

Submission of the Catholic Medical Association(UK) to the Health Committee of the New Zealand Parliament on Euthanasia and Physician Assisted Suicide

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31.1.16



Published by the Catholic Medical Association (UK)

www.catholicmedicalassociation.org.uk

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1 EXECUTIVE SUMMARY

Euthanasia and Physician Assisted Suicide (PAS) raise profound issues for Society and the medical profession. Death and human suffering pose questions of the meaning and significance of life itself. This is particularly true of those with terminal illness. Is Society ever morally justified in taking the lives of innocent members? How can this be permitted in those countries where capital punishment has been abolished? Is it ever possible for one section of society e.g. members of the medical profession to take the lives of other members such as patients whilst maintaining adequate legal safeguards against abuse? What if any should be the role of doctors in 'assisted dying'?

The prohibition on "assisted dying" is concisely stated in the Hippocratic Oath "*I will give no deadly drug to anyone, nor will I counsel such.*" Society must protect basic human rights, the most fundamental of which is the right to life itself and without which all the others would be meaningless.

Legislation allowing physician assisted suicide and euthanasia has led to both an increase in the number of deaths over time and a widening of the range of conditions that can be ended through "assisted dying".

Examination of "assisted dying" in Holland, Belgium and Oregon shows how there has been significant underreporting, a lack of judicial scrutiny and changing attitudes to palliative care and practice. Conscientious objection is threatened when the autonomous decision of patients takes precedence over the rights of doctors not to be involved in the deliberate taking of life.

Democracy is a means of promoting the common good and is not an end in itself. The value of democracy depends on the values which it embodies and promotes, including the inviolable right of individuals to life and the dignity of every human person. In September 2015 the British Parliament overwhelmingly rejected moves towards assisted dying, thereby protecting patients and maintaining the integrity of the medical profession for the service of patients.

2 DEFINITIONS

Euthanasia is usually taken to mean the direct and deliberate killing of a patient. It is termed voluntary when it is done at the patient's request. Involuntary euthanasia refers to killing against the wishes of the patient and non-voluntary euthanasia to where the consent of the patient is either not obtained or is not obtainable, for example, if the patient lacks capacity.

Physician assisted suicide (PAS) refers to assistance by a doctor in the termination of the life of a patient at their request. This usually involves the prescription and provision of lethal medication. It may also involve supervision of the patient whilst the medication is being taken up until the time of death.

3 LEGAL SAFEGUARDS AND ISSUES

There are a number of legal safeguards that have been incorporated into legislation in various jurisdictions which are summarised below.

3.1 Age. There is generally a requirement that the patient is adult. However, in the Netherlands under the Gronigen Protocol, euthanasia may be practised on children. In Belgium, there is now provision for the euthanasia of children with parental consent.

3.2 Capacity. Adult patients must have the mental capacity to make an informed decision free from coercion.

3.3 Time for consideration. The decision made by the patient is often described as either "settled" or "fixed" over time. There is usually a "cooling off" period between the time the decision is made and either euthanasia or PAS to allow for reflection and to guard against impulsiveness.

3.4 Medical consultation. Medical supervision is usually required to determine the condition of the patient, the nature and extent of the suffering, the availability of treatment including palliative care and the prognosis in the case of terminal illness. A psychiatric assessment may be required to exclude mental illness or depression, assess mental capacity and established that the decision of the patient was voluntary and free from undue influence or coercion. There is typically a requirement for a second medical opinion and for the prescription and medical supervision of the administration of lethal medication and to manage the patient up until the time of death. Where the patient does not die, the attending physician may be required, or expected, to kill the patient. Medical or other assistants may also be required to administer medication in the case of PAS where the patient is otherwise physically incapable as in cases of paraplegia or "locked in syndrome". The death certificate may give the cause of death as euthanasia or PAS or the underlying medical condition.

3.5 Medical and Judicial scrutiny. Legislation usually provides for some medical oversight and judicial scrutiny of euthanasia and PAS. This may include audit, medical investigation of individual cases and judicial oversight either before or after the event.

3.6 Decriminalisation of killing and assisted suicide

An essential part of any legislation is to decriminalise killing either through euthanasia or assisted suicide. This usually requires observance of the stated safeguards and due process.

3.7 Conscientious objection. Legislation normally makes provision for conscientious objection. This may take the form of a complete freedom not to be involved in any way, or a duty to refer.

4 EFFECTS OF LEGISLATION FOR EUTHANASIA AND PAS ON VARIOUS JURISDICTIONS

5 HOLLAND

5.1 Case law

5.1.1 Potsma case (1973)

The campaign to legalize physician-assisted suicide (PAS) began in Holland with the case of Dr Potsma. She was prosecuted for giving a lethal injection of morphine to her mother who was living in a nursing home following a cerebral haemorrhage which had left her paralysed down one side. She had repeatedly asked her daughter to end her life. Dr Potsma was charged and convicted of manslaughter as the lethal injection was not a reasonable means of ending her suffering. Nevertheless the court recognised that doctors were not obliged to prolong life at any cost and that under certain conditions it was legitimate to use medication with the intention of shortening life. The case arose a great deal of public sympathy and Dr Potsma was given a very lenient conditional jail sentence of one week in prison which was itself suspended.

5.1.2 Schoonheim case (1982-86)

The Royal Dutch Medical Association (KNMG) accepted euthanasia as part of medical practice in the 1980s. The first acquittal of a physician for euthanasia occurred in 1983. The case involved a totally dependent 95 year old bed ridden patient who, although not terminally ill had expressed a desire to die. The Court in the Hague accepted that Dr Schoonheim's conduct was justified under the defence of necessity (Article 40 of the Penal Code)¹ as a means to resolving a conflict of responsibilities between preserving life and preventing suffering. The resolution of this conflict might necessitate active euthanasia. In 1984 the KNMG issued guidelines on the practice of euthanasia. Where these were followed the doctor was unlikely to be prosecuted. Euthanasia and PAS were formally permitted after the Schoonheim case in the Supreme Court in 1984.

5.1.3 Pols case (1985)

In the Pols case, Dr Pieter Admiraal was acquitted in 1985 by the District Court of the Hague of killing a 34 year old patient with multiple sclerosis which had caused almost complete paralysis except for movement of her left hand. He performed euthanasia on 4th November 1983 in the presence of the patient's family. The Court ruled that Dr Admiraal had weighed the conflicting duties and made a justifiable choice with the patient's consent.

5.1.4 Duntinjer case (1985)

In the Duntinjer case, Dr Duntinjer assisted in the suicide of a 50 year old woman with a 25 year history of depression and alcohol abuse and three previous suicide attempts. The court held that the medico-legal requirements had been fulfilled, namely, that the patient was mentally competent, had made repeated requests to die and there was no alternative that could relieve her intolerable suffering. She also wished to die for the sake of her family although her request was not seen to have arisen through pressure from the family.

5.1.5 Kors case (1990)

The Kors case involved a 25 year old anorectic who was assisted in her suicide by her longterm paediatrician, Dr Kors in 1990. The case is of interest as it was the first time that the Supreme Court accepted assisted suicide in a patient with a psychiatric illness.

5.1.6 Chabot case (1994)

Physician assisted suicide was performed by Dr Chabot in the case of a 50 year old lady, Mrs Bosscher, who did not suffer either from a physical or mental illness. She wished to die after the death of her two sons – Peter from suicide when he was 20 years old and Robbie five years later from cancer, also at the age of 20. Dr Chabot had concluded that Mrs Bosscher was mentally competent and was not suffering from mental illness but was suffering from a complicated grief process for five years after the suicide of her son and that she saw no future after the death of both her sons. He was convinced she would commit suicide even without his assistance. She refused anti-depressant medication commenting that "*the only sense life has got for me now is to find my way to Peter and Robbie through a dignified death.*" The case is of interest in relation to the role of independent medical opinion. Four psychiatrists were consulted but none saw Mrs Bosscher. Indeed, one declined, considering that Dr Chabot's extensive documentation had convinced him that this would be unnecessary. One of the four psychiatrists felt that her condition was not hopeless and that Dr Chabot should persist in treating her. In the event, Dr Chabot assisted in her suicide on September 28th 1991 only four months after the death of her second son and he subsequently stood trial. The Supreme Court found Dr Chabot guilty but that he would not be punished as he had acted reliably in consulting colleagues and attempting to persuade his patient to reject suicide.

5.1.7 Termination of the life of newborns: Prins and Kadjik. (1995)

The *Prins* case involved a baby with life threatening spina bifida. Life-prolonging treatment was considered 'futile' by the parents and doctors. The doctor administered active euthanasia at the parents' request.

In the *Kadjik* case the baby had an incurable and fatal disorder (trisomy 13) with severe organ dysfunction. The parents took the baby home to die and after a week Dr Kadjik performed active euthanasia.

In both cases the doctors were charged with murder by the Justice Minister deeming that "*the two cases [were] suitable vehicles for securing legal clarification.*" In both instances he doctors were acquitted having met the 'due care criteria'.

5.1.8 Van Oiljen case (2005)

Dr Van Oiljen was tried for murder and falsely certifying a death as a natural death in 1997. His 85 year old patient had lapsed into a coma in a nursing home. Dr Oiljen administered a muscle relaxant and she died shortly afterwards. The Supreme Court found that justification in the principle of necessity can *"be available in the case of ending the life of a dying patient without the patient's request, but only in extraordinary cases"* but did not find this applied in van Oijen's case as his patient was already comatose. Dr Oiljen was found guilty in 2005 but given a lenient sentence of one week conditional imprisonment and two years probation.

5.2 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

The Royal Dutch Medical Association (KNMG) had accepted euthanasia as part of medical practice in the 1980s. In 1984 the KNMG issued guidelines on practice of euthanasia. Where these guidelines were followed the doctor was unlikely to be prosecuted. Euthanasia and PAS were permitted following the Schoonheim case in the Supreme Court in 1984. In 2002 both euthanasia and physician assisted suicide were decriminalised on 1st April 2002 by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. This amends section 249 of the Dutch Penal Code regarding the taking of life at the person's request. The law *"explicitly allows euthanasia by giving a physician who has performed euthanasia a special defense"* when the *"Due Care Criteria"* are met.

The *"Due Care Criteria"* are that the physician:

- a. Holds the conviction that the request by the patient was voluntary and well considered;
- b. Holds the conviction that the patient's suffering was lasting and unbearable;
- c. Has informed the patient about the his situation and his prospects;
- d. The patient holds the conviction that there was no other reasonable solution for the situation he was in;
- e. The physician has consulted the opinion of at least one other independent physician who has assessed the patient according to parts a-d;
- f. The physician has terminated a life or assisted in a suicide with due care.

The 2002 Act also permits physicians to end the life of incompetent patients who have given a prior written request and allows the same termination of life and assisted suicide in minors aged 16-18 years if they can reasonably understand their interests and have involved their parents or guardians in that decision.

5.3 Rise in numbers of cases of euthanasia and assisted suicide

The Supreme Court Attorney General Professor Rammelink commissioned the Rotterdam Public Health Department of the Erasmus Medical Centre to find empirical evidence of the incidence of euthanasia and related medical decisions at the end of life. This information was sought in order to inform Dutch lawmakers of the extent and nature of medical practice. The number of cases of assisted dying has risen in 10 years from 1,886 in 2004 to 5,306 in 2014. Since 2009 there have been persistent year on year incremental rises in the

number of cases of deaths through euthanasia and PAS with a 13.1% increase in 2009; 18.9% increase in 2010, 17.8% in 2011, 13.3% in 2012, 15.3% in 2013 and 9.8% in 2014.² The numbers of cases of euthanasia far outweighs PAS in a ratio of at least 10 to 1. In Holland, euthanasia must, by definition, be voluntary so that involuntary and non-voluntary and 'passive' euthanasia is not reported. The total rate of unreporting has been estimated to be around 20%³ but may be as high as 40%.⁴

The Rummelink report was published in 1991 with a summary published in the Lancet.⁵ Further surveys were published for 1995,⁶ 2001,⁷ 2005⁸ and 2010⁹. These surveys showed a rise in voluntary euthanasia deaths from 1.8% of deaths in 1991; 2.3% in 1995 and 2.6% in 2001%. There was a fall to 1.7% in 2005 after the passing of the 2002 Act but then an increase in euthanasia to 2.8% in 2010 with 0.1% of deaths due to PAS. However, in 0.4% of cases death followed the patient's decision to stop eating and drinking in order to end life¹⁰. There also is concern at the number of deaths that are brought about without the consent of the patient. In a recent study by *Onwuteaka-Philipsen et al*¹¹ this may account for up to 0.2% of deaths.

5.4 Terminal deep sedation

An important issue in Holland is the increasing number of deaths that have been brought about by terminal deep sedation. The practice usually also involves the discontinuation of hydration and nutrition. In 2001, it was estimated to account for between 4% and 10% of deaths in Holland.^{12 13} In 2005 it amounted to about 8.2% of deaths and by 2010 accounted for 12.3% of all deaths in Holland.¹⁴ Terminal deep sedation is often regarded either as a substitute for euthanasia, without the necessary formalities, or that it has been used when euthanasia has been rejected for other reasons. According to Rietjens et al¹⁵ "*for some patients, terminal sedation for refractory symptoms in the dying phase may serve as a relevant alternative for euthanasia.*" Terminal deep sedation may give the impression of a natural death, can be applied for at short notice without the need for a cooling off period and can be performed without the consent of the patient or relatives. There is also confusion as to whether it is part of palliative care or a form of physician assisted dying.^{16 17} ¹⁸Indeed, in their report for 2004, the Euthanasia Review Committee stated "*It is important to distinguish between terminal sedation, where the intention is to relieve suffering, and euthanasia, where the intention is to end life. Terminal sedation, accompanied in most cases by a decision no longer to administer fluids or food, is a normal medical procedure, and the patient usually dies of natural causes.*" It also referred to the Van der Waal study and pointed out that "*euthanasia was discussed in approximately half the cases in which terminal sedation was decided on, that in 14% of cases the patient opted for terminal sedation instead of euthanasia, and that in 10% of cases terminal sedation was decided on because the patient had made no explicit request for euthanasia*".

5.5 Professional and judicial oversight and regulation

Whilst there is medical and judicial oversight, there have been very few prosecutions. Indeed from 1981 to 1997 there were only 20 prosecutions for which 9 doctors were found not guilty, 3 were given no punishment and 6 were given a conditional sentence without imprisonment. On 1st April 2002 the Termination of Life on Request and Assistance with

Suicide Act (Review Procedures) Act was passed making the Netherlands the only country in the World to legalise Euthanasia. Following the 2002 Act doctors became immune from prosecution if they follow the criteria set out within the Act and notify the municipal pathologist of their actions. If a physician has ended the life of a patient without an explicit request, the municipal pathologist must submit the case directly to the public prosecutor. In the first four years after the legalisation, 16 cases (0.21% of all notified cases) were sent to the judicial authorities, few were investigated and none were prosecuted.¹⁹ In 2013 the Report of the five Regional Euthanasia Review Committees found that only in 5 cases, around 0.1% of the total, the physician had not acted in accordance with the due care criteria. In 2014 this figure was just four.

5.6 Demographics of assisted dying in the Netherlands

For a detailed analysis of deaths from Euthanasia and PAS in Holland and the most important end-of-life decisions, please see Appendix 3.

5.6.1 Place of euthanasia and PAS

The majority of cases of euthanasia occur outside of a hospital context and are performed by general practitioners and not by the specialists or palliative care consultants. In 2014 81% of deaths were at home, 7.9% in nursing or residential homes, 3.2% in hospital, 4.4% in a hospice and 1.45% elsewhere e.g. with the family. The corresponding figures for 2004 were similar: 81.1% at home; 9.3% in hospital, 3.4% in a nursing home, 3.3% in a care home, 0.26% in other institutions and 0.25% elsewhere.

5.6.2 Conditions underlying assisted dying

In 2014, 3,888 out of 5,306 reported deaths (73.2%) were for cancer; 317 (5.9%) to neurological disease; 247 (4.6%) to cardiovascular disease; 184 (3.6%) to pulmonary disease; 81 (1.5%) to dementia; 41 (0.77%) to mental disorder; 257 (4.8%) to multiple pathology and 291 (5.4%) to other causes. Ten years previously in 2004 there were: 1647 out of a total of 1886 reported deaths from cancer (87.3%); 63 from neurological disease (3.3%); 34 (1.8%) from pulmonary disease; 24 from cardiovascular disease (1.2%); 41 (2.1%) had multiple pathology and 77 (4.0%) died from other disorders and 4 (0.21%) with AIDS.

5.7 Changing pattern of notifications

The pattern of notifications was changing with respect to patients with dementia, mental disorder and those who were comatose. This raises important issues in relation to the assessment of 'unbearable suffering', whether the decision of the doctor should be subjective, objective or both and the role of advanced directives for unconscious patients who are no longer able to make decisions and may not actually be suffering.

5.7.1 Dementia

In 2004 the Euthanasia Committee only had one notification involving *"the problem of euthanasia and dementia."* The relevant regional subcommittee in North Holland concluded that the doctor who performed euthanasia had acted in accordance with *"the due care criteria"*. However, in 2013 there were 97 cases of dementia compared to 42 in 2012. The

Euthanasia Review Committee stated that *“In the vast majority of these cases, the patients were in the initial stages of the disorder and still had insight into their condition and its symptoms (loss of bearings and personality changes)”* and judged that they *“could fully grasp the implications of their request.”* Conversely, those with advanced dementia *“had often for years been discussing with their physicians their desire to terminate their lives if their suffering became unbearable”*. All 97 reported cases in 2013 were found to have been handled with due care.

The Euthanasia review recognised that in the case of dementia it is difficult to determine whether there is no prospect of improvement or alleviation of the symptoms of dementia so that the patient’s suffering would no longer be unbearable... *“No prospect of improvement”*, in this context, refers to *“the disease or disorder and its symptoms, for which there are no realistic curative or palliative treatment options that may – from the patient’s point of view – be considered reasonable”*. Furthermore, it was accepted that the concept of suffering in dementia is difficult and necessarily involves a subjective element. *“Whether suffering is unbearable is determined not only by the patient’s current situation, but also by his perception of the future, his physical and mental stamina, his personality and his life history.”* It was therefore the responsibility of the physician to determine if the patient’s suffering is unbearable. *“The physician must therefore be able to empathise not only with the patient’s situation, but also with the patient’s point of view”*. The physician must also be satisfied that the suffering has a medical dimension, that is, it arises from a recognised medical condition which does not have to be either serious or life-threatening. Finally, the decision by the patient must be both voluntary and well-considered. The question of the use of advance directives was considered in the case of comatose patients, but is clearly also of relevance to those with dementia and mental disorders.

5.7.2 Mental disorders

There were 42 notifications for patients with mental disorders, compared to 14 in 2012 and 13 in 2011. Of the 32 cases which were reviewed by the Euthanasia Committee, 14 cases were notified by psychiatrists, 14 by general practitioners, 2 by geriatricians, 1 by an (unspecified) specialist and 1 by a clinical psychotherapist. In 6 cases the notifying physician was associated with the End-of-Life Clinic. (Overall 107 of 4,829 notifications had been from the End-of-Life Clinic). All were found to have been handled with due care. According to the 2004 Review, the regional committees had noted that *“there appears to be an increase in willingness among physicians to carry out euthanasia and assisted suicide in cases involving a mental disorder”*.

In addition to the issues discussed regarding euthanasia for demented patients in relation to whether the decision is voluntary and well-considered, is the matter of whether the suffering is unbearable with no prospect of recovery despite treatment. The Euthanasia Committee advised that in addition to the independent physician, one or more independent psychiatrists are consulted.

5.7.3 Comatose or unconscious patients

The Euthanasia Committee recognised that the concept of suffering assumes a conscious state so that an unconscious patient cannot be suffering. *“In this situation euthanasia cannot be performed.”* However, it proposed one exception in the case of medically induced

coma. *“Euthanasia may be justified in the case of medically induced coma, resulting from the administration of medication to alleviate pain and symptoms and therefore in principle reversible”*. However, if the patient is in a reduced state of consciousness – either spontaneous or medically induced – *“it cannot be ruled out that he is suffering and the suffering is unbearable in which case euthanasia is possible”*.

5.7.4 Euthanasia based upon an advance directive

According to the Euthanasia Committee: *“In cases where the Guideline does not apply, a physician may – on the basis of section 2 (2) of the Act – carry out a patient’s request for euthanasia, which the patient can no longer express because he is in a state of reduced consciousness or reversible coma, but which is stated in an advance directive.”* It was argued that if the patient lost consciousness as a result of the underlying illness before an independent opinion could be sought, or alternatively, was receiving medication to alleviate the symptoms causing the patient to have a reduced state of consciousness or even coma, then the Guidelines would not apply and that *“in both situations, the independent physician can conclude that the patient’s request for euthanasia was voluntary and well-considered, based on the advance directive.”* The determination of whether the patient’s suffering *“was unbearable with no prospect of improvement must be assessed through observation (seeing the patient), information and medical records provided by the attending physician, and (if available) information from the patient’s immediate family.”*

5.7.5 Euthanasia in a decisionally incompetent patient

The Euthanasia Committee accepts that where a patient is no longer capable of expressing his or her wishes euthanasia may still be carried out if the independent physician is able to *“establish that the request for euthanasia is voluntary and well-considered on the basis of the patient’s advance directive.”* As with the comatose patient *“whether the patient’s suffering is unbearable with no prospect of improvement must be assessed on the basis of the advance directive and the patient’s current condition, the relationship between the two, information and medical records of the attending physician, and (if available) information from the patient’s immediate family.”* The independent physician *“must give his opinion on whether the due care criteria set out in (a) to (d) have been fulfilled [under section 2 (1) (e) of the Act].”*

5.8 Royal Dutch Medical Association Guidelines: “Performing euthanasia and assisted suicide procedures” (2012).

5.8.1 Requirement for a medical basis for euthanasia and PAS.

Since the Supreme Court made its ruling, which fits in with the history and text of the law, there has been much discussion surrounding the explanation of the requirement that the patient’s suffering must have *“its principal source”* in *“medically classifiable somatic or psychological illnesses or conditions”*²⁰. The KNMG maintains that contrary to what is generally assumed, the Euthanasia law includes provisions permitting assisted suicide for patients with psychiatric conditions and dementia.²¹

The KNMG holds the view that *“when suffering is assessed within the framework of ending life, there must always also be a medical basis, meaning a condition that can be defined as a disease or combination of diseases/ailments. Suffering that has no medical basis falls outside the domain of medicine and therefore outside the Euthanasia Law.”*²²

The KNMG feels it should be emphasised that the presence of a medical basis is and must always be an absolute criterion when assessing suffering within the context of a request to end life.²³ However, it would seem that physicians’ interpretations of what constitutes unbearable suffering in the context of euthanasia requests have become less restrictive than in the period immediately after the Supreme Court ruling.²⁴

5.8.2 Performance of Euthanasia

The Guidelines of the Royal Dutch Medical Association and the Royal Dutch Association for the Advancement of Pharmacy (KNMG and KNMP) outline the procedure for active euthanasia.²⁵ *“It must be absolutely certain that a patient is in a deep coma when the muscle relaxant is administered. The use of a coma-inducing substance recommended in the Guideline in the correct dosage is crucial in order to ensure that the patient cannot perceive the effects of the muscle relaxant”.*

5.8.3 Performance of assisted suicide

There may be complications with PAS such as vomiting up the lethal medication or death may not ensue as quickly as expected. The physician *“must remain with the patient or in his immediate vicinity until the patient is dead”*. The guidelines recommend a maximum time of two hours with the patient and the family. *“If the patient does not die within the prescribed time, the physician must perform euthanasia.”*

5.8.4 The role of the physician in the voluntary termination of life

The KNMG position paper entitled *“The role of the physician in the voluntary termination of life”* was published in July 2010 and sets out some statements and recommendations which underlie the practice of euthanasia and assisted suicide and are summarised below:

The KNMG recognised that physicians will be confronted with seniors in vulnerable positions with advanced age but keen to live as independently for as long as possible. The number is expected to rise to 1.5 million over the next decade or 10% of the population in the Netherlands.²⁶

When considering the voluntary termination of life, psychosocial or existential suffering fall within the medical domain.²⁷ Similarly, the Supreme Court in 1984 recognise that patients may suffer through indignity and humiliation.²⁸ The KNMG therefore concludes that the current statutory framework and the concept of suffering are broader than their interpretation and application by many physicians today.

5.8.5 Neonatal euthanasia. Gronigen Protocol for euthanasia in newborns.

Of approximately 200,000 children born annually in the Netherlands about 1,000 die in their first year. In around 600 cases, death is preceded by a medical decision regarding the end of life. A national survey showed that each year 15 to 20 cases of euthanasia occurred in

newborns although only an average of 3 cases per year were reported.²⁹ In 2002 Verhagen and colleagues developed the Gronigen Protocol to address this issue, although it was acknowledged that following the guidelines would not necessarily prevent prosecution³⁰.

Requirements that must be fulfilled in the Gronigen Protocol.

- The diagnosis and prognosis must be certain.
- Unbearable suffering must be present.
- The diagnosis, prognosis, and unbearable suffering must be confirmed by at least one other doctor.
- Both parents must give informed consent.
- The procedure must be performed in accordance with the accepted medical standard.

The percentage of cases in which drugs have been administered to newborns with the explicit intention to hasten death has fallen from 9% in 2005 to 1% in 2010. However, this figure may have been influenced by the introduction of routine prenatal ultrasound at 20 weeks gestation for the detection of abnormalities which might then lead to abortion³¹.

5.9 Choices when euthanasia or PAS are not an option

The KNMG recognises that when the suffering is not unbearable and long lasting within the meaning of the Euthanasia Law, the physician cannot perform euthanasia or assisted suicide. The patient may then decide to deny himself hydration and nutrition as a conscious choice to hasten death. Studies indicated that there may be some 2,500 such cases per annum.³²

5.9.1 Denial of hydration and nutrition

The denial of food and fluid combined with palliative care *“can offer a dignified death.”*³³ The physician may even decide to point out the option of denying food and drink.³⁴ If a patient decides to deny himself hydration and nutrition, it does not, in itself, signify depression or that the patient is *“a danger to himself”* or justify compulsory admission into psychiatric care.³⁵ The situation is regarded as a refusal of treatment.³⁶

If the patient denies himself food and fluids, the KNMG advises palliative care to control pain, confusion and other symptoms with intermittent or continuous sedation with advice, as necessary from palliative care. The death constitutes a natural death even if the patient is under continuous sedation.³⁷

5.9.2 Palliative sedation.

According to the Euthanasia Committee *“the Act does not apply to palliative sedation, which is a normal medical procedure”*. Palliative sedation may be seen as an alternative to euthanasia, but does not rule it out. *“The physician and patient may together conclude that palliative sedation is not a reasonable alternative if the patient in question wishes euthanasia. In other words, the possibility of palliative sedation does not always rule out euthanasia”*. Indeed, the Committee advised that the patient may make a conditional

request for euthanasia so that it may be carried out “*should certain circumstances arise*” for example if the patient should take longer to die than anticipated or show signs of suffering despite the reduced state of consciousness.

5.10 Conscientious objection

The KNMG maintains that whilst patients have the right to request euthanasia, physicians are not obligated to grant their request. Fundamental objections to euthanasia and assisted suicide must be respected. After all, euthanasia and assisted suicide are anything but ordinary medical procedures.³⁸ Indeed, a request for euthanasia is one of the most intrusive and onerous demands that can be made on a physician. Most physicians find it difficult to perform euthanasia or assisted suicide, especially when not prompted by terminal illness.³⁹ Suffering that has no medical basis falls outside the domain of medicine and therefore outside the domain of the physician’s professional expertise and outside the Euthanasia Law.⁴⁰ Nevertheless, the KNMG hold that a conscientious objector has a duty to refer.

*“The KNMG holds the opinion that if a physician is not prepared to consider a euthanasia request from his patient then he also should not initiate the procedure (see section 3.1 and 3.2). In that case, it is his duty to put his patient in touch with a colleague who does not have fundamental objections to euthanasia and assisted suicide. Though there is no legal obligation to refer patients, there is a moral and professional duty to provide patients with timely assistance in finding a physician (for example, within the clinic) who does not have fundamental objections to euthanasia and assisted suicide.”*⁴¹ The KNMG also advises that physicians have a duty to engage in discussion with patients who wish to stockpile drugs with the purpose of ending their life: *“Physicians may provide information and talk with patients about this issue without being liable to punishment”*.⁴²

5.11 Conclusions

The Netherlands was the first country to legalise euthanasia and assisted suicide. From 2004 to 2014 the absolute number of patients undergoing euthanasia and assisted suicide has increased significantly. The overwhelming majority are still for cancer although the percentage has fallen from 87.3 % in 2004 to 73.2% in 2014. Euthanasia outweighs the numbers of cases of PAS and both have increased considerably since they were legalised. The majority of cases of euthanasia and PAS occur outside of the context of hospital or hospice care and are performed by general practitioners at home.

In 2004 the Euthanasia Committee only had one notification involving *“the problem of euthanasia and dementia.”* The relevant regional subcommittee in North Holland concluded that the doctor who performed euthanasia had acted in accordance with *“the due care criteria”*. However, the number of deaths in those with dementia and mental disorder has increased significantly in recent years. Indeed, the 122 of deaths from mental illness and dementia in 2014 compares to the 121 deaths from cardiovascular, cerebrovascular and respiratory deaths in 2004.

The law makes provision for those who may lack capacity at the time euthanasia is performed. Advanced directives are recognised for euthanasia and PAS and the law and

professional codes do not exclude euthanasia for those with mental disorders and dementia. The KNMG recognises that there will be an increased demand for euthanasia in dementia because of the growing elderly population.

There has been a marked increase in terminal sedation which is seen as an alternative to euthanasia and PAS or alternatively is used when these are refused or considered inappropriate. Terminal sedation, when combined with the withdrawal or denial of food and fluids will lead to what is certified as a natural death. Conscientious objectors are nevertheless required by the KNMG to refer to those prepared to perform euthanasia or PAS.

It is clear that only a very few, if any, doctors are now prosecuted for euthanasia and PAS.

6 BELGIUM

6.1 Euthanasia legislation

Legislation was enacted to allow euthanasia, but not assisted suicide, in 2002. Euthanasia is defined in section 2 as "*intentionally terminating life by someone other than the person concerned at the latter's request.*"⁴³ The request must be "*voluntary, well-considered and repeated and is not the result of any external pressure*" and that the patient should be "*in a futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated.*"⁴⁴ Euthanasia may be requested in an advance directive⁴⁵ and may be performed when the patient is unconscious.⁴⁶ There is a right of conscientious objection to Euthanasia.⁴⁷ All cases must be reported⁴⁸ and if the Federal Control and Evaluation Committee is not satisfied that the proper procedures have been followed by a two thirds majority, the case may be referred for prosecution.⁴⁹ If a person dies of euthanasia the cause of death for the purposes of insurance is deemed to have been due to natural causes.⁵⁰ Under the 2002 law there is no age limit for 'emancipated' minors who can seek a lethal injection provided they are legally competent. On February 13, 2014, Belgium legalized euthanasia by lethal injection for children. By a vote of 86 to 44 with 12 abstentions, the lower house of Parliament approved the law which had previously been passed by the country's Senate. Young children are now allowed to end their lives with the help of a doctor in the world's most radical extension of a euthanasia law.

The cause of death in cases of euthanasia is certified as the underlying medical condition.

6.2 Increase in euthanasia deaths

In Holland, there had been considerable public debate for over 30 years and euthanasia had been practised since the 1980s. By contrast, in Belgium, legislation was enacted after a relatively short public debate and no previous experience in this area. The extent of euthanasia is greater and the indications are wider than in Holland. In Flanders, the Dutch speaking half of Belgium, with a population of around six million, the rate of euthanasia increased between 2007 and 2013, from 1.9% to 4.6% of all deaths. Over this time there was both an increase in requests for euthanasia, from 3.5% to 6% of all deaths, as well as in the acceptance rate for these requests, from 56.3% to 76.8%. The rate of terminal sedation had been 8.2% of deaths in 2001 rising to 14.5% in 2007 before falling to 12.0% in 2013.

Hence, in Flanders after 13 years experience, euthanasia is increasingly regarded as a medical option. However, these figures may underestimate the true incidence of euthanasia because of under reporting. In a paper by *Smets et al* the rate of reporting in 2007, some five years after the legalisation of euthanasia was estimated at only 52.8%⁵¹. In Flanders euthanasia is now permitted for psychiatric reasons, children and neonates. There were 235 cases of euthanasia in 2003 in the whole of Belgium, 1,133 cases in 2011 which had risen to 2,021 in 2015.

6.3 Increase in the range of cases for euthanasia

Belgium has the most liberal assisted dying laws in Europe. Belgium now allows euthanasia for both mental and physical illness and for children. The general tolerance of euthanasia and PAS may explain the expanding range of cases. Dr Wim Distlemans is the President of the Belgian Federal Euthanasia Review and Evaluation Commission and a leading euthanasia advocate. In September 2013 he gave a lethal injection to Nathan Verhelst aged 44 who was depressed after a failed sex change operation, he oversaw the double euthanasia of the deaf twins Marc and Eddy Verbessem aged 45 who chose to die after they learned they would lose their eyesight. He also killed Godelieva De Troyer on 19.4.12, who had depression without the knowledge of her son Tom Mortier, who heard of the event the following day.

In October 2014 the first referral for judicial review was brought after over 8,000 cases had been reviewed by the Commission since 2002. The case involved Dr Marc Van Hoey who euthanized 85 year old Mrs Simona de Moor on 22nd June 2014. Mrs Simone was suffering from what Dr van Hoey described as reactive depression following the death of her daughter three months earlier. Her case was featured in an Australian documentary.⁵²

Belgium, in common with the rest of the European Union does not have the death penalty. Indeed Frank van den Bleeken a convicted 51 year old a serial rapist and murderer who had been imprisoned for 30 years, wanted to die in order to end his mental anguish. He was due to undergo Euthanasia on 11th January 2014 but his request was refused by doctors less than a week before he was due to receive a lethal injection. Instead he was referred to a newly opened psychiatric centre in Ghent.

In January 2016, Nadine Buntjens, the daughter of Mariette Buntjens was suing a Belgian Catholic Care home for causing "physical and mental suffering" for not permitting the euthanasia of her mother on Church-led premises in Diest in 2011. The case is due to go before a court in Louvain in April. Dr Distlemans said to Flemish media that "*a majority of hospital and nursing homes in Flanders are still Catholic today*" and that "*if the right to euthanasia is refused there, that will be a problem.*"

7 OREGON

For a detailed breakdown of medically assisted suicide deaths in Oregon please see Appendix 1. By way of comparison, Appendix 2 shows figures for unassisted suicides in the State of Oregon which has a high rate of suicide. These figures illustrate how PAS has created a completely different population of patients who seek medically assisted suicide in comparison to those who otherwise have 'unassisted' suicides.

7.1 Experience in Oregon following the Death with Dignity Act (DWDA) 1997

The State of Oregon's The Dignity in Dying Act (DWDA) was passed in 1997. It allows adults to obtain and use prescriptions of lethal medication which is self-administered. The Oregon Public Health Division is required to compile annual reports. Assisted dying through the DWDA is not classified as suicide. Data on non-medically assisted suicides are collected separately and show a completely different demographic pattern. Oregon is not a typical US state as regards to unassisted suicides. It has the ninth highest suicide rate in America. The overall suicide rate is 17.1 per 100,000 of the population which is 41% greater than the national average. Since the law was passed in 1997 up to the end of 2014, a total of 1,327 people have had DWDA prescriptions and 859 (65%) patients have died. Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication and all 94 patients died. A further 11 patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014. 37 out of 155 patients (23.8%) did not take the medication and died of other causes. Of the 105 DWDA deaths in 2014 67.6% were 65 years or older with an overall median age at death of 72 years. As in previous years, the deceased were commonly white (95.2%) and well educated (47.6% had at least a baccalaureate degree). 68.6% of patients had cancer and 16.2% had amyotrophic lateral sclerosis. 89.5% of patients died at home and 93% were enrolled in hospice care when the DWDA prescription was written or at the time of death. Whilst all patients had some form of health insurance the percentage with only Medicare or Medicaid was higher than in previous years (60.2%) and fewer had private insurance (39.8%). As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%). Only 3 out of the 105 DWDA patients (2.8%) who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%). During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.⁵³

7.2 Deaths from suicide contrasted with assisted deaths under the DWDA 1997

In contrast to DWDA deaths, the pattern of 'spontaneous' suicide in Oregon is very different. Please see Appendix for detailed comparisons of the statistics. Between 2003 and 2010 there were a total of 396 DWDA deaths of which just over half were men (53% men and 47% women). This contrasts with a total of 4,772 deaths through suicide with 3.7 times more men than women. Approximately 70% of suicide victims had a diagnosed mental disorder, alcohol or substance misuse, or depressed mood at time of death.

Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health

problems at the time of death.

In sharp contrast to DWDA deaths from lethal medication, the method of suicide is radically different with significant differences between men and women. 62% of deaths in men were due to firearms, 13% due to poisoning and 18% due to suffocation or hanging. In women the corresponding figures were 31% for firearms, 43% for poisoning and 18% for hanging or suffocation.

It is clear that in Oregon assisted suicide deaths have risen almost sevenfold from 16 in 1997 to 105 in 2014 and that the demographics contrast sharply in terms of underlying medical conditions, age, race, gender ratio, means of dying, place of death and preponderance of significant mental illness and social problems in those committing 'spontaneous' suicide. The mode of death is also markedly different. This would strongly suggest that the DWDA has profoundly influenced the mode of death through assisted suicide in Oregon compared to other suicides. This is in keeping with the UK experience for suicides where most suicides have an underlying mental illness or depression in up to 90% of cases. Those at highest risk of suicide are suffering from alcoholism, clinical depression and schizophrenia. Other factors include drug abuse, unemployment, social isolation, poverty, imprisonment, violence and family breakdown.⁵⁴

The Oregon experience suggests that following the DWDA there has arisen a group of patients who have accepted medically assisted suicide who are distinct from those who would otherwise commit suicide. This suggests that societal attitudes and the actions of the medical profession have altered the approach to dying. It is significant that whilst most suicides are in those with mental illness, the majority of DWDA deaths have cancer and physical illness. Few are referred for psychiatric evaluation.

7.3 Effect of physician assisted suicide on palliative care

7.3.1 Pioneering influence on the Hospice Movement of Dr Elizabeth Kubler-Ross

Dr Elizabeth Kubler-Ross who helped to pioneer Palliative Care in America was the author of many books on palliative care including her groundbreaking publication "On Death and Dying" (1969). She outlined five stages that patients went through in coming to terms with the diagnosis of terminal illness. She described the five stages of grief model (denial, anger, bargaining, depression and acceptance). She pioneered methods of psychological support and counselling for the dying and her ideas, together with those of Dame Cicely Saunders in England, were instrumental in the Hospice Movement. It is clear from the works of Dr Kubler Ross that denial and depression are normal stages in the reaction to diagnosis of severe and life-threatening illness. *"What we often tend to forget, however, is the preparatory grief that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world."* She went on to say that: *"If we, as members of the helping professions, can help the patient and his family to get "in tune" to each other's needs and come to an acceptance of an unavoidable reality together, we can help to avoid much unnecessary agony and suffering on the part of the dying and even more so on the part of the family that is left behind."*

7.3.2 Effect of assisted suicide on palliative care: Oregon and British attitudes

In Oregon 90% of those who undergo assisted suicide under the DEDA are enrolled with hospice care. However, in January 2015 a survey conducted by the Association of Palliative Medicine of Great Britain and Ireland (APM) showed that 82% of respondents were against any change in the law on assisted suicide. The survey also highlighted fears that a change in the law would affect palliative care with 72% of respondents agreeing that legalizing assisted suicide would have an adverse effect on the delivery of palliative care, including hospice care. Dr David Brooks, President of the APM commented:

“These results give a clear message to legislators. Those who care for terminally ill people day in day-out believe society should be supporting people at this time in their lives, not putting them at risk.

They also make clear that if society does want to legalise assisting suicide, this should not be part of medical practice. People need to be confident that the doctor is there to care for them whatever happens, not to kill them.

We need to ensure that all patients, whatever their care setting, have equitable access to the care and support they need at the time when they need it and end the postcode lottery in specialist palliative care provision.”

7.3.3 Changing attitudes to suicide and medically assisted deaths.

The changing demographics of suicide and DWDA deaths in Oregon together with the work of Dr Kubler Ross and the Hospice Movement demonstrate how the attitudes towards the disabled and dying may be shaped by the medical profession. There is clearly a risk that a move towards physician assisted suicide will put the disabled, vulnerable and elderly at risk.

Reactive depression is a frequent stage in the adjustment of a patient to life-threatening and terminal illness. It is possible to exploit that risk by a negative attitude towards the terminally ill and disabled. Conversely, Dr Kubler Ross recognized a phenomenon which is common in practice, that patients will seek help from those who they feel have the time, experience and empathy to share their grief and pain. *“Such patients who use denial when faced with hospital staff who have difficulty in coping for their own reasons can be quite selective in choosing different people among family members or staff with whom they discuss matters of their illness or impending death while pretending to get well with those who cannot tolerate the thought of their demise.”*

That patients' views of illness change over time is well known to clinicians. It would be difficult to identify when a patient had a *“clear, settled and informed wish to end his or own life”* (Assisted Dying Bill). This is confirmed by the Oregon experience when over a third of patients do not take the lethal medication. The choice of an individual to end their lives is not always fixed. Indeed, Dr Kubler Ross stated that *“Our interviews have shown that all patients have kept a door open to the possibility of continued existence, and not one of them has at all times maintained that there is no wish to live at all.”*

PART III. BRITISH CASE LAW ON ASSISTED DYING AND ATTEMPTS AT LEGISLATION IN THE UNITED KINGDOM

8.1 Relevant case law

8.1.1 Airedale NHS Trust v Bland (1993)

In Bland, the House of Lords held that there was a distinction between discontinuing treatment and positive acts. Lord Browne-Wilkinson noted that “*the doing of a positive act with the intention of ending life is and remains murder.*”⁵⁵

8.1.2 R (Pretty) v Director of Public Prosecutions (2001)

Diane Pretty who suffered from motor neurone disease, challenged the assertion by Lord Browne-Wilkinson in *Bland* and argued that the refusal of the Director of Public Prosecutions (DPP) to grant her husband proleptic immunity from prosecution if he were to assist her suicide and the prohibition of assisted suicide violated her rights under Articles 2,3,8, 9 and 14 of the European Convention on Human Rights. The House of Lords held that none of these Articles were engaged.⁵⁶ Mrs Pretty appealed to the European Court of Human Rights (ECtHR). The ECtHR held that her Article 8 right to respect for her private and family life had been interfered with. However, this interference was justified as it was in pursuit of the legitimate aim of safeguarding her right to life and protecting the rights of others. The ECtHR noted: “*The Court does not consider therefore that the blanket nature of the ban on assisted suicide is disproportionate. The Government has stated that flexibility is provided for in individual cases by the fact that consent is needed from the DPP to bring a prosecution and by the fact that a maximum sentence is provided... It does not appear arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence.*”⁵⁷

Later, in the case of *Haas v Switzerland*, the ECtHR noted that “*the vast majority of member states seem to attach more weight to the protection of the individual’s life than to his or her right to terminate it... States enjoy considerable margin of appreciation in this area.*”⁵⁸

8.1.3 R(Purdy) v Director of Public Prosecutions (2009)

In *R (Purdy) v Director of Public Prosecutions*, the House of Lords, following the ECtHR decision in *Pretty*) found that the refusal of the DPP to issue guidelines regarding the approach it might take to the prosecution if her husband were to assist her in committing suicide, did violate her Article 8 rights. Lord Hope said that the DPP should be required to “*promulgate an offence-specific policy identifying the facts and circumstances which even take into account in deciding, in the case such as that which Ms Purdy’s case exemplifies, whether or not to consent to prosecution.*”⁵⁹ Following *Purdy*, the DPP published guidelines “*Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*” in 2010

which listed the public interest factors in favour or against prosecution, with particular emphasis on the motivations and actions of the suspect rather than on the characteristics of the victim.⁶⁰

8.1.4 R (Nicklinson) v Ministry of Justice (2014)

Mr Nicklinson was severely paralysed and wished to take his own life. He had unsuccessfully attempted this by refusing hydration and nutrition and required assistance to commit suicide. The nine member Supreme Court held that the rule on assisted suicide was within the United Kingdom's margin of appreciation and is a question for the UK Parliament to decide. Lord Neuberger, President of the Supreme Court, stated: "*Parliament now has the opportunity to address the issue of whether section 2⁶¹ should be relaxed or modified, and if so how, in the knowledge that, it is not satisfactorily addressed, there is a real prospect that a declaration of incompatibility may be made ... However, bearing in mind.... the attention the matter has been given inside and outside Parliament over the last 12 years, one would expect to see the issue whether there should be any and if so what legislation covering those in the situation of applicants explicitly debated in the near future, either along with, or in addition to, the question whether there should be legislation along the lines of Lord Falconer's proposals.*"⁶²

However, assisted dying has been debated on a number of occasions⁶³ before being overwhelmingly rejected in the Marris Bill on 11th September 2015.

8.2 Attempts at legislation for assisted dying

8.2.1 Assisted Dying for the Terminally Ill Bill. (Joffe Bill) 2006

This Bill sponsored by Lord Joffe had its second reading on 12th May 2006 in the House of Lords. This was the third Bill to be presented before Parliament between 2004 and 2006. The aim was to enable an adult who has capacity who is suffering unbearably as a result of terminal illness to receive medical assistance to die at his own considered and persistent request. The Joffe Bill formed the model for the subsequent Falconer and Marris Bills on assisted dying.

8.2.1.1 Qualifying conditions

In order to qualify the person must not lack mental capacity, must have a terminal illness and have made a signed, written and witnessed declaration that the patient wishes to be assisted to die. The assisting physician must conclude that the patient is suffering unbearably and has informed him of his diagnosis, prognosis, the treatment available to assist him to die and the alternatives including palliative and hospice care, pain and symptom control. The physician must also be satisfied that there is no coercion, the family have been informed and the patient has been referred to a 'consulting' physician.

The determination of mental capacity is relevant to the time the decision is made. Incapacity refers to an inability to make a decision for himself "*because of an impairment of, or a disturbance in the functioning of, mind or brain resulting from any disability or disorder*

of the mind or brain." The determination of the mental capacity must be made by a consultant psychiatrist or psychologist who is independent of the attending and consulting physicians. (s3.(1).

8.2.1.2 Declaration

The declaration by the patient of their wish to die must be made in signed writing and witnessed by two individuals one of whom must be a solicitor or a public notary (S4.(2)). The attending and consulting physicians, relatives and partners or anyone owning, operating or employed at a health care establishment cannot act as a witness (S4(5 and (6)).

8.2.1.3 'Cooling off' period

No action to assist the death by the attending or consulting physician can be taken until the expiration of a 14 day period from the time the patient informed the attending physician of their wish to die. (S. 5(2)). Before taking action the physician must inform the patient of their right to revoke the declaration (s 5(3)). The patient may revoke his decision at any time orally, or in any other manner, irrespective of his physical and mental state (S.6 (1)).

8.2.1.4 Conscientious objection

Section 7 contains the conscience clause such that *"No person shall be under any duty to participate in any diagnosis, treatment or other action authorised by this Act, apart from subsection (6), to which he has a conscientious objection."* There is no obligation for any hospital, hospice or nursing home to permit an assisted death on its premises (s. 7.(2)). No person shall be under any obligation to refer to any other source for information, or advice concerning assisted suicide or to refer to another person for assistance to die (s.7 (3)). However, the patient shall be free to consult another physician who does not have a conscientious objection (s. 7 (4 and 5)).

8.2.1.5 Protection of healthcare professionals

Under section 8, those attending a qualifying patient to die, if acting within the provisions of the Act, shall not be guilty of an offence. Similarly, a member of the healthcare team who *"assists a qualifying patient to die"* will not be guilty of an offence. Those assisting in a death *"shall be deemed not to be in breach of any professional oath or affirmation."* No physician, psychiatrist or member of the healthcare team may take part in assisting a qualified patient to die if they would benefit financially or in another way (s.8 (5)).

Peers backed an amendment to defer the Bill by six months by 148 votes to 100. Lord Joffe said this move was to end the debate but he pledged to reintroduce the Bill at a later date. Opponents of the Bill presented a petition to Downing Street signed by 100,000 people.

8.2.2 End of Life Assistance Bill. Scotland (2010)

In December 2009, Margo MacDonald, who suffered from Parkinson's disease diagnosed in 2002, presented the End of Life Assistance Bill in Scotland. This would have allowed patients who felt that their lives had become intolerable as a result of progressive degenerative conditions, trauma or terminal illness to seek the help of the doctor to end their life. The Bill was defeated in December 2010 by 85 votes to 16 with 2 abstentions. Margo MacDonald died peacefully at home surrounded by her family on 4th April 2014.

8.2.3 Assisted suicide (Scotland) Bill (2013)

This members Bill was introduced by Margo MacDonald on 13th November 2013. Patrick Harvie was designated an additional “member in charge” of the Bill in view of Margo MacDonald’s illness. The Bill was defeated on 2th May 2015 by 82 votes to 36.

8.2.4 The Assisted Dying Bill. ⁶⁴ (The Falconer Bill. 2014).

The Falconer Bill was similar to the Joffe Bill with the important addition of judicial scrutiny. The person must be over 18 years (s.1) and have been resident in England and Wales for not less than one year and wishes to undergo assisted suicide with “*a clear and settled intention*” (s.1 2(a)) and made a free and voluntary declaration to the effect in accordance with Section 3 (s.1. 2(b)) that he/she has a terminal condition from which they are “*reasonably expected to die within six months*” (s.2.1(b)). The attending doctor and independent doctor must inform the patient of the diagnosis, prognosis and available treatments, including pain control and palliative care (s3. 4). The person must confirm a clear and settled intention to end their life and have asked the attending doctor to prescribe the necessary medicines. The declaration must be signed and witnessed by the attending doctor.

The attending and independent doctors must confirm that the person is both terminally ill and has the mental capacity to make the decision to end their own life and has a clear and settled intention to do so, which was reached on an informed basis, without coercion or duress (s. 3.3(c)). The person must have been informed of the palliative, hospice and other care which is available to them.

The Secretary of State would be empowered to issue a Code of practice (s.8) in connection with such matters as the assessment of whether the person has a clear and settled intention to end their life (s.8 (1)(a)(i)) and to take into account the effects of depression or other psychological disorders (s. 8(1)(a)(ii)). The Chief Medical Officer would monitor the operation of the Act and its provisions (s. 9 (1)(a)) and report to the relevant national authority and issue an annual report (s.8(1)(b and c)).

The issue of judicial scrutiny before assisted suicide could occur was brought in through an amendment on 7th November 2014. It would provide for scrutiny by a High Court judge before the assisted suicide could occur. The amendment was accepted by Lord Falconer who felt that “*In principle, therefore, I think that judicial process, although it may deter some people, will ultimately give greater protection*”.⁶⁵

8.2.4.1 Welsh Assembly vote on the principles of the Falconer Bill.

The Falconer Bill would have applied to England and Wales. However, on 10th December 2014 the Welsh Assembly in Cardiff rejected a motion in support of the principles of Lord Falconer’s Assisted Dying Bill by an almost 2 to 1 majority. (21 v 12 with 20 abstentions).

8.2.4.2 Criticisms of the Falconer Bill

The Falconer Bill was largely based upon the DWDA in Oregon though with a late amendment in relation to judicial scrutiny before the assisted suicide. There were a number of specific criticisms of the Falconer Bill.

There were concerns that the majority of doctors saw their role as alleviating suffering and caring for patients rather than helping them to end their lives. This would leave only a minority of doctors who would be willing to be involved in assisted suicide and who would not be familiar with the patient or their history. This raises the possibility of “doctor shopping” to find compliant doctors would assist the patient to die. There is difficulty in making a precise prognosis of terminal illness.⁶⁶ Unlike the Joffe Bill, there was no requirement for a psychiatrist, or clinical psychologist, to assess mental capacity and exclude undue influence. The safeguards were consigned to codes of conduct to be decided and promulgated by the Secretary of State after enactment of the Bill so could not be scrutinised by Parliament. The issue of legal scrutiny by the high court had been raised by Lord Neuberger in the Supreme Court decision of *R v Nicklinson* (2014) who had argued that “no assistance could be given to a person who wishes to die unless and until a judge of the High Court has been satisfied that his wish to do so was voluntary, clear, settled and informed”.⁶⁷ A provision for High Court supervision was later agreed by an amendment in the Committee stage. Post mortem monitoring and reporting was very limited and less stringent than in the Joffe Bill and was to be dealt with in regulations and codes of practice. There was no requirement that the assisting physician was satisfied that the requirements of the Act had been satisfied. There was nothing in the Act (or the previous Joffe Bill) to specify how the attending physician may act to end the life of the patient, in the event of the assisted suicide attempt being unsuccessful.

8.2.5 The Assisted Dying Bill (The Marris Bill. 2015)

8.2.5.1 Introduction

The second reading of the Assisted Dying Bill was introduced by the sponsor Bob Marris MP on Friday 11th September 2015. It was defeated by 330 to 118 votes.⁶⁸ Nevertheless, points raised during the debate are of particular interest in relation to why the proposals for assisted dying were rejected so overwhelmingly by Parliament.

In introducing his Bill, Bob Marris said that “*The context is that the current law does not meet the needs of the terminally ill, does not meet the needs of their loved ones and, in some ways, does not meet the needs of the medical profession*”. He stated that following the *Tony Nicklinson* case, “*the Supreme Court recognised that there is a problem that needs to be addressed by Parliament*”. He claimed that “*In Oregon, there is not one documented case of abuse or misuse. There are many rumours and urban myths—the Barbara Wagner case is one of them*⁶⁹. *No one there has ever been charged with a crime. The Oregon health authority collects the data quite properly each year, as would be the case for chief medical officers under this Bill, and there are no documented reported cases of abuse in Washington state, Montana or Vermont*”.

He described how “*if I had a terminal illness and a prognosis of less than six months, I and many others would find it comforting to know that the choice was available—to have the option of choosing a dignified and peaceful end at a time and place and in a manner of my own choosing at my own hand*”.

Andy Slaughter pointed out that it was important for Parliament to decide the matter of assisted suicide. “*We should bear in mind the words of the President of the Supreme Court,*

Lord Neuburger, who said that it was institutionally inappropriate at this juncture for the Court to declare that clause 2 [of the Suicide Act 1961] was incompatible with article 8, as opposed to giving Parliament the opportunity to consider the position without a declaration. Lord Sumption referred to the “inherent difficulty” of the question, and to “the fact that there is much to be said on both sides”—for making—“Parliament the proper organ for deciding it.”

8.2.5.2 Concerns with the Marris Bill

There were a number of concerns with the Bill which were made during a wide ranging and thorough four hour debate.

8.2.5.3 Placing the vulnerable at risk

Mary Robinson stated that: *“Legislation that allows the taking of a life should not do so at the expense of vulnerable people.”*

Concerns were raised by Lyn Brown that the vulnerable would be at risk particularly those who were elderly and *“with families more interested in the cost of care, and its impact on their dwindling inheritance, than the priceless gift of life? Can we be absolutely sure that they would not be pressured into it? It is naive to believe that we can prevent an elderly, expensive or asset-rich relative being encouraged, coerced or emotionally blackmailed into taking their own life”.*

Glyn Davies echoed the view that Society disapproves of suicide and raised three objections to the Bill. *“If it becomes normalised it becomes an issue of debate for everyone who reaches the end of life.... It is true that there may be issues of coercion and malevolence, but the real concern is the self-imposed pressure—people asking themselves, “Is my life over? Should I remove myself from society?”*

The second worry that I have about the Bill is that it puts different values on the lives of some members of society—the people approaching the end of life, the terminally ill, the mentally disabled, the severely mentally disabled and the severely disabled. We have never put different values on the lives of different people; I think the Bill does that.

The third reason that I oppose it is that it inevitably changes the relationship between doctors and their patients. A doctor’s job has always been to do no harm. People go to the doctor because they want the doctor to help them and make them well. If assisted dying will always be part of their discussions, it will interfere with their relationship forever.”

Mark Durkan raised concerns about the possibility of coercion expressed by several members but also *“the wider conditioning effect”* on the relationship between doctors and patients as well as with their colleagues and other professionals.

Jonathan Reynolds said that *“we can offer people dignity and comfort at the end if we are willing to devote sufficient political and financial capital to that end”* with the implication that the Bill would reduce the incentives to improve and finance palliative care.

Colleen Fletcher had three main concerns: Firstly, *“how are the two registered medical practitioners and the judge able to satisfy themselves that the decision to end life “has been reached voluntarily, on an informed basis and without coercion or duress”?* Secondly, *I am concerned that the definition of a terminally ill person for the purposes of the Bill is someone who “is reasonably expected to die within six months”.* Thirdly and finally, *I am concerned that the Bill does not provide adequate safeguards or an appropriate legal framework to establish whether an individual “has the capacity to make the decision to end his or her own life”.*

8.2.5.4 Altering the fundamental doctor patient relationship

Concerns were raised that the Bill would fundamentally alter the relationship between a patient and a doctor and would inexorably change society’s attitude to death and dying. There would be an expectation that the old, disabled and infirm should *“die a dignified death , leaving the young, fit and able unencumbered by their burdensome, difficult, messy, expensive, pain-filled and challenging lives”* .(Lyn Brown).

Karl McCartney echoed the view that the Bill would affect the relationships between doctors and their patients at a critical time. *“Many of us fear that the Bill will induce uncertainty and suspicion and have the potential to fracture the doctor-patient relationship at the most critical time, when patients with the most severe illnesses are at their most vulnerable and in desperate need of sympathetic encouragement”.* He quoted Baroness Campbell, who is herself disabled, as having observed that for the Bill *“to pass into law would be a triumph of despair over hope. It says, don’t try to make things better—that’s just too difficult and, anyway, would be futile. It is far better to die now. It will be better for you, your family and society. You are defined by your diagnosis, which is also your death warrant. Society doesn’t want you around any more.”*

Conor McGinn recognised the concerns of medical professionals and asked *“Does my hon. Friend agree that those concerns are reciprocated by many patients? We trust and rely on doctors and nurses to improve the quality of life, not to bring it to a premature end.”*

8.2.5.5 Difficulties with safeguards and judicial scrutiny

“How should doctors be satisfied that the intent is settled? Would they need to see the patient once or twice, or over what period of time? The Bill is silent. What steps should doctors take to be satisfied that the intent is voluntary, and that there is no coercion behind the patient’s request? The Bill is silent”. (Fiona Bruce)

With respect to judicial overview *“The judge would not have to meet the patient; they would only have to confirm the doctors’ decision, and in a time frame of 14 days, making independent scrutiny all but impossible. Absent will be the detailed, rigorous examination that the family court gives to life and death issues, such as turning off a life-support system”.* (Fiona Bruce).

8.2.5.6 Role of the Director of Public Prosecutions

It was argued that the investigative powers of the Director of Public Prosecutions under the current legislation to rigorously investigate cases of assisted suicide proved a strong deterrent against malicious behaviour under the current law. Sir Kier Starmer MP, the previous Director of Public Prosecutions stated that the guidelines used to help determine if a prosecution should occur were underpinned by two principles. *“The first was that the criminal law should rarely, if ever, be used against those who compassionately assist loved ones to die at their request, so long as that person had reached a voluntary, clear, settled and informed decision to end their life. The second was that very strong safeguards are needed to protect those who might be pressurised in any number of subtle ways. Those who encourage the death of the vulnerable should feel the full force of the law.”*

He went on to explain that *“I personally oversaw about 80 cases, looking at the details in each of the files, and made decisions in 79 of those cases that no prosecution should be brought, and there was no clamour to change the guidelines”*.

In relation to the involvement of the medical profession Kier Starmer explained that *“I took the view then, and I still hold the view now, that if the DPP indicated that doctors or medical professionals were unlikely to be prosecuted for assisting, that would undermine the intention of Parliament when it passed the Suicide Act 1961.”*

In the case of Tony Nicklinson, who had had a series of strokes that had left him almost completely paralysed. Kier Starmer explained that in June 2014, the Supreme Court had held that *“there was an incompatibility between our current position and fundamental human rights, but because of the margin of appreciation they should not themselves make a declaration to that effect but leave it to Parliament to further consider the issue, and today is that opportunity”*.

His opinion had changed since he was the Director of Public Prosecutions because even though those who have reached a *“a voluntary, clear, settled and informed decision to end their lives can now be confident of the compassionate assistance of loved ones without exposing them to the law, cannot have the assistance of professionals..... We have arrived at a position where compassionate, amateur assistance from the nearest and dearest is accepted but professional medical assistance is not”*. Sir Kier Starmer voted in favour of the Marris Bill.

8.2.5.7 Issues for the medical profession and wider society

Jim Shannon pointed out that assisted suicide does not just affect the person who dies but creates problems *“for the wider society”* and *“undermines the motive that sustains all medicine.”* There was also a risk that once assisted suicide was permitted for the terminally ill it would be extended to those with chronic progressive conditions and the disabled. He also pointed out that the *“the vast majority of UK doctors are opposed to legalising assisted suicide or assisted dying, as are the British Medical Association, the Royal College of Physicians, the Royal College of General Practitioners, the Association for Palliative*

Medicine, the British Geriatrics Society, Disability Rights UK, Scope and the United Kingdom Disabled People's Council."

Liam Fox raised the issue of failed assisted suicide which he suggested *"make up around 7% to 16% of cases, and include failure to induce coma, or patients who come out of coma before the process is finished"*. In Holland, a doctor is present *"precisely so that euthanasia can be performed, if necessary, if the process fails."* In practice it is impossible to distinguish between assisted dying and euthanasia.

For Mr Nigel Evans, the Bill raised important matters of principle *"I believe in dignity in death, but I also believe in the sanctity of life"*. Mr Gordon Marsden emphasised the issues would impact not only on the individual but also on society. *"It is not simply for the individual—it is for the families who are impacted by it, for the doctors who have to go through agony trying to decide what to do about it, and for all of us in society who will take the consequences on board"*.

8.2.5.8 Conscientious objection

Steve Brine raised the issue of conscientious objection with its attendant danger. *"Clause 5 rightly contains provision for conscientious objection, so will we see in this country what we see in other jurisdictions, which is known as "doctor shopping"?"* He also pointed out that the robust timescale for court decisions would make robust scrutiny almost impossible. *"What would the judicial signatory require? Would there be a hearing with evidence presented, or would it just act as a rubber stamp?"*

8.2.5.9 Assisting suicide or preventing suicide

Nick Herbert raised some rhetorical questions. Why, if there is a right to die, would it be constrained to having a terminal illness with a prediction of death within six months? Is it the wish of the House that there should be either more assisted suicides or fewer? Is suicide ever a good thing? He pointed out that whilst suicide is no longer a criminal offence that law has always made it clear that *"should somebody assist that, particularly a medical professional, a line has been crossed."* Furthermore, *"the law has always regarded it as wrong to assist in someone's suicide because, in the end, we think that suicide is wrong, even if we think that it should not be a criminal offence. That is why we should take the very greatest care before taking this fundamentally different step"*.

Sir Edward Leigh insisted that *"We have to promote the hospice movement....In that sense, I think we can resolve this issue and emerge with credit from what I regard as a moral maze....What sort of society are we creating if we say that we value people who are healthy, fit, beautiful and young more than we value people who are poor, old, crippled, ill and dying?"*

Helen Jones opposed the Bill on two grounds. *"The first is that it asks us to cross a line in our attitude to life, which I believe as a decent society we should not cross. At the moment, our law strives to protect life. We regard murder as one of the worst crimes; we seek to deter people from suicide; we do not execute criminals. But if we cross the line, deciding that some lives are less valuable than others, we shall be opening ourselves up to a process that I think*

we would deeply regret. My second reason is that I think the Bill is badly drafted. What he offers in this Bill is a lower standard of proof for those who require assisted suicide than we allow to those charged with a criminal offence”.

Barbara Keeley pointed out the irony of debating the issue two days after World Suicide Prevention Day. *“Many moving messages appeared on social media about the importance of preventing suicide, so it is ironic that we should today be debating a Bill that drives our society in the opposite direction”.* Assisted suicide would create pressure on people to end their lives and a *“fundamental shift in people’s perception—that our society accepts suicide”.* She pointed out that Richard Hawkes, the former CEO of Scope, had said: *“Why is it that when people who are not disabled want to commit suicide, we try to talk them out of it, but when a disabled person wants to commit suicide we focus on how we can make that possible?”*

8.2.5.10 Doctor shopping.

Robert Ffello reinforced the issue regarding doctor shopping. *“My hon. Friend will be aware that in Oregon, which is the example most cited, almost a quarter of all cases are seen by just three doctors—and they do not know anything about them”.* He later went on to point out that the *“1961 Suicide Act as amended said that it was no longer a crime to commit suicide, and that was for a very good reason. It is not because society now thinks that everyone should have the right to commit suicide, but because society rightly thinks that someone who has tried to commit suicide needs help and support, not criminal punishment”.*

8.2.5.11 Meaning of intolerable suffering and the value of human life

Dr Sarah Wollaston questioned the concept of intolerable suffering. *“Intolerable suffering is what is intolerable to us. We have seen that definition extend in Switzerland. Indeed, a British citizen—a retired nurse— took her life in Switzerland last year because she was afraid of getting old.”* Another medical practitioner, Dr Philippa Whitford pointed out that the issue raised the circumstances in which Society allowed one person to kill another. *“It is, rather, a crossing of a Rubicon, as was mentioned earlier. It is changing and legalising the killing of one person by another, regardless of the reasons why we would want to carry that out. We should vote for life and dignity, not for death”.*

According to John Pugh, *“there is no essential right of people to demand of the state that it assists them with their suicide.”* Indeed, the social risks of allowing assisted suicide are incalculable and *“the elderly and infirm will be pressured, doctors’ motives will be questioned or confused, palliative care will be progressed less and suicide will be seen as a solution more, and life will be treated more casually—more as a disposable commodity.”* How can significant depression and psychological disorders be excluded in the dying? Ben Howlett asked *“If someone has just been given a terminal diagnosis and only six months to live, are we suggesting that they will have neither depression nor any other psychological disorders that might impair their decision making?”*

8.2.5.12 Problems with prognosis

Mr David Jones pointed out the difficulty in making an accurate prognosis and cited the example of Mr Abdelbaset al-Megrahi the Lockerbie bomber who was discharged on compassionate grounds as he was not expected to live for a further three months, but survived two years nine months. He also observed that whilst someone might come to a “rational decision that one does not wish to be a burden on one’s family”, this might be indistinguishable from being “coerced, cajoled and browbeaten into that position” and “the Bill provides no safeguards in that respect”.

On a technical, there was a danger in doctors acknowledging that someone was terminally ill. For example, Mrs Madeleine Moon pointed out that “The DS1500 is the form that your GP gives you that says you are terminally ill. It is a passport to benefits that are absolutely critical for the dying. Do not allow GPs who are opposed to the legislation to use it as a way of withholding those benefits from people who desperately need them. We must find something else.

8.2.5.13 Arguments in favour of the Marris Bill

Norman Lamb quoted J.S. Mill in relation to sovereignty when he said: “*The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.*” Norman Lamb, placed the emphasis on individual rights. “*The approach taken is that it is the individual’s own priorities that are paramount. Are we really saying that that principle, which applies to issues such as resuscitation where one wants to die, suddenly does not apply when we get to the most profound of questions? At that point, the individual has no right and is left at the mercy of the state’s decision*” He concluded that “*that in those last stages of life it is the individual’s priorities and wishes that should be paramount*”.

The theme of personal autonomy was taken up by Lucy Allan who felt that “*This Bill is about principle: it is about freedom and choice. Although I respect the views of everybody who has spoken today, it is not for us to deny people a say in how they die. It is their life, not ours.*” For Chloe Smith the issue of value was one to be decided by the individual alone. “*We all squeal when someone defines a person as worth less than we may think, but the more respectful and free response should be to resist defining a person in any way other than how that person wishes.*”

Sarah Champion. Raised five main counter-arguments against the opponents of the Bill.

“*[1] The first is about someone being given a six-month terminal diagnosis when perhaps they will live for nine or 12 months. Perhaps they will recover—that is fantastic; I want to celebrate that—but some people die after two days. The Bill is not about marching someone to a darkened room.... it gives them the choice so that if during the deterioration of their condition towards death they choose to end their life earlier, that is their choice and they have that right.*”

[2] Another argument is about disabled people. I find that quite insulting because disabled people are living full, wonderful, happy lives. Why do people want to include them in the Bill as though their lives are not fulfilled?

[3] On coercion, I do not doubt that perhaps there are evil relatives out there who will seek to coerce their elderly mother. However, that elderly mother will then have to persuade two doctors and a judge that this is her choice. I do not think that someone who is vulnerable enough to be coerced by their evil relatives could persuade a judge that they are taking such action from their own choice.

[4] We then come to the argument about the thin end of the wedge. I am sorry, but we legislate for a living here. We know that if anything was to happen, the issue would have to come back to the Chamber and we would have to agree it. I do not accept at all the argument that this is the thin end of the wedge.

[5] There is the argument that it is God's will that we should suffer, if necessary, and that it is God's choice how we end our lives. I have 100% respects for that view. If that is someone's position and choice, this Bill is not for them and I do not expect them to seek to make use of its provisions. I feel, however, that I should be able to make a different choice and that others should not be able to stop me.

I feel strongly that this Chamber does not have moral superiority over those who we serve and have elected us. Eighty per cent. of the population are in favour of this Bill".

8.3 CONCLUSIONS

The Falconer and Marris Bills were largely modelled on the Oregon Death With Dignity Act 1977. The main difference was the provision in the Assisted Dying Bill of judicial scrutiny before the event. However, if the rate of assisted dying was equivalent to that of euthanasia and PAS in the Netherland and Belgium it would require between around 12,000 and 20,000 judicial submissions per year in England.

Physician Assisted suicide was comprehensively rejected at Westminster, Edinburgh and Cardiff. In 1961 the Suicide Act was amended to decriminalise suicide, but created the crime of assisting a suicide which is punishable by up to 14 years in prison. Nevertheless, the DPP still has discretion regarding prosecutions which have to satisfy the criteria of both being in the public interest and having a reasonable chance of conviction on the evidence.

PART IV. REASONS FOR OPPOSING PHYSICIAN ASSISTED SUICIDE AND EUTHANASIA.

9 Introduction

Physician assisted suicide and euthanasia raise the most serious moral, philosophical and political issues that any Society can face. Death and human suffering pose questions of the meaning and significance of life itself. This is particularly true of those with terminal illness. For Christians, the direct deliberate killing of innocent human beings is profoundly morally wrong. This is a view shared by those of other faiths and those with no particular religious belief.

Britain and Europe have rejected capital punishment. The United Kingdom has overwhelmingly rejected assisted suicide.

9.1 Crossing the ‘Euthanasia Rubicon’ or upholding the fundamental right to life.

At the heart of the matter lies the fundamental obligation of Society to protect human life. The House of Lords Select Committee on Medical Ethics in 1994 put this succinctly:

“We do not believe that these arguments are sufficient reason to weaken society’s prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole”.

A similar view was taken by the Parliamentary Assembly in its recommendation to the Council of Europe in 1999.^{70 71} *“The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life.”*

The fundamental right to life is incorporated in Universal Declaration of Human Rights proclaimed by the General Assembly of the United Nations⁷² and Article 2 of the European Convention on human rights.⁷³

The right to life is the most fundamental of all human rights, without which all the others would be illusory. This was outlined in the Grand Chamber judgment in the case of *McCann v United Kingdom*:

“Article 2 ranks as one of the most fundamental provisions in the Convention – indeed one which, in peacetime, admits of no derogation under Article 15. Together with Article 3 of the Convention [the prohibition of torture], it also enshrines one of the basic values of the democratic societies making up the Council of Europe.”⁷⁴

In the case of *Pretty v United Kingdom*, the Court held 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”.⁷⁵ The Court also declared that with respect to Article 3 (freedom from degrading and inhumane treatment) “Article 3 must be construed in harmony with Article 2”, which (the Court recalled) “does not confer any right on an individual to require a State to permit or facilitate his or her death”.⁷⁶ Article 3, therefore did not impose a duty on the State to allow actions to terminate life.⁷⁷ The Court also held that there was no violation of Mrs Pretty’s Article 8 rights (right to private life and self determination) and concluded that in this case the interference “may be justified as “necessary in a democratic society” for the protection of the rights of others”.⁷⁸ Finally there was no infringement of Article 14 on the grounds of discrimination for those who were physically incapable of committing suicide since “to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse.”⁷⁹

Mrs Pretty slipped into a coma and died peacefully on 11 May 2002 twelve days after the ruling.

In case of *Nicklinson* the European Court of Human Rights (ECtHR) was asked to decide if the ban on assisted suicide for Mr Nicklinson who had “locked in syndrome” was incompatible with Article 8. In June 2014 the UK Supreme Court had found that it was for Parliament to resolve such a sensitive issue. The ECtHR did not accept that Article 8 imposes procedural obligations which require the domestic courts to examine the merits of a challenge brought in respect of primary legislation as in the present case. Indeed this would force upon the courts an institutional role not envisaged by the constitutional order. Parliament was best placed to decide such issues in the light of the sensitive ethical, philosophical and social issues involved. The ECtHR noted that there had been no substantial changes since the judgment in *Pretty* and that the application was therefore ill-founded and was declared inadmissible. In the event, Parliament did reject assisted suicide on 11th September 2015.

9.2 The Hippocratic Tradition

In the Hippocratic tradition there is a clear prohibition both euthanasia and assisted suicide. In the words of the Hippocratic oath “I will give no deadly drug to anyone, nor will I counsel such.”

The Anthropologist, Margaret Mead explained the necessity to carefully define the role of the emerging medical profession in Ancient Greece: “For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He who had the power to kill had power to cure, including specifically the undoing of his own killing activities. He who had power to cure would necessarily also be able to kill”. Margaret regards the Hippocratic

tradition as a *“priceless possession which we cannot afford to tarnish; yet... “society always is attempting to make the physician into a killer-to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient[it is] the duty of society to protect the physician from such requests.”*⁸⁰

The purpose of Medicine according to the Hippocratic Oath was to benefit the sick whether they *“were male or female, bond or free”* and *“to refrain from any act of wrongdoing.”* Nevertheless according to Margaret Mead *“Society is always attempting to make the physician into a killer,”* and *in the rise of the new medicine it is succeeding. Killing has been restored to clinical practice and the clock put back to the days before Hippocrates”*.

The absolute prohibition on direct deliberate killing of innocent human beings through PAS and euthanasia is necessary to protect fundamental human rights of which the foundation is the right to life itself.

The purpose of Medicine is to benefit the sick. This too requires a profound recognition of the inviolable rights of individual patients. It is therefore essential to maintain a respect for those with a conscientious objection to intentional killing. *“To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right.”*⁸¹

The purpose of the civil law is to recognise the common good and fundamental human rights.⁸² Indeed, St Thomas Aquinas argued that *“human law is law in as much as it is in conformity with right reason and thus derives from the eternal law.”*⁸³ Furthermore, *“every law made by man can be called a law insofar as it derives from the natural law. But if it is somehow opposed to the natural law, then it is not really a law but rather a corruption of the law.”*⁸⁴

Pope John Paul II summarised the position by saying *“laws which legitimize the direct killing of innocent human beings through euthanasia are in complete opposition to the inviolable right to life proper to every individual; they thus deny the equality of everyone before the law.... Disregard for the right to life, precisely because it leads to the killing of the person whom society exists to serve, is what most directly conflicts with the possibility of achieving the common good.”*⁸⁵ According to Pope John Paul II *“Euthanasia in the strict sense is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering.”*⁸⁶ However, the practice of euthanasia, should be distinguished from a legitimate refusal of aggressive medical treatment which is either disproportionate to any expected results or because it places an unacceptable burden on the patient.⁸⁷ When death is clearly imminent and inevitable, such forms of treatment can be refused in conscience where they would only secure a precarious and burdensome prolongation of life, so long as the normal care of the sick person is not interrupted.⁸⁸

The fundamental principles of the objective moral law, *“which, as the “natural law” written in the human heart, is the obligatory point of reference for civil law itself”* is the fundamental

basis of the democratic system. Otherwise, democracy would be reduced to a mechanism for regulating different and opposing interests on a purely empirical basis.⁸⁹ Indeed, as Pope John Paul II pointed out *“Fundamentally, democracy is a “system” and as such is a means and not an end. Its “moral” value is not automatic, but depends on conformity to the moral law to which it, like every other form of human behaviour, must be subject: in other words, its morality depends on the morality of the ends which it pursues and of the means which it employs.”*⁹⁰

9.3 Is there a Slippery Slope once PAS and euthanasia are allowed?

The Catholic Medical Association (UK) is opposed to both PAS and euthanasia on principle. There are also reasons for this opposition in relation to practice, not least because of the effects on the doctor patient relationship and the trust of patients in the medical profession.

9.4 False distinction between PAS, euthanasia and “assisted dying”.

PAS and ‘assisted dying’ imply that the fundamental choice is that of the patient but that the death is brought about with the assistance of the physician. In reality, the Dutch experience clearly shows that if the patient does not die within a given period of time the attending physician is expected to practice euthanasia. Indeed PAS raises the possibility of a doctor being held negligent if lethal medication is prescribed and administered and the patient does not die but is rendered comatose. Would the doctor ever be held liable for failing to bring about the death of the patient? Although physician assisted suicide and assisted dying are both done at the patient’s request they nevertheless require compliance from the medical attendant.

PAS and assisted dying might be considered more acceptable particularly when legislation is being considered. However, it appears those in Holland prefer euthanasia to PAS as it does not require the active involvement of the patient as with suicide. Indeed, as the Dutch experience shows, there are alternatives to euthanasia to bring about the death of the patient when euthanasia is either inappropriate for example because of the time constraints or because it has been refused. These other forms of ‘assisted dying’ include terminal station the withdrawal of hydration and nutrition and/or the stockpiling of drugs for later suicide attempts.

Whilst legislation in Europe and North America requires a clear and persistent desire for the patient to end their life, it is clear from the Oregon experience that the provision of lethal medication is often seen as an “insurance policy” to be used in case the patient’s circumstances deteriorate.

9.5 The illusion of safeguards

9.5.1. Reporting.

Notwithstanding the view of the proponents of PAS and euthanasia that the main determinant should be personal autonomy, there remains the presumption that there should be adequate safeguards to protect the vulnerable.

The issues involved include whether safeguarding showed the true reporting after the event, or judicial review beforehand. The question of mental capacity is important and whether the patient has a fixed determination to die. There is clearly an issue over the underreporting of cases and the fact that the scrutiny committees may be staffed by active proponents of euthanasia as in Belgium.

There are no figures for the regular reporting in Oregon but there is considerable underreporting in both the Netherlands and Belgium. Few if any doctors are subject to judicial sanction. In the Briefing Paper for Lord Falconers' Commission on Assisted Dying, it was pointed out that there were few if any referrals by the board of examiners in Oregon.⁹¹ There have been no convictions in Holland or Belgium. However, Dr Marc van Hoey, a leading advocate of euthanasia and chairman of one of Belgium's main euthanasia advocacy groups, Right to Die, could face criminal charges for euthanasia in the case of 85 year old woman suffering from reactive depression. His was uncovered in an Australian documentary film.⁹² In the documentary he also admitted to performing "maybe hundreds" of cases of euthanasia since 2002. Perhaps one of the reasons for the lack of referrals for judicial review, after over 13 years and 8,000 cases of euthanasia, is the fact that the chairman of Belgium's Federal Euthanasia Review and Evaluation Commission, Dr Wim Distlemans, is himself one of the foremost campaigners for Euthanasia in Belgium.

Professor Theo Boer is Professor of Healthcare Ethics at Kampen University in the Netherlands and was a member of one of the five Regional Review Committees on Euthanasia from 2005 to 2014. Having "*for years supported the Dutch law on assisted dying*" he now argues for caution in any country contemplating legislation.⁹³

"In the years of my membership, the review committee saw a rise in the number of reports from 1,800 to close to 5,500 last year. Now about one in 25 deaths in the Netherlands is the consequence of assisted dying with, by the way, suicide rates going up as well.

Whereas assisted dying in the beginning was the odd exception, accepted by many — including myself — as a last resort, it is on the road to becoming a preferred, if not the only acceptable, mode of dying in the case of cancer. Public opinion has shifted dramatically toward considering assisted dying a patient's right and a physician's duty. A law that is now in the making obliges doctors who refuse to approve assisted dying

to refer their patients to a willing colleague. Pressure on doctors to conform to patients' or relatives' wishes can be intense.

Other developments have taken place as well. The Dutch Right to Die Society founded a network of travelling euthanizing doctors, thus taking assisted dying out of the patient-doctor relationship. There is a strong public movement toward legalizing euthanasia for children 1 to 11 years of age. Whereas in the first years hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given assisted dying consisted of being aged, lonely or bereaved”.

The role of doctors is important not only in relation to their supervision of the dying process but also with regards to conscientious objection, it is also clear from the practice of euthanasia and PAS in Europe and North America that the criteria used become more broad-based with time as the number of cases increases. It is also important to consider the effect on the medical profession, including effects on those who have chosen to engage in this type of activity as well as the effects of patients with respect to their views on the medical profession.

9.5.2 Criteria for PAS and euthanasia.

9.5.2.1 A fixed and voluntary decision to die

The essential criteria include a fixed voluntary determination by an adult patient with mental capacity that they wish to die as a result of unbearable suffering whether or not there is the additional criterion of having a terminal illness with a definable prognosis of six months.

A normal reaction to a diagnosis of terminal illness is denial, anger and depression. Patients seen early after diagnosis might therefore be more inclined to wish to die than after a period of adjustment and adaptation. Death is one of the most challenging episodes that we face. The knowledge of impending death raises issues both in relation to the illness itself and its consequences and also existential concerns in relation to the meaning and significance of life itself. Dame Cicely Saunders use the term “total pain” to describe the immediate situation of those faced with a terminal diagnosis.

The degree of mental capacity required to consent to medical treatment depends upon the seriousness of the decision to be made. Few decisions can be more critical and difficult than choosing to die. It is clear from the experience in Oregon that lethal medication may be obtained as an “insurance policy” and that in a significant proportion of cases it is never taken. It is a matter of everyday clinical experience that patients who take drug overdoses do not necessarily intend to kill themselves and the majority who survive do not repeat the attempt. Even the survivors of serious attempts may also live to regret them.

The position of psychiatrists who are required to determine mental capacity and the desires of patients to kill themselves is at best ambiguous. The medical profession is asked to adjudicate between on the one hand assessing the patient's desire to end their lives and on the other helping the patient at a time of extreme difficulty. There is an obvious ambiguity in referring to a psychiatrist under the circumstances not knowing whether they will help to kill or cure the patient.

The demographics of suicide in Oregon clearly show that since the Death With Dignity Act a new class of suicidal patient has emerged. Those seeing a medically assisted suicide are radically different from those who spontaneously attempt an unassisted suicide. The two groups are clearly distinguishable in terms of age, gender balance, racial background, history of mental illness, alcohol and drug addiction and social problems. The mode of death is also different with a preponderance of death through firearms drowning and association in those making suicide attempts outside a medical context (Please see Appendix 2 for the demographics of unassisted suicide).

9.5.2.2 Unbearable suffering

Assessment of 'unbearable suffering' involves both an objective and subjective component. Moreover, the perception of suffering may vary over time and be influenced by the attitude of doctors, family and also by social circumstances and loneliness. Patients may feel depressed because of the uncertainties of available treatment and prognosis and the lack of support available. The perceived 'right to die' might become a 'duty to die' in the interests of others. There is evidence from Belgium that the test is becoming increasingly subjective and now includes being tired of life, failed surgery and the prospect of future disability.

Whilst unconscious patients cannot be said to be suffering unbearably, the Dutch accept that patients on ventilators might be considered to be suffering unbearably if legislation or sedation would be withdrawn. This makes for the possibility that patients undergo euthanasia if they had previously signified their wish to die through an advance directive.

It is clear that the definition of unbearable suffering has been extended far beyond what was originally intended. The effect of neonatal and childhood euthanasia in Belgium and Holland also raises questions as to how unbearable suffering can be determined and moves away from the concept of autonomous decision-making. In Belgium, Holland and Oregon the numbers of cases of Euthanasia and PAS are increasing rapidly.

9.5.2.3 Problems with prognosis.

There are inherent difficulties in assessing prognosis, the most obvious being the paucity of reliable studies. The pathophysiology of dying may be very different in different malignant diseases compared to non-malignant conditions. Prognostic tools apply to group statistics and do not take into account inter-individual variability. The extrapolation of group statistics to individuals introduces a further element of bias and subjectivity. It is also important to separate the natural history of disease from the effects of treatment on disease progression.

In the context of palliative care a poor prognosis may lead to “giving up” on the patient. However, Dr Elizabeth Kubler-Ross rightly cautioned in her book *On death and Dying* (1969): “I would add that we should not “Give up” on any patient, terminal or not terminal. It is the one who is beyond medical help who needs as much if not more care than the one who can look forward to another discharge.”

9.5.2.4 Conscientious objection

The right of conscientious objection to assisted dying must be maintained. Doctors must not be complicit in any form of direct and deliberate killing of patients. The purpose of Medicine is to benefit the sick and trust is the necessary foundation of this help. There should be no ambiguity in the role of the doctor. Assisted dying must not become a routine part of medical practice. However, in Holland, there is now an End-of-Life Clinic which reported its finding in 2015.⁹⁴ In the first year of operation, 162 requests were granted including 113 for a somatic condition, 21 with cognitive decline, 11 who were tired of living and 6 with a psychological condition.

9.6 Conclusions

Absolute respect for every innocent human life requires the exercise of conscientious objection in relation to euthanasia. "Causing death" can never be considered a form of medical treatment, even when the intention is solely to comply with the patient's request.⁹⁵ The paradox at the heart of the current debate is that the autonomous decision of the patient to end their life may take precedence over the conscientious objection of others not to be involved in taking of life. Hence, the right-to -die of the individual is determined by the will of the majority through the democratic process, whilst the right to conscientious objection of the professional is denied. Individual conscience and responsibility is therefore handed over to the civil law. However, fundamentally democracy is a means not an end in itself. The value of democracy depends on the values which it embodies and promotes, including the inviolable right of individuals to life and the dignity of every human person.⁹⁶

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31.1.16

APPENDIX 1. OREGON ASSISTED SUICIDE DEATHS

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. These figures are taken from the Oregon Public Health Division website at: <http://www.healthoregon.org/dwd>.

DWDA Deaths in Oregon

Year	Prescriptions	Deaths
1997	24	16
1998	33	27
2000	39	27
2001	44	21
2002	58	38
2003	68	42
2004	60	37
2005	65	38
2006	65	46
2007	85	49
2008	88	60
2009	95	59
2010	97	65
2011	114	71
2012	116	85
2013	121	73
2014	155	105

End of life concerns	Number (%)	Number (%)	Number (%)
	2014	1998-2013	
Losing autonomy (%)	96 (91.4)	686 (91.5)	782 (91.5)
Less able to engage in activities making life enjoyable	91 (56.7)	667 (88.9)	758 (88.7)
Loss of dignity	75 (71.4)	504 (80.6)	579 (79.3)
Losing control of bodily functions	52 (49.5)	376 (50.1)	428 (50.1)
Burden on family, friends/caregivers	42 (40.0)	300 (40.0)	342 (40.0)
Inadequate pain control or concern about it	33(31.4)	178 (23.7)	211 (24.7)
Financial implications of treatment	5 (4.8)	22 (2.9)	77 (3.2)

Duration in weeks of doctor patient relationship

Median (weeks)	19	12	13
Range	1-1312	0-1905	0-1905

Duration between 1st request and death

Median (days)	43	48	47
Range	15-439	15-1009	15-1009

Source:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

2 APPENDIX 2. SUICIDES IN OREGON.

- In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.
- The rate of suicide among Oregonians has been increasing since 2000.
- Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men aged 85 and over..
- Non-Hispanic white males had the highest suicide rate among all races / ethnicity (27.1 per 100,000).
- Firearms were the dominant mechanism of injury among men who died by suicide (62%).
- Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000)
- Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death.
- Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.
- Compared to the national average, Oregon suicide rates have been higher for the past three decades.
- The most recently available national data shows Oregon age-adjusted suicide rate of 17.1 per 100,000 in 2010 was 41 percent higher than the national average
- Oregon ranked 9th place among all US states in suicide incidence.
- Between 2003 and 2010, Oregon suicide rates were significantly higher than the national average among all age groups except ages 10-17 and women ages 18-24

Mode of death

Method	Males %		Females %		Total %	
Firearm	2300	62	332	31	2632	55
Poisoning	488	13	450	43	938	20
Hanging / suffocation	675	18	185	18	860	18
Fall	91	2	29	3	120	3
Sharp instrument	65	2	25	2	90	2
Drowning	45	1	26	2	71	1
Motor Vehicle	13	<1	2	<1	15	<1
Other MV	11	<1	1	<1	12	<1
Fire / Burn	10	<1	2	<1	12	<1
Other / Unknown	17	<1	5	<1	22	<1

Circumstances surrounding suicide incidents, Oregon, 2003-2010

	Males (N=3715) (%)	Females (N=1057) (%)
Mental Health Status		
Mentioned mental health problems *	2544 (68)	863 (82)
Diagnosed mental disorder	1342 (36)	665 (63)
Problem with alcohol	784 (21)	195 (18)
Problem with other substance	446 (12)	180 (17)
Problem with alcohol and other substance	214 (6)	78 (7)
Diagnosed mental disorder and problem with alcohol and /or other substance	440 (12)	215 (20)
Current depressed mood	1724 (46)	548 (52)
Current treatment for mental health problem **	1066 (29)	613 (58)
Interpersonal Relationship Problems		
Intimate partner problem	1088 (29)	282 (27)
Other relationship problem	97 (3)	28 (3)
Victim of interpersonal violence within past month	9 (<1)	17 (2)
Perpetrator of interpersonal violence within past month	199 (5)	13 (1)
Death of family member or friend within past five years	252 (7)	96 (9)
Suicide of family member or friend within past five years	50 (1)	15 (1)
Family stressor(s)***	131 (13)	51 (17)
History of abuse as a child***	2 (<1)	9 (3)
Life Stressors		
A crisis within the two weeks	1387 (37)	351 (33)
Physical health problem	935 (25)	280 (26)
Financial problem	502 (14)	121 (11)
Lost job / job problem	549 (15)	123 (12)
Recent criminal legal problem	467 (13)	49 (5)
Noncriminal legal problem	190 (5)	67 (6)
School problem	41 (1)	7 (1)
Eviction/Loss of home***	52 (5)	23 (7)
Suicidal Behaviours		
Disclosed intent to die by suicide	1363 (37)	397(38)
Left a suicide note	1189 (32)	437 (41)
History of suicide attempt	606 (16)	365 (35)

Number and percentage* of people experiencing mental illness among suicide victims by sex, Oregon, 2003-2010

Mental illness

	Males	Females	All
	(N=1296)	(N=665)	(N=1961)
	Count (%)	Count(%)	Count (%)
Depression / Dysthymia	961 (74)	496 (75)	1457 (74)
Bipolar	149 (11)	121 (18)	270 (14)
Schizophrenia	64 (5)	26 (4)	90 (5)
Anxiety disorder	169 (13)	106 (16)	275 (14)
Posttraumatic stress disorder	27 (2)	15(2)	42 (2)
Attention deficit disorder /	16 (1)	7 (1)	23 (1)
Attention deficit and hyperactivity disorder			
Eating disorder	0 (0)	1 (<1)	1 (<1)
Obsessive compulsive	4 (<1)	2 (0)	6 (<1)
Other	28 (2)	8 (1)	36 (2)
Unknown	64 (5)	10 (2)	74 (4)

* Percentages might exceed 100% because some victims might have more than one problem.

Reference

February 2, 2015 Oregon Public Health Division
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

APPENDIX 3

DEATHS IN HOLLAND FROM EUTHANASIA AND PAS

Taken from Regional Euthanasia Review Committee Reports. Available at:

<http://www.euthanasiacommissie.nl/overdetoetsingscommissies/jaarverslag/>

YEAR	2004	2008	2009	2010	2011	2012	2013	2014
Total number of notifications	1886	2331	2636	3136	3695	4188	4829	5306
Cancer	1647	1893	2153	2548	2797	3251	3,588	3,888
CVS disease	24	62	54	158	114	156	223	247
Neurological disorders	63	117	131	75	205	257	294	317
Pulmonary disorders	34		-	-	-	152	174	184
Dementia	-		-	-	-	42	97	81
Mental disorders	-		-	-	13	14	42	41
Multiple pathology	41	114	130	118	185	172	251	257
Other disorders	73	145	168	237	394	144	160	291
AIDS	4							

MOST IMPORTANT END-OF-LIFE DECISIONS IN HOLLAND (Expressed as % of deaths)

YEAR	1990	1995	2001	2005	2010
EUTHANASIA	1.7%	2.4%	2.6%	1.7%	2.8%
ASSISTED SUICIDE	0.2%	0.2%	0.2%	0.1%	0.1%
ENDING LIFE WITHOUT EXPLICIT REQUEST	0.8%	0.7%	0.7%	0.4%	0.2%
INTENSIFIED ALLEVIATION OF SYMPTOMS	18.8%	19.1%	20.1%	24.7%	36.4%
FORGOING LIFE PROLONGING TREATMENT	17.9%	20.2%	20.2%	15.6%	18.2%
TOTAL	39.4%	42.6%	43.8%	42.5%	57.8%
CONTINUOUS DEEP SEDATION	N/A	N/A	N/A	8.2%	12.3%
STOP EATING AND DRINKING	N/A	N/A	N/A	N/A	0.4%

From:

Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. Bregje D Onwuteaka-Philipsen, Arianne Brinkman-Stoppelenburg, Corine Penning, Gwen J F de Jong-Krul, Johannes J M van Delden, Agnes van der Heide.

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⁶² *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38 per Lord Neuberger at para. 118

⁶³ Assisted Dying has also been debated on a number of occasions, both in connection with draft bills and separately – see, for example, 10 October 2005 (debating Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill (published on 4 April 2005)); 13 February 2012 (application of the policy published by the Director of Public Prosecutions relating to cases of encouraging or assisting suicide); 5 December 2013 (debate on assisted dying legislation for terminally ill patients); 12 December 2013 (debate on proposals to legalise physician-assisted suicide); 5 March 2014 (debate relating to the application of the policy published by the Director of Public Prosecutions relating to cases of encouraging or assisting suicide).

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⁶⁹ Barbara Wagner had recurrent lung cancer. She was refused a \$4,000 a month drug that her doctor had prescribed by her insurance company but was offered \$50 for a physician-assisted death. She told ABC News "It was horrible, I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."

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⁸¹ *Evangelium vitae*. Para 74.

⁸² *Evangelium vitae*. Para 71. Encyclical letter of Pope John XXIII (1963) in which he stated: “*it is generally accepted today that the common good is best safeguarded when personal rights and duties are guaranteed.*”

⁸³ *Summa Theologiae*, I-II, q. 93, a. 3, ad 2um.

⁸⁴ *Ibid.*, 1-11, q. 95, a. 2. Aquinas quotes Saint Augustine: "Non videtur esse lex, quae iusta non fuerit", *De Libero Arbitrio*, I, 5, 11: PL 32. 1227.

⁸⁵ *Evangelium vitae*. Para 72.

⁸⁶ *Evangelium vitae*. Para 65.

⁸⁷ *Evangelium vitae*. Para 65.

⁸⁸ Congregation for the Doctrine of the Faith, Declaration on Euthanasia *Iura et Bona* (5 May 1980), II: AAS 72 (1980), 546

⁸⁹ *Evangelium vitae*. Para 70.

⁹⁰ John Paul II. *Evangelium vitae*. 1995. Para 70

⁹¹ The Effectiveness of legal safeguards in jurisdictions that allow assisted dying. Penny Lewis and Isra Black. January 2012. The Commission on Assisted Dying: Briefing Paper. In collaboration with the Commission on Assisted Dying.

⁹² Allow me to die. At <http://www.sbs.com.au/news/dateline/story/allow-me-die>

⁹³ *Catholic Medical Quaterly*. Theo Boer. November 65(4) 2015. Available at: http://www.cmq.org.uk/CMQ/2015/Nov/dutch_experiences_on_regulating.html

⁹⁴ A study of the first year of the end-of-life clinic for physician-assisted dying in the Netherlands. Snijdewind MC, Willems D L, Onwuteaka-Philipsen B D, Chambaere K. *Journal of the American Medical Association Internal Medicine*. 2015; 175(1);1633-40

⁹⁵ *Evangelium vitae*. Para 89.

⁹⁶ *Evangelium vitae*. Para 70.