Reforming the Law Concerning Physician Assisted Suicide: A Kind Heart but a Rational Mind

This paper will seek to address the problems currently faced by the law and by society in general, by proposing a workable solution to the current confusion concerning Assisted Suicide (AS) in this country. The proposed reform will attempt to reconcile the principles of personal autonomy with appropriate respect for the sanctity of life, and balance them within a comprehensive and workable legislative solution by promoting a strongly regulated form of Physician Assisted Suicide (PAS). In doing so, it will seek to restore democratic and moral legitimacy to the issue, by replacing the Director of Public Prosecution’s (DPP) interim guidelines\(^1\) on PAS with a legislative solution.

The aim of the reform is to bring greater clarity to the law and to demonstrate that by allowing PAS within robust legal safeguards it will actually provide greater protection for the sick and elderly of our society than they are currently afforded by the confused state of the law. This essay seeks to show that although the current law may perhaps have a “stern face and a kind heart”\(^2\), as Professor Baroness Llandaff recently stated, unfortunately, it still retains an irrational mind and an unpredictable will. Instead of rectifying this situation, it is clear that the DPP’s guidelines have, as Lord Falconer of Thoroton noted, “unquestionably changed the law”\(^3\) and has left the area in greater need of reform and clarification than ever before. It is this lack of principled logic that this

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1 “Interim Policy on Cases of Assisted Suicide” by the DPP (DPP’s Guidelines)  
   http://www.cps.gov.uk/consultations/as_consultation.pdf

2 “Doctors oppose legal protection for assisted suicide relatives”, The Guardian Newspaper, 8th July 2009

3 “Assisted Suicide: DPP unlikely to Prosecute”,  
   http://business.timesonline.co.uk/tol/business/law/article6845582.ece
essay seeks to rectify, whilst still leaving room for prosecutorial discretion for situations that fall outside the scope of PAS for the terminally ill and suffering.

I. The Area For Reform

This proposal seeks to prescribe the circumstances under which to allow Physician Assisted Suicide (PAS). PAS is defined as the provision of a lethal substance to an applicant, by a registered doctor, with the intention and result that the lethal substance provided to the applicant be self-administered with full capacity and informed consent.

Such a definition would therefore exclude circumstances covered by the Principle of Double Effect, where the main purpose of the act is not to cause death, but where this is the unavoidable secondary result of the primary action. Examples would include the provision of high does of morphine for the relief of pain by a physician with the unavoidable side effect of eventually proving terminal for the patient. Such actions are common place within modern medicine and are relatively uncontroversial.

Similarly, the reform does not seek to include consideration of Passive Euthanasia (PE), defined as occurring through the withdrawal of treatment or the failure to provide it, a distinction that was clearly expressed by Hoffmann LJ (As he then was) in Airedale NHS Trust v Bland [1993]4 and a practice now widely accepted under English Law.

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4 Airedale NHS Trust v Bland [1993] AC 789 at 831
This proposal does not seek to legalise Active Euthanasia (AE), which, is defined as occurring when the death of another is artificially induced by the administration of a lethal substance or the use of deadly force with deliberate intent.

II. The Current Problem

The law currently stands at an impasse following the case of Purdy v Director of Public Prosecutions [2009] where Lord Hope of Craighead encapsulated the sentiments of all the Law Lords when he stated:

“It is no part of our function to change the law in order to decriminalise assisted suicide. If changes are to be made, as to which I express no opinion, this must be a matter for Parliament” 6

Ms Purdy sought to clarify whether her husband, Omar Puente, would be prosecuted if he travelled abroad with her to the Swiss clinic Dignitas to assist her suicide. Ms Purdy also sought to argue that her rights were engaged under Article 8(1), “respect for private life”, of the Human Rights Act 1998 and distinguish her case from the Pretty7 case where the Lords refused to accept this assertion. The Lords agreed on both counts and Ms Purdy was therefore entitled to the disclosure of the criteria that the DPP would take into consideration in deciding whether to prosecute her husband.

5 R (on the application of Purdy) (Appellant) v Director of Public Prosecutions (Respondent) [2009] EWCA Civ 92

6 Ibid. at 26

4 Ibid. at 31

7 Pretty v Director Of Public Prosecutions & Anor [2001] EWHC Admin 788
Thus, although there are currently 1158 recorded cases of Assisted Suicide by members of the British public at the Dignitas Clinic without a single prosecution, *Purdy* has fundamentally changed the position the DPP may take in relation to such acts. The noble lie governing the shifting boundary between law and fact was declared no longer sustainable and the DPP has consequently issued specific criteria governing when the offence of *Assisted Suicide*, contrary to *Section 2(1) of the Suicide Act 1961* will be pursued by the Crown.

**a) The Inadequacy of the DPP’s Guidelines**

The Guidelines issued following the *Purdy* Ruling have sought to clarify the reasoning not only behind *Purdy*, but also behind the DPP’s decision of December 2008 not to prosecute the parents of the quadriplegic Daniel James, on the grounds of public interest, despite the fact that there was “sufficient evidence for a realistic prospect of conviction”\(^\text{10}\). The guidelines seek therefore to address when to prosecute those involved in AS for the terminally ill and those not suffering from a terminal illness.

Unsurprisingly, the resulting guidelines are impossibly broad and the exercise of CPS discretions remains as opaque as ever. As the DPP noted himself, “In the absence of a legislative framework, cases of this sensitive nature present a significant challenge for prosecutors”\(^\text{11}\).

\(^9\)DPP’s Guidelines

\(^{10}\)“Statement of DPP Keir Starmer Q.C”

\(^{11}\)“CPS Statement on Debbie Purdy by DPP Keir Starmer Q.C”
The most fundamental point to be made on the guidelines is that any decision on AS, whatever the substance, cannot and should not be made by an unelected figure such as the DPP and must be left to Parliamentary legislation in reflection of the general democratic will of the people.

Further, from the specifics of the guidelines, there persist far too many areas in need of greater clarification and consequently the law remains as uncertain as before. Whilst the DPP has emphasised eight factors out of 16 that suggest prosecution and seven of 13 that weigh against the new guidelines raise numerous new problems.

More specifically, under the “Public Interest Factors in favour of Prosecution”, the DPP suggests prosecution in cases where there the “the victim’s capacity to reach an informed decision was adversely affected” and “the victim did not have a clear, settled and informed wish to commit suicide”. In addition, a number of other factors concerning whether “The suspect was not wholly motivated by compassion” or whether the victim’s was able to perform the act themselves are equally as problematic. The problem emerges as to how such evaluations can ever effectively be made. Such assessments as to capacity, motivation, medical condition and physical ability are much more effectively made before any AS, rather than after the fact.

12 “If people comply with these seven, they will not and cannot be prosecuted.”, DPP’s Guidelines

13 DPP’s Guidelines, at page 4

14 Ibid.

15 Ibid.
Inevitably however, any such investigations of this sort will usually only be made after the “victim’s” death, as otherwise there will have been no offence committed and no reason for the CPS to investigate.

Consequently, the only way for a person contemplating AS to protect themselves from prosecution would be to seek such assessments as necessary before the act. The problem remains however, that there would be no accepted uniform system in place to make such assessments and the majority of doctor’s would remain unwilling to assist for fear of the potential legal repercussions and possible moral reasons.

Even assuming however that it were possible to obtain such assessments, those who found themselves in the same position as Omar Puente and the parents of Daniel James, would remain unable to say with any degree of certainty whether or not they would be subject to prosecution until the CPS had completed their investigation.

Further, the guidelines of the DPP do not prescribe as to how and by whom the act of assisted suicide should be performed. There is therefore no requirement that the act be done by anybody with medical training and this leaves open the possibility of unsuccessful attempts and unnecessary suffering for the intended victims. It is this unacceptable prosecutorial vagueness that is indicative of the entire guidelines.

III. The Case for Reform
Before seeking to outline the proposal for reform I would like to invite the reader to consider the ethical dilemma proposed by Professor John Harris, Bio-Ethicist and Philosopher at the University of Manchester, to the House of Lords Select Committee dedicated to drafting a response to Lord Joffé’s original Bill\textsuperscript{16}. It envisaged

\begin{quote}
\textit{a motor accident in the United States in which a lorry driver in the cab of a burning vehicle and in which it is clear that he will burn to death before he can be freed. In these circumstances he asks the policeman who is at the scene to shoot him rather than to let him be burnt alive}\textsuperscript{17}
\end{quote}

This reform seeks to modify the question slightly, positing that the trapped man in question asks to be given the gun himself in order to end his own life, rather than asking for the policeman to do it for him, changing the situation from AE to PAS and bringing it into line with our own proposed reform. If we can ensure the following in the proposed reform, then it is argued that no humane person could deny the request of the doomed and suffering man, namely:

i. that the person was inevitably going to die in a short time

ii. that the person was in unbearable suffering and that his condition would only deteriorate

iii. that the death itself was as painless as possible

iv. that the policeman’s assistance was not provided solely for his own benefit

\textsuperscript{16} Assisted Dying for the Terminally Ill Bill [HL] 2005

\textsuperscript{17} First report of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill 2005 at 47 (Lords Select Committee)
v. that no undue pressure was exerted on the free choice of the trapped man
vi. that the trapped man could elect to change his mind at anytime
vii. that the eventual death would be by his own final act
viii. that if any of the above requirements were not met then the passing of the handgun would fail to be justified in the circumstances.

As Professor Harris told the Select committee:

"I have not met a single person who could look me in the eye and say that the policeman had done a wicked thing and did something that he should not have done. If we concede this case, then we concede the principle of assisting death in extreme distress where the condition, as the lorry driver's was, is clearly a terminal one"18

If we take the above as the morally correct position and as the opinion shared by the majority of society, the question now turns as to how we might seek to make this a legislative reality for the terminally ill.

For clarification, it must be added that PAS for those who are not certain of imminent death and in unbearable pain, and fall outside the essential requirements of i. and ii. They therefore fall outside the scope of this proposal.

IV. The Proposal

(a) Those Eligible

18 Ibid. at 47
The only people eligible for PAS would be those that are:

i. terminally ill, and,

ii. are in unbearable and irreversible pain

This would reflect opinion of the large majority of the public as demonstrated by a recent YouGov Poll on behalf of The Sunday Times that showed public support for such a measure at over two thirds of the population, at 69%\(^\text{19}\). Further, all major polls conducted between 1972 to 2005 show public support for AS polling at 72% to 82%\(^\text{20}\).

\((b)\) The Form of the Application

The application must be made in writing and be signed by the applicant in the presence of an independent witness. An independent witness would be someone who not does have any financial gain to be made from the act or any ulterior motive. Two written declarations would be required, an Initial Request for Assistance and a Final Confirmation of a Request for Assistance.

i. An Initial Request for Assistance would have to be made in front of an independent witness. No part of the process of PAS would begin until this written application was received by a doctor treating the applicant.

ii. A Final Confirmation Request for Assistance would take place after both assessments outlined below and could not be made until at least 14 days after the Initial Request.

\(^{19}\) "Public in strong backing for right to assisted suicide”, The Sunday Times, December 14th 2008

\(^{20}\) Lords Select Committee at 218
(c) Capacity

Any such application would only be granted if, in the opinion of at least two doctors, the applicant had sufficient capacity to make the decision. The doctors making such an assessment would be:

i. *A registered National Health Service medical practitioner with more than five years experience who had been sufficiently involved with the treatment of the applicant’s condition to form an opinion on any such request.* It is submitted that a minimum of five years experience for practitioners would help to reduce the risk of misdiagnoses. Stipulating that they must be NHS Doctors would alleviate the risk of private clinics making profits by acting as specialised PAS clinics.

ii. *An independent medical practitioner who has not previously been involved in the applicant’s case.* This would be by a member of any independent body based broadly upon the Support Consultation Euthanasia Network currently operating in the Netherlands. For ease of reference, we shall call this association the Physician Assisted Suicide Consultancy (PASC). PASC members would be provided with extra legal, medical and bio-ethical training to better equip them for the task. This would have the benefit of creating a specially trained and experienced group of practitioners best suited to the task of verifying any PAS request and would create a centralised and uniform approach to the practice. It would also help alleviate the inevitable problem of many doctors not wishing to get involved in PAS.

(d) Requirement of Informed Consent
Assuming however that the applicant is considered to be competent, the applicant will only be deemed to have given full consent to any such decision if it has been made with “informed consent”. This would require that the patient is fully informed of the full consequences of his choice and of the other options that are available to him by both assessing doctors. This would help to allay some of the concerns raised by a number of leading medical practitioners\textsuperscript{21}, including Professor Ian Gilmore, President of the Royal College of Physicians, in relation to the potential dangers of Lord Falconer’s recent Bill, concerning “the capacity to make a declaration”\textsuperscript{22}. It would also bring the law in to alignment with other similar declarations, such as when a patient seeks to decline life-prolonging treatment\textsuperscript{23}.

Informed Consent would also require information to be provided concerning palliative care and hospice care, as well as options concerning the management of pain and any other potential forms of treatment.

\textit{(e) Supply of the Lethal Substance}

It is conceded that the decision as to which substance should be administered, how and where, is beyond the competence of this author. The most appropriate solution would be to establish a medical body to investigate the various methods used in other jurisdictions and for them to arrive at a solution whereby death is induced as painlessly, quickly and effectively as possible.

\textsuperscript{21} Coroner and Justice Bill: A Clinical Practice Perspective,  

\textsuperscript{22} Section 1(b), Amendment 173, “Acts not capable of encouraging or assisting suicide”

\textsuperscript{23} Coroner and Justice Bill: A Clinical Practice Perspective,
(f) Conscientious Objectors

Any medical practitioner who felt unable to involve themselves in any part of the process for moral or ethical reasons could refuse on grounds of conscientious objection from being involved in any way.

Were the applicant to be unable to find any practitioner involved in any stage of the procedure then the applicant would pass the level of having to find a practitioner involved in his treatment. He would then pass straight to the PASC who would be required to provide two separate and independent assessments as whether the application was valid and appropriate.

(g) Ancillary Legal Provisions

This reform applies only to procedures carried out within England and Wales and does not apply to those travelling abroad for Assisted Suicide, contrary to Section 2(1) of the Suicide Act 1961. This is because the reform is widely considered as removing the need to facilitate any such services in the large majority of cases. It is also considered that in the Swiss jurisdiction there are insufficient safeguards in place to prevent potential abuse, as it is not regarded as a medical procedure and therefore insufficiently regulated.

PAS would only be available for British Citizens or those who had been resident in the UK before the diagnosis of their illness. This would help to prevent fears of the kind of “death tourism” occasionally levelled at Switzerland.
For the purposes of all legal documents and relationships, including death certificates, life insurance policies, contracts for goods and services, the applicant, upon completion of PAS, shall not be deemed to have died of suicide, unless the above legal relationships were entered into with the intent of avoiding legitimate legal responsibilities.

b) Conclusion

It is submitted that the proposal outlined seeks to find a practical solution to the confusion that the law currently finds itself in. It is contended that the proposal would help to clarify the legal and ethical quandary currently faced by society and help to bring a modicum of peace and security to the terminally ill and their loved ones at a point a time when they need least burdens.

Such legislative bravery would also reflect the clear majority of public opinion and restore rationality and legal certainty to the justice system. More importantly, such a decision, concerning fundamental choices in relation to the autonomy of the individual and the sanctity of life within the state should be made where they belong, in the hands of Parliament, rather than the unelected DPP.

Most importantly, the proverbial sword of Damocles’ hovering over the heads of the friends and loved ones of those desiring PAS would be removed, reflecting broad public opinion. As Cicero noted over two thousand years ago, “Does not Dionysius seem to have made it sufficiently clear that there can be nothing happy for the person over whom some fear always looms?”

24 “Tusculan Disputations 5.1”, Cicero.