying with their doctor, and a Code of Practice would provide more detailed information on how the safeguards would operate effectively.

The Commission on Assisted Dying proposed a national commission to monitor and review every case for compliance with the law, taking further investigatory action in cases of potential non-compliance and referring instances of malpractice to the professional bodies or prosecutorial authorities where appropriate (Commission on Assisted Dying 2011).

Assisted Suicide (Scotland) Bill

Margo MacDonald, Member of the Scottish Parliament (MSP) (who died aged 70 earlier this year), introduced the Assisted Suicide (Scotland) Bill to the Scottish Parliament on 13 November 2013, and it is currently at stage 1 of the legislative process. The Bill's proposals are similar to those of Lord Falconer's Bill, with a proposed lower age limit of 16 rather than 18.

European experience

In this section I consider various countries also subject to the ECHR (the list is not exhaustive).

In France, Finland, Germany and Sweden assistance in the suicide of another is not illegal. However, in cases of assisted suicide a person could still be charged with failure to assist a person in danger. In other countries, there is a lesser charge associated with assisted suicide of killing in response to 'the person's earnest and insistent demand' (Poland, Denmark) or 'out of compassion' for a 'hopelessly ill person' (Austria, Denmark, Norway, Portugal and Spain). Spain amended its penal code (Box 6) in 1995 to recognise that active cooperation in the assistance of another person's death at the 'express desire of the patient who is suffering from a terminal disease or a disease which produces serious and permanent suffering' will be punished with a lesser penalty.

BOX 6 Legal systems

England and Wales have a common law system based on case-centred decisions. Most European states have a civil law system based on Roman law and comprising laws detailed in a system of codes. The development of the Scottish legal system has been heavily influenced by other legal systems, including Roman law and English law, but has retained its own unique characteristics.

A penal code is the codified body of the laws in any legal system that relate to crime and punishment.

France's President François Hollande aims to legalise 'medical assistance to end one's life with dignity in cases of incurable diseases causing unbearable and intractable physical and psychological suffering' as campaign pledge number 21 (Spranzi 2013), but in July 2013 France's official Ethics Advisory Committee (the Comité Consultatif National d'Ethique, or CCNE) made public its rejection of legalisation by a majority vote (Schadenberg 2013). It rejected legalisation of euthanasia in December 2012.

Four European countries have a legalised system of assisted dying: The Netherlands, Belgium, Switzerland and Luxembourg.

The Netherlands

In The Netherlands, voluntary euthanasia and physician-assisted suicide have been permitted by the courts since 1984, with legislation in force since 2002. The physician ensures that the request for termination of life or assistance with suicide is made voluntarily by the patient, and establishes that the patient's situation entails unbearable suffering with no prospect of improvement. The Termination of Life on Request and Assistance with Suicide (Review Procedures) Act 2001 provides a statutory defence. No psychiatric assessment or capacity assessment is required. The momentum for this change in the law in The Netherlands came through the medical profession (compare this with Oregon, below).

The procedural requirements include that:

- the termination of life should be performed by a physician

- before assisting the patient, the physician must consult a second physician
- the death must be reported as euthanasia or physician-assisted suicide.

The Telegraph reported that the number of Dutch people killed by medical euthanasia has more than doubled since legislation was altered to permit it (Waterfield 2013).

Belgium

Belgium legalised voluntary euthanasia carried out by a physician in 2002. The Belgian Act does not regulate physician-assisted suicide and the legal status of assisted suicide is unclear (Bosshard 2008). Euthanasia is defined as an act of a third party that intentionally ends the life of another person at that person's request. On 13 February 2014, Belgium legalised euthanasia by lethal injection for children: young children will be allowed to end their lives with the help of a doctor (Patients Rights Council 2014). Persons must be resident in Belgium and suffering unbearably either physically or psychologically. The process is reviewed by a commission whose role is to determine whether the euthanasia was performed in accordance with the legislation. If two-thirds of the commission are of the opinion that the conditions were not fulfilled, the case is referred to the public prosecutor.

Switzerland

The Swiss Penal Code (article 114) prohibits voluntary euthanasia, although it has a lesser sentence than other acts deemed homicide. The current policy on assisted suicide stems from a gap in the law in article 115 of the Swiss Penal Code, which states that 'every person who, for selfish reasons, incites or assists someone to commit suicide, shall be sentenced to imprisonment of up to five years or a fine'. This allows the interpretation that it would not be a criminal offence if carried out for non-selfish reasons. Hence also the lack of necessity for a physician or a terminal illness or unbearable suffering (Andorno 2013).

Assisted suicide is therefore carried out by volunteers working for non-profit non-governmental organisations, mainly EXIT and Dignitas. EXIT offers its services only to Swiss residents, but Dignitas also to non-residents. The role of doctors is in assessing capacity and prescribing medication (Andorno 2013).

Switzerland currently requires people to be healthy enough to travel and physically able to take the medicine. Since 2002, almost 200 British citizens have been assisted to end their lives in Switzerland, including an 83-year-old man who was the first Briton to end his life at Dignitas because of dementia (Saul 2013).

Luxembourg

Luxembourg is the most recent country to have passed a law legalising voluntary euthanasia and assisted suicide, in February 2008. Some conditions apply (Watson 2009):

- the patient must be suffering from a terminal or incurable illness
- the patient must repeatedly make the request
- two doctors and a panel of experts must give consent.

In Belgium and Luxembourg, voluntary euthanasia legislation was introduced alongside palliative care legislation.

Outside Europe (notable examples)

Oregon, USA

The Death with Dignity Act 1997

In November 1994, Oregon legislated to allow terminally ill adult residents of Oregon, with a prognosis of less than 6 months to live, to obtain a prescription for medication for the purpose of taking their own lives. The Death with Dignity Act (DWDA) was enacted in 1997 and the first cases of legal physician-assisted suicide in Oregon occurred in 1998. Before a physician can issue such a prescription, certain conditions must be met:

- the patient has to make two oral requests and one written request for the medication
- a second medical opinion must be obtained
- at least 15 days must have elapsed since the initial request for the medication
- the patient must have mental capacity to take the decision, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist.

Furthermore, if the physician is of the opinion that a patient's judgement may be impaired by a psychiatric or psychological disorder or depression, a referral must be made to a psychiatrist or psychologist (Oregon Health Authority 1994). The physician must verify that the patient is making an informed decision and has been fully informed by the attending physician of their medical diagnosis, prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control. Terminal illness is specified and 18 years of age is the lower age limit.

MCQ answers
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Notably, the impetus for this change in the law was citizen based and the Oregon Medical Association was a major opponent. The system of physician-assisted suicide was created following a state-wide public ballot in 1994.

The Oregon system most closely mirrors Lord Falconer's proposals, with some modifications (e.g. that the medication is taken while the attending doctor or nurse is present). Oregon Health Authority's annual reports show that prescribing physicians were present at the time of death for eight DWDA patients (11.4%) in 2013, compared with 16.5% in previous years. Of the 122 patients for whom prescriptions were written during 2013, 63 (51.6%) took and died from the medication (Oregon Public Health Division 2014).

The three most common reasons for requests were loss of autonomy, decreasing ability to engage in activities that make life enjoyable and loss of dignity. Of the 71 DWDA patients who died in 2013, two were referred for formal psychiatric or psychological evaluation (Oregon Public health Division 2014). The median number of weeks a patient has known the assisting physician is 10 weeks, but the length of the relationship varied considerably, up to a maximum of 27 years.

To comply with the law, physicians must report to the Department of Human Services all prescriptions for lethal medicines (as must pharmacists) and they must also keep a record of all oral and written requests of the patient. The relatively low use of the Death with Dignity Act may be as a result of a high quality of care provided by hospices in Oregon (Ganzini 2002).

Washington State, USA

In 2008, Washington State gave terminally ill people the option of medically assisted suicide. Patients must be at least 18, mentally competent and residents of Washington State. The patient makes two oral requests, 15 days apart, and submits a written request witnessed by two people, including one person who is not a relative, heir, attending doctor or connected with a health facility where the patient lives. Two doctors certify that the patient has a terminal condition and 6 months or less to live.

Montana, USA

In December 2008, Montana became the third US state to allow assisted suicide, although the judicial decision is currently under appeal.

Vermont, USA

In May 2013, Vermont ended legal penalties for doctors who prescribe medication to terminally ill patients seeking to end their own lives.

Canada

In a recent Canadian case, British Columbia's Court of Appeal overturned a lower court ruling that found Canada's laws against physician-assisted suicide to be unconstitutional (Hainsworth 2013). The case will now go to the Canadian Supreme Court. In October 2014, the Canadian Supreme Court will hear an appeal by the British Columbia Civil Liberties Association (BCCLA) that terminally ill Canadians should have the right to assisted suicide (CBC News 2014).

Quebec's move to legalise medical assisted death for the terminally ill is facing legal challenges from physicians and others. The Quebec law was passed having been approved by more than 80% of the provincial legislators on 5 June 2014 (Menon 2014), although the national implications are uncertain, as federal law criminalises euthanasia. Quebec is expected to argue at the federal level that medically assisted suicide is a health issue, not a criminal matter, and so is within provincial jurisdiction.

Australia

Euthanasia was legalised briefly in the Northern Territories by the Rights of the Terminally Ill Act 1995. It specified that the patient had to be over 18 and be mentally and physically competent to request their own death, and that the request had to be supported by three doctors, including a specialist, who confirmed that the patient was terminally ill, and a psychiatrist, who certified that the patient was not suffering from treatable depression. A 9-day cooling-off period was necessary before the death could proceed. The law was nullified 2 years later by the Federal Parliament.

Conclusions

Whatever the ethical arguments that rage for and against euthanasia and assisted suicide, in the private and public domain, it is self-evident that the legislature in the UK (in the form of Parliament) and the judiciary (in the form of the courts and judges) are being required to play these out with ever-increasing frequency. Complex legal argument and emotive individual life stories form the basis of each successive new legal challenge. Although the current status of the UK law in this area is clear, how likely is it to change, in light of the above? And are we really protecting our most vulnerable citizens under the current system, where, arguably, euthanasia tourism to Switzerland is sanctioned, and certain categories of individual are immune from prosecution for assisting in the suicide of others?

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MCQs

Select the single best option for each question stem

1 **The current status of the law on assisted suicide and euthanasia in England and Wales is best described by:**
- a both are legal if carried out by physicians
- b both are legal if carried out by family members on compassionate grounds
- c assisted suicide is legal but euthanasia is not
- d euthanasia is legal but assisted suicide is not
- e neither is legal, and the law applies to everyone.

2 **The Human Rights Act 1998 includes:**
- a article 2 – the right to life
- b article 3 – the right to respect for private and family life and correspondence
- c article 8 – prohibition of torture and inhuman treatment
- d article 14 – freedom of conscience
- e article 9 – prevention of discrimination.

3 **Public interest factors set out by the Director of Public Prosecutions that favour prosecution under section 2(1) of the Suicide Act include:**
- a that the person was physically unable to take their own life
- b that the individual who assisted the suicide was reluctant to do so
- c that the individual who assisted suicide was acting in their capacity as a doctor or nurse or healthcare professional
- d the expressed desire of the person to take their own life
- e that there was a request from the person for assistance to take their own life.

4 **Proposals in Lord Falconer's Assisted Dying Bill include:**
- a a lower age limit of 16
- b application to the whole of the UK
- c psychiatric capacity assessments in all cases
- d doctors will raise the issue of assisted dying with patients deemed suitable
- e the person must be terminally ill.

5 **Regarding assisted suicide in Switzerland:**
- a EXIT is the main organisation providing assisted suicide to non-residents
- b about 2000 British citizens have been assisted to end their lives there in the past 10 years
- c voluntary euthanasia is permitted
- d pharmacists prescribe the lethal medication and assess capacity
- e no one who has accompanied a Briton to Switzerland for assisted suicide has been prosecuted.