Dissertation Question:

“Assisted suicide and euthanasia are impossible to regulate and administer. Abuses are inevitable and their consequences are terrible.”¹ To what extent is this assessment, for regulating assisted suicide in the UK, accurate?

Abstract

In this dissertation I set out to evaluate the possibility of creating legal regulations for the UK that would prevent the known, and commonly referred to, abuses of assisted suicide. I felt this was an important area to study because of the ongoing challenges in the courts to the assisted suicide legislation. My research approach in the dissertation was to analyse the literature on the law as it currently stands, including the Liverpool Care Pathway, to establish why change was needed. This was followed by a literary analysis of the potential abuses and practical problems to assisted suicide, including evaluation of foreign examples that have regulated to prevent these abuses and practical problems, and the statistical success they have had. The conclusion I draw in Chapter 1 is that the law on assisted suicide is currently unclear, and open to piecemeal expansion by the courts, and that the Liverpool Care Pathway is providing a method of euthanasia for a limited group of patients by exploiting the legal position. Chapter 2 sets out the main abuse concerns and explains, through reference to Holland, Belgium and Oregon the best regulatory methods to avoid such abuses and practice problems. In Chapter 3 the main

conclusion drawn is that due to the fluid mental state of a person requesting help dying, a psychiatric consultation period would be required to avoid abuse of the mental state of the patient. Also that proposed Advanced Directive would involve too many medical uncertainties to be viable. This dissertation concludes that with caution and sufficient oversight it would be possible to regulate to avoid the known abuses of assisted suicide.
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## Abbreviations

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<tr>
<td>DPP</td>
<td>Director of Public Prosecutions</td>
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<td>LCP</td>
<td>Liverpool Care Pathway</td>
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<td>PAS</td>
<td>Physician Assisted Suicide</td>
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<td>AD</td>
<td>Advanced Directive</td>
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<td>DPP policy</td>
<td>Director of Public Prosecutions policy for prosecutors in respect of cases of encouraging or aiding assisted suicide</td>
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List of Statutes

Suicide Act 1961
Mental Capacity Act 2005
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R v Adams [1957] Crim LR 365

Pretty v United Kingdom (2002) 35 EHRR 1

R (on the application of Pretty) v Director of Public Prosecutions [2001] UKHL 61, [2002] 1 AC 800

R (on the application of Purdy) v Director of Public Prosecutions [2009] UKHL 45, [2010] 1 AC 345
Introduction

In this dissertation I will firstly evaluated why the law on assisted suicide needs changing. I will then question the validity of the main arguments supporting the assertion that assisted suicide would be impossible to regulate because of practical obstacles for its legalisation. Through references to foreign experiences, I will evaluate the extent to which these arguments would actually prevent a regulatory framework for legalised assisted suicide within the UK. The main focus will be on establishing if a legal framework to regulate assisted suicide is possible. In order to focus on the possibility of achieving a legal framework I will, to a large extent, park considerations about the ethical implications and the philosophical desirability of assisted suicide.

The classic debate on the moral plausibility of assisted suicide centres around the societally entrenched idea of the sanctity of life: human life is of absolute value and should be maintained at any cost. This leads many to believe that to make it legally permissible to end the life of another human being, in even a limited capacity, is morally wrong. Some would even go as far as claiming it is the first step on a road to the extermination of people seen in Nazi Germany. On a more rational level assisted suicide seems to disagree with the Hippocratic Oath, the moral code of doctors, who swear to protect life, not to help end it. However the counter argument to that proposition is that the sanctity of life doesn't relate solely to the extension of life as far as possible, but the provision of a quality of life. Furthermore, those who are mentally capable should be able to decide if life has reached such an insufficient quality, and that if they want to terminate their life they should be

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3 Peter Signer, *Practical Ethics* (2nd Edn, CUP, 1993) 175
4 Ibid
allowed to do so.\textsuperscript{5} This synopsis barely does these arguments justice however, it will provide a basic reference point when necessary.

“Words are important: they express the values and cultural sensitivity of a nation.”\textsuperscript{6} Selection of definitional terms is therefore important when considering a topic such as this. Assisted suicide is the most familiar term, however this falls within a broader umbrella term: euthanasia. This encompasses a wide scope of ideas considered within the topic. Ranging from perhaps the most extreme version of active euthanasia, mercy killing: the notion of providing somebody with the deadly act out of compassion because they are in so much pain or suffering,\textsuperscript{7} to the already established passive and indirect euthanasia methods of termination of life prolonging measures.\textsuperscript{8}

An important distinction to make is the difference between voluntary euthanasia, requesting or consenting to a life terminating act, and involuntary euthanasia which is the termination of a person with a terminal illness without request or consent from the patient.\textsuperscript{9} Involuntary euthanasia might take place with the best intentions, but the idea of terminating a life without request or consent falls too closely to the boundaries of murder. This suggests that an acceptable definition needs to be found within the parameters of voluntary euthanasia. Indirect active euthanasia concerns the alleviation of pain for the terminally ill, with death as a predictable or considered side effect,\textsuperscript{10} an idea that will be discussed further in Chapter 1. Similarly passive euthanasia covers the ending of life supporting treatment,\textsuperscript{11} a commonly understood and requested practice in British end-of-life decision-making. An acceptable legal definition must lie somewhere between these two sets of concepts. Assisted suicide seems to be the neutral reference point, defined as: any action taken to encourage

\textsuperscript{5} Stauch (n 2)
\textsuperscript{8} Ibid 11
\textsuperscript{9} Herbert Hendin, “Seduced by death” (1994) 10 Issues L. & Med. 123, 154
\textsuperscript{10} Becker-Schwarze (n 7) 13
\textsuperscript{11} Guillod (n 6) 26
or help somebody to kill themselves.\textsuperscript{12} However through the course of analysis of the arguments surrounding legalisation of assisted suicide, an evaluation on the merits of active euthanasia must be made, as an extension of assisted suicide: meaning the deliberate killing of another person in order to shorten his or her suffering.\textsuperscript{13}

By using terms that have established definitions in foreign countries, such as Switzerland, there is a danger that it misses the UK cultural understanding of the terms, however it allows me to see how far the different definitions extend, and draw lines not only between them but also within them. This will also allow me to create a better idea of legal certainty, than if I used definitions known simply within the limited euthanasia explorations in the UK. Differences can be subtle, for example the difference between intravenously administering a lethal substance upon that persons request, and putting the same person on a drip and letting them administer the drug themselves.\textsuperscript{14} Analysis of foreign definitions allows me to see where lines are drawn and therefore the subtle differences in the two examples above, which realistically mirror the differences in end-of-life situations.

Chapter One will scrutinise the law as it currently stands, following recent challenges in the Supreme Court, and the creation of the Director of Public Prosecutions (DPP) Policy for Prosecutors in respect of cases of assisted suicide (DPP policy).\textsuperscript{15} I will analyse the effect that a non-legal policy document has on the legal position of assisted suicide. I will then move on to critically analyse current UK end-of-life practices, particularly the widely adapted Liverpool Care Pathway (LCP) as NHS policy,\textsuperscript{16} questioning the assertion that this does not fall under the umbrella of euthanasia, and evaluating the dangers of this remaining largely legally unregulated.

\textsuperscript{12} Ibid
\textsuperscript{13} Ibid
\textsuperscript{14} Ibid 31
\textsuperscript{15} Director for Public Prosecutions, “DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide” (DPP Guidance, February 2010) <http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html> accessed 14\textsuperscript{th} November 2012
\textsuperscript{16} Department of Health, “End of Life Care Strategy: Promoting high quality care for all adults at the end of life” (2008)
In Chapter Two I will deliberate the various different abuses that could occur and value the strength of these problems against the plausibility of regulating against such “terrible consequences”\(^{17}\). I will look at the Dutch system for comparisons, because it had difficulties with making sure every instance of assisted suicide was reported.\(^{18}\) I will do this to see how they originally aimed to operate and how they have had to adapt to resolve this.

Finally I will engage the arguments surrounding mental capacity, in Chapter Three. Here lies perhaps the biggest obstacle to a regulatory system for assisted suicide, determining the mental competency of the individual. I will evaluate the various facets of this. I will also analyse the concept of the advanced directive, looking at how this would be applicable to dementia sufferers, including the subsequent problems this could cause, such as when the directive becomes active.

Through evaluation of the current law I will establish its insufficiency, and that a carefully, considered piece of legislation would provide a better solution than gradual legal change through the courts.\(^{19}\) I will conclude by establishing that by improving on, and adapting structures currently in place, it is possible to create a regulatory system for assisted suicide in the UK.

\(^{19}\) Hendin “Seduced by death” (n 9) 166
Chapter One

Steps towards assisted suicide

How the law currently stands: a brief background

The Suicide Act currently makes it illegal for anyone, including healthcare professionals, to help or encourage another person to commit suicide. This also means there is an offence even if no suicide takes place, whilst s.2A(1) provides that the offence can be committed through a third-party. Issues have arisen around the law on assisted suicide in relation to helping others travel to countries where assisted suicide is legal, which requires particular clarity on whether this would lead to criminal prosecution upon return to the UK. In Pretty v DPP it was established that the DPP had no power to state that he would not prosecute someone (X) who aided another (Z) in committing suicide when Z was unable to commit suicide on their own due to terminal illness. It was also established that for consistency in prosecution practice the DPP must consent to prosecuting for aiding or encouraging suicide.

This was further complicated in Purdy v DPP when the House of Lords ruled that the DPP must publish guidance on what factors would be taken into account when deciding whether or not to prosecute X for assisting Z to travel abroad to a country where assisted suicide is legal. This resulted in the “DPP Policy for Prosecutors in respect of cases of encouraging or aiding assisted suicide.” This in itself causes

20 Suicide Act 1961, s 2(1), as amended by Coroners and Justice Act 2009, s 59
21 Ibid s 2 (1) (b)
22 Ibid s 2 (a) (1)
24 R (on the application of Pretty) v Director of Public Prosecutions [2001] UKHL 61, [2002] 1 AC 800
25 Ibid
26 R (on the application of Purdy) v Director of Public Prosecutions [2009] UKHL 45, [2010] 1 AC 345
27 Director for Public Prosecutions (n 15)
problems, because the policy document effectively states that; as long as the motives of the person assisting the suicide are good and that they are not seeking to gain from it, then it will not reasonably be within the public interest to prosecute that person.28

The insufficiency of the law

By doing this the DPP policy document de facto legalises helping someone travel abroad to be assisted in committing suicide.29 Ben Living argues that, it may be a convenient way to change policy in a difficult legislative area, but raises practical, ideological and constitutional questions.30 The policy seems to go beyond the mandate envisaged by the House of Lords ruling in Purdy, where the leading speech by Lord Hope seemed to suggest that the policy should simply cover those providing assistance with travel to another country where assisted suicide is legal.31 Pennay Lewis asserts that moving away from Lord Hope’s leading speech has “accelerated informal legal change on assisted suicide”,32 by creating a set of circumstances in which it won’t be in the public interest to assist another person to commit suicide. This almost creates a Code of Practice for assisting suicide taking place abroad.33 This is an idea that seems to be confirmed by Keir Starmer in a statement about Daniel James, where he makes it clear that enough evidence was available for prosecution, however prosecution wasn’t in the public interest.34 This shows that where the motivation of a person assisting suicide is compassion, rather than the driving force behind the decision, it is unlikely that prosecution will be a consequence.35 Julia Shaw asserts “the current legal position is rendered ineffective

30 Ibid 43
31 Purdy (n 26)
32 Pennay Lewis, “Informal legal change on assisted suicide: the policy for prosecutors” (2011) 31 LS 119, 121
33 Mullock (n 28) 298
35 Mullock (n 28) 296
by the ostensible policy of non-prosecution of those who compassionately assist their friends or family members with implementing their final wishes.\textsuperscript{36}

The CPS is aware of this criticism and keen to highlight that the policy has “firmly rejected any factor against prosecution that could be said to be a stepping stone towards the creation of such a regime.”\textsuperscript{37} While there have yet to be any prosecutions for assisted suicide, it can be considered that the DPP has retained the potential right “to pursue a prosecution for even quite inconsequential acts in assistance of a suicide where the motives of the defendant are less honourable than in the James case.”\textsuperscript{38} This seems to align with the reasons behind the decision in \textit{Pretty v United Kingdom},\textsuperscript{39} that the government has to be able to protect vulnerable persons who otherwise might suffer under a blanket change of policy.\textsuperscript{40}

Michael Hurst contends that there ought not be any legal reason why if a UK citizen helped someone commit suicide abroad they would be prosecuted upon their return.\textsuperscript{41} The law has become unclear and unpredictable due to a lack of clarity on this subject,\textsuperscript{42} despite Lord Hope’s obiter comments.\textsuperscript{43} Shaw submits that the current law has “need for greater clarity in both definition and application of the offence,”\textsuperscript{44} adding “that we are stymied by a body of law, characterised by uncertainty, obfuscation and injustice.”\textsuperscript{45} The greatest concern in the confusion over the position of assisted suicide is that the law fails to protect those vulnerable to abuse of the system.\textsuperscript{46} When the law becomes unable to fulfil the role it is created

\textsuperscript{37} “CPS Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide by the Director of Public Prosecutions: Summary of Responses” (February 2010) <http://www.cps.gov.uk/consultations/as_responses.pdf> accessed April 20\textsuperscript{th} 2013 para 7.6
\textsuperscript{38} Mullock, (n 28) 298
\textsuperscript{39} \textit{Pretty} (n 24)
\textsuperscript{40} Laurie, “Physician Assisted Suicide in Europe: Some Lessons and Trends” (2005) 12 Eur. J. Health L. 5, 6-7
\textsuperscript{42} Michael Hurst, “Assisted Suicide after Purdy: the unresolved issue” (2009) Crim. L. R. 870
\textsuperscript{43} \textit{Purdy} (n 26)
\textsuperscript{44} Shaw (n 36) 348
\textsuperscript{45} Ibid 349
\textsuperscript{46} Ibid 340
to achieve, it becomes clear that changes need to be enacted. This is the position that has been reached with assisted suicide.

It may be argued that tighter regulations, and parliamentary clarification over when assisting somebody with suicide will be illegal, would resolve the above issues, however they would only worsen the following situations. Whilst there is public demand for assisted suicide there will be assisted suicide happening in secret.\(^{47}\) This means assisted suicide without government-sanctioned criteria, guidelines, oversight, or scrutiny.\(^{48}\) This is obviously an undesirable position because it is leaves people completely exposed to manipulation, or allows for painful unsuccessful attempts. Another concern that will remain in the absence of a legal alternative, is citizens taking the situation into their own hands, with aid of ‘do it yourself’ texts available, such as Final Exit and The Suicide Kit, or lethal drugs purchased via the Internet.\(^{49}\)

Furthermore, as Livings eludes,\(^{50}\) questions over the legitimacy of the DPP policy and its inclusion in the democratic process of our society must be raised, because regardless of the aims, rational, or motives for doing so, creating a regulatory system for assisted suicide should surely come from those with an elected mandate to make such changes, rather than unelected officials.

**Doctrine of Double Effect: Liverpool Care Pathway**

Here we evaluate one of the grey areas of medical practice, and examine the extent to which a care pathway such as this draws a line between medical treatment and assisted suicide. In addition to that balance, there are also demanding political and

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\(^{48}\) Ibid

\(^{49}\) Shaw (n 36)

economic implications of such practice which must also be considered as an explanation of why care pathways are allowed to carry their remit so close to assisted suicide.

The rationale for the Liverpool Care Pathway, and similar adoptions, is “[to be] used at the bedside to drive up sustained quality of the dying in the last hours and days of life.” 51 John Ellershaw claims that too many patients die with uncontrollable symptoms and that the LCP offers a controlled death that is kinder on patients. 52 Ellershaw’s rationale does need to be contextualised, as one of the biggest proponents and founding fathers of LCP, however we must be careful not to underestimate the good intentions he highlights behind the LCP. The argument behind the pathway being that it is possible to separate the pathway and killing the patient by differentiating between the primary effect, to alleviate pain and suffering from the symptoms, and the secondary “side effect” of the treatment, death of the patient. 53 The founding case for this was R v Adams, which established that a doctor could do all he can to alleviate pain and suffering, even if it incidentally shortens the patients’ life. 54

In a vacuum the LCP seems like a good system, however we should bear in mind that it blurs the distinction between treatment and early death of a patient, and remains unregulated by statute. It is also balanced unclearly in the case law, 55 with very little by the way of universal guidance on how to train doctors and nurses in the process. 56 The factor differentiating treatment and death is that with the LCP death is a side effect. Richard Huxtable highlights examples of practitioners admitting that they have given enough medication to kill a person, suggesting the “danger is that impermissible, “directly” intended death may too readily be assumed innocent by the

52 John Ellershaw, “Care of the dying patients: the last house or days of life” (2003) 326 BMJ 30, 30
54 R v Adams [1957] Crim LR 365
55 Ellershaw (n 52)
56 Mary Helen Spooner, “Care or killing?” (2009) 182(1) CMAJ 17
various legal officials. Yet due to this obscuring of boundaries, commentators are led to describe the LCP as “facilitating a good death” and creating a “dignified death”. There are descriptors used with equal effect when describing the purpose of assisted suicide, prompting media claims from foreign doctors that UK doctors perform euthanasia. Whilst this is a media exaggeration, and euthanasia in its truest form isn’t taking place in the UK, it can be seen that the LCP has an element of crossover with assisted suicide, insofar as doctors are helping patients die quicker than they would have naturally.

Palliative care purists claim that palliative care should never have the consequence of shortening lives, but, if absolutely necessary, should be to sedate at the point of death. Gillian Craig raises her concerns that as more and more people die in hospital under this system of sedation, the LCP could become the norm for death, stating that it is “a whisker away from state-sponsored euthanasia.” This is a notion that is clearly meant as an impact statement, however it is not one that should be taken lightly. This is because the doctor knows, or should know, that the treatment has the distinctly predictable possibility of causing death, but that the primary function of the treatment is to relieve suffering. Clearly this is only applicable in cases where patients are reaching the end of their life. However in such cases it is clear that the patient should have requested or consented to a treatment that would accelerate the process of dying.

It is a fine line between the cancer patient with a week left to live, and a hospital bound patient suffering from advanced motor neurone disease, asking for help dying. One case is indirect active euthanasia, and one is assisted suicide. One is permissible under UK law currently, and one is a criminal offence. How well that line

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57 Huxtable (n 53)
58 Tessa Watts, “End-of-life care pathways as tool to promote and support a good death: a critical commentary” (2012) 21 Eur J Cancer Care 20, 20
59 Ibid 31
62 Ibid 156
63 Guillod (n 6) 26
is upheld, and how often the line is crossed, but disguised under the cloak of the permissible is unclear. It is unclear because of the legal vagueness surrounding the issue. This blurring of boundaries is encompassed by the difference between active and passive euthanasia, essentially aiding death through pain treatment, and simply allowing someone to die.64

This is an on-going debate that does not seem to have reached a definitive conclusion in countries seeking to legalise assisted suicide. James Rachels argues that in countries holding this debate it is societally permissible to allow someone to die, yet never permissible to take direct action to kill a patient,65 and that this has almost become a moral stand point that doctors have endorsed and hidden behind.66 Rachels contends that the moral defence is not a particularly convincing one, explaining that there is no difference between letting someone die and killing them, through hypothetical reference.67 Rachels explains that the moral argument for a doctor supplying a lethal drug to a patient, or letting a patient die, share the same intention and result.68

Rachels further contends that while withholding treatment may be morally justifiable, it is often going to increase and prolong suffering.69 This can be seen in cases where fluids and nutrition are withheld for patients that are close to death.70 It seems counter-intuitive that assisted suicide would not be an available option, given that many in this position might find it preferable.

LCP supporters argue that the possibility of a prognosis of death causes the doctors to think more carefully about their course of treatment,71 rather than to take the simple option and continue with the current course of treatment, whilst nature takes its course. Not only is this causing suffering and distress for the patient and

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65 Ibid
66 Ibid (n 36) 340
67 Rachels (n 64) 79
68 Ibid 80
69 Ibid 79
70 Craig (n 61) 157
71 Spooner (n 56) 18
relatives, it is costly and of no value to anyone, rather unnecessarily costing the National Health System, especially when the inevitable outcome remains clear to the doctors. This highlights the competing nature of bureaucratic and political reasoning against health care ideology, raising the question: it is acceptable to have healthcare policies that are be driven by either economic or political motives?

This leads to the accusations that hospitals are prematurely ending the lives of ill patients to save on the money required to treat them, and to resolve the bed shortage resulting from a number of ward. Furthermore, Craig explains that use of the LCP promotes bad medicine practice; with doctors claiming that patients are dying, stopping treatment, and removing food and liquids, because it’s an easier option to tell a elderly patient that they are dying, than to continue or change a treatment plan. Spooner talks of examples where elderly patients have been admitted to hospital, with few tests, if any, carried out on them before they are told that they are dying, and placed on the pathway. Some popular media would suggest that stories like this are merely the tip of the iceberg, with the Daily Mail, for example, regularly publishing examples such as the one above. Although stories like this are always open to interpretation by the media, and are often dramatised or report statistics selectively, they highlight that there are cases where placing patients on the pathway isn’t, or shouldn’t be, the best way to treat a patient. Furthermore, media reports like these highlight that we have a system in place that is open to abuses. Widespread uses of such care pathways have created a legitimate reason for doctors not to give their best endeavours to save, or extend the life of a patient.

72 Margaret McCartney, “The Assault on the Liverpool Care Pathway” (2012) 345 BMJ 7236
73 Ibid
74 Tessa Watts, (n 58) 24
75 Craig (n 61) 156-7
76 Ibid 157
77 Spooner (n 56)
78 McCartney (n 72)
Craig argues that whilst there is clearly an element of good intention, and perhaps more accurately a foundation of good intentions, the LCP is primarily a political and/or economic policy\textsuperscript{80} aimed at making dying in hospital more time and cost efficient. Alternatively, it can be argued that there is a much more altruistic nature, as Ellershaw suggests.\textsuperscript{81} Conversely, the LCP can be seen as a covert policy for introducing assisted suicide upon doctor recommendation. Huxtable argues that use of the doctrine of double effect (where the LCP finds it’s legal basis) undermines the legitimacy of the law for murder, by creating a limited allowance for mercy killing.\textsuperscript{82} By creating an allowance for doctors to accelerate death under the shroud of pain relief it allows them to legitimise their discreptional mercy, or compassion. While in essence this can be seen as compassionate medical practice, it does seem that the law in this respect has developed to treat people unequally, appeasing the terminally ill approaching death, but yet extending the pain and suffering of the people like Diane Pretty and Debbie Purdy.

**Summary**

The law currently finds itself in a position where it is morally justifiable to allow someone to die, and even to indirectly allow help to die by prescribing treatment that will hasten death; yet actively helping someone die in the same circumstances is morally and legally impermissible. The difference between the current legal position, and the one I will suggest, is not the intent or result, because they are the same,\textsuperscript{83} but the justification and legitimacy of the outcome.

Overall it would seem that the only sensible way to progress from this dangerous and unclear area of law is to bring an end to policy decisions that create the scope for such dangers and ambiguity, and bring in clear legislation on assisted suicide.

\textsuperscript{80} Craig (n 61) 158
\textsuperscript{81} Ellershaw (n 52) (also many other medical journal articles exploring the various different facets of the LCP)
\textsuperscript{82} Huxtable (n 53) 67
\textsuperscript{83} Shaw (n 36) 344
Bringing about the end of the LCP and introducing assisted suicide would maintain it’s founding values, but remove the politicisation of doctors’ decisions in such circumstances.

I believe that we can build on existing policy, in the form of the DPP policy, and Lord Joffe’s failed proposal: Assisted Dying for the Terminally Ill Bill. I will build on the provisions and safeguards set out between these two documents, alongside an evaluation of the main dangers of assisted suicide, and an analysis of how these issues have been dealt with in countries where assisted suicide is already legal. This will enable a fair assessment of whether it is possible to create a piece of legislation, that would allow assisted suicide for those who are suffering through terminal illness, or with a medical condition, which causes them unbearable suffering and/or hopeless, without compromising the safety of those who are vulnerable, unsure or in opposition. This expands the earlier proposed Bill remit of when assisted suicide will be available (for terminally ill patients only), to the Dutch definition, for the sole reason that to legislate otherwise would be discriminatory towards those without terminal illnesses that have to deal with unbearable suffering. When entering such unchartered territory for the UK, I think it is especially important to take stock of the lessons that can be learnt from elsewhere, “after all what is at stake is a matter of life and death.”

84 Director for Public Prosecutions (n 15)
85 Assisted Dying for the Terminally Ill Bill, HL Bill (2005) 36
86 Lewis “Informal legal change on assisted suicide” (n 32) 125
87 Assisted Dying for the Terminally Ill Bill s.2 (2) (c)
88 Lewis “Informal legal change on assisted suicide” (n 32) 125
89 Ibid 134
Chapter 2
Abuses and Practical Problems

Introduction
When discussing assisted suicide a few common arguments are made, most often; the slippery slope idea,\(^91\) undue influence of those who stand to gain by the death of the patient,\(^92\) the notion that assisted suicide becomes part of the doctor’s agenda preferential to actual treatment of patients, and that oversight and safeguards are insufficient to prevent abuses. This chapter will evaluate these arguments individually through reference to foreign experiences, rather than speculative ideas, as evidence of any truth behind such claims. By using comparisons I will seek to establish, and propose new legislation from the systems which are the most effective, and contain the best regulations and safeguards to prevent the abuses and practical problems associated with assisted suicide.

In order to establish what makes good and/or effective law, regulation and safeguards a set of criteria will be needed. Margaret Otlowski suggests that certainty, fairness, and transparency are needed for good law.\(^93\) I intend to use these criteria, if not by name but by the principles they encompass. Certainty is important because it must be clear to physicians what their role is, and what is acceptable practice. Fairness is vital to any proposed legislation; regulation must contain sufficient checks and balances in order to guarantee a fair outcome that ensures patient autonomy. The need for transparency is great because this links to oversight and been able to be clear that no abuses of the system have taken place. The requirement of legislation and regulation to achieve these goals are paramount to the success of assisted suicide; “\textit{regulation ensures the continued control of the}”

\(^{91}\) Hendin “Seduced by death” (n 9) 427
\(^{92}\) Shaw (n 36)340
\(^{93}\) Margaret Otlowski, “Getting the law right on Physician Assisted Suicide” (2011) 3 Amsterdam LF 127, 130
practice, protection of both the instant patient and other, a means to monitor activities, and a mechanism to respond more effectively to abuses, should they occur."\textsuperscript{94}

Abuses and Problems

1. Slippery Slope

This is the argument that the logical progression from assisted suicide through different types of euthanasia to the far end of the slope: involuntary euthanasia at the discretion of the physician.\textsuperscript{95} Similarly assisted suicide would mutate into a valid medical treatment,\textsuperscript{96} rather than solely a patient requested end-of-life option. Theoretically once assisted suicide and/or limited euthanasia is permitted then we may struggle to make the distinction between the legally permissible and impermissible.\textsuperscript{97}

Wesley Smith contends that once assisted suicide is accepted, even in a limited form, that there will be a gradual broadening of the categories of people eligible, until eventually the far end of the slope described above is reached.\textsuperscript{98} Furthermore Smith argues that "adopting killing as an acceptable answer to human suffering eventually changes popular outlooks."\textsuperscript{99} This alludes to the idea that euthanasia could become a genuine medical treatment, and that the benevolence of doctors could lead to them treating death as the ultimate cure, with the regulations as mere hurdles or challenges to reach that goal.\textsuperscript{100} This would be the result of doctors interpreting rules and regulations less rigidly over time, coupled with the courts "loosening the meaning of the guidelines".\textsuperscript{101} This could allow the law of euthanasia to be extended

\textsuperscript{94} Laurie (n 40) 6  
\textsuperscript{95} Hendin (n 9) 124  
\textsuperscript{96} Shaw, (n 36) 340  
\textsuperscript{97} Pennay Lewis, “The empirical slippery slope: from voluntary to non-voluntary euthanasia” (2007) 35 LJ Med & Ethics 197, 199  
\textsuperscript{98} Wesley Smith, “Assisted Suicide: Bad medicine and even worse public policy” (2007) 24 T M Cooley LRe 99, 120  
\textsuperscript{99} Ibid  
\textsuperscript{100} Ibid 121  
\textsuperscript{101} Ibid 102
to a patient with a non-somatic problem, as was seen in the Netherlands with the Chabot case.\textsuperscript{102}

Whilst it could be suggested that strict legislation and regulations would be able to prevent this, the problem comes with the cases that are on the borders such as when the patient is perfectly competent to make the decision, but due to physical illness or disability is unable to carry out the final act.\textsuperscript{103} In cases such as this the patient would be reliant on the physician to administer the life ending drugs, which would move the act from assisted suicide or physician-assisted suicide (PAS) into voluntary euthanasia. This poses the question of whether a proposed assisted suicide bill would have to include limited use of euthanasia, or risk discriminating against those who would be eligible for assisted suicide, but unable due to their own physical limitations.\textsuperscript{104}

However we can look to countries where assisted suicide is legal, in particular the Netherlands, where voluntary euthanasia is also legal. Judith Rietjens’ assessment of the statistics available suggests that there is no evidence of legalisation causing a slippery slope effect for medical end-of-life decision-making.\textsuperscript{105} An idea that is supported by Raphael Cohen-Almagor’s assessment of the Belgium transition to legalisation of euthanasia, insofar as the statistics suggest that the number of mercy killings in Belgium has remained consistent post-legislation.\textsuperscript{106} This idea is supported by Lewis’ assessment of the statistics for both the Netherlands and Belgium.\textsuperscript{107} Lewis, in earlier work, explains the vital flaws in the slippery slope argument: primarily that slippery slope proponents fail to demonstrate the causal link between legislation and the rise or occurrence of involuntary euthanasia.\textsuperscript{108} Nor can it be demonstrated that involuntary euthanasia is much more likely in Holland because

\textsuperscript{102} John Griffiths, “Assisted Suicide in the Netherlands: The Chabot case” (1995) 58 Mod. L. Rev. 231, 247
\textsuperscript{103} Guillod (n 6) 31
\textsuperscript{104} Lewis (n 32) 37-40
\textsuperscript{105} Judith Rietjens, “Two decades of research on Euthanasia from the Netherlands. What have we learnt and what questions remain?” (2009) 6 Bio. Inq. 271, 279
\textsuperscript{106} Cohen-Almagor (n 90) 213
\textsuperscript{107} Pennay Lewis, “Euthanasia in Belgium 5 years after legislation” (2009) 16 Eur J Health L. 125, 130
\textsuperscript{108} Pennay Lewis, “The empirical slippery slope” (n 97)
voluntary euthanasia is legal; the available statistical evidence supports both arguments.\textsuperscript{109} Furthermore Lewis purports that even if the statistical evidence could clearly suggest an increase in involuntary euthanasia following legalisation of assisted suicide and voluntary euthanasia, it would still make for insufficient comparisons to countries considering adopting legislation.\textsuperscript{110} The statistics fail to take into account other factors such as: social feeling, the legal norms of the country, the legal starting and the cultural experiences (for example Harold Shipman and the atrocities he committed),\textsuperscript{111} making any statistical comparisons speculative at best.\textsuperscript{112}

Shaw contends that in countries where assisted suicide and/or voluntary euthanasia are permitted there is a very clear legislative distinction between asking for help dying and not asking to be killed.\textsuperscript{113} It is therefore difficult to accept the slippery slope argument “when a clear distinction can be made between the desired and the undesired behaviour.”\textsuperscript{114} It must then be said that when the slippery slope argument is broken down, and statistically analysed, that there is no reason to assume a causal relationship between the limited use of assisted suicide and voluntary euthanasia, and further undesirable medical treatment.\textsuperscript{115} However it must be noted that if legalisation of assisted suicide were to happen through judicial intervention in an incremental approach, then slippery slope arguments hold much greater force.\textsuperscript{116}

From a practical perspective it seems that there are more dangers attached to assisted suicide without aid from a physician, than there are for physician-assisted suicide (PAS). The alternative to complete physician involvement is leaving the patient with the medicine to complete the process themselves, either as a

\textsuperscript{109} Ibid 200  
\textsuperscript{110} Ibid 202  
\textsuperscript{111} Ibid  
\textsuperscript{112} Ibid 205  
\textsuperscript{113} Shaw (n 36) 341  
\textsuperscript{114} Ibid  
\textsuperscript{115} Griffiths (n 102) 247  
\textsuperscript{116} Pennay Lewis, Assisted Dying and Legal Change (OUP, 2007) 186
prescription to take home, as in Oregon, or the patient is left with the drugs to take in a room at their leisure. Firstly, the problem with take-away prescriptions, once the patient has taken the prescription home the responsibility, and control of the doctor, ends with reporting that they have issued a lethal prescription. This means that there is no control over: drugs that are unused, if the drugs are administered correctly, or if the drugs are administered voluntarily. With this system in place it would be impossible to regulate against abuses of the lethal drug. It is alleged that 18% of PAS cases in the Netherlands require the physician to administer a lethal injection because of complications. Therefore leaving a patient alone in a room to take the drugs has its drawback too. I propose mandatorily requiring the physician to be present when the patient makes the final act, as is a legal requirement in Holland, therefore guaranteeing certainty of outcome.

The logical extension of this is to allow the limited use of voluntary euthanasia. Firstly in the form of physician intervention when complications arise, and secondly for allow those who are physically unable to administer the lethal drugs themselves. Arguably the difference between PAS and voluntary euthanasia is minimal, and therefore they can, and should, be tied to the same legal standard. However it would prevent discrimination, as mentioned earlier, creating a piece of legislation that treats all citizens fairly and equally in this respect. This would however, be a last resort. Given modern technology there could be alternatives to

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119 Jeffrey (n 117) 66
120 Ibid 83
121 Margaret Dore, “Death with Dignity”: a recipe for elder abuse and homicide (albeit not by name)” (2010) 11 Marq Elders Advisor 387, 390
122 Jeffrey (n 117) 83
123 Ibid 71
124 Otlowski (n 93) 133
125 Ibid 138
126 Ibid 137
128 Lewis, “Assisted Dying and Legal Change” (n 116) 37-40
the patient swallowing the tablets, for example pressing a button to open a valve, and releasing a lethal fluid into the blood stream.

2. Influences

One of the main arguments against legalising assisted suicide is that regulation couldn’t be effective enough to prevent the potential catalogue of abuses, which could occur from interested parties influencing the decision of the patient. This includes; relatives burdened by caring for the patient, or fuelled by financial motivation, or doctors influencing patients for an easier care option. Lewis talks about the Belgian law which states that a request for assisted suicide must “not be the result of any external pressure.”129 A feeling that seems to be echoed in our own policy on assisting someone with suicide, that whilst it is not legal, it won’t be in the public interest to prosecute unless the assistance is the driving force behind the suicide.130 A sentiment that Kier Starmer seems to have made clear in his role of deciding when to prosecute as DPP.131

Hendin highlights the danger that sometimes it is the families rather than the patients who decide when the time has come for assisted suicide.132 He gives the example of a case in Holland where a wife gave her chronically ill husband the choice between a nursing home and euthanasia, and not wanting to be cared for by strangers he chose euthanasia.133 Smith further contends that families could be tempted by financial gain, through inheritance and life insurance, to encourage or coerce a relative into choosing assisted suicide.134 A further difficulty is that it can be very difficult to determine when a selfish motive has taken place.135

Of equal concern is the influence of doctors on patients when making their end-of-

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129 Lewis, “Euthansia in Belgium 5 years after legislation” (n 107) 127
130 Mullock (n 28) 296
133 Ibid
134 Smith (n 98) 117
135 Guillod (n 6) 34
life decisions. “That the doctor is clearly the conductor of the orchestra controlling the tempo and pitch of patients’ deaths” shows a concern that the doctor would have a lot of control over deciding if the patient would be eligible for assisted suicide or not. In society we have a lot of respect for doctors, and their opinions on the best medical treatment, due to their expertise and (generally speaking) our distinct lack of expertise. This causes a societal tendency to be heavily influenced by the recommendations of our doctors. Therefore if a doctor implies to a patient that assisted suicide is a good idea, this could influence a scared and unsure patient into choosing assisted suicide, rather than life prolonging treatment or hospice care. Hendin highlights this with an American case that involved a doctor suggesting that his patient’s decision to seek assisted suicide was the best choice, a situation that can easily be envisaged happening in the UK. Cohen-Almagor raises his concern that the legislation in Belgium contains no provisions concerning the appropriateness of doctors recommending assisted suicide to their patients, but is very clear that “The role of the physician is not to push patients to choose euthanasia.” This clearly highlights a deficiency in Belgian law, which if a similar policy were to be adapted in the UK would have to be addressed. This issue will be considered shortly.

3. Policy Abuses

A further fear is that medical practice could evolve to inappropriately use assisted suicide or euthanasia. Shaw highlights the underlying political problem that could lead to an abuse of any proposed assisted suicide system; due to the current economic situation the NHS is continually facing cuts and struggling to fund some basic medical care. This could lead to a policy push towards assisted suicide rather than life prolonging or hospice care because it is a cheaper option. Margaret Dore highlights a case in Oregon whereby the Oregon Health Plan refused

136 Hendin, “Seduced by death” (n 9)160
137 Jeffrey (n 117) 70
138 Cohen-Almagor, (n 90) 202
139 Hendin, “Seduced by death” (n 9) 125-127
140 Cohen-Almagor, (n 90) 202
141 Hendin, “Seduced by death” (n 9)
142 Cohen-Almagor, (n 90) 201
143 Ibid 203
144 Shaw (n 36) 334
145 Smith (n 98) 116
to pay for a drug that would have possibly prolonged the life of a patient, who unable to personally afford it, was pushed towards assisted suicide.\textsuperscript{146} Although this type of situation would be limited in the UK due to the NHS, as opposed to private healthcare in the USA, it could still occur due to the restrictions in funding and budget cuts that are in force due to the current economic climate.

Smith raises the idea that the public image of the severely disabled in the USA is one of a fate worse than death.\textsuperscript{147} A notion that might not be as prevalent in the UK but that is certainly one that is not in such a small minority to be of no concern. He claims that these prejudices already seep into the delivery of medical care for the disabled, and worries that legalised assisted suicide could lead to a radical utilitarian societal view whereby it is better to provide assisted suicide or euthanasia to severely disabled patients than to let them continue struggling and suffering in life.\textsuperscript{148} The extreme of this situation would be where doctors, either out of a radical humanitarian ideology, societally accepted view, or politicised/economic motivations, started ending the life of patients without consent or request.\textsuperscript{149}

**Possibility of regulating against abuses**

It is obvious that all of these possibilities are undesired, and that nobody should be pressured into death. However I believe that strictly prohibiting assisted suicide is not the solution to this, as anti-assisted suicide proponents argue,\textsuperscript{150} but that strict regulations, which contain a sufficient number of checks and balances, would be a better resolution to this problem.\textsuperscript{151} Through use of extensive procedural safeguards legislation would be able to protect patients from hasty decisions and ensure voluntariness.\textsuperscript{152} By evaluating the individual potential abuses of assisted suicide legislation in the context of countries where it has been legalised, it allows for the

\textsuperscript{146} Margaret Dore (n 121) 398
\textsuperscript{147} Smith (n 98) 118
\textsuperscript{148} Ibid 118-119
\textsuperscript{149} Signer (n 3) 175
\textsuperscript{150} Smith (n 98) 118
\textsuperscript{151} Otlowski (n 93)
\textsuperscript{152} Ibid 135
suggestion of the ideas that meet the criteria for good legislation, to improve on the rejected Bill.\textsuperscript{153}

**Regulations and Safeguards**

Central to this idea is that patients must be making well informed and clearly thought through decisions, that aren’t rushed or based on misconceptions of the options available. Jeffrey discusses the importance of patients having all their options explained to them by a doctor,\textsuperscript{154} however given the societal influence of doctors I believe it would be a better system if doctors were not allowed to suggest PAS as an option.\textsuperscript{155} The primary role of the doctor is to recommend the best way to provide life saving or sustaining treatment.\textsuperscript{156} Building on Lord Joffe’s proposition that legislation should mandate the patient be made aware of the palliative care options,\textsuperscript{157} I believe that to truly provide the patient with the best information available it should be mandatory for patients to be informed of all their life-prolonging options.\textsuperscript{158} This would allow the legislation to bring certainty to the process, insofar as patients would have certainty over the options available to them. It would also result in fairness and transparency because the patient would have a fair and complete assessment of their options. A further way of limiting the influence a single doctor could exert would be by following Lord Joffe’s suggestion, and having another doctor conduct the same procedure with the patient and reach an agreement with the original doctor.\textsuperscript{159}

**Review**

Reporting, review and evaluation is often cited as a good way of ensuring abuses don’t slip through the net, and is very much an idea I will be recommending, however this is not a perfect system. In many instances the reports are completed by the healthcare professionals involved, which means that they are subject to their

\textsuperscript{153} Assistance for the Terminally Ill Bill 2005
\textsuperscript{154} Jeffrey (n 117) 65
\textsuperscript{155} Cohen-Almagor (n 90) 196
\textsuperscript{156} Signer (n 3) 174
\textsuperscript{157} Assistance for the Terminally Ill Bill 2005 s 3 (1)
\textsuperscript{158} Miller (n 47) 121
\textsuperscript{159} Assistance for the Terminally Ill Bill s 2 (2) and (3)
reporting bias’, and allows for ‘bad facts’ to be omitted. To minimise the potential impact of this I propose two solutions that would operate alongside each other in this aim. Firstly, to require the patient to complete a declaration that would emphasise any abuses or influence that could have taken place, and a similar declaration for a witness present during the decision-making process. Ideally this would be another healthcare professional that has dealt with the patient, but had no involvement in the doctor’s decision-making process. An important lesson that can be learnt from Oregon, which would minimise any potential negative influence of beneficiaries or family, is not to place them in a position of power or control over the decision. However I appreciate that family members are the most likely to recognise a policy abuse, or inappropriate influence from a doctor, therefore a family member should also complete a declaration, to registering any objections on these grounds. Jeffrey argues, simply reviewing everything retrospectively, whilst holding importance for professional sanctions etc., holds little value for preventing a death that the patient didn’t want. These declarations should take place before a decision has been made if assisted suicide is appropriate for the patient or not. This would mean that if there were any claims of influence, coercion, or abuse of procedure, that they would be detected before it was too late. This would create good regulation because sufficient checks and balances would show certainty, and transparency of the patient’s decision, by providing evidence that the patient wasn’t taken advantage of, or coerced in any way into the decision they made.

Secondly, in Holland every case is reviewed and scrutinised to ensure uniformity. Miller states that independent monitoring and review is vital because PAS is outside of usual medical treatment, and there are opportunities for abuse of the system and/or vulnerable patients. If an independent review committee could be established for each NHS trust this would not only ensure complete uniform scrutiny, but it’s independence would also ensure that there are no superior

160 Jeffrey (n 117) 66
161 Mullock (n 28) 299
162 Margaret Dore (n 121) 389
163 Jeffrey (n 117) 84
164 Judith Rietjens (n 105) 272
165 Miller (n 47)
pressures on the committee, therefore policy abuses for political or economic reasons would be not tolerated. Furthermore constant investigation and review provides a cycle of feedback data, which can be used to improve the quality of care for patients, and further reduce the risk of abuses.\textsuperscript{166}

Cohen-Almagor, in a critical review of euthanasia practice and policy in post-legislation Belgium, states that the Dutch review system is better, because it has access to all the related documents, rather than just part of them, and has the ability to summon the doctors involved in the case if they feel the process was flawed.\textsuperscript{167} Both convincing arguments for adopting a review system similar to the Dutch one, as this meets both the certainty and transparency criteria set out above. However I believe it fails the fairness test because the committee know the identity of the doctors involved.\textsuperscript{168} I believe that this could lead to familiarity, and a willingness to overlook mistakes of ‘good’ doctors. Therefore I propose adopting the anonymity aspect of the Belgian review process, whereby the committee are unaware of the doctors involved in each case, but if necessary can waive the anonymity by a majority vote.\textsuperscript{169} This would ensure that all doctors’ actions are reviewed fairly and equally.

**Penalties**

Smith suggests that in countries where assisted suicide is legal, the penalties for breaching the regulations are too soft, resulting in physicians being prepared to push the boundaries without risk of heavy sanctions, if any.\textsuperscript{170} An example of this can be seen in pre-legislation Holland with Chabot case, which operated on a very similar set of rules and guidelines to the post-legislation position, whereby there was no precedent for aiding a patient who had a non-somatic disorder with death.\textsuperscript{171} Chabot was convicted of breaking the law, however the court decided not to impose

\begin{footnotesize}
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\item[166] Otlowski (n 93) 132
\item[167] Cohen-Almagor (n 90) 193
\item[168] Ibid 194
\item[169] Ibid 195
\item[170] Smith (n 98) 106
\item[171] Griffiths (n 102)
\end{itemize}
\end{footnotesize}
any punishment. By not strictly enforcing the rules and regulations it reduces the incentive for doctors to follow them, therefore increasing the risk of doctors influencing patients, broadening boundaries, or manipulating policy. To prevent this Cohen-Almagor recommends strict professional sanctions such as suspension or revocation of a doctor’s medical licence. This I believe would be appropriate action for doctors who fail to properly comply with reports, forms and most importantly procedure. However for actions that are clearly unacceptable, which could encourage a slippery slope situation by performing involuntary euthanasia, or be such severe cases of doctors influencing patients, then stronger consequences should be available. As Otlowski and others suggest criminal sanctions ranging from fines to prison sentences would be appropriate. This clarity on the consequences for breaching the rules would provide certainty for doctors of the outcome should they fail to adhere to regulations. The combination of clear penalties and an anonymous review system would create certain, fair, and transparent regulations.

Summary

In this chapter I have analysed the potential abuses and practical problems to a system of assisted suicide, and evaluated solutions by using criteria that consider what makes effective regulation. Firstly I examined the slippery slope argument and, by using statistical evidence from countries that have already legalised assisted suicide, I have been able to conclude that there is no statistical correlation between legalisation of assisted suicide and involuntary euthanasia. However it did become evident that a incremental approach to changing the law through the courts could result in a slippery slope effect. I expanded on this by questioning what the most appropriate form of assisted suicide was, and when in a regulatory system it would be optimal to move past this to voluntary euthanasia. Research suggests that PAS is the safest way to practice assisted suicide and provide the most safeguards, but that there are limited instances where voluntary euthanasia would be appropriate, in order to avoid discrimination and in some instances achieve fatality.

172 Ibid 239
173 Cohen-Almagor (n 90) 216
174 Ibid 216, Otlowski (n 93) 133 and Miller (n 47) 121
Potential influences on the patient, such as that of: family, financial, doctors or other healthcare professionals or abuses of policy for external reasons, are often cited as reasons not to have assisted suicide legislation. While these influences were widespread and varied, research suggests that an outright ban on assisted suicide would be a disproportionate manner of resolving these problems. Strict regulations, complete documentation, and on-going anonymous review would allow for safe, but clearly limited assisted suicide. Furthermore, as a consequence of on-going review, a strong system of penalties for doctors and other healthcare professions who breach regulations, ranging from professional sanctions to criminal sentences, would ensure a balance to the legislative checks.
Chapter 3

Competency and Consent

Introduction

One of the biggest challenges to legislating for PAS and the limited use of euthanasia is determining if a person has the mental competency to consent. The lynchpin to ensuring a person legitimately consents to PAS or euthanasia is that they are doing so voluntarily,\(^\text{175}\) are fully informed of their options and the gravity of the action they are about to take,\(^\text{176}\) and that they are legally recognised as able to make a decision.\(^\text{177}\) This chapter will, as a starting point, evaluate how Lord Joffe’s proposed Bill,\(^\text{178}\) and the DPP policy,\(^\text{179}\) meet these criteria by drawing comparisons to foreign systems and their methods of achieving this aim.

There are many arguments that the news of terminal illness, or life-changing disability, can severely alter the mental state of the person receiving such news. This can cause depression and a desire for death, and it is this new mental state that impairs the decision-making process, therefore questioning the competency of any person in this position to seek PAS or euthanasia. I will investigate the reasoning behind this, and the proposals that would seek to address this. This will also include an evaluation of mental disabilities and psychological disorders and the ability of patients suffering from these to consent to PAS or euthanasia.

Finally I will investigate the idea of the Advanced Directive (AD), and its limited use abroad, along with the problems that are tantamount to such a system. This investigation will allow me to evaluate the practical concerns surrounding AD’s, and the theoretical use of them for dementia sufferers.

\(^{175}\) Lewis “Euthansia in Belgium 5 years after legislation ” (n 107) 127
\(^{176}\) Miller (n 47)
\(^{177}\) Ibid 121
\(^{178}\) Assisted Dying for the Terminally Ill Bill 2005
\(^{179}\) Director for Public Prosecutions (n 15)
Mental Competency

Lord Joffe’s Bill fails to address this issue sufficiently, merely stating that the patient must be competent,\(^{180}\) without establishing a mechanism for ascertaining if they are (a problem that Belgian law also faces)\(^ {181}\). The DPP policy suggests that where a victim lacks mental capacity under the Mental Capacity Act prosecution is more likely.\(^ {182}\) Therefore I would propose that as a starting point lacking mental capacity is given its meaning under the Act: “\textit{person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.}”\(^ {183}\) Any of the reasons listed under the aforementioned act could arise in relation to making a decision about PAS or euthanasia.\(^ {184}\)

Perhaps the most pertinent factor would be the inability to make a decision through not been able to use or weigh up information as part of the decision-making process.\(^ {185}\) This would arise in cases where the patient is suffering from depression because “\textit{impaired cognitive function is one of the characteristics of a depressive disorder; a rigid tendency to see only one possible solution (such as suicide) to their problems is also characteristic.}”\(^ {186}\) Furthermore it has been purported that those who ask to die are suffering from a confusing array of emotions, making them unstable and lacking the mental capacity to consent.\(^ {187}\) Whilst this may be an exaggeration for political debate, Herbert Hendin & Kathleen Foley provide support for the idea that terminal illness causes suicidal thoughts and depression, through research linking hopelessness and depression.\(^ {188}\) Research also supports the notion that the desire for death is a common reaction to diagnosis with a terminal illness.\(^ {189}\) Hendin argues that allowing assisted suicide for patients suffering from depression is

\(^{180}\) Assisted Dying for the Terminally Ill Bill 2005 s 2(3)(b)
\(^{181}\) Cohen-Almagor (n 90) 201
\(^{182}\) Director for Public Prosecutions (n 15)
\(^{183}\) Mental Capacity Act 2005 s.2 (1)
\(^{184}\) Ibid s.3 (1) (a-d)
\(^{185}\) Ibid s.1 (c)
\(^{186}\) Hendin and Foley (n 118)
\(^{187}\) Baroness Finlay of Llandaff, \textit{Hansard (Lords)}, Vol 681, Col 1201, 12\textsuperscript{th} May 2006
\(^{188}\) Hendin and Foley (n 118) 16
\(^{189}\) Hendin “Seduced by death” (n 9) 127
bad psychiatric practice, and that such a person would be in no position to be making a decision to end their life.\(^{190}\)

With this in mind, any system regulating PAS and euthanasia must be able to adequately recognise patients suffering with depression, or depressive tendencies. The primary concern here is that, generally speaking, doctors often have limited psychological training,\(^ {191}\) which results in them to failing to recognize a patient lacking capacity.\(^ {192}\) Alternatively doctors may be overwhelmed by the emotion of a patient,\(^ {193}\) highlighting the societal difficulty in distinguishing between mental anguish and suffering.\(^ {194}\) This leads to the logical proposition that potential PAS patients would need a psychiatric assessment,\(^ {195}\) as the best way to provide certainty of the patients’ mental state to consent. This would appease one of the main mental health based arguments against PAS.\(^ {196}\) Additionally, I believe that for this to be successful, referral of patients requesting PAS must be mandatory, because statistical evidence of optional referrals in Oregon would suggest it is unsuccessful, with only 4% of patients requesting PAS referred to psychiatrists.\(^ {197}\)

It would seem that we could learn from elsewhere about good working practices for the mentally unwell. In the Dutch Chabot case Griffiths explains that the psychiatrist insisted on meeting the patient several times before he was prepared to assist her with her suicide, because it takes numerous meeting for a psychiatrist to understand the mental position that the patient is in.\(^ {198}\) In Oregon a basic test is carried out to establish competency, however no deep or meaningful exploration is made into the mental state of the patient.\(^ {199}\) The vast majority of psychiatrists state that multiple meetings are required to establish the mental state of a patient,\(^ {200}\) and that by using psychiatrists to merely evaluate competency in a one-off meeting treats them as

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190 Ibid 164
191 Jeffrey (n 117) 83
192 Ibid 82
193 Ibid 83
194 Smith (n 98) 111
195 Hendin & Foley (n 118) 1621
196 Smith (n 98) 108
197 Hendin & Foley (n 118) 1621
198 Griffiths (n 102)
199 Hendin & Foley (n 118) 1622
200 Sleeman “Caring for a dying patient in hospital” (2013) 346 BMJ 2174, 2176
gatekeepers to PAS, rather than medical professionals aiding a patient.\textsuperscript{201} Furthermore, given the link between terminal illness or life changing disability and depression, multiple consultations with a psychiatrist could prevent PAS because psychiatric treatment can explore the roots of the depression and treat it,\textsuperscript{202} or in cases where fear has caused a request for PAS, treatment can also help a patient overcome it.\textsuperscript{203} Legislating for this would allow the patient to evaluate their life in the clearest possible manner, creating certainty over the choice the patient is making. Hendin and Foley further contend that without a firm understanding of the emotions and anxieties that a patient is feeling, then the patient can’t be considered well informed.\textsuperscript{204}

Psychiatric treatment would alleviate this problem, and potentially free patients from the fear of death, allowing them to focus on their battle for life.\textsuperscript{205} Moreover, multiple conversations with a psychiatrist are likely to uncover any influences on the patient,\textsuperscript{206} providing a further check that the patient is making a completely voluntary decision.\textsuperscript{207} To put a number on how many times a psychiatrist must meet a patient requesting PAS is not for me to say, and would require further analysis of the profession before incorporation into law. Mentally incompetent patients would not qualify for euthanasia and PAS; by creating vigorous mental competency screenings this would ensure the upmost fairness and certainty in PAS or euthanasia. This would certify that a person suffering with Dementia would be inapplicable for PAS or euthanasia, because they would lack competency.\textsuperscript{208} Even considered in terms of ‘lucid moments’ it would be impossible to consider the patient competent because these moments are in flux and could be drastically different moments later.\textsuperscript{209}

\textbf{Advanced Directives}

\textsuperscript{201} Hendin & Foley (n 118) 1623
\textsuperscript{202} Ibid 1623
\textsuperscript{203} Ibid 1621
\textsuperscript{204} Ibid 1624
\textsuperscript{205} Hendin “Seduced by death” (n 9) 127
\textsuperscript{206} Hendin & Foley (n 118) 1624
\textsuperscript{207} Cohen-Almagor (n 90) 194
\textsuperscript{208} John B. Mitchell, “Physician-Assisted Suicide and Dementia: The Impossibility of a Workable Regulatory Regime” (2009) 88 Or LR 1085, 1086
\textsuperscript{209} Cohen-Almagor (n 90) 209
The Advanced Directive (AD) is the idea of a perfectly healthy and competent person creating a legal document that would state *should X happen in the future, and my competency cannot be proven, I state now that PAS or euthanasia would be my request.*\(^{210}\) It is thought that AD’s would be available for people who fear becoming a shell of the person they were, or in a passive vegetative state.\(^{211}\) This would include patients with dementia. This is the strongest argument for allowing AD’s for dementia sufferers, however the argument is vitally flawed. The notion that the dementia sufferers are no longer the people they were, that they are vegetables, or shells of people,\(^{212}\) pervades society.\(^{213}\) However doing so devalues dementia sufferers as people,\(^ {214}\) failing to account for the fact that even in the most advanced cases patients still have lucid moments.\(^ {215}\) Whilst this paints a fairly rose-tinted picture of life for dementia sufferers, we must consider that a great proportion of their time is frustrated, angry and unhappy. What must be taken from this, however, is the essence of what dementia is: the gradual breakdown of the neurological cells that make up the brain and nervous system, resulting in the gradual failure of the mind and body.\(^ {216}\) However this said dementia doesn’t stop a person feeling emotions, both negative and positive,\(^ {217}\) or always result in personality disintegration,\(^ {218}\) which is why the empty shell argument doesn’t hold; there will always be the ‘original’ person there, unfortunately not all the time. Furthermore it is virtually impossible to state in an AD a point at which you wish PAS to take place, because dementia affects everyone differently.\(^ {219}\) To do so would be “delegating unbound discretion”\(^ {220}\) to another person, who could be swayed by financial influences, or care burdens etc.\(^ {221}\)

The difficulty of establishing a cut off point goes beyond dementia sufferers, and

\(^{210}\) Ibid 206
\(^{211}\) Ibid 206
\(^{212}\) Mitchell (n 208) 1092
\(^{213}\) Ibid 1100
\(^{214}\) Cohen-Almagor (n 90) 209
\(^{215}\) Mitchell (n 208) 1103
\(^{216}\) Ibid 1093
\(^{217}\) Ibid 1101-1103
\(^{218}\) Gevers (n 18) 37
\(^{219}\) Mitchell (n 208) 1123
\(^{220}\) Ibid 1092
\(^{221}\) Ibid 1132-1134
permeates throughout AD discussions. It can be argued that to force a human to continue living and suffering in pain, when they have mandated that they wish not to would be a breach of their personal autonomy. However difficulties arise with determining the condition of the person. It is argued that doctors are notoriously poor at diagnosing when a patient is close to death, or now much longer they are likely to be alive. Whilst it is clear that people creating AD’s would want to avoid living in a ‘vegetative state’ there are multiple parameters that must be considered: the present condition of the patient, their age, the likelihood of improvement, the amount of brain function, the time spent in that condition, and many other criteria. Leaving the impossibly difficult question of how long is the patient given? When is the right time to administer the lethal drug? “[T]he advance directive is not a suitable instrument for decisions for which self-determination is necessary.” Given the importance of voluntary consent at all times, it would seem that due to the lack of medical certainty the AD would not currently be a viable option.

**Summary**

The aim of this chapter was to understand the practical problems around competency and consent. Critical analysis of the literature suggests that a fundamental foundation for this is that the patient must be requesting PAS completely voluntarily, and must have reached their decision completely autonomously.

The DPP policy, as part of its guidance for when prosecution will be more likely, uses existing legislative mechanisms to determine competency. However analysis of the literature revealed the depth of problems with determining the competency of a

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222 Shaw (n 36) 343
223 Sleeman (200) 2174
224 Cohen-Almagor (n 90) 206
226 Cohen-Almagor (n 90) 206
227 Gever (n 18) 37
228 Mental Capacity Act 2005
patient, therefore the Mental Capacity Act would be a good starting point. Yet further checks would need to be put in place to ensure certainty of the patients’ wishes. Research suggests that depression can be a largely influential factor in making an end-of-life choice, therefore a system that mandatorily requires requesting patients to have multiple consultations with a psychiatrist would be the process most appropriate to deal with the stresses of this problem. This would also provide a further check on the autonomy of patients’ decisions.

Finally this chapter evaluated the Advanced Directive, which appears to be a system that superficially would be excellent, and would alleviate the concerns of many, especially those diagnosed early on with dementia. However scrutiny of the circumstances that would activate an AD exposed the many difficulties that would arise. With the current medical understanding available to physicians, the decision about when to activate an AD would be an impossible decision to make with any certainty, meaning that currently this wouldn’t be able to provide sufficient legal certainty, fairness or transparency to be incorporated into legislation.

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Ibid
Conclusion

This dissertation set out to analyse the shortcomings and problems within the law of assisted suicide currently, and the subsequent effects this has had on the medical profession. By identifying the main practical problems and abuses that could occur if assisted suicide were to be legalised, and how they are solved in countries that have already legalised assisted suicide, I have sought to demonstrate and recommend, through analysis of these problems, the best manner to legally regulate against such issues. I have also sought to analyse the various different psychological problems related to consent, and, through a similar method of evaluation, recommend the best means to protect potential patients against these problems, ensuring the best possible care for the patient.

Chapter one demonstrates that the DPP policy has undermined the legal position on assisted suicide, causing a lack of clarity, and creating ambiguities in how the law will be applied: “[it has] left the UK’s stance on assisting suicide in a position of uncertainty and disarray.”230 In this disarray alternative methods have developed to help those patients dying unpleasant and painful deaths; the addition of the LCP to NHS policy has at a policy level given an unregulated licence to carry out passive euthanasia. Whilst this system was undoubtedly created with good intentions, aimed at improving end-of-life care,231 a lack of regulations has led to a catalogue of abuses. Chapter one concludes that neither the law, nor the LCP, are fit for purpose, and that legislating for assisted suicide would be the most appropriate resolution.

Chapter two sets out the potential problems with legislating for assisted suicide, namely: the slippery slope argument, undue influences, and policy abuses. By comparatively examining the countries that have legalised assisted suicide against

231 Catriona R Mayland et al, “Does the ‘Liverpool Care Pathway’ facilitate an improvement in quality of care for dying cancer patients?” 203 Brit J Cancer 1, 1
criteria for good legislation I have been able to recommend the best solutions to resolve the issues, and in some cases suggest improvements to existing policies used abroad. The most important findings of the Chapter are; that PAS and limited use of euthanasia is the safest format to allow assisted suicide, and that regulation with a sufficient amount of checks and balances can significantly minimise, if not prevent, any potential abuses.

Chapter three focuses on the notion of consent. My research highlighted the wide array of psychological concerns that were relevant to assisted suicide. Primarily this chapter recommends that to optimise patient treatment every patient requesting PAS should be subject to a psychological assessment, over a number of sessions. This would not only help determine their mental capacity, but help them understand their own feelings, and uncover any undue influences. Following an evaluation of the Advanced Directive, chapter three concludes that this process should not be recommended because of the scope for medical uncertainty.

Overall I believe that this dissertation proves that it is not impossible to create effective legislation for assisted suicide. However, care and consideration is required, given the significance of any margin of error, to minimise the chance of oversight allowing abuses of patients. For this reason it is highly recommended that the legalisation of PAS should be pursued through parliament, rather than through the courts. Whilst I can assert with confidence that it is possible to create a regulatory system that would prevent the vast majority of abuses, and their inevitable consequences, it must be noted that perfection is difficult to achieve in any regulatory system. The risk with legalising PAS is that any improvements based on failures or errors in the system come at the highest cost.
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