

**RESPONSE OF THE JOINT MEDICAL ETHICS COMMITTEE OF
THE CATHOLIC MEDICAL ASSOCIATION AND THE CATHOLIC
UNION OF GREAT BRITAIN TO THE DPP CONSULTATION ON
'ASSISTED SUICIDE'.**

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EXECUTIVE SUMMARY AND RECOMMENDATIONS.

1. Suicide is always gravely wrong.
2. The Suicide Act 1961 rightly decriminalised suicide and attempted suicide for the victim on humanitarian grounds. However, assisting in the suicide of another is always a serious matter and should be prohibited by the law.
3. There should remain a strong presumption in favour of prosecution unless the chances of conviction are poor.
4. To forgo prosecution on the grounds of compassion will encourage 'mercy killing'.
5. Healthcare workers should not be involved in encouraging or assisting suicide. Such cooperation should remain both unethical and illegal.
6. Prosecutions should not be excluded on the basis of the age, physical or mental health of the victim or the relationship between the suspect and victim.
7. Rarely, a prosecution may not be in the public interest if the suspect is too frail to stand trial and there is no realistic possibility of the offence being repeated, or where the involvement was both minimal and reluctant.
8. Where the Director of Public Prosecutions has decided in all the circumstances to divert a prosecution, alternative remedies should be considered according to the Code for Crown Prosecutors.

INTRODUCTION.

The Joint Medical Ethics Committees is composed of members draw from two parent bodies, the Catholic Union of Great Britain and the Catholic Medical Association. The Catholic Union is an organisation of Catholic Laity founded in 1871 which represents the Catholic viewpoint, where relevant in Parliamentary and legislative matters. The Catholic Medical Association represents catholic healthcare workers of the United Kingdom.

We welcome this opportunity to respond to the draft guidelines issued by the Director of Public Prosecutions regarding assisted suicide.

Our response is divided into two parts.

Part I addresses a number of important issues by way of background:-

1. Ethical issues in ‘assisted suicide’
2. The ethics of cooperation in assisted suicide.
3. The role of law in protecting the right to life
4. Review of clinical aspects of suicide

Part II addresses the questions raised in the Consultation and includes:-

1. The law in relation to assisted suicide.
2. Article 2 and the obligation to investigate unlawful killing.
3. DPP Consultation
4. Conclusions and recommendations

PART I

1. ETHICAL ISSUES IN ‘ASSISTED SUICIDE’

Hippocratic prohibition on deliberate killing

In the Hippocratic tradition, the purpose of medicine is to benefit the sick.

“Wheresoever I go and whosoever’s house I enter there will I go for the benefit of the sick, refraining from any act of wrongdoing or any act of seduction of male or female, bond or free.”

The Hippocratic Oath which has formed the basis of civilised medical practice unequivocally prohibits active euthanasia and assisted suicide:

“I will give no deadly drug to any, though it be asked of me, nor will I counsel such.”

The anthropologist Margaret Mead, explains the need for the Hippocratic Oath as the basis of Medical practice in the ancient world¹. “Throughout the primitive world the doctor and the sorcerer tended to be the same person.... He who had the power to cure would necessarily be able to kill. Depending on who was paying the bill, the doctor/witch doctor could try to relieve pain or send the patient to another world. Then came a profound change in the consciousness of the medical profession – made both literal and symbolic in the Hippocratic Oath. For the first time in our tradition there was a complete separation between killing and curing. With the Greeks the distinction was made clear. One profession was to be dedicated completely to life under all circumstances, regardless of rank, age or intellect.’

There still remains now, as in the ancient World, an ever present danger to patients whenever doctors depart from giving opinions regarding the value of treatment to their patients and engage in deciding the value of life of their patients or purpose of their continued existence. As the German physician Christoph Wilhelm Hufeland (1806) wrote: “It is not up to the [doctor] whether life is happy or unhappy, worthwhile or not, and should he incorporate these perspectives into his trade the doctor could well become the most dangerous person in the state.”

Importance of human dignity in the Catholic tradition.

The Church proposes a vision of mankind based upon the unique relationship between Man and his Creator that begins on Earth and ends in Eternity. Human dignity arises from being a person made by God. When personal dignity, which demands respect, generosity and service, is replaced by the criterion of efficiency, functionality and usefulness, human beings are considered not for what they "are", but for what they "have, do and produce". This latter attitude leads to the supremacy of the strong over the weak. Life is an intrinsic good even when it is at its most vulnerable: “Human life finds itself most vulnerable when it enters the world and when it leaves the realm of time to embark upon eternity and deserves great care and respect when undermined by age or illness”.²

Birth and death, are primary experiences demanding to be "lived" and should not become things to be merely "possessed" or "rejected".³ Dignity is a reality intrinsic to the very existence of the individual and applies to all stages of human development.⁴ It is the basis for respect and the way human beings ought to be treated⁵: "A person...is recognized and loved because of the dignity which comes from being a person and not from other considerations, such as usefulness, strength, intelligence, beauty or health."⁶

Human dignity cannot be conferred by the will of society without democracy contradicting its own principles and risking a form of totalitarianism.⁷ Life is a God given gift in which God shares something of Himself with man.⁸ Man was created for one eternal and ultimate purpose namely the love of God. Therefore, "for no reason can he be made subject to other men and almost reduced to the level of a thing."⁹ "The dignity of this life is linked not only to its beginning, to the fact that it comes from God, but also to its final end, to its destiny of fellowship with God in knowledge and love of him. In the light of this truth Saint Irenaeus qualifies and completes his praise of man: "the glory of God" is indeed, "man, living man", but "the life of man consists in the vision of God."¹⁰

Dignity and autonomy

Moral action requires the freedom to develop towards that person 'we ought to be and become' and is a means of spiritual growth in the love of God and neighbour. In the Catholic tradition, autonomy is seen as the expression of free will in relation to an objective moral order based upon the truth of man's existence in relation to his Creator.

In contrast, the secular view of autonomy "carries the concept of subjectivity to an extreme and even distorts it" and leaves "no place in the world for anyone who, like the unborn or the dying, is a weak element in the social structure."¹¹ According to this view only self-conscious individuals who can determine the course of their own existence can be the subject of human rights, according to which view, rights are assigned only to those who are capable of conscious relationships and communication with others. Human rights are denied to those who remain or become dependent on others. As Wesley J Smith points out: "Our culture is fast devolving into one in which killing is beneficent, suicide is rational, natural death is undignified, and caring properly and compassionately for people who are elderly, prematurely born, disabled, despairing, or dying is a burden that wastes emotional and financial resources."¹²

Man as a relational being

Central to the concept of human dignity is the reality of creation of each individual by God who is created in the image and likeness of God (in *imago Dei*), in whom we live and move and have our being (Acts 12:18) and with whom we share an eternal relationship and destiny.

The Second Vatican council (*Gaudium et Spes*) asserts that each individual is worth more than the rest of the whole material Universe. "Man judges rightly that by his intellect he surpasses the material universe, for he shares in the light of the divine mind.... For his intelligence is not confined to observable data alone, but can with genuine certainty attain to reality itself as knowable."¹³

However, humans are not only rational but also relational beings. Whilst a relationship with others is important the relationship with God is paramount. The relationship between man

and the Creator derives from the relationship arising from creation by God, the imprint of the Divine image on the creature and the Incarnation. (*Gaudium et Spes*): “The root reason for human dignity lies in man’s call to communion with God. From the very circumstances of his origin man is already invited to converse with God. For man would not exist were he not created by God’s love and constantly preserved by it.”

Through the Incarnation, Christ became identified in His Own Person with all human beings, both individually and collectively. “By his incarnation the Son of God has united himself in some fashion with every human being”. Christ who came “not to be served but to serve” showed the depth of his love on the Cross at a time when we were still sinners.

Prohibition of intentional killing by euthanasia or assisted suicide.

The inestimable value of each human being, made in the image of God with whom he shares an eternal destiny, underlies the prohibition of any form of intentional killing. Such killing is forbidden whether or not it is requested by the victim or sanctioned or permitted by the State.

Euthanasia is any act or omission, which, of itself or by intention, causes death in order to eliminate suffering. This constitutes murder and is gravely contrary to the dignity of the human person. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded¹⁴. Intentional euthanasia, whatever its forms or motives, is murder. ¹⁵“Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action.”¹⁶

2. THE ETHICS OF COOPERATION IN ASSISTED SUICIDE

Doctors and other healthcare workers could be implicated in “assisting and encouraging” suicide in a number of ways. Their involvement may be entirely unintentional and even retrospective, if, during an enquiry, medical records were used to determine the nature and extent of the victim’s illness, response to treatment and prognosis. Psychiatrists may be asked to assess patients who have attempted suicide and comment on their mental health, mental (in)capacity and suicide risk. If the DPP is minded to disallow prosecutions on the basis of the victim’s age, degree of disability and pain or prognosis in ‘terminal’ illness, then health workers may be required to provide statements which would be used to determine a prosecution. More contentious issues would include certifying the patient fit to travel to a suicide clinic, and/or providing documentation regarding the patient’s illness, prognosis and response to palliative care prior to ‘assisted suicide’ abroad. If palliation was deemed insufficient by the patient could this be used a mitigating factor for ‘assisted suicide’ albeit retrospectively? Further difficulties would arise in the currently routine referral of patients for psychiatric assessments following deliberate self-harm or taking drug overdoses. Could a psychiatric opinion that the patient was not depressed, mentally ill or in need of psychiatric treatment be used as a factor in favour of not prosecuting a subsequent assisted suicide, particularly if the patient was terminally ill, had a progressive and incurable condition or was ‘suffering unbearably’? Many doctors would have ethical difficulties with such referrals if

they led to a lowering of the threshold for ‘assisted suicide’ as a ‘therapeutic option’ to the patient’s problems. Further difficulties’ would arise in the prescription of medication that could be used in overdose. Would such prescriptions be construed as proper and appropriate treatment for those who were suicidally depressed or conversely as acts ‘encouraging and assisting’ suicide? Clearly, any relaxation of the law in this area could cause considerable difficulties for those trying to help those who are suicidal or who have engaged in deliberate self-harm or taken drug overdoses, especially if they are chronically or terminally ill.

Formal and Material Cooperation

It is impossible to do good without at times running the risk of cooperating in the wrongdoing of others. On the one hand, we must not do evil that good may come from it (Romans 3:8) yet, on the other hand, the good that we should do is often connected to some evil.

The principles of cooperation were introduced into the Catholic tradition, by St Alphonsus Ligouri. The principles begin with the presumption that subjectively good intentions, good consequences, or other circumstances cannot transform an objectively immoral act (i.e., an intrinsic evil) into a morally licit act. St Alphonsus said: “Cooperation is formal and always sinful when it concurs in the bad will of the other; cooperation is material when it concurs only in the bad action of the other, not his intentions. The latter is licit when the action is good or indifferent in itself; and when one has a reason for doing it that is both just and proportioned to the gravity of the other’s sin and to the closeness of the assistance which is thereby given to the carrying out of that sin.”

Formal cooperation is always wrong irrespective of the degree of material cooperation because the person freely participates in the actions of the principal agent and shares in the agent’s intended wrongdoing. John Paul II defines formal cooperation as “an action, which either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [evil] act... or a sharing in the immoral intention of the person committing it.”¹⁷ Material cooperation may be justified if the act done is not of itself wrong (or is even good in itself) and is done for a proportionate good reason. The degree of assistance is also an important consideration, for example, if the cooperation is immediate (proximate) or remote. Another important consideration is the seriousness of the action in question. Formal cooperation that leads to the loss of innocent human life is always seriously wrong even when sanctioned or condoned by the civil law.¹⁸

Implicit formal cooperation occurs when there could be no other explanation to explain an action, but cooperation with the wrongdoer’s intention. For example, taking someone to a suicide clinic in Switzerland would strongly imply an intention that the person commits suicide¹⁹.

Taking the examples above, the doctor whose medical reports are subsequently used to facilitate an ‘assisted suicide’ by providing evidence of the patient’s underlying condition, treatment and prognosis may well not have agreed to the assisted suicide at the time and may even have been ignorant of it. A doctor may rightly prescribe antidepressants without any intention that they are used in a suicidal overdose. This would constitute material but not

formal cooperation since the prescription was good in itself and intended to help treat depression rather than procure suicide. However, if a doctor prescribed lethal medication in order to encourage or assist a suicide and instructed the patient as to how to commit suicide using the drugs he would be guilty of both formal and material cooperation.

Particular difficulties would arise for palliative care specialists if, as part of the prospective or retrospective ‘certification’ process for assisted suicide, either at home or abroad, they were required to advise on palliative care and/or treat the patient as part of the requirements for legally recognised or sanctioned ‘assisted suicide’. At present those travelling to the suicide clinic run by Dignitas in Switzerland, must forward medical reports in favour of the assisted suicide. In so far as these are directly necessary for the “assisted suicide” the deliberate and knowing provision of such papers would constitute formal and material cooperation. It would also appear likely to constitute performing an act capable of encouraging or assisting suicide under the Justice and Coroners Act 2009. Certification that the patient was mentally competent had a fixed and persistent wish to die by a doctor or solicitor could also be formal and material cooperation in ‘assisted suicide’.

In the light of this present Consultation it is of interest to consider how the relaxation of prosecutions for assisted suicide and euthanasia in Holland in 1984 eventually led to their legalisation in 2002. In 1981 a Rotterdam court had defined the conditions under which aiding suicide and administering voluntary euthanasia would not lead to prosecution. In 1984, the Supreme Court of the Netherlands declared that voluntary euthanasia was acceptable subject to ten clearly defined conditions. The Royal Dutch Medical Association published criteria in 1984 which were that the patient makes a voluntary and well considered request, that the wish for death was durable and the patient had unacceptable suffering. The physician had to consult a colleague to agree the course of action. A notification procedure was then agreed between the Royal Dutch Medical Association and the Ministry of Justice in 1990 which was recognised in Dutch law when incorporated into the Burial Act in 1994. The notification required the physician performing the euthanasia or assisted suicide not to issue a declaration of natural death, but to inform the local medical examiner of the circumstances by filling in an extensive questionnaire. The medical examiner reported to the district attorney who then decided whether or not a prosecution should be instituted. In 2002 the Dutch formally legalised Euthanasia and Assisted Suicide.

The Dutch experience demonstrates how a relaxation in the prosecution of cases of assisted suicide and euthanasia in 1984 was the first step in introducing legalising physician assisted suicide and euthanasia in 2002.

3. THE ROLE OF THE LAW IN PROTECTING THE RIGHT TO LIFE

Recognition of the inviolable right to life is the basis of a civilised society.

The inalienable right to life of every innocent human individual is a constitutive element of a civil society and its legislation²⁰:

"The inalienable rights of the person must be recognized and respected by civil society and the political authority. These human rights depend neither on single individuals nor on parents; nor do they represent a concession made by society and the state; they belong to human nature and are inherent in the person by virtue of the creative act from which the person took his origin. Among such fundamental rights one should mention in this regard every human being's right to life and physical integrity from the moment of conception until death."²¹

"The moment a positive law deprives a category of human beings of the protection which civil legislation ought to accord them, the State is denying the equality of all before the law. When the State does not place its power at the service of the rights of each citizen, and in particular of the more vulnerable, the very foundations of a State based on law are undermined".²²

Euthanasia, suicide and assisted suicide are all gravely wrong and constitute a "violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity."²³ The value of democracy stands or falls with the values which it embodies and promotes. "Of course, values such as the dignity of every human person, respect for inviolable and inalienable human rights, and the adoption of the 'common good' as the end and criterion regulating political life are certainly fundamental and not to be ignored".²⁴ The natural moral law which is "written in the human heart" therefore becomes the "obligatory point of reference for civil law itself."²⁵ Therefore it is essential in a sound democracy "to rediscover those essential and innate human and moral values which flow from the very truth of the human being and express and safeguard the dignity of the person: values which no individual, no majority and no State can ever create, modify or destroy, but must only acknowledge, respect and promote."²⁶

4. REVIEW OF CLINICAL ASPECTS OF SUICIDE

A useful and up-to-date literature review of the risk and protective factors for suicide was published by the Scottish Government Social Research Unit in 2008²⁷. The review summarises a great deal of complex information regarding suicide and suicidal behaviour. It was sponsored by the Scottish Government because of the concern in Scotland about actual suicides. The Scottish suicide rate is high (14.7 per 100,000 compared to 8.2 per 100,000 in England and Wales).

It is widely accepted that suicide and suicidal behaviour have a multi-factorial aetiology and involve a complex interplay between risk and protective factors. These include psychiatric, psychosocial, environmental and social phenomena. The balance of protective and risk factors for any individual may vary over time and cannot be regarded as fixed. "Suicidal intent is not conceptualised as a binary (on/off) phenomenon; rather, it is a dimension or continuum, from no intent at one end to serious intent at the other"²⁸.

Suicide rates may also vary over time. For example in 1950 the rate for adolescent suicides was 2.7 per 100,000 but by 1980 the rate had increased to 8.5 per 100,000²⁹.

For the individual who commits suicide, the act usually represents a solution to a problem or life circumstance that the individual fears will only become worse. Alvarez puts it graphically:

“The logic of suicide is different. It is like the unanswerable logic of a nightmare, or like the science-fiction fantasy of being projected suddenly into another dimension: everything makes sense and follows its own strict rules; yet at the same time, everything is also different, perverted, upside down. Once a man decides to take his own life he enters a shut-off, impregnable but wholly convincing world where every detail fits and each incident reinforces his decision.”³⁰

Suicide is not usually a reaction to an acute problem or crisis in one's life or even to a terminal illness. Single events do not cause someone to commit suicide. Contrary to popular belief, those who are terminally ill constitute only a small percentage (2-4%) of those who commit suicide³¹.

Risk factors for suicide

Risk factors for suicide include, mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders, alcohol and other substance misuse, feelings of hopelessness and despair, impulsive and/or aggressive tendencies, a history of trauma or abuse, early parental deprivation, major physical illness, previous suicide attempts and a family history of suicide. Psychiatric diagnoses were present in the majority of cases in all regions. This ranged from 89.7 % of the American suicides with at least one diagnosis, compared with 88.8 % of the European suicides, 83.0 % of the Asian suicides and 78.9 % of the Australian suicides.³² In a study by Fleishmann et al (2005) the majority of cases (88%) have a diagnosis of at least one mental disorder, mood disorders being the most frequent (42.1%), followed by substance-related disorders (40.8%) and disruptive behaviour disorders (20.8%). The lifetime risk of suicide in certain major forms of psychosis such as schizophrenia is in the order of 1.8% with the highest risk around the time of diagnosis or first onset of symptoms. Those who deliberately self-harm have a much greater risk of dying by suicide compared with those who do not engage in this behaviour. Whilst women are more likely to attempt suicide, men are more likely to succeed.

There is an increased risk of suicide with certain chronic illnesses e.g. epilepsy compared to the general population

“Environmental’ risk factors include job or financial loss, relational or social loss, including unemployment and marital disruption, easy access to lethal means and local clusters of suicide which seem to have a contagious influence. Sociocultural factors include a lack of social support and a sense of isolation, living alone, recent migration, early parental deprivation, stigma attached to help-seeking behaviour, barriers to accessing healthcare and particularly mental health and substance abuse treatment, certain cultural or religious beliefs e.g. a suggestion that suicide is a noble means of resolving personal dilemmas, exposure to others who have committed suicide including via the media.

Protective factors against suicide.

In addition to risk factors for suicide, there are also well established protective factors which reduce the risk of successful suicide. These include effective clinical care for mental, physical and substance use disorders, easy access to a variety of clinical interventions and support for those seeking help, restricted access to highly lethal means of suicide, strong connections to family and community support, support through ongoing medical and mental health care relationships, skills in problem solving, conflict resolution and nonviolent handling of disputes and cultural and religious beliefs that discourage suicide and support self-preservation.

Effects of legislative changes on euthanasia and assisted suicide.

In 2008 the Dutch controlling committees received 2,331 declarations, of which 2,146 were cases of euthanasia, 152 cases of assisted suicide and 33 cases of a combination of the two. It would therefore appear that those wishing to die prefer to undergo active euthanasia rather than commit suicide albeit with assistance. This implies that individuals are reluctant to take what appears to be the main responsibility for dying, whereas they are more willing to have others perform the killing. As already noted, a failure to prosecute assisted suicide paved the way to the legalisation of assisted suicide and euthanasia in the Netherlands 21 years later. Recently, Dr Els Borst, a medical doctor and former Health Minister who guided the Euthanasia laws through the Dutch Parliament now admits a damaging impact on palliative care services. Meanwhile there has been an increase in cases of declarations for assisted dying from 1,626 in 2003 to 2,331 in 2008.

Ironically, whilst the DDP Consultation has arisen out of the Purdy case regarding assisted suicide in Zurich, two popular initiatives have called upon the Zurich canton that may limit “suicide tourism” in the future. One calls for a residency requirement of one year for those requesting assisted suicide, the other insists on a change in Swiss federal law to ban all encouragement of and assistance to people committing suicide.

PART II.

Part II addresses the questions raised in the Consultation and includes:-

1. Problems inherent in dealing with assisted suicide.
2. Factors for and against prosecution in the interim guidelines.
 - (i) Infringement of Article 2 (“right to life”).
 - (ii) Presumption in favour of prosecution.
 - (iii) Specific criteria for or against prosecution in the interim guidelines.
 - (iv) State of the victim
 - (v) Persistent and fixed wish to commit suicide
 - (vi) Behaviour of the person assisting suicide.
 - (vii) Intentions of the suspect in encouraging or assisting suicide.
3. Conclusions and recommendations

1. PROBLEMS INHERENT IN DEALING WITH ASSISTED SUICIDE

From the account of suicide and attempted suicide given in Part I there are clearly inherent problems in dealing with the issue of attempted suicide.

First, the overwhelming majority of those who make serious suicide attempts will be depressed. "Mental disorders (particularly depression and substance abuse) are associated with more than 90% of all cases of suicide; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socio-economic, family and individual crisis situations (e.g. loss of a loved one, unemployment, dishonour)."³³ Physical and even terminal illnesses are not necessarily, or even usually, linked to suicidal ideation. For example in a large study of deaths in patients with multiple sclerosis in Sweden only 1.8% were attributed to suicide.³⁴ Nevertheless those with depressive tendencies may experience true depression when they become ill. This is likely to be exacerbated by a sense of helplessness or hopelessness if they are not given adequate help and support or their symptoms are not being properly addressed.

Second, even in those with serious suicidal ideation, intentions may not be fixed and may vary over time even in the same individual. "Individuals who wish to kill themselves may be suicidal for only a limited period of time. In our experience, emotional support can help people come through a suicidal crisis. Talking and listening can make the difference between choosing to live and deciding to die."³⁵ Indeed, it is normal for patients with severe illness, especially terminal illness, to undergo periods of denial, anger, frustration and depression as part of the process of coming to terms with their condition. Dr Elisabeth Kubler-Ross described the five phases of dying as denial, anger, bargaining, depression and acceptance. Indeed, the reaction to life-threatening or terminal illness has been likened to a bereavement reaction for the patient. As Charles Peguy (1873-1914) wrote "When a man lies dying, he does not die from the disease alone. He dies from his whole life." It is therefore very difficult to distinguish the normal reaction to severe and life threatening disease from genuine depression and mental illness. What is part of the very understandable reaction to terminal illness may therefore be misinterpreted as a desire to die when it is, in fact, a wish to have distressing symptoms relieved.

Third, doctors and patients may differ in the perception of a patient's quality for life. Debbie Purdy writing of her experiences of multiple sclerosis in the BMJ stated "I have been helped to embrace the disease and what it gives me, not just what it takes away. Quality of life is one judged to be lower by medical professionals than it is by the patient, because the able bodied see which of their abilities you don't have, rather than what you have that maybe they don't".³⁶ A recent study in the BMJ³⁷ reported interviews with physicians and patients in the Netherlands where the patients had been refused euthanasia. Not all patients who requested euthanasia thought their suffering was unbearable, although they had a lasting wish to die. Where they said they were suffering unbearably they put more emphasis on psychosocial sufferance, such as dependence and deterioration, whereas physicians placed more emphasis on physical suffering. Patients mentioned that whilst pain was an element of their suffering it did not make their suffering unbearable. Hence physicians and their patients have different perspectives on what constitutes unbearable suffering. Those seeking PAS will not necessarily be terminally ill or 'suffering unbearably' but rather see PAS as an aspect of personal autonomy. Dr Pieter Admiraal, a pioneer of euthanasia in Holland, has stated that "essentially all pain can be controlled...euthanasia for pain relief is unethical" and that in his opinion "there are many good reasons for euthanasia, pain control is not one of them."³⁸ He accepts that "in fact, for most patients "cancer pain" means real physical pain combined with fear, sorrow, depression, and exhaustion. This kind of "pain" is an alarm signal indicating shortcomings in interhuman contact and misunderstandings of the patient's situation. One can treat this "pain" with good terminal care based upon warm human contact."³⁹

Fourth, a change in the attitude towards assisted suicide may well alter the threshold at which it occurs. An acceptance of physician assisted suicide may well lower the standards of palliative care. A Dutch doctor, in evidence to the House of Lords select committee considering the Joffe Bill stated that: "I would rather die in a country where euthanasia is forbidden but where doctors do know how to look after a dying patient in a humane manner than I would in a country where palliative medicine is ignored but euthanasia can be easily

arranged”.⁴⁰ Dame Cicely Saunders described the effects of a request for suicide or euthanasia succinctly when she said that “When someone asks for euthanasia or turns to suicide, I believe in almost every case someone, or society as a whole, has failed that person. To suggest that such an act should be legalised is to offer a negative and dangerous answer to problems which should be solved by better means.”⁴¹

Fifth, many of those involved in assisted suicide will be known to the victim and will not have clinical experience in dealing with the underlying problems. This raises the problems of emotional involvement on the one hand and lack of the professional skills needed to deal with often complex, difficult and emotionally demanding clinical issues on the other. It is likely that in the majority of cases, those proposing assisting in suicide will not have much, if any, experience in dealing with individuals with severe disability, chronic pain or terminal illness.

Sixth, assisted suicide involves one private individual encouraging or assisting in the death of another private individual. This arrangement must necessarily be a matter of concern. There will always be questions about the motives and intentions of the assister and the circumstances in which death occurs. If assisted suicide were to occur in the case of someone under the age of 18 years, there will be questions of abuse and neglect and child protection issues to be addressed. If the victim is elderly, frail, chronically disabled or terminally ill there will also be question of potential abuse. It must be remembered that domestic violence and elder abuse are all too common. “Assisted suicide” could easily provide a vehicle for concealing manslaughter or murder. The mental state, mental health and mental capacity of the assister may also be in doubt. If the condition of the victim was such that they considered suicide, it also raises the question of systemic failure of the appropriate Social and medical services as it would if the victim was a child.

Seventh, assisted suicide is a unique crime in so far as it removes the main source of evidence as to the mental state of the victim. It may therefore be very difficult to ascertain the mental capacity and mental health of the victim, their state of mind at the time of the suicide would be impossible to determine. Furthermore, once the victim is dead it may be that the only one capable of giving evidence as to the exact sequence of events is the person assisting in the suicide.

Eighth, the distinction between assisted suicide and deliberate homicide may be difficult in practice and is ethically dubious. Assisted suicide implies that the victim was unable to kill themselves unaided. Hence, if the victim is unable to ingest a lethal cocktail of drugs would syringing the medication into the victim’s mouth or via a gastrostomy feeding tube constitute murder or assisted suicide? What degree of ‘assistance’ would constitute murder? In practice, once the victim is dead the main witness may be the one assisting at the death so that there would be significant evidential problems in deciding if the death was due to assisted suicide, manslaughter or murder. “Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable.”⁴²

Rationale for the Suicide Act 1961

The Suicide Act 1961 was a humane piece of legislation that recognised that those who had attempted suicide were in need of help and support. Those who have attempted suicide and survived should be helped not criminalised. A greater understanding of suicide including the risk and protective factors meant that attempted suicide became a clinical, rather than a criminal matter for the victim. Indeed, prosecuting the victim and threatening imprisonment is likely to prevent humane help, support and rehabilitation of those who have attempted suicide. Nevertheless, this does not mean that individuals assisting suicide attempts should not be penalised. It was therefore logical and necessary for the new offence of assisting suicide to be created by the Suicide Act.

2. FACTORS FOR AND AGAINST PROSECUTION OF ASSISTED SUICIDE IN THE INTERIM GUIDELINES

(i) Infringement of Article 2 (“right to life”).

The most important factor in relation to a prosecution for assisted suicide in the public interest is that innocent human life has been taken.

Article 1 of the Convention binds member states to secure to everyone within their respective jurisdictions the rights and freedoms defined in Section 1 of the Convention. The first of those rights, expressed in article 2(1), is the right to life.

Article 2 of the European Convention on Human Rights (‘right to life’) states:

“Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally”

Exceptions include loss of life from the lawful use of force when absolutely necessary in the defence of any person from unlawful violence, to quell a riot in making arrests and preventing the escape of legally detained prisoners. In practice these exception would rarely apply to medical practice. There are no exceptions for assisting in suicide.

States are under a ‘positive obligation’ to protect life and must conduct effective investigations of deaths, where a breach of Article 2 may be in question.

In *Pretty v United Kingdom* [2002] it was argued that Article 2 protects the right to life and not life itself. The European Court of Human Rights disagreed and, in its judgment, stated that:

“Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose

death rather than life. [...] The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention”.

The European Court of Human Rights has taken the view that Article 2 of the ECHR not only prohibits unlawful killing by agents of the State, but also places States under a ‘positive obligation’ to take preventive operational measures to protect those whose lives are threatened, even if the threats are from another private person (*Oman v UK* 1998) or through self-harm (*Keenan v UK* 2001)).

In 2001, the European Court made clear that Article 2 requires that all complaints about unlawful killing are investigated in an effective way. (*Kelly and others; Hugh Jordan and Shanaghan v UK*). The onus is on the State to prove that the investigation is Article 2 compliant and that it was independent, effective, prompt and transparent (i.e. open to public scrutiny). More recent judgments have re-emphasised the need to meet these standards. (*McShane v UK* [2002]; *Finucane v UK* 2003])

In *R v. Secretary of State for the Home Department* [2003] UKHL 51, Lord Bingham of Cornhill stated:

“30. A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence under articles 1 and 2 of the Convention. This means that a state must not unlawfully take life and must take appropriate legislative and administrative steps to protect it.

31. The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred.... The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others”.

(ii) Presumption in favour of prosecution.

The Crown Prosecution Service is a public authority for the purposes of the Human Rights Act 1998. Crown Prosecutors must apply the principles of the European Convention on Human Rights in accordance with the Act. The Code for Prosecutors sets guidance to ensure fair and consistent decisions.

The first test is a consideration of the evidence to ensure that there is a ‘realistic prospect of conviction’ (5.1). S2(4) of the Suicide Act requires the consent of the DPP for a prosecution for assisted suicide. However, as stated above it may be difficult to be sure that the death was in fact due to assisted suicide and not manslaughter or murder. If there is doubt about the nature and cause of death a prosecution should proceed. If there is a reasonable prospect of

conviction and the crime is that of assisted suicide, then the DPP should consider the public interest test.

According to the Code (5.7). “A prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour, or it appears more appropriate in all the circumstances of the case to divert the person from prosecution (see section 8 below)”. That said, “public interest factors that can affect the decision to prosecute usually depend on the seriousness of the offence or the circumstances of the suspect” (5.7).

The more serious the offence, the more likely it is that a prosecution will be needed in the public interest (5.9). Of the listed factors favouring a prosecution, the following would seem to be particularly relevant to assisted suicide: **(g)** there is evidence that the offence was premeditated; **(i)** the victim of the offence was vulnerable, has been put in considerable fear, or suffered personal attack, damage or disturbance; **(k)** the offence was motivated by any form of discrimination against the victim’s ethnic or national origin, disability, sex, religious beliefs, political views or sexual orientation, or the suspect demonstrated hostility towards the victim based on any of those characteristics; **(q)** a prosecution would have a significant positive impact on maintaining community confidence. Of the listed factors against prosecution is factor **(g)**: the defendant is elderly or is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is real possibility that it may be repeated.

Where a prosecution is not considered appropriate “the availability of suitable rehabilitative, reparative or restorative justice processes can be considered.” (8.1).

(iii) Specific criteria for or against prosecution in the interim guidelines.

The criteria for or against prosecution focus mainly on the physical and mental health status and mental capacity of the victim and their determination to commit suicide, the relationship between victim and suspect, the intentions of the suspect in assisting suicide and in particular whether the assisted suicide was ‘wholly motivated by compassion’.

(iv) State of the victim

Mental and physical health and mental capacity.

In the guidelines, prosecutions are less likely if the victim had a terminal illness, severe or incurable physical disability or a severe degenerative condition from which there was no prospect of recovery.

This is to create an underclass of individuals with severe disability and terminal illness who will receive less protection from the law than the physically healthy. It will also encourage and support the idea of ‘mercy killing’. As outlined in Part I, the Euthanasia laws in Netherlands were enacted in 2002. However, 21 years earlier Dutch prosecutors turned a ‘blind eye’ to the prosecution of doctors involved in assisted suicide and active euthanasia. Our colleagues in the Christian Medical Fellowship have drawn attention to the real prospect

of ‘euthanasia by stealth’ through changes to the prosecutorial system in this country. “We fear that publishing any such guidelines runs the real risk of leading over the years to what would effectively be legal sanctioning of the practice of assisted suicide”.⁴³

As explained in Part I the overwhelming majority of patients who actually commit suicide do not have chronic disability, pain or terminal illness but have mental illness and/or depression. Moreover, a determination to commit suicide may be part of the ‘normal’ reaction to severe or life-threatening disease and will usually be temporary.

It is difficult to understand how the assister could make a medical assessment of the victim without involvement of the medical profession. As indicated in Part I this will raise significant issues of complicity and cooperation for doctors and nurses involved in the care of the chronically sick and terminally ill. At present there are no ethical difficulties in providing a thorough medical and psychological assessment with recommendations as to treatment and prognosis of patients as there is no question of assisted suicide. However, if assisted suicide becomes tolerated, such assessments might be used, knowingly or unwittingly, as ‘evidence’ in favour of assisted suicide. However, if a doctor were to discover that a patient was contemplating ‘assisted suicide’ what action should be taken? Should it be reported as a case of potential elder abuse? Might it result from undue pressure on the patient who sees their life as a burden, or in order to avoid the expense of institutionalised care? Baroness Warnock has already suggested that the demented may be a burden on others. She put it graphically when she wrote: “If you’re demented, you’re wasting people’s lives – your family’s lives – and you’re wasting the resources of the National Health Service.....I’m absolutely, fully in agreement with the argument that if pain is insufferable, then someone should be given help to die, but I feel there’s a wider argument that if somebody absolutely, desperately wants to die because they’re a burden to their family, or the state, then I think they too should be allowed to die”.⁴⁴

Doctors might also be complicit in actively encouraging patients to end their lives. Such doctors are likely to be a minority but could nevertheless account for a number of lives. For example, in the Oregon Public Health Department reports for 2004⁴⁵ and 2005⁴⁶, the maximum number of lethal prescriptions by any one doctor was seven in 2004 and eight in 2005. However, the authors of a study into the workings of the Oregon Law over a 10 year period in the Michigan Law Review⁴⁷ discovered in one hospice that had 28 cases of physician assisted suicide (PAS) since 1997, a single doctor was involved in 23. In addition, it is clear that in Oregon patients may consult several different physicians when seeking PAS. In 1999, ten of the twenty-seven cases obtaining a lethal prescription went to a second physician and eight went to a third or fourth physician⁴⁸.

The Oregon experience of over 10 years of PAS also indicates that reporting of events is poor perhaps because it relies on self-reporting by doctors and assessments of patients is inadequate. No collaborative information is required from relatives. PAS may be a cover for negligent or substandard practice. “They [physicians] are expected to make decisions about voluntariness without having to see those close to the patient who may exert a variety of pressures, from subtle to coercive. They are expected to do all of this without necessarily

knowing the patient for more than fifteen days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is permitted, physicians are protected from the consequences, and patients are left unprotected while believing they have acquired a new right".⁴⁹

Even in Oregon, Psychiatrists did not feel competent to assess whether patients were mentally competent to commit suicide. When surveyed, only six percent felt very confident that, in the absence of a long-term relationship with a patient, they could satisfactorily determine whether a patient was competent to commit suicide⁵⁰.

There is also evidence that not only many patients seek compliant doctors when requesting PAS but that the Oregon Death with Dignity Act has altered the approach to patients. In States outside of Oregon, patients requesting assistance in suicide are assessed in the same way as any other patient intent on suicide recognising that "although physical illness may be a precipitating cause of despair, these patients usually suffer from treatable depression and are [almost] always ambivalent about their desire for death."⁵¹ Conversely, terminally ill cancer patients preoccupied with assisted suicide had symptoms of depression or hopelessness.⁵² Oregon's assisted suicide guidebook⁵³ indicates a totally different approach. It stresses that any mental health consultation should focus on mental capacity and the patient's capacity to make a decision. Indeed, of the 49 people who died by lethal medication under the Oregon Act in 2007, none were referred for mental health evaluation⁵⁴.

Conclusion.

We do not think that a prosecution for assisted suicide should be less likely in the face of chronic incurable disease, physical suffering or terminal illness as a matter of principle. This runs the risk of identifying an underclass of vulnerable persons who will have less protection by the law. Patient's perceptions differ from those of doctors as to what constitutes unbearable suffering. Moreover their views are likely to change over time. Those with suicidal ideation are overwhelmingly suffering from mental illness and/or depression. When 'assisted suicide' is tolerated, the attitudes of attending physicians towards patients change and patients may well seek out doctors who will acquiesce to their request. Where the law permits PAS, assessment of patients often centres on mental capacity and the patient's ability to make a competent decision. Mental health assessments and screening for depression are often absent. If assisted suicide is to escape prosecution for such patients, the treatment of chronic disability and terminal illness and the palliation of symptoms are likely to deteriorate.

Age

The use of age of the victim as a factor in prosecution for assisting suicide is a matter of concern. Clearly, if it is proposed for those under the age of 18 there would be concerns about the real possibility of child abuse and neglect. It would be unconscionable for the DPP to support this in any way. However, if the patient is elderly, vulnerable or incurably disabled there would equally be concern about the possibility of abuse and neglect. Elder abuse and abuse of the chronically sick and disabled must remain a matter of the utmost concern.

(v) Persistent and fixed wish to commit suicide

As already indicated, the wish to commit suicide is almost always underlined by depression and/or serious mental health problems. The risk and protective factors were outlined in Part I. A desire to commit suicide is usually temporary and either resolves as the underlying precipitating causes are addressed, or sadly, leads to an actual suicide. However, those who have made a previous attempt at suicide are at much greater risk of making a further successful attempt. This in turn may be a manifestation of ongoing mental illness or depression and should not be a reason for relaxing the law on assisted suicide. Such patients need skilled psychiatric support and often treatment for mental illness.

Increasingly, assisted suicide is seen as an insurance policy against worsening disability, pain or ill-health or loss of control. Indeed, Debbie Purdy in her BMJ article wrote. “I want a law that will allow me to die if living becomes unbearable. I don’t want to make this choice, and I certainly don’t know when I would, even if I could. I just know that if it were a legal possibility, a safety net. I would just be able to get on with dealing with each new symptom and keep my marriage healthy.”⁵⁵

Clearly, since Debbie Purdy does not know if she would or could make the choice to end her life and wants the option of assisted suicide as a ‘safety net’, she does not intend to kill herself – and is unsure if she ever would. A determination to commit suicide cannot be provisional in view of the nature of suicide which extinguishes life and abolishes autonomy.

(vi) Behaviour of the person assisting suicide.

Prosecutions for assisted suicide would of course focus not on the victim, who will have died, but the person assisting.

The interim guidelines stress the relationship between the suspect and the victim and the number of other suicides that may have been procured.

Since domestic violence and abuse are common and involve persons known to the victim, it is difficult to understand why being a ‘spouse, partner or close relative’ should make a prosecution for assisted suicide less likely. Moreover, close relatives may well benefit from the Will of the deceased and be freed from the expense of ongoing care. Of course, if the suspect was paid by the victim or those close to the victim, this should favour prosecution. Similarly, if the suspect was paid to care for the victim in a care or nursing home or was otherwise placed to care for the deceased he or she should be prosecuted. Prosecutions should also be pursued for those who provide premises for promoting assisted suicide. The Justice and Coroners Act prohibits encouraging or assisting suicide by providing information services over the Internet.

(vii) Intentions of the suspect in encouraging or assisting suicide.

Malicious encouragement and personal gain

There should be no doubt that those engaged in assisted suicide for gain, or who pressured or maliciously encouraged the victim to commit suicide or exercised undue influence over the victim should be prosecuted.

Compassion

The draft guidance also suggests that being “wholly motivated by compassion” should be factor against prosecution.

This is a novel defence against an unlawful killing and would promote ‘mercy killing’ as it did in the Netherlands from 1981 onwards.

No definition of compassion has been given. Compassion is a motive for helping those in difficulty. However, what is actually done is determined by the intention of the moral agent. Hence, two people may be motivated by compassion to help a terminally ill patient in distress. One may feel that this requires palliative care the other that the patient should be killed.

It is seldom the case that there is a single motive behind euthanasia and assisted suicide. Indeed, as already indicated, the motives of the patients may differ from those of the doctors. Moreover, the perception of ‘unbearable suffering’ also differs. Healthcare personnel may perceive suffering in terms of physical pain and depression whereas patients may view it more in relation to hopelessness, helplessness and loss of control. A perceived need for assisted suicide may disappear if the underlying reasons are addressed.

There would undoubtedly be evidential problems in determining the presence of compassion. The principle witness will have died and cannot give evidence.

CONCLUSIONS AND RECOMMENDATIONS

1. Suicide is always gravely wrong and has been recognised as such since the time of Hippocrates.
2. The Suicide Act 1961 rightly decriminalised suicide and attempted suicide for the victim on humanitarian grounds. The decriminalisation of suicide recognised the importance of providing care and support for the victim. Families, relatives and others close to those who have committed suicide also share in the trauma. The decriminalisation of suicide removed part of the stigma attached to suicide and reflected the recognition by society that there are always many victims, including those who survive and have to live with the tragedy. However, the decriminalisation of suicide was never meant to signal that it was ever appropriate to encourage or assist in suicide. Assisting or encouraging in the suicide of another is always a serious matter and should be prohibited by the law.
3. There is a strong public interest in maintaining the prohibition on assisted suicide. There should remain a strong presumption in favour of prosecution unless the chances of conviction are poor.

4. To forgo prosecution on the grounds of compassion will encourage 'mercy killing'. This was the case in the Netherlands.
5. Doctors and nurses should not be involved in encouraging or assisting suicide. Those that are contemplating suicide may well require skilled professional help and will often have had access to healthcare workers before taking their life. Any cooperation between healthcare professionals and potential victims should remain both unethical and illegal.
6. Prosecutions should not be excluded on the basis of the age, physical or mental health of the victim or the relationship between the suspect and victim.
7. Rarely, a prosecution may not be in the public interest if the suspect is too frail to stand trial and there is no realistic possibility of the offence being repeated, or where the involvement was both minimal and reluctant. In such circumstances alternative remedial solutions should be considered according to the Code for Crown Prosecutors.

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- ³ *Evangelium Vitae*. Para 22.
- ⁴ *Evangelium Vitae*. Para. 63. "It must nonetheless be stated that the use of human embryos or fetuses as an object of experimentation constitutes a crime against their dignity as human beings who have a right to the same respect owed to a child once born, just as to every person."
- ⁵ *Evangelium Vitae*. Para 99
- ⁶ *Evangelium Vitae*. Para 99. "Women first learn and then teach others that human relations are authentic if they are open to accepting the other person: a person who is recognized and loved because of the dignity which comes from being a person and not from other considerations, such as usefulness, strength, intelligence, beauty or health".
- ⁷ *Evangelium Vitae*. Para 20. In relation to the right to life: 'the "right" ceases to be such, because it is no longer firmly founded on the inviolable dignity of the person, but is made subject to the will of the stronger part. In this way democracy, contradicting its own principles, effectively moves towards a form of totalitarianism".
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- ¹⁸ *Evangelium Vitae*. Para 78.
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