



University
of Glasgow

Ward, Amanda Jane (2015) *Who Decides? Balancing competing interests in the Assisted Suicide debate*. LL.M(R) thesis.

<http://theses.gla.ac.uk/6394/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Who Decides? Balancing competing interests in the Assisted Suicide debate.

By Amanda Jane Ward

BA (Hons)

Submitted in fulfilment of the requirements for the Degree of LLM by Research

School of Law

College of Social Sciences

University of Glasgow

Submitted: 31st March 2015

Abstract

This thesis examines the subject of assisted dying in the UK. This subject raises complex legal and ethical issues about autonomy, capacity and human rights. For the last 30 years 69 to 82 per cent of the British population has consistently stated support for a change in legislation to allow a choice of an assisted death for the terminally ill and mentally competent adult. Such laws do exist in other jurisdictions, but there is currently no law in the UK allowing such an act despite proposals in both Westminster and the Scottish Parliament.

This thesis will examine the background of the assisted dying movement in the UK, from its origins and conception to the present day, to enable consideration of the central argument of this paper which is that, if the UK public are pronouncing strong support for a change in the law and have done so for some time, then why are we not seeing this support materialise in the form of legislation. In particular, this thesis looks at the influential stakeholders in the UK assisted dying debate and assesses the impact they may have on members of Parliament. The groups include professional medical bodies such as the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP), vulnerable groups and religious bodies to understand why they have opposed various legislative proposals. A central theme is to try to reconcile this opposition with the evidence which clearly shows that the UK public would favour a change in the law.

There is considerable information on the subject publicly available via the media and academics; this thesis will be useful in providing a succinct point of reference as to why the law stands as it does at present. Other jurisdictions will be considered and compared to the UK. The question of how they have managed to overcome the thematic obstacles which occur will be addressed, and it will be argued that such legislation may now be appropriate in the UK.

Keywords: Autonomy, Capacity, Assisted Dying.

Contents

Abstract	2
Contents	3
Table of Cases	5
Table of Legislation	6
Acknowledgements	7
Author’s Declaration	8
Introduction	9
Introduction to the study	9
Background	10
A good death	11
Outline of the thesis	12
Definitions	14
Interested Parties	15
The UK public	15
Professional Medical Bodies	16
Vulnerable People	17
Religious Groups.....	17
Chapter 1: The Legal Position	18
1.1 Introduction	18
1.2 Statutory provisions	18
1.3 Previous Attempts at Legislation	19
1.3.1 The Patient (Assisted Dying) Bill 2003.....	19
1.3.2 Assisted Dying for the Terminally Ill Bill [HL].....	19
1.3.3 The Coroners and Justice Bill 2008-09	20
1.3.4 End of Life Assistance Bill 2010	20
1.4 Current attempts at legislation	20
1.4.1 Assisted Suicide (Scotland) Bill 2013	20
1.4.2 Assisted Dying Bill	21
1.5 Considerations	22
1.6 Legal position – common law	23
1.6.1 <i>Diane Pretty v DPP</i>	23
1.6.2 <i>Daniel James (2008)</i>	24
1.6.3 <i>Debbie Purdy v DPP</i>	24
1.6.4 <i>R (on the application of Nicklinson and another) v Ministry of Justice</i>	25
1.7 Summary	26
1.8 Conclusion	27
CHAPTER 2: Relevance of Professional Bodies in the Assisted Suicide debate	28
2.1 Introduction	28
2.2 Scottish Culture	30
2.3 Background/Historical Stance	31
2.3.1 British Medical Association (BMA)	31
2.3.2 Considerations: A truly representative stance?	32
2.3.3 Neutrality should be present where agreement is absent.....	33
2.4 Other Professional Medical Bodies	34
2.4.1 Royal College of General Practitioners	35
2.4.2 Royal College of Nursing.....	37

2.5 Skewed opinion polls?	38
2.6 Oregon and the Oregon Medical Board	39
2.7 The Netherlands and the Dutch Medical Association.....	41
2.38 Conclusion	42
Chapter 3. Arguments for and against Assisted Dying considered in a medical context. The emergence of themes as common concerns.....	44
3.1 Introduction	44
3.2 Palliative Care.....	44
3.2.1 Improved Palliative care will remove the need for AS.....	44
3.2.2 AS would lead to a reduction in palliative care.....	46
3.2.3 Reporting/Gradual Uptake from other countries	47
3.2.4 Emotional insurance.....	48
3.2.4.1 Oregon Figures.....	48
3.3 The Hippocratic Oath.....	50
3.4 If not the medical professional, who else?	51
3.5 Subjective/Objective considerations: Concerns when things are not absolute.....	53
3.5.1 Terminal Prognosis	53
3.5.2 Capacity.....	54
3.5.3 Depression.....	54
3.3 Conclusion	55
Chapter 4: Considerations in the AD debate specific to vulnerable groups.....	57
4.1 Introduction	57
4.2 Culture.....	58
4.2.1 Interest Groups which may be affected	59
4.2.3 Vulnerable groups; The <i>need</i> for Assisted Suicide.....	63
4.3 How would a Bill affect the vulnerable - Under current Scottish proposals, are they eligible? ...	64
4.4 Reasons for opposition	66
4.4.1 Slippery Slope	66
4.4.2 Duty to die.....	68
4.4.3 Coercion/Abuse.....	68
4.5 What's the alternative?	69
4.6 Conclusion	70
Chapter 5: Religious Considerations	72
5.1 Introduction	72
5.2 Background/History.....	72
5.2.1 Relevance of Religious Groups.....	74
5.2.2 Contrasting views.....	76
5.2.3 Official Stances – A true reflection?	77
5.2.4 Going against the grain.....	78
5.3 Reasons for Opposition	80
5.3.1 Sanctity of Life.....	81
5.4 Conclusion.....	83
Conclusion.....	85
Bibliography	88

Table of Cases

Haas v Switzerland 2011 53 EHRR 33

R (Nicklinson and Others) v Ministry of Justice [2012] EWHC 2381

R v Director of Public Prosecutions ex parte Diane Pretty and Secretary of State for the Home Department (Interested Party) [2001] UKHL 61

R. (Purdy) v Director of Public Prosecutions (2010) 1 A.C. 345

Vacco v Quill, 521 US 793 (1997)

Washington v Glucksberg, 521 US 702 (1997)

Table of Legislation

Scottish Parliament:

Assisted Suicide (Scotland) Bill (Introduced 2013)

End of Life Assistance (Scotland) Bill (Introduced 2010)

UK Parliament:

Coroners and Justice Act 2009

Human Rights Act 1998

Human Fertilisation and Embryology Act 1990

HFEA (Research Purposes) Regulations 2000

Mental Capacity Act 2005

Scotland Act 1998

Assisted Dying Bill (Introduced in 2013)

Assisted Dying Bill (Introduced in 2014)

Assistance for the Terminally Ill Bill (Introduced 2004)

Patient (Assisted Dying) Bill (Introduced in 2003)

HFEA (Research Purposes) Regulations 2000

International:

Oregon:

Death with Dignity Act 1997

Belgium:

Belgium Act on Euthanasia 2002

Netherlands:

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

Acknowledgements

Grateful thanks go to my supervisor Professor Alison Britton for overseeing the study and for her consistent invaluable advice, support and patience throughout the preparation of this thesis. Her constant encouragement and belief in my abilities have been a pillar of strength to me throughout the years. I am very blessed to now consider her a great friend and inspiration.

I also thank the wonderful Professor Fiona Leverick and Susan Holmes for their unwavering support, patience and kindness. I am very blessed to have had their support over the years.

Particular thanks go to Friends at the End for the invaluable practice experience working for them has afforded me. Special consideration must be given to my dear friend Dr Libby Wilson.

My family and friends have experienced long periods of neglect. I thank them all for their forbearance, help and encouragement during the past years, especially my wonderful husband James.

Finally, I remember my darling son Noah who this thesis is dedicated to.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature _____

Printed name _____

Introduction

This thesis aims to answer the following question:

For the last 30 years 69–82 per cent of the British population has consistently stated support for a change in the legislation to allow a choice of an assisted death for the terminally ill, mentally competent adult. Given these statistics, are politicians being constrained by lobby groups?

Introduction to the study

The practitioners of modern medicine have more knowledge and, potentially, greater skill in the relief of suffering than their predecessors ever possessed. Despite that, many individuals continue to witness their loved ones enduring a lingering and painful death. Occasionally that dying process will have been prolonged by medical advances which were originally designed to improve treatment. Technological advances including prolonged artificial ventilation and parenteral feeding have brought problems as well as solutions. This unforeseen and unwelcome incongruity could be at least partly responsible for the groundswell of opinion in favour of changes in end-of-life care.

Historically, when all avenues had been exhausted and death was inevitable, a sympathetic and willing doctor may have helped a patient to die with more ease than natural occurrence would allow. A 1996 study found that 57 per cent of a sample of doctors practising in the United States of America (US) reported receiving a request for Physician Assisted Suicide (PAS)¹ while a recent survey in the United Kingdom (UK) showed that 0.21 per cent of deaths attended by a medical practitioner were the direct result of voluntary euthanasia.² 0.3 per cent of UK deaths were as a result of non-voluntary euthanasia.³ Those figures may have altered in the past years, but the help doctors are willing and able to give to their patients to ensure a peaceful and dignified death has decreased. Euthanasia is illegal in the

¹ A L Back, J I Wallace, H E Starks and R A Pearlman 'Physician assisted suicide and euthanasia in Washington State: patient requests and physician responses'. *JAMA* (1996) 275(12): 919–925.

² C Seale 'End-of-life decisions in the UK involving medical practitioners' *Palliative Medicine* (2009) 23: 198–204. 'Voluntary Euthanasia is the act of killing someone painlessly, especially to relieve suffering from an incurable illness, with their consent', Collins Dictionary 2015. Non-voluntary euthanasia in contrast is where no such consent has been given and the wish of the patient may not be known.

³ Ibid, ref 2

UK and it is understandable that many practising and retired practitioners are reluctant to speak out for fear of repercussion; in reality the percentages noted may be significantly higher. However, these findings must also be set in context as greater teamwork with other health care professionals, together with a decline in continuity of care, have changed the doctor–patient relationship detrimentally.⁴ As a consequence, the opportunities for well-intentioned doctors to act independently in this fashion have undoubtedly diminished.

Perhaps the solution to the discordance mentioned in the opening paragraph would be to ensure that everyone who needs it has access to excellent palliative care. However this is not an entirely satisfactory answer. For example, Baroness Ilora Finlay, a palliative care expert opposed to any change in the law, admits that better care is not a panacea. She acknowledges that, for some patients, even the best available care cannot allow them to die with dignity and at peace.⁵ Despite progress in the provision of palliative care, many people in the UK still die in hospital,⁶ a situation universally recognised as unsatisfactory. That could be compared to the position in the Netherlands, where caring for patients at home, particularly towards the end of their lives, is well established. It may not be coincidental that that country was also the first to allow both euthanasia and physician assisted dying.⁷ The flexible, less paternalistic approach adopted in the Netherlands may well have set the scene for the development of jurisprudence in this area.

Background

Over the past decades, there has been a greater involvement of the public in deciding how matters which directly affect them should be taken forward. Within the National Health Service (NHS), this trend has been gathering pace since the early 1990s. The establishment of community health councils in 1974⁸ and the Griffiths Report of 1983⁹ in their separate

⁴ G Freeman and J Hughes ‘Continuity of care and the patient experience. An inquiry into the quality of general practice in England’ (2010) Kings Fund. See also Institute of Medicine (US) and National Academy of Engineering (US) roundtable on ‘Value and science-driven health care’ (2011) – ‘Engineering a learning healthcare system: a look at the future: workshop summary’.

⁵ Hansard: HC Deb, 27 Mar 2013.

⁶ Around 51% of people die in hospital, with 21% dying at home, 22% in a care home and 6% in a hospice. See: ‘First national VOICES survey of bereaved people: key findings report’, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216894/First-national-VOICES-survey-of-bereaved-people-key-findings-report-final.pdf Accessed on 12/03/15. See also; G Catto and I G Finlay ‘Assisted death: a basic right or a threat to the principal purpose of medicine?’ *J R Coll Physicians Edinb* (2014) 44: 134–138.

⁷ D Johnson ‘Dutch legalization of assisted suicide sparks international debate’. Available from: <http://www.infoplease.com/spot/euthanasia1.html#ixzz3V6QX9SRZ> Accessed on 22/03/15.

⁸ Community Health Councils were established to provide a voice for patients and the public in the NHS in England and Wales. The key function was to represent the interests of the public in the health service in their district. CHCs have since been superseded by various bodies with similar powers.

ways gave expression to the need for the interests of the public to be represented to health professionals and policy makers.

Many consumer groups and community organisations have also challenged professional and expert authorities, demanding that their voices be heard. Such groups now play an increasing role in health decision-making at both the political and executive levels. A widening of the access to information, previously dependent on professional gatekeepers, has enabled individuals and groups to pose relevant questions to health professionals. This growing desire to be involved in one's healthcare has led to pressure being brought upon those in power to allow greater autonomy to the individual, occasionally summarised in the slogan, 'No decision about me, without me'.¹⁰ That pressure now extends to decisions concerning end-of-life care.

A good death

In a survey of Oregon nurses and social workers who were caring for hospice patients dying by legally prescribed medication, a desire to manage their own death was an important factor in patients' decisions.¹¹ Assisted suicides (AS) are most often sought by individuals who have been accustomed to having a great deal of control over their own lives. These are generally well-educated middle to upper class individuals¹² who have a strong desire to take their healthcare, treatment and fate into their own hands. This is essentially why AS exists in the first place – to allow those who feel they are losing control of their minds or bodies to regain power and see their own will take shape again. Ronald Dworkin, in his book *Life's Dominion*, argues that one has a 'critical interest' in his or her own death. It may be in a person's best interest to allow him or her to complete their biographical life in a way that is consistent with their values. He writes: 'There is no doubt that most people treat the manner of their deaths as of special symbolic importance: they want their deaths to express and in that way vividly confirm the values they believe most

⁹ The Griffiths report heralded a change in managerial culture in the NHS. It involved a new NHS management board, at arm's length from the Secretary of State and civil servants, and identifying general managers with overall responsibility for performance and budgets at district health authorities and hospital units.

¹⁰ This is a political catchphrase and describes a vision of healthcare where the patient is – if not an equal partner – then certainly an active participant in treatment decisions.

¹¹ L Ganzini, T A Harvath, A Jackson, E R Goy, L L Miller and M A Delorit, 'Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide' (2002) *NEJM* 347(8): 582–588. PMID: 12192019.

¹² Oregon Public Health Division's Death with Dignity Act Report 2012 shows that, as in previous years, most people were white (97.4%) and well educated (42.9% had at least a baccalaureate degree). Information available from:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>. Accessed on 15/11/14.

important to their lives.’¹³ For a sincerely dutiful person, a good death may be the desired end to their story.

Outline of the thesis

With the rise of technological medicine, lives which were once beyond rescue can now be saved, at least temporarily. However, that success sometimes comes at too great a price, inflicting a life suffused in suffering, pain and despair on the individual.¹⁴ Over the last 30 years, the British public, as evidenced through polls, media campaigns and lobby groups, has consistently supported a change in legislation which would allow a terminally ill, mentally competent adult to request assistance to die. This thesis seeks to uncover why this change in legislation has not occurred in the UK, when it has been increasingly incorporated into the law of many other countries, not only in Europe but also further afield.¹⁵ The aim here is to consider the influence interested parties have on politicians’ voting behaviours in relation to the proposals laid before the Scottish and Westminster Parliaments to allow AS, with a view to uncovering why there is such a consistent rejection, when their constituents are consistently calling for change.

Previous failed attempts to change the law in the UK have not concluded the matter and the debate continues.¹⁶ Whilst it is impossible to give this subject full consideration without drawing on legislation not only from England and Wales, but also the US and Europe where various forms of self-deliverance have been legalised, the focus will be directed upon Scots law, Scottish legislative proposals and current Scottish provisions.

This thesis will consist of six chapters and a conclusion. This first introductory chapter will provide a framework for subsequent chapters, by considering relevant definitions and outlining the UK public’s considerations, substantiating claims that the majority is in favour of legislative proposals for assistance to die. This chapter will give a brief outline of the parties to be studied in subsequent chapters.

¹³ R Dworkin *Life’s Dominion. An Argument about Abortion, Euthanasia, and Individual Freedom* (1993) 208–213.

¹⁴ J J Paris and M P Moreland ‘A Catholic perspective on physician-assisted suicide’ in M Pabst Battin, R Rhodes, and A Silvers (eds), *Physician Assisted Suicide: Expanding the Debate* (1998) 328.

¹⁵ As of 2015, assisted suicide is legal in Switzerland and in the US states of Washington, Oregon, Vermont, New Mexico and Montana. Euthanasia is legal in the Netherlands, Belgium, and Luxembourg.

¹⁶ Previous failed attempts at legislation will be discussed in Chapter 1 at para 1.3

Chapter one will focus on the legal position in the UK both past and present. It will provide the legal background and context in which this area of study is set and is substantially an information chapter on which to base further analysis.

It is evident from media surveys and opinion polls that a majority of people in the UK support a change in the current law on assisted dying.¹⁷ Yet attempts to pass legislation in both Westminster and the Scottish Parliament continue to be unsuccessful. Several reasons have been put forward to suggest why this is so, and can be categorised under medical, vulnerable, religious and political considerations.

Chapter two then considers the relevance of professional medical bodies in the AS debate, both in the UK and abroad. A profound and recurring suggestion is that the culture in the UK within the healthcare environment is traditional, paternalistic and deferential. This tends to result in a highly structured, doctor-centred approach to end-of-life care.

This then leads into chapter three, which considers arguments presented in a medical context both for and against AS and analyses the emergence of themes in the common concerns. Other matters relating directly to the history of medical practice and its culture will also be considered, including the role of the Hippocratic Oath. Whilst much has been written on the purpose and relevance of this archaic pledge within 21st century medicine, other jurisdictions have succeeded in finding ways of resolving such issues.

Chapter four focuses on considerations specific to groups who are considered vulnerable and considers through a case study how AS legislation would affect them if it were passed. Infamous arguments against legislation such as the Slippery Slope will be analysed and its validity tested.

¹⁷ The 2010 British Social Attitudes survey found that 82% of the general public agreed that a doctor should probably or definitely be allowed to end the life of a patient with a painful incurable disease at the patient's request. The 2007 BSA survey found that 80% agreed that a person with a terminal and painful illness from which they will die should be allowed an assisted death.

74% of submissions to the Scottish Parliaments Health and Sport Committee asked for the Scottish legislation to be passed, and almost 4000 people signed a petition to MSPs in favour of the Bill.

My Life, My Death, My Choice (MLMDMC) Poll, 3 Feb 2015, found that 78% of the Scottish electorate believe it was of medium or high importance that the Assisted Suicide (Scotland) legislation became law. MLMDMC poll in 2014 showed 69% support.

Available from: <http://www.lifedeathchoice.org.uk/news/news/more-than-three-quarters-of-scots-say-important-assisted-suicide-bill-becomes-law/>. Accessed on 17/03/15.

See also: E Clery, S McLean and M Phillips 'Quickening death: the euthanasia debate', in A Parks, J Curtice, K Thomson, M Phillips and M Johnson (eds) *British Social Attitudes: the 23rd report: perspectives on a changing society* (2007) 35–54. See also: S. McAndrew 'Religious faith and contemporary attitudes' in Park, Curtice and Thomson (n 16, ch 1) 87–113.

Chapter five considers the relevance and challenges the validity of prominent religious arguments against AS in the UK. Consideration will be given to the clear discordance between the hierarchies and congregations they represent.

This thesis will conclude by reflecting upon the influence that the groups studied have on politicians. It is suggested that the influences of the three groupings – medical, vulnerable and religious parties – are primary reasons for politicians blocking legislative proposals. This idea will be discussed more fully in subsequent chapters.

Definitions

It will initially be useful to provide definitions on the terms used in relation to assisted dying. This thesis will consider only assisted suicide and not euthanasia. This is because the historical and current legislative proposals have involved only AS and do not extend to euthanasia in any form.

Throughout this thesis, the concept of an assisted death will be referred to as either Assisted Suicide (AS) or Assisted Dying (AD), which are interchangeable terms with essentially the same meaning.

Assisted Dying is usually defined as voluntary active euthanasia or assisted suicide – sometimes these terms are used interchangeably but there are important differences. ‘Active’ euthanasia is a deliberative intervention to end life; so-called ‘passive’ euthanasia involves a withholding or sometimes withdrawing of treatment.¹⁸ ‘Voluntary’ implies helping an individual who wishes to die at their request, whereas ‘involuntary’ means that no such request has been made.

Assisted Suicide is any act which intentionally helps another person to commit suicide; legislative proposals usually suggest that the act is still suicide as the individual is ending their own life, albeit with assistance to die provided by another.¹⁹ As noted, this is the subject study of this thesis.

In the case of ‘voluntary euthanasia’, in contrast, someone else administers a substance to the person to enable them to die, for example by giving them a lethal injection.²⁰ The distinction is ultimately a matter of responsibility. Britton²¹ argues that this is an important

¹⁸ Whether withdrawing or withholding can indeed logically be defined as ‘passive’ is outwith the scope of the discussion here.

¹⁹ Oxford Dictionaries 2015.

²⁰ Collins Dictionary 2015 (n 2).

²¹ A Britton, ‘Assisted Suicide Bill lacks clarity, Society argues’ 4 June 2014, JLSS.

and fundamental distinction. She argues that responsibility for the act of dying is the cornerstone of the legislative provision, namely whether a jurisdiction provides for euthanasia, assisted suicide – including ‘physician’ assisted suicide – or both. It is also suggested here that it is one of the reasons that the professional healthcare organisations may be so reticent to support legislative proposals. If legislation allows for physician-assisted suicide, the responsibility for confirming that an individual qualifies for assistance to die will be the doctor’s. In the case of euthanasia, the doctor may have sole responsibility for the dying process and the death itself. The reticence may then be understandable for a professional group whose ethics are to ‘come for the benefit of the sick’²² and it may also explain why some legislation – both existing and proposed – has removed the role of the medical practitioner altogether.²³

Many jurisdictions have experienced difficulties in agreeing on terminologies and definitions. For example, how can it be shown that a person’s suffering is at a point that it can no longer be endured? Legislative proposals have included descriptions such as unbearable, intolerable, unrelievable, hopeless, intractable, and irremediable. It has been questioned whether any of these words capture the essence of what an individual may feel at that moment and, if that is so, how the concept can be adequately reflected in legal provision. There is much to be said about the level of detail involved in draft provisions, but given such an important subject matter one could argue it is thoroughly justified.

Interested Parties:

The UK public

The surveys used in this research come from varying sources: government polls, BSA surveys, academic studies as well as independent studies from interested parties. The use of a wide variety of sources will give a better understanding of the breadth of this topic and the public’s views on it. Collectively, the figures show that a substantial majority of British people consistently support Assisted Suicide (AS).²⁴

²² An interpretation based on the Hippocratic tradition.

²³ The idea of removing the medical professional from the final act will be discussed in chapter three at para 3.4. Current Scottish proposals under the Assisted Suicide (Scotland) Bill introduce a licensed facilitator (as well as GP involvement), and the Swiss clinic Dignitas does not employ any medical professionals. Most jurisdictions however do see a role for medical practitioners.

²⁴ (n17).

This thesis aims to consider why, when the large majority of UK citizens support AS, we are not seeing it enacted through legislation. It is suggested that this is because the law makers and the people called upon to give evidence such as the British Medical Association (BMA), disability rights groups and religious bodies, have consistently taken an opposing view. The views of these organisations will be considered as part of the research with the view to uncovering why they take a particular stance and how influential that position is.

The UK population overwhelmingly supports a change in the law (see above). As noted, however, three powerful institutions have expressed concern. Firstly, the medical bodies are mostly opposed although more than two-thirds of individual GPs believe that the Royal College of General Practitioners (RCGP) should change its stance on the issue, subject to a number of safeguards.²⁵ Those with disabilities are in favour (75 per cent) while their organisations are against.²⁶ The churches are opposed, although 78 per cent of people of faith are in favour.²⁷ How these institutions have determined their position on assisted dying given the difference between their official view and the opinions of their members will be explored in later chapters.

Professional Medical Bodies

The first organisation studied will be the BMA, which represents doctors in negotiations over their terms and conditions of their employment. They debate the issue of Assisted Suicide each year and at present have voted to oppose. The RCGP's (UK wide) are the academic organisation which seeks to encourage and maintain the highest standards of general practice and are also opposed will then be analysed. Interestingly, the Scottish branch of the Royal College of General Practitioners has, after consulting its members, adopted a neutral stance on the Scottish Bill. A similar view has been taken by the Nursing and Midwifery Council, the Royal Pharmaceutical Society in Scotland, Community Pharmacy in Scotland and the Royal College of Physicians and Surgeons of Edinburgh. A large number of people and organisations are becoming more openly in favour, but their governing bodies are not always reflecting this in their official stance.

²⁵ C Price 'More than two-thirds of GPs think RCGP should change its stance on assisted dying'. *Pulse*, (2013)

²⁶ Clery, McLean and Phillips (n17). Additional analysis of survey results supplied by Clery, in correspondence with Dignity in Dying, March 2010.

²⁷ YouGov Fieldwork study by the University of Lancaster (2013), http://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/qsaxtu2j4/YG-Archive-University-of-Lancaster-300113-faith-matters-euthanasia.pdf Accessed on 11/03/15.

Vulnerable People

The group of people who might seek assisted dying is amongst the most vulnerable in society and many see it as their duty to protect them. However, only 8 per cent of disabled people believe disability rights groups should maintain their opposition to assisted dying²⁸ and “79 per cent of disabled people support a change in the law to allow the choice of assisted dying for terminally ill, mentally competent adults within strict legal safeguards”.²⁹ It will be shown in chapters one and four, through an analysis of case law and studies, that these are the members of society who would most likely be directly impacted by an AS law, as they are the people who would qualify to use the legislation.³⁰

Religious Groups

It can be argued that opposition to AD comes mainly from those with religious convictions. We cannot fail to acknowledge the religious forces at work in our society’s conflict over abortion. AS is another issue where religious convictions play a significant role in the public debate. The Church of England, the Catholic Church and the Church of Scotland (the largest denomination in Scotland), alongside many other religious bodies all oppose the historic and current bills. Interestingly, many high profile authority figures from religious hierarchies have come out recently in favour, mirroring polls which state that the churches’ congregations do not support the bodies’ official stance. This will be analysed in chapter five.

Chapter one will now provide some analysis on the evolution of the law both in the UK and in other jurisdictions which have passed AD legislation. The law will be considered in relation both to its statutory contributions and to the development of the common law.

²⁸ ‘Dignity in Dying’ Press Release, <http://www.dignityindying.org.uk/press-release/just-8-disabled-people-surveyed-believe-disability-rights-groups-maintain-opposition-assisted-dying/> Accessed on 26/05/14

²⁹ Disabled Activists for Dignity in Dying, <http://www.dadid.org.uk/> Accessed on 26/05/14

³⁰ Under current Scottish and Westminster proposals, the person must be either terminally ill or have a life shortening condition. People in this state of poor health are generally regarded as being vulnerable due to their illness.

Chapter 1: The Legal Position

1.1 Introduction

The evolution of legislation on AD has developed in an incremental way. It is generally recognised that the starting point occurred in the Netherlands in the early 1970s.¹ Today, the Netherlands has been joined by Belgium, Luxembourg, Switzerland and, in the US, the states of Oregon, Washington, Montana, Vermont and New Mexico as jurisdictions which have enacted legal provision to permit assistance at the end of life.² Whilst most have reached this point by different means, it is natural that one looks to the experience of other jurisdictions to inform the recent proposals which have been laid before the Scottish and Westminster Parliaments. This chapter's objective is to outline the legal evolution of AD in the UK by considering historical statutory applications, current proposals and a case law analysis.

1.2 Statutory provisions

It is commonly asserted that suicide has never been illegal in Scotland, although there are no statutory provisions to support this.³ For example, an article published in the *Juridical Review* in the aftermath of the decisions in *R (on the application of Purdy) v DPP* (2010)⁴ stated: 'Suicide has never been a crime in Scotland. There is no Suicide Act or equivalent...'.⁵ Prior to 1961, the law of England and Wales was to treat suicide as contrary to criminal law and, as such, an individual who unsuccessfully attempted to commit suicide could be prosecuted. Section 1 of the Suicide Act 1961 changed this to provide that suicide was not a criminal offence. However, section 2 (1) of the 1961 Act makes it an offence to **encourage or assist** the suicide or attempted suicide of another.

If a person actively assists in helping another to take their life they may be charged with murder or manslaughter in England and Wales and murder or culpable homicide in

¹ This refers to the Postma case where a physician helped her mother to die. See: T Sheldon (2007) Obituary: Andries Postma. *BMJ* 334: 320.

² (n Intro, ref 15)

³ For a helpful summary see J Chalmers (2015) *Assisted suicide in Scotland: (not) clarifying the law*. Available from: <http://schooloflaw.academicblogs.co.uk/2015/02/10/assisted-suicide-in-scotland-not-clarifying-the-law/> Accessed on 22/03/2015. Also, Crown office; "There is no crime of Assisted Suicide in Scotland", final para, <http://www.heraldscotland.com/news/health/i-will-go-to-our-supreme-court-for-the-right-to-die.23383749> Feb 2014.

⁴ *R (on the application of Purdy) v DPP* (2010) 1 AC 345.

⁵ S A M McLean, C Connelly and J K Mason, 'Purdy in Scotland: we hear, but should we listen?' (2009) *JR* 265 at 276.

Scotland.⁶ In England, this could involve a maximum sentence of as much as up to 14 years.⁷ Interestingly, as has been pointed out by Stark,⁸ there is no such maximum sentence in Scotland so the consequences could be even more severe.

The decision on whether to prosecute is one for the DPP in England and the Procurator Fiscal Service in Scotland, taking account of all the circumstances of the case, including the public interest.⁹ The lack of relevant case law, particularly in Scotland, makes it difficult to establish how likely prosecution is to happen in any particular case. A particular public interest factor is the motivations of the suspect – for example, whether the suspect was wholly motivated by compassion or had sought to dissuade the deceased from taking the course of action that resulted in his or her suicide.¹⁰

Legislative proposals draw the attention of both the public and politicians. It is an interesting moment to reflect, given that AS Bills are currently being considered by both the Scottish and Westminster Parliaments.

1.3 Previous Attempts at Legislation

1.3.1 The Patient (Assisted Dying) Bill 2003

The first attempt at legislation to allow AS was by Lord Joffe in 2003. He presented *The Patient (Assisted Dying) Bill* which had its Second Reading in June 2003 but did not proceed any further.¹¹

1.3.2 Assisted Dying for the Terminally Ill Bill [HL]

In 2004 Lord Joffe again attempted to legislate by introducing a bill which aimed to enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make

⁶ Scottish Parliament Information Centre Briefing, Assisted Suicide (Scotland) Bill. January 2015, Pg 8.

⁷ The Crown Prosecution Service ‘Policy for prosecutors in respect of cases of encouraging or assisting suicide’ (2010), http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html Accessed on 25/05/14.

⁸ F Stark ‘Necessity and policy in *R (Nicklinson and Others) v Ministry of Justice*’ (2014) ELR 18 1 104–109 at 7.

⁹ Under section 2(4) of the 1961 Act, the consent of the DPP is required to initiate proceedings for a prosecution relating to assisted suicide. The DPP can also dispense with prosecution if it deems it appropriate.

¹⁰ CPS 2010 Policy (n 7)

¹¹ HL Deb 6 June 2003, cols 1585–1690.

provision for a person suffering from such a condition to receive pain relief medication. It was remitted to a select committee and the final second reading debate was on 12 May 2006.¹² However, on division the Lords voted by 148 to 100 against a Second Reading.

Writing in the *Times*, Lord Joffe commented that the opponents of assisted dying are unwilling to hold a constructive debate and give such legislation a fair hearing. They had so shown

by their conduct at the last hearing of my Bill when they broke a longstanding tradition in the Lords of never opposing a Private Member's Bill at Second Reading. They succeeding in summarily bringing the debate to an end before a detailed examination of its provisions could even take place.¹³

1.3.3 The Coroners and Justice Bill 2008–2009

During the passage of the *Coroners and Justice Bill* (now the *Coroners and Justice Act 2009*), two amendments that sought to amend the law on assisted suicide were tabled. Neither was successful and, on a free vote, the amendments were defeated by 194 votes to 141.¹⁴

1.3.4 End of Life Assistance Bill 2010

In Scotland, the now late Independent MSP Margo MacDonald proposed the *End of Life Assistance Bill* in 2010, which aimed to make it legal for someone to seek help to end their life. This bill would have allowed people whose lives had become intolerable through a progressive degenerative condition, a trauma or a terminal illness to seek a doctor's help in dying. MSPs were allowed a rare free vote on the bill, rather than having to vote on party lines, and it was supported by a number of members from across the Holyrood parties. However the bill was defeated by 85 votes to 16 with two abstentions.¹⁵

1.4 Current attempts at legislation

1.4.1 Assisted Suicide (Scotland) Bill 2013

This bill is currently being considered by the Scottish Parliament.

¹² HL Deb 12 May 2006, cols 1184–1296.

¹³ *The Times* Newspaper. 'Debbie Purdy deserves a less terrible choice', 30 October 2008.

¹⁴ HL Deb 7 July 2009 col 634.

¹⁵ BBC news website, 'How MSPs voted on the End of Life Assistance Bill', <http://www.bbc.co.uk/news/uk-scotland-11893286> Accessed on 12/01/15.

It proposes to allow people with terminal, progressive or life-shortening illnesses to obtain assistance in ending their own life by suicide.¹⁶ It is not within the scope of this thesis to give a thorough examination of the proposed legislation, as this particular bill raises numerous concerns.¹⁷ It is, however, helpful to understand the procedure that an assisted suicide would follow.

There is a three-stage process to be followed before assisted suicide would be lawful:

- **Stage 1:** The person must sign a Preliminary Declaration. This can be made by someone who is in good health.
- **Stage 2:** At least 7 days later, the person must sign a “First Request for Assistance” which must be endorsed by two medical professionals.
- **Stage 3:** At least 14 days later, the person must sign a “Second Request for Assistance”, which must also be endorsed by two medical professionals.¹⁸

At both requests for assistance, the medical professionals must certify that the person is suffering from a terminal, progressive or life-shortening illness and are capable of making a decision to make the request, communicating the decision, understanding the decision, and retaining the memory of the decision.

Only if all of these conditions are passed will a drug or other substance to end the person’s life be prescribed. A licensed facilitator will be assigned to collect the drug from the pharmacy, and provide comfort and assistance for the person when they take the drug or other substance prescribed to help them end their own life by suicide.¹⁹

1.4.2 Assisted Dying Bill

In the last months before the 2015 election, the House of Lords considered the *Assisted Dying Bill*, a Private Member’s Bill introduced by Lord Falconer of Thornton. The Bill is to enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life.²⁰ The Government has indicated that it considers this issue to be a matter of individual conscience.²¹ There was general consensus among those who spoke in the Second Reading debate – whether for or against the Bill – that Parliament needed to properly address the issue following the Supreme Court’s judgment

¹⁶ AS (Scot) Bill 2013, Section 8, (5)

¹⁷ Some concerns are: the age limit being 16, which may be too young to have an AS or be a ‘facilitator’; the time limits between each stage may not give enough flexibility for consideration, ambiguity regarding the role of the licensed facilitator and what their duties extend to; ambiguity over what constitutes ‘assistance’ and how far this extends

¹⁸ AS (Scot) Bill, Part 2, S4-12

¹⁹ AS (Scot) Bill, Section 19, Licensed Facilitators

²⁰ Assisted Dying Bill (HL Bill 24) 2013–2014.

²¹ HC Library. Assisted Suicide. Standard Note: SN/HA/4857.

in *Nicklinson*²² and that the Bill should proceed to Committee for detailed consideration. The Bill was therefore given its Second Reading without division and had its committee stage in the Lords before the end of the Parliament.

The content of the Bill was shaped by the findings of the Commission on Assisted Dying, which was chaired by Lord Falconer. The Commission was established following a tender from two private individuals, Terry Pratchett and Bernard Lewis (both advocates of assisted dying), with support provided by the think-tank Demos. The Commission published its final report in January 2012.²³ It described the current legal status of assisted suicide as ‘inadequate and incoherent’ and proposed that Parliament should consider developing a new legal framework.

Under Lord Falconer’s bill, two doctors, acting independently, would be asked to confirm the diagnosis, indicate that the prognosis is likely to be six months or less and confirm that the patient has been informed of all the available palliative care options, is mentally competent and has formed a settled wish without coercion for an assisted death.

Appropriate training courses would be provided and the National Institute for Health and Care Excellence has offered to provide guidance on lethal medication. Doctors with a conscientious objection to assisted dying would be able to opt out.²⁴

1.5 Considerations

Note that the Westminster bill stipulated that the individual has to be terminal and to have less than six months to live;²⁵ this is the fundamental difference between Lord Falconer’s bill and the Scottish equivalent, which does not impose such restrictions.²⁶ Lord Falconer’s bill also stated that all available palliative care options must be explored. Whilst the Scottish bill may assume this would happen in practice, it does not stipulate it.

Another distinct difference is that the Scottish Bill does not include a ‘conscience clause’ which would allow doctors with moral concerns to refuse to take part in the process. This is not included on the face of the Scottish legislation because, had such a provision been

²² *Q on the appn of Nicklinson v MOJ* [2012] EWHC 2381.

²³ The Commission on Assisted Dying ‘The current legal status of assisted dying is inadequate and incoherent’ (2012), http://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363 Accessed on 14/01/15.

²⁴ Assisted Dying Bill (HL Bill 24) 2013–2014 s2 ‘Terminal Illness’ ss 1 (b) ‘as a consequence of that terminal illness, is reasonably expected to die within six months’.

²⁵ *ibid.*

²⁶ The Scottish bill does include terminal but also life shortening or progressive which Falconer does not, the Scottish bill does not impose any time limit

included in the Bill, it would not have received a statement of legislative competency from the Presiding Officer of the Scottish Parliament and so could not have been considered. This is because the powers to regulate the health professions are reserved to Westminster and are not within the powers of the Scottish Parliament.²⁷

It is argued that the Westminster bill was a much more robust piece of legislation with appropriate safeguards to protect against any unnecessary harm whilst allowing individuals who wish to avail themselves of their afflictions the autonomy to do so. The framework in which it was drafted seems much more likely to achieve acceptance than the Scottish bill's framework. At the time of writing it is not yet known whether either will proceed to become law.²⁸ The significance of these two proposed pieces of legislation will be considered throughout, with particular focus on the recent deliberations of the Health and Sport Committee of the Scottish Parliament.

The interpretation of assistance to die, or indeed the inequity in not being able to receive assistance, particularly for those whose illness may prevent them ending their own lives, has resulted in some poignant but interesting case law which will now be explored.

1.6 Legal position – common law

The development of the common law is essential and its interpretations allow us to fill in some of the uncertainties in an attempt to understand the current law in relation to assisted dying in the UK. There have been some landmark cases in recent years, which indicate that the legal position in the UK is now unclear. This is not only suggested by domestic law but the influences of the Court of Human Rights are now also directing interpretation and discussion in the UK courts. The leading cases will now be given some detailed consideration.

1.6.1 *Diane Pretty v DPP*²⁹

Ms Pretty suffered from motor neurone disease and her condition was such that, without help, she was unable to take her own life. She sought an advance undertaking from the DPP that, if her husband assisted her, he would not be prosecuted. She was unsuccessful,

²⁷ Scotland Act 1998, Sch 5, Section G (2).

²⁸ The Westminster bill had its Committee Stage in the HL in January 2015. No further proceedings had taken place by the time of the dissolution of the parliament. The Scottish Parliament awaits the Health and Sport Committee report before a Stage 1 debate (March 2015).

²⁹ *R v Director of Public Prosecutions ex parte Diane Pretty & Secretary of State for the Home Department (Interested Party)* [2001] UKHL 61.

with the House of Lords unanimously dismissing her appeal, finding that none of Ms Pretty's rights under the European Convention on Human Rights were infringed by the DPPs failure to give the advance undertaking she desired. Ms Pretty then took her case to the European Court of Human Rights, challenging the domestic decisions under Article 2 (right to life) – she argued this included the right to self determination in respect of life and death; Article 3 (freedom from inhumane and degrading treatment); Articles 8 and 9 (right to respect for private life and freedom of conscience); and Article 14 (freedom from discrimination) – she argued that a person without her disease might be physically able to end their lives whereas her incapacity prevented her from doing so.

The European Court of Human Rights ruled unanimously that the UK Government had not violated the Convention. Ms Pretty died 10 days after the ruling.

1.6.2 *Daniel James (2008)*

A different question was posed in the case of 23-year-old Mr. Daniel James. A rugby scrum had collapsed on Mr. James, dislocating his neck vertebrae, trapping his spinal cord and rendering him immediately tetraplegic. Daniel made several failed attempts at suicide before contacting Dignitas³⁰ to request assistance to end his life. There was no ambiguity to whether Daniel had been coerced into this decision. His parents sent documentation on his behalf to Dignitas in Switzerland, made travel arrangements and accompanied their son so that he could receive assistance to end his own life. After his death, the DPP made a public statement noting that whilst there was sufficient evidence for a conviction of Daniel's parents, such a prosecution would not be in the public interest.³¹

The DPP published his full decision on the CPS website. This was the first time that the full reasoning behind a decision not to prosecute an assisted suicide offence had been made public.³²

1.6.3 *Debbie Purdy v DPP*³³

Ms Purdy suffered from multiple sclerosis and she wanted to know from the DPP if

³⁰ Dignitas is a Swiss clinic based in Zurich which assists people to die.

³¹ Bar Council. 'Reforming the law concerning physician assisted suicide: a kind heart but a rational mind', http://www.barcouncil.org.uk/media/61910/liam_loughlin__43_.pdf Accessed on 26/11/14.

³² CPS/DPP, *Decision On Prosecution - The Death By Suicide Of Daniel James*, 9 December 2008

³³ *R (Purdy) v DPP* (2009) UKHL 45.

her husband would be prosecuted under the current law if he accompanied her to Switzerland where she could lawfully be assisted to die.

The DPP stated that he would not create a specific policy for cases of assisted suicide but would consider each case individually in deciding whether or not to prosecute.

Ms Purdy sought judicial review of the DPP's refusal to create this policy, on the ground that her right under Article 8 of the Convention (right to respect for private life) had been violated. Article 8(2) requires any interference with the right of respect of one's private life to be 'in accordance with law'.³⁴

On this basis, all five Law Lords agreed that the right to respect for private life in Article 8 was engaged in the case brought by Ms Purdy. Consequently the Court ordered the DPP to immediately draw up a policy that would clarify when prosecutions would and would not be pursued but their Lordships also ruled that changes in the law on assisted suicide could only be decided upon by Parliament.³⁵

1.6.4 *R (on the application of Nicklinson and another) v Ministry of Justice*

The discussions are brought up to date with Mr Nicklinson, who suffered from locked in syndrome. Again the question was whether his rights under Article 8 could be addressed by the courts or whether this was a matter for (the Westminster) Parliament. Whilst the Supreme Court (SC) dismissed Mr Nicklinson's appeal by majority of 7 to 2. Their Lordships were divided upon:

1. Whether the SC had the constitutional authority to declare that the current law was not compatible with Article 8.
2. Whether a Declaration of incompatibility should be made.

Four Justices³⁶ held that the SC should defer to Parliament on this matter, given the issues involved. It would therefore be inappropriate to consider the question of whether to grant a declaration of incompatibility. Only Lady Hale and Lord Kerr concluded that the SC both had the authority to make a declaration of incompatibility and should in fact do so in this case.

³⁴ Article 8 of the ECHR provides that: 'There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law...'

³⁵ Lord Brown's judgment set out the reasons why a policy was required: 'indicating the various factors for and against prosecution,... to distinguish between those situations in which, however tempted to assist, the prospective aider and abettor should refrain from doing so, and those situations in which he or she may fairly hope to be...forgiven...for giving assistance'.

³⁶ Lord Sumption, Lord Hughes, Lord Reed and Lord Clarke.

Lord Neuberger provided 4 reasons why it would be institutionally inappropriate for the court to consider the issue:

1. Modifying provisions of s 2 of the 1961 Act, ‘raises difficult, controversial and sensitive issues’ which justifies a cautious approach by the courts;
2. Difficulties in identifying compatibility;
3. Acknowledgement of its consideration in Westminster;
4. Any action would be to reverse the H of L decision in *Pretty*.

1.7 Summary

What these cases have demonstrated is that the right to a private life under Article 8 of the ECHR **can** be engaged if there are restrictions placed upon an individual’s end-of-life decision making,^{37, 38} In addition, the right to a private life has to be considered in conjunction with Article 8(2) which provides that any interference with a person’s liberty and self-determination must be in accordance with the law, pursue a legitimate aim and be proportionate. It is the latter which has raised some interesting discussion on whether having a blanket ban on assisting death is disproportionate. It is argued that the current situation is so ambiguous that, as the courts have proposed, legislating in this area is now an appropriate route to take: a difficult task for legislators but one which must be undertaken to give clarity to this area of law.

Following the decision in *Purdy*, England now has the benefit of the DPP guidelines. No such guidance has been given by the Lord Advocate in Scotland, despite calls for the law to be clarified. It is argued by Chalmers³⁹ that the present situation in Scotland is thus ‘hopelessly unclear’ despite statements from the Lord Advocate suggesting otherwise.⁴⁰

During the Scottish Parliament Health Committee’s evidence session in 2010, the Solicitor General reminded us that ‘a prosecutor’s role was to apply the law, not change or innovate

³⁷ See *R(Purdy) v DPP* [2009] UKHL 45, [2010] 1AC 345 and *Haas v Switzerland* 2011 53 EHRR 33.

³⁸ Although the decision in the Swiss case of *Haas* noted, ‘that states had a wide margin of appreciation in such matters’.

³⁹ (n chapter 1, ref 3 at 1.2)

⁴⁰ Following the decision of the House of Lords in *Purdy*, the Lord Advocate, Elish Angiolini, stated that legal guidelines on AS would not be prepared in Scotland. Ms Angiolini said it would be inappropriate for her to publish detailed guidance in light of a separate decision covering England and Wales. ‘It is important to recognise the different legal landscape in Scotland, where involvement in a suicide might amount to homicide, as well as a different system of public prosecution’, <http://news.stv.tv/scotland/125194-no-legal-change-for-assisted-suicide-in-scotland/> Accessed on 02/02/2014

on it by means of a prosecution policy'.⁴¹ This is primarily true and, although it is argued that some form of guidance is long overdue and highly necessary, the final point must be that if the guidance or policies become too detailed then this may result in a fundamental and probably unconstitutional change in the law as it currently stands.⁴²

1.8 Conclusion

The aim of this chapter was to outline the evolution of assisted dying set against a legal backdrop. Lack of statutory provisions and the difficulties as a consequence of this were explored. Historical attempts at legislation in both Scotland and England were considered, before the subsequent current attempts at statutory provisions in both jurisdictions were analysed. A comparison between the two current pieces of legislation was considered before an outline of relevant case law was detailed. It was noted that the relevant difference between the position in England and Scotland is that the DPP has been obliged by the court to produce guidelines on the prosecution of assisted suicide and to date the Lord Advocate has not been required to undertake a similar exercise.⁴³ To conclude, it was suggested that the current legal position in the UK is unsatisfactory and clarification is needed in the form of either guidelines in Scotland or legislation in both jurisdictions.

In the introductory chapter, the role and influence of the professional bodies in any decision-making concerning the introduction of AD legislation has been noted. Chapter two will now consider the unique role that these professional organisations occupy in the United Kingdom and their influence on public policy.

⁴¹SP, Health Committee Report, Stage 1 Report on the End of Life Assistance (Sc) Bill, (2010) at p. 5.

⁴²At the time of writing, a Judicial Review has been submitted to the Inner House of the Court of Session by Gordon Ross, but the outcome is not yet known. See <http://www.heraldsotland.com/news/health/i-will-go-to-our-supreme-court-for-the-right-to-die.23383749>

⁴³ J Chalmers 'Assisted suicide: jurisdiction and discretion' (2010) 14 ELR 295.

CHAPTER 2: Relevance of Professional Bodies in the Assisted Suicide debate

2.1 Introduction

This chapter aims to outline the positions adopted by Professional Medical Bodies in the Assisted Suicide debate, specifically the BMA and the Royal Colleges. Within a healthcare context, few decisions will be taken, including on legislative provisions, that do not involve them in some way or another. They have a marked interest in AS legislation being adopted as current proposals and past attempts at legislation involve medical professionals in crucial roles at some stage in the process of assisting a death.¹

There has long been a history of paternalism in the National Health Service (NHS); some would argue that at times it has been endemic.² Benign and well intentioned it may be, but it has the effect of creating and maintaining an unhealthy dependency which is out of step with other currents in society. Assumptions that ‘doctor knows best’, making decisions on behalf of patients without involving them and perhaps feeling threatened when patients have access to alternative sources of medical information are all signs of paternalism and should have no place in modern health care.³ Yet arguably they do and medical professionals in particular are at pains not to allow complete control of medical care to be removed from their grasp.

Those jurisdictions which have enacted AD legislation operate under professional bodies also and, although they have reached this point by different means, it is natural that one looks to the experience of other jurisdictions to inform the recent proposals which have been laid before the Scottish and Westminster Parliaments. The relevance and influence of the UK professional bodies including the BMA and RCGP in end-of-life discussion and debate will now be analysed. It is argued that this issue is too important to leave to doctors who are often historically reluctant to change⁴ and, although there has been a conscious

¹ The AS (Sc) Bill 2013 involves doctors as it is they who would ascertain capacity and assess motivations to die, manage declarations and requests and ultimately prescribe lethal quantities of drugs.

² BMJ 1999; 319:719.

³ *ibid.*

⁴ The majority of doctors were opposed to the creation of the National Health Service being established in 1948.

shift from paternalism to partnership,⁵ these aspects are arguably still present and will now be discussed in the context of opposition to legalising assisted deaths.

It is suggested that professional medical bodies have a significant and profound impact on the way Scottish society, and particularly those who govern it, draws its conclusions on medical matters. For many, doctors are seen to be at the head of the British medical hierarchy. It is argued that the traditional views of the ‘doctor knows best’ are still very prominent in British society, often stemming from our traditionally deferential attitudes and social mores in general. Because of this, the professional bodies have a strong influence on how people react to moral and ethical issues. It will be shown that the medical profession in the UK still has a strong reliance on tradition, conservatism and deference to the courts. Conversely, it will be shown that the UK public are far more likely to make autonomous decisions concerning AD and, despite the negative views of those bodies representing the medical profession, the public are still showing consistent support for it.

A final question posed in this chapter is that, if other jurisdictions with a robust framework of professional bodies, for example the Netherlands, have managed to pass AD laws then why has the role and influence of these bodies been such an impediment towards the passing of similar legislation in the United Kingdom? One hypothesis is that other parts of Europe and America culturally differ from the stereotypically conservative culture of British society, its medical profession and its courts. This chapter will therefore look at experiences from Oregon and the Netherlands, two jurisdictions which successfully implemented AS legislation by working with the professional bodies, to illustrate that consensus can be reached between professional bodies and public opinion.

The chapter will start by considering Scottish culture, whether this has any significant impact on legislative proposals, and whether the views of a majority of the witnesses called by the Scottish Parliament might be excessively polarised without commensurate representation from organisational representatives and individuals holding objective views on AS. The chapter also aims to determine whether one of the reasons for such reluctance to legislate in the UK may be attributed to the influence of medical professional bodies and a paternalistic culture.

⁵ Enforced, for example, through patient charters and emphasis on rights, particularly post 1997 when the Human Rights Act came into force throughout the UK.

2.2 Scottish Culture

In Scotland, cultural norms surrounding health, the healthcare system and autonomy, differ from those of other jurisdictions in which end-of-life legislation has been passed. As far back as the UK Warnock report,⁶ there was reluctance and opposition towards fundamental change in current practices. Hansard extracts from this time record shock, emotion and distrust toward *in vitro* fertilization.⁷ Some 30 years later, thousands of families have benefited from this technology and fears and distrust now focus on other things.⁸ As recently as the Stage 1 report from the End of Life Assistance (Scotland) 2010 Bill, when observing what had happened in other jurisdictions, it was stated that ‘there are fundamental differences in the culture in which their laws evolved, as well as in the breadth and scope of the legislation’⁹ and ‘Scotland’s culture and existing structures differ from those in other jurisdictions’.¹⁰ This illustrates that the environment in which end-of-life laws have been previously considered and rejected could be very different to that in which the preliminary processes were undertaken elsewhere. Perhaps Scotland is simply not ready for such legislation, although if this is the case the statistics show exactly the contrary with overwhelming public support for a change in the law.¹¹

It is suggested that UK culture and the influence of hierarchical organisations on public opinion are a contributing factor to the failure of laws permitting assistance to end one’s life to reach the statute books. Also, many of the organisations relating to the regulation of healthcare professionals are not based in Scotland. Whilst this may not at first seem a significant point, it has to be set in the context of Scottish culture and Scottish attitudes to health and lifestyle which can be quite different to those of their English counterparts.¹² Finally, of course, Scotland’s health is a devolved issue and the preserve of the Scottish Parliament. In principle, this suggests that the views of the Scottish public should be given their own distinctive legislative expression.

⁶ Between 1982 and 1984, Mary Warnock chaired the Committee of Inquiry into Human Fertilisation and Embryology. Her report gave rise to the Human Fertilisation and Embryology (HFEA) Act 1990, which governs human fertility treatment and experimentation using human embryos. The initial reaction to this report was considerable opposition.

⁷ HFEA (Research Purposes) Regulations 2000. HL Deb 22 January 2001 vol 621 cols15–124.

⁸ For example, the current debate around what is being referred to as ‘3 parent families’.

⁹ End of Life Assistance Bill 2010. Stage 1 Committee report, para 53 ‘Comparisons with other jurisdictions’.

¹⁰ *ibid*, para 253.

¹¹ (n Intro, ref 17, pg. 13)

¹² Some of Scotland’s low life expectancy seems to be down to specific health issues such as higher levels of drinking and smoking than in England. See The Scottish Government, Scottish Health Survey – UK Comparison, 31/08/2010. Also see: <http://samathieson.com/sa-mathieson/uk-male-life-expectancy-mapped-from-glasgow-to-kensington/>.

The role of the state in an individual's right to a private life is becoming an increasing area of discussion and extends beyond the confines of merely a legal framework. In the twenty-first century people live longer, and, in pursuit of regulating the quality of their lives, people wish to ensure that they have a say in all aspects of their health and welfare. Given the power and accessibility of the media, the Scottish public are well aware of the development and consequences of the end-of-life debate in other jurisdictions which have successfully implemented legislation even within states with prominent healthcare professional bodies.

Where the balance of power lies in the political debate will now be analysed; do the professional bodies' abilities to persuade and lobby outweigh the will of a Scottish public on matters concerning the passing of assisted dying legislation?

2.3 Background/Historical Stance

2.3.1 British Medical Association (BMA)

With over 200,000 doctors on the General Medical Council's register, the BMA is the professional association and registered trade union for over half of all registered doctors in the UK.¹³ Therefore the BMA provides a powerful voice representing the medical profession in public debates on ethical issues such as whether or not to legalise AS. The BMA first debated this issue in 1950, when it rejected the idea of euthanasia. Policy reinforcing that view was established in 1969,¹⁴ when the annual representative meeting (ARM)¹⁵ declared that doctors' fundamental objectives must be the relief of suffering and preservation of life. While such early policy statements categorically rejected AS, later ones continued to do so but also acknowledged the existence of a wide spectrum of views within the membership. They also ceased to see preservation of life at all costs as the objective.¹⁶ Other avenues were also explored, and discussion gradually turned to matters of responsibility. In other words, could there be a way of removing the responsibility of doctors to bring about the death of a patient through euthanasia. The definition of assisted suicide partly addressed this, since the final act is carried out by the individual, removing

¹³ BMA website, bma.org.uk. The BMA are very prominent in opposing AD legislation. They are consistently called to give evidence to parliamentary committees and actively and publicly oppose all forms of AD.

¹⁴ S Brannan *et al.* The BMA's *Handbook of Ethics and Law*, 3rd edition (2012).

¹⁵ Annual Representatives Meeting (ARM) is the policy-making body for the BMA.

¹⁶ Brannan (n 14)

doctors from the fatal stage of the process. What has been evident in recent years is the mixture of views within the membership; an acknowledgment of the fact that people's views are not uniform on this matter.

In 2005 its ARM recognised that there were diverse opinions within society and the profession, agreeing that Parliament should decide the issue of possible legalisation. This resulted in the BMA taking a neutral stance on assisted dying. However, in 2006, through a vote at the ARM, it once again reversed this decision, to again oppose any form of legislation.¹⁷ The consensus since 2006 has remained that the law should not be changed to permit assisted dying or doctors' involvement in assisted dying.¹⁸

2.3.2 Considerations: A truly representative stance?

The BMA are supportive of members' views expressed at annual meetings. However, the whole membership has never been surveyed, and meetings can be overwhelmed by particular factions. It is interesting to note that, on two occasions, members have voted against surveying the full membership.¹⁹ Voting follows the BMA's stated procedure and is 'intended to capture a representative **snapshot** of BMA members' views.'²⁰ However, these meetings are not always well attended, allowing voting to be skewed in favour of one faction or another. Also, Dr Peter Bennie of the BMA was chairman of the ARMs and chaired no fewer than six of the annual ethics debates, several of which have dealt with assisted death and assisted suicide.²¹ He was also invited to give evidence to the committee in charge of scrutinising the Assisted Suicide (Scotland) Bill 2013. It is evident that his position is strongly against the Bill and thus his influence at BMA meetings is unlikely to be impartial. It could be suggested that the BMA decision making at these meeting would benefit from a neutral chair when debating ethical issues such AS. It appears therefore that these meetings have not resulted in a legitimate representation of members' views upon which to base BMA policy.²²

¹⁷ HC Library. (n 21, ch.1).

¹⁸ BMA website, 'BMA Policy on Assisted Dying', <http://bma.org.uk/practical-support-at-work/ethics/bma-policy-assisted-dying> Accessed on 25/06/14.

¹⁹ Info from Gail Grant, BMA public affairs manager. Received on 12/01/2015

²⁰ *ibid*

²¹ Dr Bennie declared an interest at 3 Feb Evidence session of the H&S Committee of the Scottish Parliament. <http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9762>

²² Motions relating to AD have been debated at 7 out of the 10 ARMs held since 2003. Other than the move to a position of neutrality in 2005, BMA representatives have voted against adopting a neutral or supportive position; against surveying membership; or in favour of retaining opposition to a change in the law. Numerous divisions have called for either support of neutrality, most recently the Shropshire/Bournemouth division in 2012

2.3.3 Neutrality should be present where agreement is absent

There is clearly discontent and disagreement within the organisation, further proven by the Deputy Chair of the BMA Dr Kailash Chand speaking out in favour of a change in the law.²³ He told *The Observer* in November 2014 that:

No change is not an option, ... The present law definitely needs changing. It discriminates and is very bad law. We currently have a two-tier system – one for the people who have the resources and money to go to the Dignitas clinic in Switzerland and another for the majority of people who don't have the resources or money.

Chand also went on to imply that the BMA was out of step with the public:

Look at the surveys. Between 60% and 70% of the public are in favour of a change in the law. Three-quarters of nurses are in favour. Only the doctors' community is not substantially in favour. But if you ask a doctor a personal question whether, if they were in that sort of situation, would they want it, their answer would be yes.

Further incongruity surfaced when the British Medical Journal (BMJ), the BMA's weekly journal, called for Lord Falconer's bill in England and Wales to become law. Dr Ray Tallis and Healthcare Professionals for Assisted Dying (HPAD) joined the BMJ in calling on medical organisations such as the BMA and the royal colleges to stop opposing assisted dying for terminally ill, mentally competent adults.²⁴

People should be able to exercise choice over their lives, which should include how and when they die, when death is imminent. In recent decades, respect for autonomy has emerged as the cardinal principle in medical ethics and underpins developments in informed consent, patient confidentiality, and advance directives. Recognition of an individual's right to determine his or her best interests lies at the

²³ Seen in, *The Guardian*, Nov 2014. 'Assisted Dying will be made legal in the UK within two years'. Available from: <http://www.theguardian.com/society/2014/nov/08/assisted-dying-will-be-legal-within-two-years-bma-deputy> Accessed on 01/06/2014.

²⁴ BMJ 2014;349:g4349.

heart of efforts to advance patient partnership. It would be perverse to suspend our advocacy at the moment a person's days were numbered.²⁵

Fiona Godlee, BMJ editor in chief, argued that 'legalisation is a decision for society not doctors ... A change in the law, with all the necessary safeguards, is an almost inevitable consequence of the societal move towards greater individual autonomy and patient choice'.²⁶ This call from the BMJ is a significant development in the campaign for reform. The journal is a leading academic publication in the medical profession and support from leading voices in academic medicine is significant if any changes are to present themselves.

The public however will see their official stance as opposed and may believe there is more depth behind their objections than simply the result of a perhaps poorly representative ARM meeting. It is argued that neutrality should be present where agreement between members is absent. However, it is argued by Ilora Finlay, a consultant in palliative medicine in Cardiff and crossbench member of the House of Lords, that: 'Neutrality does not bring balance to the debate. It will tell parliament we see this as an acceptable option'.²⁷ Agreement could be reached if Ms Finlay was speaking about being in favour here but; neutrality means just that – not acceptance. Reasoning precludes thus far that the BMA should not be attempting to influence others by way of their proactive movements to oppose the legislation.

2.4 Other Professional Medical Bodies

It is difficult to gauge medical opinion on assisted suicide, as the available polls tend to focus on euthanasia or on 'assisted dying' more generally. However, the relevant professional bodies and unions (e.g. the BMA, Royal College of General Practitioners, Royal College of Physicians, and the Royal College of Surgeons) tend to oppose assisted dying officially, although this opposition has been contended in some quarters. For example, a recent survey found that two-thirds of GPs did not support the Royal College of General Practitioners' opposition to assisted dying.²⁸ Similarly, a poll conducted by the Royal College of Physicians found that an increased proportion of doctors polled (32.3 per

²⁵ *ibid.*

²⁶ *ibid.*

²⁷ BBC news website, 'Oppose assisted dying, says BMA', <http://www.bbc.co.uk/news/health-18608965> accessed on 29/02/2015

²⁸ Price (n25 Intro).

cent) supported a change in the law to permit physician-assisted suicide for the terminally ill. More than 21 per cent said they would personally participate in helping a patient end their life.²⁹ However, it should be noted that a majority of respondents (57.5 per cent) still opposed such a change in the law.³⁰

There are a vast number of royal colleges; analysis of them all individually would not be relevant or practical for this discussion. General practitioners are often the first person that someone will visit when considering end-of-life issues. The reasons for this are unsurprising: the individual may have been part of a practice for some years and would feel more comfortable having this discussion in familiar surroundings; the doctor would know the patient's medical history and sometimes their values and preferences beyond that of the clinical.³¹ Choosing a GP to talk to also takes it out of the family circle, often an important consideration for someone not wishing to place such a burden on loved ones. The Royal College of General Practitioners (RCGP) is the professional body which represents doctors in the UK, so it is to this organisation that we will now turn.

2.4.1 Royal College of General Practitioners

General Practitioners are at the forefront of any healthcare provision in most jurisdictions worldwide.³² Additionally, as can be demonstrated in the current Scottish provisions, it is they who would ascertain capacity and assess motivations to die, manage declarations and requests, and ultimately prescribe lethal quantities of drugs.³³

The RCGP's is the largest membership organisation in the UK solely for General Practitioners (GPs), with over 49,000 members, making it the most representative voice in the UK for GPs. Historically, the UK branch of the RCGP has been opposed to AD; between May and October 2013 the RCGP ran a consultation on it.

²⁹ Royal College of Physicians, 'RCP reaffirms position against assisted dying', <https://www.rcplondon.ac.uk/press-releases/rcp-reaffirms-position-against-assisted-dying> Accessed on 01/02/2015

³⁰ *ibid.*

³¹ As outlined in the introductory chapter, the doctor-patient relationship is for the majority of people no longer a close, familiar one. The remit of this thesis does not extend to consider the effects of legalising AS on the doctor-patient relationship. No substantial evidence could be found on whether it was adversely affected.

³² Jurisdictions which allow euthanasia all have legislative provisions which rely on doctors to end life and the very definition of 'physician'-assisted suicide makes it clear who has the role in providing such assistance.

³³ If they so wished, they could facilitate a death as a 'licensed facilitator' although it could not be for one of their own patients.

This consultation was one of the most extensive ever conducted by the college with a particularly key role being played by Devolved Councils and Faculties in ensuring members across the UK were given opportunities to express their views. A significant timeframe was built into the consultation process to allow local and regional organisations enough time to effectively consult members and the consultation was conducted through a range of methods, including debates at local meetings, online polls and individual correspondence.³⁴ The college and its members recognise that the issue of assistance at the end of life is a complicated and highly emotive one and they must be commended for assigning it such scrutiny. This is in stark contrast to the BMA who have not applied the same level of rigorous scrutiny to date but still actively seek to influence policy and the public given their official stance.

More than 1700 members³⁵ responded to the consultation. Of the members who submitted response forms directly to the College, 77 per cent (1309 people) indicated that they felt the College should maintain its opposition to a change in the law, with 18 per cent wishing to see the College move to a position of neutrality, and a mere 5 per cent supporting a move to a position of being in favour of a change in the law.³⁶ However, if the figures are approached from a different angle, the RCGP's consulted its 49,000 members throughout the UK, 1,309 – or 2.6 per cent – remained opposed to any change in the law. If that is presented as a majority, one has to ask how representative that is.

Although a minority of respondents put forward cases to shift the College's collective position to 'neutral' or 'in favour' of a change in law on assisted dying, most respondents were against a change in the law for a range of reasons, including that a change in the legislation would be detrimental to the doctor–patient relationship. This can be interpreted in different ways. On one hand, it gives the patient a chance to open discussion and consider options and prognosis, but on the other, it may lead patients who are already feeling vulnerable to see death as the inevitable and perhaps that the GP is giving up on them.³⁷ It remains a polarised argument but, nonetheless, other jurisdictions have managed to find a resolution.

Once again, consideration has to be given to differences north and south of the border. In contrast to the UK-wide body, the Scottish branch of the Royal College of General

³⁴ RCGP website, 'RCGP announces continued opposition to change in law on assisted dying', <http://www.rcgp.org.uk/news/2014/february/rcgp-remains-opposed-to-any-change-in-the-law-on-assisted-dying.aspx> Accessed on 12/09/14

³⁵ Of a total membership of 49,000.

³⁶ RCGP (n 34).

³⁷ BMA website, 'Assisted dying bill threatens doctor–patient relationship', <http://bma.org.uk/news-views-analysis/news/2015/january/assisted-dying-bill-threatens-doctor-patient-relationship>. Accessed on 24/03/15

Practitioners, after consulting its members, adopted a neutral stance on the 2010 Scottish Bill.

As a membership organisation, RCGP Scotland has consulted with and must reflect the current views of its members in Scotland. Having reviewed comments submitted by members, RCGP Scotland cannot offer a clear statement on the issue of assisted suicide as responses received directly from members are polarised, with equally strong views submitted both in support and against the concepts addressed within the Bill.³⁸

They did not submit evidence to the most recent Scottish bill.

Results of the RCGP consultation contrasts sharply with findings from a recent poll conducted by GP trade magazine *PULSE*, which found that, of 689 respondents, 38 per cent said they favoured the college adopting a neutral stance on assisted dying, while 31 per cent said the college should go even further and support a change in the law to allow doctors to help the terminally ill patients to die in the UK.³⁹ The discrepancies and manipulations between polls and thus their reputability needs some consideration.

2.4.2 Royal College of Nursing

Interestingly, in 2009, in contrast to the BMA and RCGPs, the Royal College of Nursing (RCN) moved to a 'neutral' position on assisted suicide, having previously opposed it.⁴⁰ The decision, voted on by the RCN Council, followed a three-month consultation by the RCN with its members. Over 1,200 individual responses⁴¹ were received; 49 per cent of individuals supported assisted suicide, although a substantial minority of 40 per cent opposed it.⁴² The decision provoked some controversy among nurses; some argued that the consultation process was inadequate and that 1,200 responses out of around 400,000

³⁸ Scottish Parliament Archive 'End of Life Assistance Bill 2010, Written evidence from RCGP', <http://archive.scottish.parliament.uk/s3/committees/endLifeAsstBill/evidence/ELA446.pdf> Accessed on 18/07/14

³⁹ Price (n 25, Intro).

⁴⁰ RCN news release, 'RCN moves to neutral position on assisted suicide', 24 July 2009, http://www.rcn.org.uk/newsevents/press_releases/uk/royal_college_of_nursing_moves_to_neutral_position_on_assisted_suicide Accessed on 01/03/2015

⁴¹ Of a possible membership of 415,000 (info from RCN media office (Kate Vine) on 25/03/15.

⁴² The remaining submissions were either neutral on the issue (9 per cent.) or failed to record a position (1 per cent).

members was not a sufficient mandate for change.⁴³ In 2011 the RCN issued guidance to nurses on how to respond to requests to hasten death.⁴⁴ It is argued that this guidance is far better than the guidance issued by the BMA to doctors which states avoidance in all circumstances and that even holding a conversation about perhaps travelling to Switzerland, an accepted practice for those who are able in our society, is forbidden.⁴⁵ Surely at this point in one's life the medical practitioner is precisely the person to speak about death with?

Professional bodies including the Royal Colleges (GPs and Nursing) have taken their official positions based on surveys of non-representative samples of their members. This raises questions about how representative of members' views these official positions might be, and whether a neutral stance might be preferable in the circumstances. Unlike the Royal Colleges, the BMA has not undertaken its own survey of the whole membership on which to base its official stance, but instead appears to rely on the views of the ARM attendees. There are clearly problems in establishing the reliability of both professional and public views, as the results of opinion polls are similarly open to question. Let us now consider this apparent mismatch between official views and those of the wider population.

2.5 Skewed opinion polls?

The Lords' Select Committee on the 2005 House of Lord's Bill⁴⁶ noted the varying quality and scope of opinion polls involving doctors and agreed that 'most research is superficial in coverage and only a few attempts have been made to understand the basis of the opinions of doctors'.⁴⁷ While this view may limit people's confidence in the opinion polls, they cannot be dismissed entirely. The Committee also recognised that doctors were significantly less in favour of any legal change than the lay public and 'the closer the

⁴³ *Telegraph* Newspaper, 29 July 2009, 'Nurses need to speak up against euthanasia', <http://www.telegraph.co.uk/comment/personal-view/5932050/Nurses-need-to-speak-up-against-euthanasia.html>; and *The Observer*, 26 July 2009 'Christian nurses speak against assisted suicide', <http://www.theguardian.com/society/2009/jul/26/assisted-suicide-christian-nurses-rcn> Accessed on 02/02/15

⁴⁴ RCN website, 'When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death', www.rcn.org.uk/a/410638. See also RCN press release, RCN launches guidance for nurses on assisted suicide, 20 October 2011.

⁴⁵ BMA guidance to doctors issued in 2010 states: 'The BMA advises doctors to avoid all actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt. This means that doctors should not: advise patients on what constitutes a fatal dose; advise patients on anti-emetics in relation to a planned overdose; suggest the option of suicide abroad; write medical reports specifically to facilitate assisted suicide abroad; nor facilitate any other aspects of planning a suicide'. bma.org.uk

⁴⁶ House of Lords, Session 2003–2004.

⁴⁷ House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) [HL] Vol I: Report, HL Paper 86-1, p.80 and Annex 7.

experience of end-of-life patients, the less sure professionals are about the prospect of a change in the law in favour of euthanasia'.⁴⁸ The same view was later echoed by a UK wide survey in 2009.⁴⁹ This finding will be discussed more in chapter three under palliative care concerns. Repeated studies show that doctors' organisations and most UK doctors appear to be opposed to the legalisation of AS, a result which tends to differ markedly from the views expressed by the general population.

However, between 69 and 82 per cent of the public support a change in the law allowing assisted dying,⁵⁰ although, as we have seen, opinion among doctors is more divided. One poll found that around two thirds (65 per cent) of doctors are against legalisation of euthanasia or physician assisted suicide,⁵¹ whereas a more recent poll of 1000 GPs commissioned by Dignity in Dying found that almost two thirds (62 per cent) support neutrality among medical organisations on assisted dying.⁵² This is a good example of why opinion polls are sometimes helpful, but they are not always an accurate or reputable source and they can be interpreted in different ways.

To summarise, it is clear that so far neither the BMA, the Royal Colleges nor public opinion can be reliably ascertained due to the inadequate methodologies used to gather both professional and public views about AS, although successive public opinion polls have produced broadly similar results over many years.

Let us now look at practical applications of such laws and what can be learnt from other jurisdictions. These territories also operate under the hierarchy of professional bodies, similar to that of the UK, but have managed to implement AD legislation and have never seen fit to repeal such laws.

2.6 Oregon and the Oregon Medical Board⁵³

The Oregon Death with Dignity Act (DWDA) was a citizens' initiative first passed by

⁴⁸ *ibid.*

⁴⁹ Seale (n 2, Intro, pg 9) 205–212.

⁵⁰ (n 17, Intro)

⁵¹ Seale (n 2, Intro, pg.9.)

⁵² Dignity in Dying. Doctors.net.uk survey of GPs' attitudes towards medical bodies' positions on assisted dying. May 2012. Accessed on 03/03/15.

⁵³ Oregon Medical Board (OMB) regulates the practice of medicine in Oregon. Including licensing, applications, research, complaints and investigations. The OMB was heavily involved in consultations and drafting procedures for AS in Oregon. The OMB is similar to the GMC in the UK. The GMC is not being studied here as they do not involve themselves in the political debates but only give guidance when the law is established

Oregon voters in 1994 with 51 per cent in favour.⁵⁴ Physicians' views were very mixed following the passing of this legislation but they now report that since the state's DWDA was passed they are more aware of their terminally ill patients' needs. However a commonality of approach can be seen in which 76 per cent of Oregon physicians, whose patients include those with terminal illness, made a positive effort to learn more about palliative care after the Act was passed. Of these physicians, 69 per cent said they had also worked since 1994 to improve their ability to identify depression and other psychiatric disorders.⁵⁵

Thirty per cent of the responding physicians said they had referred more patients to hospice services after the passage of the Act.⁵⁶

A total of 2641 practicing physicians responded to the survey, which was sent to 3981 practitioners throughout the state. An earlier article based on the same survey focused on the characteristics of people who requested a prescription for a lethal medication and physicians who cared for these patients. The new report examined physicians' attitudes and concerns about the Death with Dignity Act and discussions of the act between physicians and patients.⁵⁷

Of the physicians, 4 per cent of those who opposed assisted suicide and 1 per cent of those who favoured the idea reported that a patient had left the physician's practice because of differences in opinion about assisted suicide.

Half of the physicians admitted that they were 'only a little' or 'not at all' confident of their ability to determine a patient's life expectancy, which, under the Act, must be six months or less in order for a lethal prescription to be legal.⁵⁸ This is common theme for concern through all jurisdictions which pass similar legislation. The current Westminster bill requires a life expectancy term but the Scottish bill does not for the reasons cited - that it is not an exact or absolute science.

Of the physicians who discussed the act with patients, 21 per cent said that at least one patient had become more comfortable after knowing the physician's views on the subject. Of physicians who discussed their opposition to the act with patients, 28 per cent and 21 per cent of physicians who talked about their support for the law said that at least one

⁵⁴ Oregon Public Health Department 'Death with Dignity Act History', <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/history.pdf> Accessed on 02/03/14.

⁵⁵ L Ganzini, H D Nelson, M A Lee et al. 'Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act'. JAMA. 2001; 285:2363-9.

⁵⁶ *ibid.*

⁵⁷ 'Oregon Death with Dignity Act May Improve End-Of-Life Care' AJHP 2001;58(12).

⁵⁸ *ibid.*

patient had been comforted by the conversation. It is argued this is one of the best things to come out of any provision: the opening of dialogue, and to be able to discuss options and values which should extend beyond the clinical but should never exclude it.

2.7 The Netherlands and the Dutch Medical Association

A different picture can be seen in the Netherlands where the Royal Dutch Medical Association undertook important steps towards formal delegating of discussion and debate to the broader representation of Dutch society as a whole. Processes and practices therefore developed, throughout the 1980s, in a more ‘ground upwards’ and holistic manner. The organisation took an official affirmative position regarding the legalisation of euthanasia, and called for the elimination of barriers for physicians who intended to report their life-ending acts. It emphasized that only physicians should be allowed to perform euthanasia and that euthanasia can only take place within a physician–patient relationship. The Royal Dutch Medical Association further tried to improve formal societal control of euthanasia through encouraging physicians to report their cases. It introduced their vision on euthanasia for the first time in 1984, describing how physicians could prudently deal with patients’ request for euthanasia.⁵⁹ Dialogue was kept open, to allow review of this policy. In this way, the medical professionals, through their professional organisation, influenced the development of what became known as the ‘due care’ criteria.⁶⁰ This was further consolidated and developed through case law and finally all the component parts came together in statutory form in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

The Dutch approach highlights that if doctors and organisations are willing to openly cooperate they can contribute to the development and enhancement of legislative reform. The current legal system has been shown to be uncertain and untested in Scotland and cooperation rather than resistance from professional bodies should be a vital element of addressing this.

This seems to be the key difference across the jurisdictions. Comparatively, areas which have legislated have done so by working **with** the medical professions, who have openly considered constructive ways to implement the laws. There have clearly been attempts in the UK to work with the medical bodies, by inviting them to give evidence to both the Westminster and the Holyrood parliaments but arguably those who are invited may

⁵⁹ Central Board of the Royal Dutch Medical Association. ‘Vision on euthanasia’ (1984) *Medisch Contact* 39: 990–997. [in Dutch].

⁶⁰ *J Bioeth Inq.* (2009) 6(3): 271–283.

represent a more polarised stance. It was interesting to note that the Scottish Parliament's Health and Sport Committee in 2015 could have invited the Royal College of Physicians Edinburgh who take a neutral stance⁶¹ and could have provided both sides of the argument; instead they invited the Glasgow branch which is opposed.⁶² Similar trends can be seen that the committee invited an overwhelming majority of opposed organisations rather than neutral or supportive bodies⁶³ but 74 per cent of submissions to the Health and Sport Committee in 2014 were supportive of the bill so it was not because of a lack of a positive pool from which to choose.

2.8 Conclusion

First world countries have witnessed the sweeping away of the traditional perspectives surrounding a paternalistic approach to clinical decision-making. This has been replaced by a public who wish to be more actively involved in all decision-making processes regarding their health and wellbeing, including those decisions at the end of life. This however, can sit uneasily with UK culture, which, it is argued, has retained a level of deference to professional groups and organisations. This is particularly so within the practice of medicine and provision of healthcare more generally. Here, the professional bodies have been seen to be conservative in their approach but continuing to exert major influence on the political debate surrounding healthcare.

It has also been argued that this influence may not be representative of the membership of, for example, the British Medical Association. Other organisations, such as the Royal College of General Practitioners, do appear to be more democratic in their representations of member's views. Many are now adopting a 'neutral' stance in an attempt to step back and let the discussion take place out with their particular professional interests. An additional consideration is that many of these organisations will prioritise the needs of the majority of their membership who will live and work outwith Scotland. They may also reflect a culture more suited to the southern part of the UK. This sits uneasily with a

⁶¹ The Royal College of Physicians of Edinburgh responding to the Assisted Suicide (Scotland) Bill consultation in 2014 stated neutrality, See: http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Assisted%20Suicide%20Bill%20submissions/RoyalCollegeofPhysiciansofEdinburghASB410.pdf.

⁶² This particular branch are opposed, see: http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Assisted%20Suicide%20Bill%20submissions/RoyalCollegeofPhysiciansandSurgeonsofGlasgowASB438.pdf.

⁶³ In total, 69 groups or organisations are listed as having responded to the consultation. Of these, 11 agreed with the general purpose of the Bill, 32 disagreed and 26 adopted a neutral stance or did not comment on the purpose of the Bill.

recognised unique Scottish health care culture and even more so when the regulation of health is devolved to the Scottish Parliament.

Other jurisdictions have managed to overcome these hurdles and work collaboratively with the professional organisations to promote a regulation of healthcare which fits the needs of its society.

Chapter 3 will now consider some of the more general arguments for and against legislation which permits assistance to die. This will provide context in which to evaluate the stance not only of the professional bodies but also of other interested parties.

Chapter 3. Arguments for and against Assisted Dying considered in a medical context. The emergence of themes as common concerns.

3.1 Introduction

Chapter 2 has alluded to some of the arguments which indicate the influences that the professional organisations have in relation to discussions and possible legislation for assistance to die at the end of life. This chapter will now consider some of the many arguments which are put forward in favour of or against legalisation in a medical context. Such arguments tend to present themselves in diverse ways but, on more careful consideration, they emerge as themes. A thematic approach will therefore be adopted to review these arguments. In addition, the main contention of this work is to accept that there is public support for such legislation and to examine the various groups which may be impeding legislative advance. The arguments, therefore, will be considered in the light of those which have the most resonance for professional healthcare organisations, and vulnerable and religious groups.

Firstly, this chapter looks at specific arguments against legislation for AS presented in a medical context. It is impossible to consider all the arguments against AS presented by doctors, so the focus will be on the most prominent concerns, namely that of palliative care, rate of uptake of AS, and the Hippocratic Oath, with some more broad themes considered towards the end of this chapter. Challenges to the validity of the basis of arguments against AS will be considered with constructive proposals offered to address the concerns raised.

3.2 Palliative Care

3.2.1 Improved Palliative care will remove the need for AS

One argument which receives repeated and consistent support from all three groups mentioned above is that improved palliative care would make assisted dying unnecessary. It is suggested that this argument is very influential in the Scottish Parliament's (SP) consistent rejection of legalisation of AS. However, since rejecting the 2010 Scottish Bill,

the SP has not undertaken any thorough research into the provisions of palliative care. Thus it is not clear whether they have established if it is insufficient,¹ or ‘needs improvement’ or ‘more investment’ all reasons cited for refusal to pass the previous bill. The last research conducted by them was in 2008,² thus it is argued that they have insufficient contemporaneous evidence to inform their debate about the current Bill and should not again reject proposals on the basis of improving palliative care as an alternative. It could be argued that to reject the current Bill without sufficient objective information about the current provision of palliative care services could raise questions about such a decision.

There is very little research on terminally ill people’s views on assisted dying. However, in 2006 a qualitative study to examine the views of those who were ‘close to death’ found overall support in favour of a change in the law.³ Another study found 9.8 per cent of patients expressed a request for the end of their life to be hastened, and in the majority of cases (74 per cent) the request stayed consistent.⁴

Studies have shown that access to palliative care can be very variable. For those who have cancer, the figure can be as high as 75 per cent, while for those who have non-malignant diseases, the figure can be as low as 20 per cent or only one in five.⁵ However, if palliative care was as good as it could be and as widely available as necessary, if the fear of (future) suffering could be removed, is there still a need to change the law? The UK was ranked first in the world in overall quality of death, according to research conducted by the Economist Intelligence Unit.⁶ Even so, as was concluded by the House of Lords Select Committee Report on the Assisted Dying for the Terminally Ill Bill, there are a number of patients whose desire for medically assisted dying will not be addressed by more or better palliative care.⁷ The National Council for Palliative Care, the BMA and Macmillan Cancer Relief have all acknowledged this fact.⁸

¹ Since rejecting the 2010 bill, the SP has not undertaken any thorough research into the provisions of palliative care as of 2015.

² Duncan McNeil MSP, SP Ev Session, 27 Jan 2015.

³ A Chapple, S Ziebland, A McPherson, A Herxheimer ‘What people close to death say about euthanasia and assisted suicide: a qualitative study’ (2006) *JME* 32 706–710.

⁴ C Seale ‘Hastening death in end-of-life care: A survey of doctors’ (2009) *Social Science & Medicine* 69(11): 1659–1666

⁵ Review of Palliative Care Services in Scotland. Available from: http://www.audit-scotland.gov.uk/docs/health/2008/nr_080821_palliative_care.pdf Accessed on 24/03/15.

⁶ Lien Foundation ‘The quality of death: ranking end-of-life care across the world. A report from the Economist Intelligence Unit’ (2010).

⁷ HL Select Committee: Assisted Dying for the Terminally Ill Bill (2005) HL Paper-86, Volume 1 Report.

⁸ NCPC <http://www.hospice-spccouncil.org.uk/publicat.ons/text/euthanas.htm>, (1997); BMA, Medical Ethics Today: *The BMA’s Handbook of ethics and law*, 2nd Ed. (2004); Macmillan Cancer Relief, ‘End of life issues position statement’ (2003).

3.2.2 AS would lead to a reduction in palliative care

As outlined in chapter two,⁹ opposition to assisted dying is particularly strong among palliative care specialists and geriatricians; this is interesting as these are the specialities in which doctors have most contact with dying people. However not all are opposed and the Scottish Partnership for Palliative Care have adopted a neutral position on the current Scottish Bill.¹⁰ Where opposition is expressed it is usually through an underlying fear that there may be a reduction in palliative care if such acts were legalised.

As noted in chapter two, the BMA established its current policy on AD which focuses very much on the urgent need to improve palliative care across the UK.¹¹ The organisation views assisted dying as ‘distracting attention from other important issues, in particular improving palliative care’.¹² However, there appears to be no evidence to substantiate this argument.

Comparison with other jurisdictions is helpful. In Oregon, for example, the quality of palliative care is considered excellent and the rate of use of assisted dying legislation has been described as ‘very low’ by researchers, who suggest that the reason for this may be the high quality of care provided by Oregon’s hospices.¹³ Investment in palliative care has increased in Belgium and the Netherlands since legislation.^{14, 15} Evidence demonstrates that assisted dying legislation complements palliative care, encourages wider discussions around end-of-life care, increases investment in end-of-life-care, and increases the uptake of palliative care training by health care professionals.^{16, 17}

Reduction in investment/research into palliative care is a major motivation for opposing AS legislation; it could be argued, however, that the provisions of the AS (Scotland) Bill

⁹ Chapter two, (n 48).

¹⁰ M Hazelwood_SP H&S Committee, ev sess 27 Jan 2015., said that the partnership were ‘not able to adopt a position on the principle of whether or not assisted suicide should be legalised. This is because the topic raises issues of a moral, personal and ethical nature’.

¹¹ SP Archive. Written evidence from BMA on AS Bill. Available from: <http://archive.scottish.parliament.uk/s3/committees/endLifeAsstBill/evidence/ELA154.pdf>.

¹² *ibid.*

¹³ Ganzini (n11, Intro).

¹⁴ Centeno *et al.* ‘Facts and indicators on palliative care development in 52 countries of the WHO European region: results of an EAPC task force’ (2007) *Palliative Medicine* 21: 463–471.

¹⁵ Lien Foundation (n 6).

¹⁶ A Brinkman ‘NPTN: palliative care comes under the spotlight in the Netherlands’ (2009) *EJPC* 16(3): 151–153.

¹⁷ K van Beek and J Menten ‘The organisation of palliative care in Belgium’ (2010) 117–136 and K Woitha,, Y Engels, J Hasselaar and K Vissers ‘The organisation of palliative care in the Netherlands’ (2010) 181–195, both in S Ahmedzai, X Gomez-Batiste, Y Engels et al. (eds.) *Assessing Organisations to Improve Palliative Care in Europe* (2010).

would complement palliative care, rather than damage it, and so should be made available to those few individuals who legitimately request it.

Pain is not the only factor in intolerable suffering, and account needs to be taken of emotional responses such as loss of dignity and autonomy. The official report from Oregon shows that reasons for choosing an assisted death centre on the patient's wish to gain control and on their poor quality of life rather than pain. Loss of autonomy (97 per cent), being less able to engage in enjoyable activities (86 per cent) and loss of dignity (92 per cent) are the main reasons for patients choosing an assisted death. Inadequate pain control (10.2 per cent) was much less of a priority.¹⁸

3.2.3 Reporting/Gradual Uptake from other countries

Fears that legalisation of AD may lead to the disregarding of palliative care have not been borne out by evidence from other countries. To illustrate, in Belgium, despite headline of 'euthanasia cases soar by 25% in last year alone',¹⁹ the reality shows that AS deaths in 2013 were under 2 per cent of overall deaths in that year – 1 in every 62 deaths.²⁰ In the Netherlands, just 3 per cent of 2013 deaths were from assisted suicide; in Oregon, it was under 0.3 per cent of deaths. A prudent examination of these figures shows that overall AS deaths in Oregon are still just 0.31 per cent of deaths. If this was replicated in Scotland, then approximately 170 people would die from AS, among overall deaths of 55,000 per year.²¹ This is in contrast to the SP's current projected number of cases, estimated at around 70 to 80 per year.²²

In the Netherlands, Van der Mass *et al.* argue that close monitoring of such decisions is possible, and in a study spanning five years they found no signs of an unacceptable increase in the number of decisions or of less careful decision making.²³

¹⁸ 2010 Summary of Oregon's Death with Dignity Act (2011)., <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> Accessed on 24/03/15.

¹⁹ Welfare Society Territory, Press Release. 'Euthanasia cases soar by 25% in last year alone', <http://www.west-info.eu/cases-of-euthanasia-up-25-in-belgium/> Accessed on 24/03/15.

²⁰ 1816 deaths in 2013 compared with 1432 in 2012.

²¹ This is a personal calculation based on a comparison with the Death with Dignity Act in Oregon.

²² Patrick Harvie MSP quoted this number at the SP H&S Comm ev session on 17 Feb 2015, See also: AS (Scot) Bill 2013, explanatory notes.

²³ Van der Mass *et al.*, 'Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands 1990–1995' (1996) *NEJM*; 335:1699-1705.

Baroness Finlay, in her 25 years experience of working in palliative care, can only recall one instance where someone had a determined and fixed wish to end their life.²⁴ Surely this then represents to her that such a minimal number would request it. A National Survey of Physician-Assisted Suicide and Euthanasia in the United States,²⁵ using physicians in the 10 specialties in which doctors are most likely to receive requests from patients for assistance with suicide or euthanasia, found that a substantial proportion of physicians in the United States in the specialties surveyed reported that they receive requests for physician-assisted suicide and euthanasia, and about 6 per cent have complied with such requests at least once.²⁶ The point to emphasise here is that based on international comparisons a minimal progressive uptake may occur in the UK not a sweeping phenomenon of individuals requesting AS. Concerns regarding uptake have not been realised when one considers other jurisdictions.

3.2.4 Emotional insurance

There are clearly concerns on the part of the medical profession about how the legalisation of AS would impact on their field. It has been illustrated that there is a slow and steady increase in the number requesting it, but a point which may quieten concerns is that not all the individuals who request AS go on to avail themselves. Once again it is helpful to consider jurisdictions which have successfully passed AS laws.

3.2.4.1 Oregon Figures

The availability of the option of assisted dying brings comfort to far more people than actually use it. The Oregon Hospice Association reported in 2007²⁷ that, of the 30,000 people who died in Oregon that year, almost 10,000 considered seeking an assisted death,

²⁴ Baroness Finlay giving evidence to SP H&S committee on 27 Jan 2015,

<http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9750&mode=pdf>.

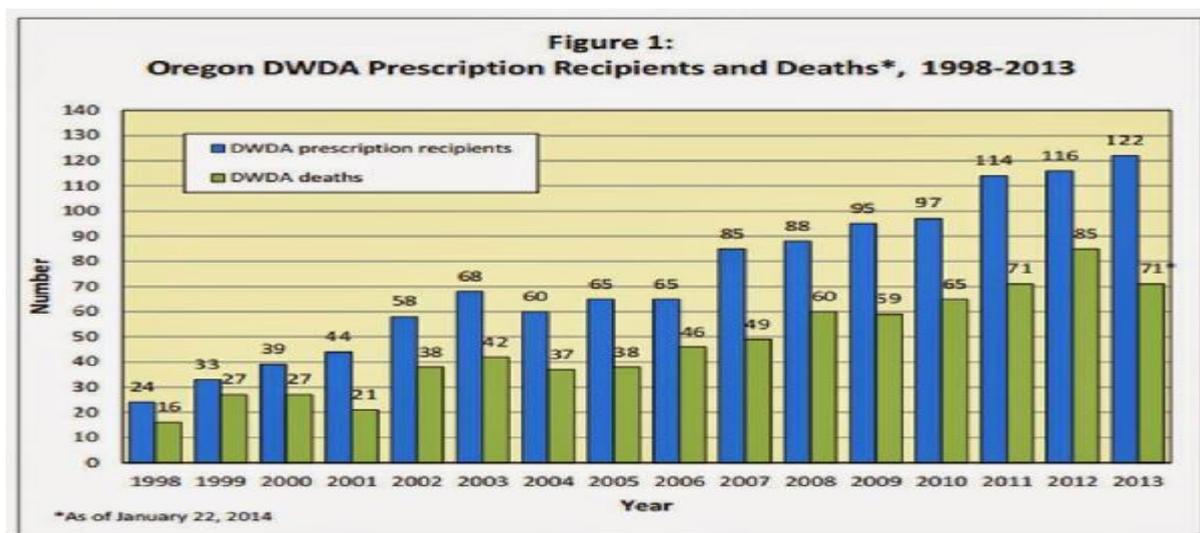
²⁵ D E Meier, C-A Emmons, S Wallenstein, T Quill, R Sean Morrison, and C K Cassel 'A national survey of physician-assisted suicide and euthanasia in the United States' NEJM 1998; 338:1193-1201.

²⁶ 36 per cent and 24 per cent, respectively, said that they would provide a lethal dose if it were legal. Since entering practice, 18.3 per cent of the physicians (unweighted number, 320) reported having received a request from a patient for assistance with suicide and 11.1 per cent (unweighted number, 196) had received a request for a lethal injection. Sixteen per cent of the physicians receiving such requests (unweighted number, 42), or 3.3 per cent of the entire sample, reported that they had written at least one prescription to be used to hasten death, and 4.7 per cent (unweighted number, 59), said that they had administered at least one lethal injection.

²⁷ Ann Jackson presentation (14 October 2009) at Dignity and Choices – a symposium on end-of-life practices. Washington State Choice Political Blueprint: Lessons from Oregon.

around 1,000 spoke to their doctor about getting a prescription, 85 received the prescription and only 49 people actually went on to have an assisted death.²⁸

Oregon citizens who acquire the medication under the terms of their legislation do not always take it.²⁹ In 1998 there were 24 prescriptions written and 16 assisted suicide deaths. By 2012 these numbers had risen to 116 with only 85 used. For many, simply having access to the means to end their life gives them the will to continue to live.



Over the years, the proportion of terminally ill patients opting for an assisted death has remained relatively constant at around 0.25 per cent, although the absolute numbers have increased slightly each year.

It is perhaps no co-incidence that a European-wide study found that patients in the Netherlands had the highest regard and trust for their doctor, with 97 per cent of patients feeling confident in their GP.³⁰ According to Ganzini *et al.*, physicians found that people requesting an assisted death in Oregon are independent, determined and strong-minded individuals who want control over the time and manner of their deaths.³¹ Physicians also stated that their requests to die are forceful and persistent. In reality, rather than passing more power to healthcare professionals, and threatening patient choice by empowering doctors, assisted dying represents a clear shift from doctor-led decision-making to patient autonomy.

²⁸ Dignity in Dying, ‘A matter of facts publication’ (2011), <http://www.dignityindying.org.uk/wp-content/uploads/2013/05/A-matter-of-facts.pdf> Accessed on 01/03/15.

²⁹ In Oregon, almost three years after the law was enacted, just 255 people had obtained a lethal prescription from a physician. Of those 255 prescriptions, 40 were written for terminal cancer patients and only 60 per cent (24 people) chose to use their prescription to hasten their death, <http://health.usnews.com/health-news/news/articles/2013/04/10/physician-assisted-suicide-program-rarely-used-study-finds>.

³⁰ Z Kmietowicz ‘R.E.S.P.E.C.T. – why doctors are still getting enough of it’ (2002) *BMJ* 324 (7328): 11–14

³¹ Ganzini (n55, ch.2).

In summary, it has been noted that in Oregon, the quality of palliative care is considered excellent and the rate of use of assisted dying is very low. Investment in palliative care has increased in Belgium and the Netherlands since legislation.³² In Belgium, at the same time as voluntary euthanasia legislation was passed, a parallel piece of legislation, namely a Palliative Care Act, mandated nationwide coverage and an increase in funding for palliative care. Implementing this made it clear that palliative care was also deemed to be a priority and the passing of the legislation reinforced this to the public at large. If a similar approach was taken in Scotland, this might go some way to allay the fears of the professional bodies and other interested groups.³³

3.3 The Hippocratic Oath

As already noted in chapter 2, the BMA has firmly stated that assisted dying is not a role for doctors. A fundamental and recurring reason given for this is that it contravenes the principles of the Hippocratic Oath. It is argued that a different and more pertinent question should be whether or not the Hippocratic Oath serves any useful purpose in 21st century medicine. Is it just a convenient shield for doctors to hide behind when difficult decisions have to be taken? The Oath is not mandatory for doctors or medical students to take, but the reasoning is that AD is against the principles of the profession and that physicians should not be involved with anything that does not preserve life, their primary function being to come for the benefit of the sick, or, at least to do no harm.³⁴ Medical training and ethos is oriented towards improving and prolonging effective human life where possible, not facilitating its demise although clearly this is not absolute as the profession has gone against other Hippocratic traditions, most notably in relation to termination of pregnancy. However the other side of this argument has been put forward by Kure³⁵ who argues that such a prohibition can be deduced. In other words, any death of a patient that has been brought about by a physician is not in accordance with either the Hippocratic Oath or the spirit of the Hippocratic tradition.

³² (n15 & 16)

³³ Note that Lord Falconers bill requires all palliative care options to be explored

³⁴ W H S Jones 'Epidemics' 1:11 in *Hippocrates*, vol 1, (1923).

³⁵ J Kure 'Good death within its historical context and as a contemporary challenge: a philosophical clarification of the concept of euthanasia' (2011) in J Kure *Euthanasia - The 'Good Death' Controversy in Humans and Animals* (2011).

It can be said that prolonging the process of dying is not in the patient's best interests, as it goes against the ethical principles of beneficence and non-maleficence. Everything should be done to ensure the comfort of a dying patient, which is as important as any earlier attempts to achieve restoration to health.³⁶ This point was further developed by Ivan Illich,³⁷ who highlighted what he saw as the disempowerment of the individual which comes from handing over the power of decision-making and control of life and death to one professional body.³⁸ As Thompson nicely summarises:

The Hippocratic Oath is not the only time-honoured school of ethical and moral thought to be discarded because of inflexibility. Rules stated as always or never are sooner or later discredited by failure to withstand the 'Yes but, what if...?' questions. The Oath's didactic references to abortion and euthanasia are too simplistic to be useful to those seriously debating the professional, political, ethical and religious aspects of these complex topics. Perhaps it is not necessary for a pledge of professionalism to be so specific. If it is necessary, then Hippocrates fails us by omitting mention of stem cell research and genetic engineering.^{39, 40}

3.4 If not the medical professional, who else?

If prescribing a lethal medication with the explicit intent of ending life is really at odds with the role of a physician as a healer, let us consider removing them from the situation. Switzerland has an unusual position on assisted suicide: it is legally condoned and can be performed by non-physicians. Euthanasia is illegal, but there is a debate about decriminalisation that also discusses of participation by non-physicians.⁴¹ What is proposed in the Assisted Suicide (Scotland) Bill is that a licensed facilitator would facilitate the death of the patient but not actually carry out the final act.⁴² This particular section of the Bill has come under much scrutiny and many believe that to leave this matter in the hands of physicians is the safest and most appropriate method.

³⁶ BMJ 1999;319:306.

³⁷ I Illich *Limits to medicine: medical nemesis – The expropriation of health.* (1977) 256

³⁸ *ibid.*

³⁹ R E Thompson 'I Swear by Apollo, the Hippocratic Oath is Obsolete' (2004) *The Physician Executive.*

⁴⁰ The next part seemingly concerns euthanasia (a term which was not coined until a century after the writing of the oath): 'And I will not give a drug that is deadly to anyone if asked, nor will I suggest the way to such a counsel'. Two leading scholars of the Oath, Litte and Miles, have however suggested that this passage alludes to the then common practice of using doctors as skilled political assassins. See: <http://news.bbc.co.uk/1/hi/7654432.stm>.

⁴¹ BMJ. 2003 Feb 1; 326(7383): 271–273.

⁴² AS (Scot) Bill 2013, s. 19 Licensed Facilitator.

More than two-thirds of American doctors object to physician-assisted suicide, according to a 2008 study⁴³ published in the *American Journal of Hospice and Palliative Care*. And Lehmann⁴⁴ argues that removing doctors from assisted dying could make it more available to patients:

I believe patients should have control over the timing of death if they desire. And I suggest rethinking the role of physicians in the process so we can respect patient choices without doing something at odds with the integrity of physicians.

In other words what Lehmann is arguing for is that instead of prescribing the life-ending medication, physicians should only be responsible for diagnosing patients as terminally ill. Finlay concurs with this concept of removing the process from medics but goes further to propose:

the Bill attempts to take the matter out of medicine. That is a good thing to do but, by involving medicine at all, you create a fundamental problem...I suggest that you seriously consider taking any processes for the adjudication of eligibility completely outside medicine.⁴⁵

The involvement of a physician is usually considered a necessary safeguard in assisted suicide and euthanasia. Legislation in Holland, Belgium, and the various US states all require it, as did the legalisation of euthanasia in Australia's Northern Territories.⁴⁶ Within these jurisdictions, physicians are trusted not to misuse these practices; along with pharmacists they are in control of prescription drugs. Physicians are believed to know how to ensure a painless death, and they are in a position to offer palliative care knowledgeably. It would also be reasonable to assume that their patients are reassured by their involvement not only in the death itself but also in the dying process. Under the current Scottish proposals, the role of a third party in the form of a 'licensed facilitator' may be an unnecessary requirement in an already complex legislative proposal, but it may make the medical professionals more willing to consider AS if they were required to share responsibility with another official appointed to oversee the legal process.

⁴³ F A Curlin, C Nwodin, J L Vance, M H Chin, and J D Lantos 'To Die, to Sleep: US Physicians' Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support' (2008) NCBI, *Am J Hosp Palliat Care* 25(2): 112–120.

⁴⁴ Compassion and choices website, 'Assisted Dying: Experts Debate Doctor's Role', <https://www.compassionandchoices.org/tag/oregon-death-with-dignity-act/> accessed on 31/03/2015

⁴⁵ Baroness Finlay, SP H&S Committee evidence session, 27 Feb 2015.

⁴⁶ 'Holland decriminalises voluntary euthanasia' *BMJ*. 2001;322:947

Oregon Death with Dignity Act, Rev Stat 127.800-97.

I H Kerridge and K R Mitchell 'The legislation of active voluntary euthanasia in Australia: will the slippery slope prove fatal?' *JME* (1996) 22: 273–278.

R Watson 'Belgium gives terminally ill people the right to die'. *BMJ*. 2001;323:1024.

The above themes have noted the main concerns relevant to professional bodies and other interested groups. There are, however, other considerations, some which have been addressed in earlier chapters and some which will be further explored in subsequent chapters.⁴⁷ The remainder are discussed below and considered under broad themes which appear prominently and repeatedly in discussions surrounding AD.

3.5 Subjective/Objective considerations: Concerns when things are not absolute

3.5.1 Terminal Prognosis

One concern raised by medical opponents of assisted dying is that it is difficult, if not impossible, to define terminal illness. The point that life expectancy is not an exact science was raised in chapter two.⁴⁸ However, within the UK, we have several definitions of terminal illness. The rules for the Disability Living Allowance⁴⁹ define terminal illness as a progressive disease from which you are not expected to live for more than six months. The Department of Health's End of Life Care Strategy suggests that healthcare professionals use the question: 'Would I be surprised if this patient was to die in the next six months or one year?'⁵⁰

Opponents of assisted dying have argued that it can be very difficult to deliver accurate prognoses for terminal illness. While there is some truth in this, it is a reflection of the nature of medicine, which is always based on an assessment of probabilities. Calculating prognosis and survival time to aid end-of-life decision-making is not an exact science. The complex nature of this work means that healthcare professionals often use their 'gut feeling' rather than a specific tool for determining their prognosis.⁵¹ Evidence suggests that, where errors in prognosis occur, they are far more likely to be overestimates in life expectancy than underestimates, particularly in cases of cancer. Three studies have found that between 63 per cent and 71 per cent of predictions were too optimistic.⁵² It is also

⁴⁷ For example, it is apparent that there are duplicate concerns shared by the parties being studied. Philosophical debates on the slippery slope which is a shared concern will be discussed in chapter 4 and the sanctity of life will be reviewed in chapter 5 in a religious context.

⁴⁸ Chapter two, section 2.6.

⁴⁹ Disability Living Allowance special rules, [http://www.direct.gov.uk/en/ DisabledPeople/FinancialSupport/DG_10011731](http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/DG_10011731).

⁵⁰ DOH 'Life and Death Helping people to live well until they die. General practice guidance for implementing the RCGP/RCN End of Life Care Patient Charter', <http://www.goldstandardsframework.org.uk/cdcontent/uploads/files/Primary%20Care/RCGP%20Matters%20of%20Life%20Death%20-%20Jul12.pdf> Accessed on 24/03/15.

⁵¹ Stiel *et al.* 'Evaluation and comparison of two prognostic scores and the physicians' estimate of survival in terminally ill patients' *Supportive Cancer Care* (2010) 18: 43–49.

⁵² *ibid.*

important to appreciate that a request for assisted dying generally takes place within days or weeks of a person's death, when prognosis is much more secure.

3.5.2 Capacity

As outlined in the introductory section of this chapter, there are concerns that stakeholders in the AS debate have in common. How to assess capacity and how to be sure of intentions is one shared and recurrent concern. This will be looked at in more detail in chapter four in relation to vulnerable people.⁵³ The Mental Capacity Act 2005 and its Code of Practice define mental capacity (also known as mental competency) as the ability of a person to make decisions.⁵⁴ With regard to the mental capacity safeguards in assisted dying legislation, this would mean that, should a person request assistance in dying, they would be deemed mentally competent only if they fully understood the information they requested about assisted dying, retained that information long enough to make a decision, were able to weigh up the information available in making the decision, and able to communicate and understand the consequences of such a decision.

3.5.3 Depression

Another recurring theme specific to medical staff is concerns about the prevalence of depression in patients who have been assisted to die, suggesting that some individuals may choose this option when they are not entirely competent to make the decision. A study from Oregon⁵⁵ examined the prevalence of depression in terminally ill patients who requested assistance to die. Symptoms of depression occurred in 1 in 4 participants who requested assisted dying and 1 in 6 who died had symptoms. However, the researchers acknowledged that some of the indicators used to measure depression may have in fact been measuring the side effects of terminal illness (e.g. loss of appetite). Other researchers also found that a level of 'appropriate sadness' or depression is considered normal in terminally ill patients approaching the end of their life.⁵⁶ Further, whilst more research is

N A Christakis and E B Lamont 'Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study' (2000) *BMJ* 320:469–472.

S Gripp, S Moeller, E Bolke *et al.* 'Survival prediction in terminally ill cancer patients by clinical estimates, laboratory tests, and self-rated anxiety and depression' (2007) *Journal Clinical Oncology* 25:3313–3320.

⁵³ Chapter 4, section 4.2.1.

⁵⁴ Mental Capacity Act (2005) Code of Practice, Section 4. 2007.

⁵⁵ L Ganzini, E Goy, and S Dobscha 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey' (2008) *BMJ* 2008;337:a1682.

⁵⁶ *Ibid*

needed on how depression may affect the decision-making of terminally ill patients, the existence of depression does not necessarily mean that a person lacks mental capacity. Although studying depression is relevant to medical staff, it is also relevant to vulnerable people and will be discussed further in chapter four.⁵⁷ It is argued that building in a compulsory evaluation with a specialist consultant psychiatrist as part of future legislation would resolve this issue.⁵⁸

3.3 Conclusion

This chapter has provided a thematic overview of reasons for and against legislation as they present themselves in a medical context. For palliative care, the recurring view is that less attention will be given to its enhancement if AD legislation is in place. However, statistics have shown that, in jurisdictions where AD legislation exists, this is not the case. The numbers who use the legislative provisions remain fairly constant and small, and in fact in some instances the reverse has been shown and there has been increased investment. Where legislation exists, people will take comfort from the fact it is there but will not necessarily take that final step of utilising it. Some jurisdictions, notably Belgium, have introduced parallel legislation to enhance the provision of palliative care.

The Hippocratic Oath has existed as a philosophical construct for nearly 2000 years and, whilst this still occupies a place in twenty-first century medicine, its usage and relevance has changed. Many of its provisions have either been ignored or contextualised and its prohibition on the taking of life should not be used by the medical profession as a reason not to be involved in decision-making at the end of life. Earlier chapters have shown that the courts now recognise that how we choose to die is a necessary consideration in how we live our lives.

Most jurisdictions do see a role for physicians in AD. It is generally considered that, as a profession, they are best placed to be able to provide medical opinion on diagnosis, prognosis and state of mind. Their involvement, however, differs from jurisdiction to jurisdiction, and Switzerland provides an example of where the physician's role is limited.

Definitions of terminal illness may be challenging but they can be settled within a legislative context. Rationality of choice remains a predominant theme in whether we can

⁵⁷ Chapter 4, section 4.2.1.

⁵⁸ The current Scottish bill does not require a psychiatric assessment and puts the onus to assert capacity on doctors. It does however allow a referral by a GP to a psychiatric specialist if they think it necessary.

ever choose to end life rationally, if we are in either an emotional state or lack capacity. It is suggested that this argument is impossible to resolve. Our choices are affected by so many things, why should they not also be affected by our health, wellbeing and quality of life.

The fact that death has become more medicalised and institutionalized in the 21st century cannot be ignored. It is no co-incidence that we now talk of ‘battling disease’, and ‘fighting’ cancer, seeing this as something to be overcome at all costs. The issue ultimately is what happens when it cannot?

Chapter four will now consider the second interested groups of people in the debate on AS, those who may be considered to be vulnerable.

Chapter 4: Considerations in the AD debate specific to vulnerable groups

4.1 Introduction

This chapter's objective is to consider the arguments against legislation put forward by those groups of people whose concerns about the legislation centre on the alleged 'vulnerability' of persons who might wish to end their lives with assistance should a future need arise.¹ This chapter argues that these groups have had a significant impact in preventing any form of AS legislation from being passed. Individuals or groups in this category are particularly worthy of scrutiny because of the amount of detailed consideration both the Westminster and Scottish Parliaments afford them. Interest groups representing disabled people in particular have been continually invited to give evidence to committees at the Scottish Parliament. In justification for not supporting previous bills, members of parliament, repeatedly cite the fear that such a law will have a negative impact on the so-called vulnerable members of society.²

This chapter begins by setting the scene and considering British culture again, this time in the context of how we view impairment and its relationship with AS. A case study of societies representing vulnerable people that recently submitted evidence to the Scottish Parliament will be analysed in order to see what direct concerns they raised. Many vulnerable people are not physically able to take their own lives if they wish to do so, so it is argued that this is one group that AS legislation could potentially be of use to. Practical applications of the current Scottish proposals will be discussed in order to consider how vulnerable people would actually be affected by this legislation.

As discussed in chapter three, distinct themes reflecting common concerns about AS legislation emerge from submissions to the SP: the slippery slope argument and interrelated medical and religious arguments.

It is the slippery slope argument that is most commonly discussed in the context of vulnerable people and so it will be in this chapter. Other recurring themes shared with

¹ Vulnerability is defined as: 'Exposed to the possibility of being attacked or harmed, either physically or emotionally. A person or group in need of special care, support, or protection because of age, disability, or risk of abuse or neglect'. Oxford Dictionaries 2015.

² Stage 1 official report on End of Life Assistance bill outlined considerable concerns for disabled people and recommended rejection of the bill,

<http://archive.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm#60>

other groups, concerned with abuse, coercion and being a burden, will also be explored. As discussed in chapter one, under legal considerations, most case law has developed from cases involving vulnerable people, so it is this group who could potentially be most affected by AS legislation. The aim here is to develop counter arguments in the hope of putting the minds at rest of those who are concerned for the wellbeing of vulnerable groups, by looking at practical applications from other countries.

Consideration will now be given to vulnerable groups and individuals in the context of the current ongoing AS debate in Scotland.³

4.2 Culture

Society today is increasingly seeing impairment, disability and aging as facets of life to be avoided. This is evidenced through advances in the genetic sciences indicating the possibility that we can have impairment free children, that it is acceptable to discard embryos with genes that may lead to disabling impairments, that we will eradicate aging and that we will soon be able to alter genes so that many of life's problems will be solved.⁴

Because of medical advances, society has also grown less and less tolerant of pain and suffering. The medical profession is believed capable of finding a solution to most problems we may encounter. Death is an infrequent visitor to families as we live longer and are more likely to survive birth, infections and childbirth. As was outlined in the introductory chapter of this work, when death does occur it is more likely to occur in an institutional setting.⁵ But in reality, the medical profession cannot be infallible and, towards the end of their lives, people do not always receive the necessary treatment or they will suffer pain and indignity. Not all vulnerable people have adequate support, either financial or personal, and many live highly restricted, solitary and poverty-stricken lives,⁶ but there are many who do and enjoy a full quality of life.

The British Social Attitudes Survey consistently finds that 80 per cent of the population of the UK supports assisted dying for terminally ill adults.⁷ Vulnerable people usually fall into the groups of people portrayed as opposed, but have been shown to be largely

³ Note that the potential threats against vulnerable groups in Scotland will differ from those in other jurisdictions. A disabled or elderly person in the poorest parts of Glasgow is not going to be at risk of an unscrupulous relative coercing them to have an assisted suicide for want of inheritance that may come their way. This could be the case in more affluent areas of the country.

⁴ R Hurst, DAA The International Disability and Human Rights Network. 'Assisted suicide and disabled people – a briefing paper' Available from: <http://www.daa.org.uk/uploads/pdf/Assisted%20Suicide.pdf>.

⁵ (n6, Intro).

⁶ DAA 'Assisted Suicide. The point of no return'. Available from: <http://www.daa.org.uk/index.php?page=bioethics> Accessed on 25/02/15.

⁷ Clery (n16, Intro).

supportive of assisted dying for terminally ill people, with 75 per cent of disabled people⁸ believing this should be allowed. This indicates that disabled people recognise that they will eventually become terminally ill just like the non-disabled population. However support for assisted suicide for disabled or incurably ill adults who are *not* terminally ill is consistently found to be lower at around 40 per cent.⁹ This was of direct relevance in the case of the disabled individual in *Purdy*¹⁰ which was discussed in chapter one.

4.2.1 Interest Groups which may be affected

For the purposes of this thesis, particular attention was paid to those groups who submitted evidence to the Scottish Parliament, voicing concern about how the proposed legislation would negatively impact upon them. A summary now follows.

Inclusion Scotland: The focus of this submission was the argument that disabled people already face many disadvantages and prejudicial attitudes which undermine their quality of life more than their impairments do, and that the focus should be on addressing those other factors rather than facilitating them in dying.

There is a notable absence of emphasis on the ‘voluntary’ principle in submissions to the Scottish Parliament against the AS Bill. But the Bill in its current draft may be open to misinterpretation leading to misunderstanding as to its purpose by some disabled people. It is essential that disadvantages and prejudicial attitudes faced by disabled people are addressed in order to improve the quality of their lives. The current Scottish AS Bill has a rather broad focus and would benefit from more specificity about precisely who would be eligible to apply for AS, ensuring that a future law would specifically exclude people from eligibility for AS on the grounds of disability only. A voluntary option to end lives should only be available for people at the end of their lives whose suffering is both intolerable and irremediable. This is a very different focus, and totally separate from people suffering from poor service provision or stigma imposed by society. Disabled people eventually become terminally ill, like everyone else, and only then would an AS law have any relevance to them, in the same way as it would to any other member of society.

⁸ (n25, Intro) Clery et al. Additional analysis of survey results supplied by Clery E, in correspondence with Dignity in Dying, March 2010

⁹ *ibid.*

¹⁰ *R. (Purdy) v Director of Public Prosecutions* (2010) 1 A.C. 345.

Scottish Youth Alliance (SYA):¹¹ The SYA opposes the Bill on the grounds that it continues to rely on criteria that particularly target the disabled; and that there is no evidence that providing a legal mechanism would reduce the incidence of illegal ways to assist suicide or practise euthanasia. The introductory chapter to this thesis outlined that in the UK 0.21 per cent of deaths attended by a medical practitioner were the direct result of voluntary euthanasia. 0.3 per cent of UK deaths were as a result of non-voluntary euthanasia.¹² Therefore the SYA's statement is somewhat biased, as it has been shown that legalising such practices reduces the instances of abuse.¹³ Countries that have regulated assistance to die have seen the incidence of non-voluntary euthanasia significantly fall. In the Netherlands, non-voluntary euthanasia fell from 0.8 per cent of deaths in 1990 to 0.4 per cent in 2005, and, in Belgium, non-voluntary euthanasia fell from 3.2 per cent of deaths in 1998 to 1.8 per cent of deaths in 2007.¹⁴ There are also strict safeguards in place in the current Scottish bill to prevent this, for example a pre-registration document, numerous assessments with doctors, nobody who could financially gain from the death allowed to be involved and so on.¹⁵

The submission also refers to fears of a slippery slope, and questions the argument that a Bill is needed to bring clarity to the law. The SYA refers to the Solicitor-General's evidence to the End of Life Assistance Bill Committee in 2010, that providing lethal drugs for a person to self-administer could still be regarded, in law, as killing, since the voluntary ingestion would not 'break the chain of causation'.¹⁶ However, this is precisely why a Bill is required – to ensure that people who play a part in assisting a terminally ill person to die near the end of their life are not vulnerable to prosecution (as they otherwise would be).

Alzheimer Scotland: The Alzheimer submission opposes the Bill, arguing that the priority is to improve palliative care. It points to continuing stigma associated with dementia, which may make sufferers more likely to wish to end their own lives, and suggests that people with Alzheimer's can more easily be made to feel that they are a burden to others.

¹¹ When researching this association, no trace of their existence was found. Further investigation found that the Scottish Parliament who called this 'group' to give evidence were not aware of their background or that they are a non substantive organisation. Because this non-existent 'association' was invited to give evidence apparently under false pretences the slot was not available for Parliament to receive submissions from a substantive organisation rather than one individual with vested interests in opposing the Bill.

¹² (n2, Intro).

¹³ A Van der Heide, M Rurup, J Hanssen-de Wolf *et al.* (2007) 'End-of-life practices in the Netherlands under the Euthanasia Act' *NEJM* 356(19): 1957–1965. J Bilsen, J Cohen, K Chambaere *et al.* 'Medical end-of-life practices under the euthanasia law in Belgium' (2009) *NEJM* 361(11) 1119–1121.

¹⁴ *ibid.*

¹⁵ AS (Scot) Bill 2013, Part 2 Safeguards, Essential Safeguards.

¹⁶ The Solicitor General for Scotland made clear in his evidence that the chain of causation is not broken by voluntary ingestion. Supplying lethal drugs is sufficient causation. Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report*, 28 September 2010, col 231.

The negative impact of legislation on palliative care was disproved in chapter three¹⁷ and the idea of being a burden will be explored later in this chapter under subheading 4.4.2 Duty to die.

In summary, a theme is emerging that highlights the importance and influence of this group. It is not just vulnerable people themselves who see this as adversely affecting them, as evidenced in the following from the American College of Physicians:

Both society in general and the medical profession in particular have important duties to safeguard the value of human life. This duty applies especially to the most vulnerable members of society – the sick, the elderly, the poor, ethnic minorities, and other vulnerable persons. In the long run, such persons might come to be further discounted by society, or even to view themselves as unproductive and burdensome, and on that basis, ‘appropriate’ candidates for assistance with suicide ... the ramifications [of legalisation] are too disturbing for the ... value our society places on life, especially on the lives of disabled, incompetent, and vulnerable persons.¹⁸

Supporters of these statements also come from what is termed ‘pro-life’ groups¹⁹ whose aim is to prevent AS laws from being passed. Again their viewpoints carry substantial weight as they are well-organised, wealthy groups who appear before parliaments and feature prominently in the media. Some examples of these are given below.

CARE for Scotland: CARE responded to the Health and Sport Committee’s call for evidence stating that ‘to describe a life with disability and a dependence on carers as lacking in basic human dignity is deeply flawed’,²⁰ but nowhere does the Bill or accompanying documents suggest this. Evidence given in favour of the Bill shows that people often find the advanced stages of debilitating illnesses/conditions undignified, and that regaining control over one’s own death is partly about retaining that sense of dignity. Personal dignity is a quality of life issue that people value, and is distinct from any concept of fundamental or inherent human dignity. It is possible to believe that a person can never

¹⁷ AS would lead to a reduction in palliative care. (n14 –18, ch3).

¹⁸ L Snyder and D P Sulmasy, for the Ethics and Human Rights Committee, American College of Physicians–American Society of Internal Medicine ‘Physician assisted suicide’. *Ann Intern Med* 2001. 135209–216.216 [PubMed]

¹⁹ Not Dead Yet UK, Care Not Killing (CNK), Living and Dying Well and CARE for Scotland.

²⁰ CARE for Scotland written ev to SP. Page 1, Qu. 1, http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Assisted%20Suicide%20Bill%20submissions/CAREforScotlandASB393.pdf Accessed on 25/03/15.

lose their inherent human dignity, while recognising that towards the end of life undignified situations brought about by disease can cause great distress.

CARE suggests that the subjective nature of the ‘quality of life’ criterion²¹ could result in depressed people being given assistance to end their lives, a view shared by the professional medical bodies as outlined in chapter three.²² Another concern shared with the professional bodies is that of capacity,²³ and the submission goes on to say (in the context of the lack of a requirement for psychiatric assessment) that, although the definition of capacity excludes people with a mental disorder from access to AS, ‘there is no mechanism’²⁴ to prevent people with depression requesting assisted suicide. But the Bill’s definition of capacity excludes persons with a mental disorder which might affect their ability to make a considered request. Under the Mental Health (Care and Treatment) (Scotland) Act, depression is defined as a mental illness. If a person’s depression is such as to ‘affect the making of the request’, they will not be eligible. It is an ongoing debate whether the presence of disease, whether mental or physical, impairs our ability to make a rational choice.²⁵

It has also been argued by CARE that the definition of capacity would not exclude those with a dependence on alcohol or drugs. But it is not clear why this should (on its own) be a disqualifying factor and arguably it cannot be assumed that all alcohol and/or drug abusers are necessarily mentally incompetent. Concerns have been raised that capacity is not static, and can come and go – but this is precisely why the Bill requires it to be assessed by two separate doctors at both request stages (which must be at least 14 days apart).²⁶

It is evident that there are genuine concerns raised by pressure groups. But, as previously, discussed, there is a substantial majority, including groups and individuals classed as ‘vulnerable’, who support the enactment of legislation.²⁷ However, it appears that the views of those opposing the Bill on disability grounds may have been weighted more positively than those of disabled people in favour of the legislation. It is suggested that, while the selection of groups to give evidence to the debate was even handed, amongst

²¹ AS (Scot) Bill 2013, Section 8(3)(d): has, after reflecting on the consequences for the person of the considerations set out in subsection (4) and in light of that reflection, concluded that the quality of that person’s life is unacceptable.

²² Chapter three, section 3.5.3.

²³ (n60, ch3).

²⁴ (n19, ch3).

²⁵ It is a contentious issue that the current Scottish proposals do not require a psychiatric assessment at any stage. However, GPs assess capacity as part of their day to day duty of care and it is open to them to refer on to any specialist if they see it fit to do so.

²⁶ AS (Scot) Bill 2013, Part 2 Safeguards, Essential Safeguards.

²⁷ These include Disabled Activists for Dignity in Dying and Scottish Disability Equity Forum.

those opposed to legislation the arguments tended to rely on hypothetical situations based on ‘what ifs’ as opposed to factual evidence about their member’s views. ‘Many legal barriers to end-of-life care are more mythical than real, but sometimes there is a grain of truth.’²⁸

The cases highlighted in chapter one attracted a great deal of media attention and there is little doubt that they will have shaped public views and opinion.^{29, 30} Saunders³¹ argues that initially people agree that legislation, on the face of it, should be passed. However, he argues that once people are fully informed and have considered and balanced the views of all interested parties, then the majority change their opinion. This point was highlighted at note 8 in this chapter, where we see support for AS dropping from 75 to 40 per cent when the person is not terminally ill. However, there is little evidence to support the contention that people do not change their minds once they have experienced the deaths of partners, relatives and friends, or when they become terminally ill themselves. But as a long term anti-AS activist, who has consistently opposed any attempts toward legalisation, Saunders’ bias against AS is well documented if unsupported by valid research.³²

4.2.3 Vulnerable groups: the *need* for Assisted Suicide

Otlowski³³ states ‘it is reasoned that where the patient is capable of performing the death-inducing act, there is no justification for others to do what that patient can do for him or herself’.³⁴

Explaining the decision in *Nicklinson*, Lord Justice Toulson, said such cases were ‘deeply moving’.³⁵ However, as earlier discussed,³⁶ they provided no remedy in law for the

²⁸ A Meisel, L Snyder, T Quill, for the American College of Physicians-American Society of Internal Medicine End-of-Life Care Consensus Panel ‘Seven Legal Barriers to End-of-Life Care Myths, Realities, and Grains of Truth’ JAMA (2000);284(19):2495–2501.

²⁹ Further public supporters of AS include: Baroness Warnock, Baroness Brinton (disabled), and Lord Low of Dalston (disabled) all spoke in support of Lord Falconer’s Bill. Both Stephen Hawking and Melanie Reid, the *Times* columnist, also support AS, Stephen Hawking having been previously opposed. The influence of pro-choice celebrities are also likely to sway public opinion in favour.

³⁰ M Judd and C Seale ‘Joining a right-to-die society: Motivation, beliefs and experiences’. *Mortality*, Vol. 16, No. 3, August 2011.

³¹ Dr Peter Saunders, 3 Feb 2015, H&S Committee oral evidence session.

³² *Mirror* Newspaper (August 2013) ‘Euthanasia: the right to die can so easily become the duty to die’ Available from: <http://www.mirror.co.uk/news/uk-news/euthanasia-right-die-can-easily-2182129> Accessed on 27/03/14.

³³ M Otlowski ‘Voluntary euthanasia and the Common Law’ in M Stauch and K Wheat with J Tingle *Text, Cases and Materials on Medical Law and Ethics*. 4th edition. 2012, at p 613

³⁴ *ibid*.

³⁵ Q on the appn of *Nicklinson v MOJ* [2012] EWHC 2381. Toulson judgement at paragraph 50, conclusions. Full judgement available from: <https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Judgments/nicklinson-judgment-16082012.pdf>.

³⁶ Chapter 1, section 1.6.4.

plaintiffs.³⁷ It is argued that, in a civilised society such as the UK, it may be considered uncivilised and wrong for authorities to ignore a suffering individual when the legal recourse available to the claimant has been exhausted or failed to provide a remedy.

It is unsurprising that many of the legal challenges to UK law have come from disabled people. It is they more than anyone that need to rely on assistance from others because they are not in a position to end their lives themselves.

Saunders, notes that ‘This is not about the right-to-die, this is about a right to enable a third party to actively terminate his life for him’.³⁸ But here Saunders refers to an act of euthanasia, not assisted dying where the dying patient actively terminates his own life. This may be precisely the problem that people can accept and are sympathetic towards a terminally ill person who commits suicide or wishes to die because of an understandably intolerable life. It may be that implicating others in that act sits particularly uncomfortably with the courts and legislators. How to deal with the other party involved, assess their motives, uncover the scope of their ‘help’, ‘assistance’ ‘facilitation’ is no doubt a particularly difficult area to quantify. But it is argued that it is not beyond the remit or the capabilities of the law or crown office to do this. That is, in fact, precisely their purpose.

4.3 How would a Bill affect the vulnerable - Under current Scottish proposals, are they eligible?

The Assisted Suicide (Scotland) Bill 2013 would currently allow a wide scope of application. The criterion of suffering from a terminal or life-shortening illness or a progressive condition³⁹ must be satisfied but the latter part of this condition is open to very broad interpretation. It is not within the scope of this thesis to analyse the proposed legislation in depth, but it is helpful to consider a practical application based on the proposed Bill.

Loose and relative terms such as ‘life-shortening condition’ mean that tens of thousands of seriously ill and disabled people throughout Scotland would be eligible⁴⁰ and that people with conditions such as diabetes would qualify. This may seem an extreme example but it

³⁷ The case was contested on the issue of ‘necessity’ arguing that the only way to end Mr Nicklinson's suffering is to allow him to die. This argument was used in 2000 when conjoined twins were separated, saving one twin even though doctors knew the other would die.

³⁸ BBC news website, Tony Nicklinson loses High Court right-to-die case, <http://www.bbc.co.uk/news/health-19249680> Accessed on 31/03/15

³⁹ AS (Scot) Bill, Section 8, First Request for Assistance Section (5) (a) and (b).

⁴⁰ ‘Care not killing’ written submission and oral evidence session to H&S Committee 2015.

is true that people with type 2 diabetes can expect to live 20 years fewer than someone with average life expectancy.⁴¹ Life shortening or progressive conditions are not useful terms, as when practical application is applied, all lives are inevitably limited.

Another issue about terminology in the current draft of the Bill concerns the inclusion of ‘unacceptable quality of life’,⁴² assessed largely on the subjective judgement of the applicant. In contrast to the Scottish bill, the Westminster bill contains very specific and strict safeguards – the person must have a terminal illness and be reasonably expected to die within six months. The definition of ‘terminally ill’ in the Falconer bill, although equally difficult, crucially includes the phrase ‘within six months’. The reliability of a specified time limit has already been noted as impossible to predict with certainty; at best it can only be a ‘guestimate’ but its greater specificity is aimed toward addressing some concerns about protecting vulnerable people from coercion to seek an AS. Having stricter safeguards with tighter terminology in the Scottish Bill would help ensure vulnerable people were protected from pressure from unscrupulous others, while not excluding them from access to AS if they fulfilled all legal requirements

The breadth of possible interpretation suggests that concern for the vulnerable is warranted and justified. The current draft of the Scottish Bill is too loosely drawn so that many might fulfil the criteria for assisted suicide even if they were not nearing the end of their lives. The question then arises of who should be in a position to decide who should and should not be allowed to utilise this legislation. Currently it could be argued that this piece of legislation gives autonomy to the individual requesting the Assisted Suicide; it is for them to initiate proceedings, and for two doctors to agree whether they fit the criteria. This is arguably the most fitting arrangement.

As set out in the introductory section, the aim of this chapter is to disprove common concerns about vulnerable people being adversely affected by AS legislation. Examples from Oregon show that such concerns are unfounded once AS legislation is in place.

The most comprehensive research carried out on the impact of AD on vulnerable groups was conducted in 2007 by Battin *et al.*⁴³ and looked at experiences in the Netherlands and Oregon. Within the study, ‘vulnerable’ patients included adults aged 85 or older, disabled

⁴¹ Dr Richard Simpson, 3 Feb, H&S Committee,
<http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9762#.VP8JzP9ybVc>

⁴² AS (Scot) Bill, Section 8, First Request for Assistance Section 8 (3) (d).

⁴³ M P Battin, A van der Heide, L Ganzini, *et al.* (2007) ‘Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ‘vulnerable’ groups’ JME 33: 591–597.

people, people of lower socio-economic status and those with mental health problems. Researchers found that vulnerable groups had not been adversely affected by legislation, and in fact those groups were under-represented in the numbers of assisted deaths.⁴⁴ The typical person who seeks an assisted death in Oregon tends to be aged between 55 and 84, white, has a ‘good education’, has cancer as the underlying illness and has medical insurance.⁴⁵

However, the above research was contested by Finlay and George,⁴⁶ who question the conclusions drawn from it – namely, that there is for the most part ‘no evidence of heightened risk’⁴⁷ to vulnerable people from the legalisation of PAS or VE. They argue⁴⁸ that, contrary to the conclusions drawn by Battin *et al.*, most people who resort to PAS in Oregon are elderly and, on the basis of research published since Battin *et al.* reported in 2007, there is reason to believe that some terminally ill patients in Oregon are taking their own lives with lethal drugs supplied by doctors, despite having had depression at the time when they were assessed and cleared for PAS.⁴⁹ It was outlined in chapter three that the prevalence of depression is a common concern amongst medical staff,⁵⁰ and Emanuel *et al.* supports this view in their findings, concluding that patients with depression and psychological distress were significantly more likely to have seriously discussed euthanasia, hoarded drugs, or read specific literature about ending their life.⁵¹ These differences in perspective only serve to illustrate how challenging it is to achieve a balance but robust drafting of legislative proposals should provide a breadth and depth to allow us to consider the complexities of each case.

4.4 Reasons for opposition

Let us now examine the most prominent concerns which surround the vulnerable groups.

4.4.1 Slippery Slope

The slippery slope argument has played a major role in public, political, and professional debates over assistance in dying. It is argued that once assisted dying becomes lawful,

⁴⁴ *ibid.*

⁴⁵ Summary of Oregon’s Death with Dignity Act 1999-2010 (2011) Oregon Department of Human Services.

⁴⁶ I G Finlay and R George ‘Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon's data.’ *JME* 2011;37:171–174.

⁴⁷ (n43)

⁴⁸ On the basis of official reports from the Oregon Health Department on the working of the Oregon Death with Dignity Act since 2008.

⁴⁹ (n46)

⁵⁰ Chapter 3, Depression, section 3.5.3.

⁵¹ E J Emanuel, E R Daniels, D L Fairclough, B R Clarridge ‘Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public’ *The Lancet* Vol 347, No. 9018, p1805–1810, 29 June 1996.

however narrowly the permission was circumscribed, the scope of the law would gradually become wider, leading to descent down a ‘slippery slope’ which would lead to a more permissive interpretation of the law than was originally intended. One example of this would be to condone assisted death for vulnerable people who were not necessarily terminally ill, but felt their lives were of little worth. Such arguments are empirical in that they rely, not on a principle (though they assume the value of human life) but on the supposed consequences of introducing an enabling law. The consequences cannot be proved to follow, since they refer to a hypothetical future.⁵² However the ‘slippery slope’ concern is still widely prevalent in statements and position papers from a variety of groups, including many professional medical groups.

Hoppe and Miola⁵³ have observed the slippery slope argument and comment; ‘slippery slope arguments...are inadmissible in serious medio-legal and medical ethics debates. These types of arguments reject fundamental tenets of scientific discourse: because they concern events that may or may not occur in the future, they are not open to either falsification or sensible verification’.⁵⁴ Nevertheless we encounter such arguments every time this subject is debated, especially in the courts.⁵⁵

The slippery slope argument is a powerful one and is afforded great consideration as it is precisely this argument which generates fear and ultimately discourages people from supporting AS. During oral evidence sessions at the Scottish Parliament in February 2015, emotive references were continually made to the holocaust, Harold Shipman and doctors who would get a ‘taste for killing’.⁵⁶ Concerns were raised about giving such a dangerous legal power to any individual or group. But it is argued that doctors already have such power: they can act legally to relieve suffering, at the same time bringing about a more speedy death for their patient, justified by the doctrine of double effect.

Surely, whatever the dangers of legislation are, it must make possible a less dangerous situation through regulation than is already in existence without such legislation.

⁵² M Warnock, ‘A duty to die?’ (2008) Available from: <http://fagbokforlaget.no/filarkiv/Mary%20Warnock.pdf>

⁵³ N Hoppe and J Miola, *Medical Law and Ethics*, Cambridge University Press, 2014 at p 286.

⁵⁴ *ibid.*

⁵⁵ See quote from *Bland* at 865, per Lord Goff.

⁵⁶ P Saunders. H&S committee evidence session on AS (Scot) Bill, 3 Feb 2015. Available via Scottish Parliament official report.

4.4.2 Duty to die

Another concern raised by opponents of the Bill is that, once death on request becomes permissible, people might feel they have not only a right but a *duty* to die, and this would be an intolerable outcome. Elderly/sick people are known to fear becoming a burden to their loved ones through penalising them emotionally, physically, socially or financially. Also, once death becomes inevitable, people may question why their own and loved ones' suffering must be prolonged.⁵⁷

It is suggested that at some time in ones' life one may depend on others emotionally, physically, or financially; for some that is an acceptable 'burden' to lay on relatives or friends, while for others it can be unacceptable. This partially explains why legislation is favoured by individuals who want choice about the timing and manner of their deaths. In fact, many people get a lot out of caring for people towards the end. It is argued by Warnock,⁵⁸ however, that to request death and receive assistance to die out of a sense of duty is not something to be abhorred. It may be a genuinely desired *good death* for someone who has lived his life, partly at least, seeking to act in *the interest of others*.

Legalising assisted dying is not about an objective valuation of the life of a terminally ill person. There is absolutely no evidence to suggest that societal valuations of terminally ill or disabled people's quality of life are affected in jurisdictions where assisted dying is legal.⁵⁹

4.4.3 Coercion/Abuse

As already noted above, another common argument against the Bill concerns the abuse of vulnerable people, suggesting that it will allow unscrupulous relatives to put pressure on the elderly and infirm to request death by AD.⁶⁰ However, evidence from Oregon, Switzerland and the Netherlands shows that uptake of AS is very low.⁶¹ The figures would be much higher if vulnerable people were being abused by being coerced into requesting

⁵⁷ C J McPherson, K G Wilson, and M A Murray (2007) 'Feeling like a burden: Exploring the perspectives of patients at the end of life'. *Social Science & Medicine*, 64, 417–427

⁵⁸ Warnock (n52),

⁵⁹ Battin *et al.* (n 43)

⁶⁰ When opposing the 2010 Bill the then Scottish Health Secretary Nicola Sturgeon, now Scotland's First Minister stated she was 'particularly concerned and fundamentally concerned about the difficulty I think would always and inevitably be present in determining that someone choosing to end their life had not been subjected to undue influence'.

⁶¹ Ganzini (n10, Intro).

AD. It may be that individuals citing abuse are not fully informed about the Scottish Bill's provisions: its three-stage process that imposes cooling off periods between each application; the need for uninvolved witnesses; the requirement for two independent doctors and four separate consultations; the presence of a facilitator; and the compulsory reporting of cases to the police. Taken together, these requirements set a very high standard of protection. If they are fully informed, however, it is difficult to understand how they justify rejection of the Bill on the grounds of abuse.

The current situation is far from perfect. The DPP policy states 'It may sometimes be the case that the only source of information about the circumstances of the suicide and the state of mind of the victim is the suspect'.⁶² This is the inherent difficulty with after-the-event investigations. If AS were legalised, the person would have to follow the three-stage process, meeting professionals along the way who could perhaps pick up on any subtle pressures from ill-intended family members. In the absence of legislation we are currently operating in a vacuum. However, it is not realistic to assume that a standard application process can take into consideration the dynamics of every family and each person's circumstances.

Due to the lack of UK case law, we must once again look overseas to our American counterparts where it was observed by the US Supreme Court in a joint opinion in *Washington v Glucksberg* (1997) and *Vacco v Quill* (1997)⁶³ that:

the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons – from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as ludicrous on its face ... We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations.

Sadly, not everyone, especially when very old or terminally ill, would be capable of resisting pressure from family members or relatives to have an AS.

4.5 What's the alternative?

The inadequate funding for palliative care and pain management, and successive governments' reliance on nursing homes rather than care at home, all contribute to the despair felt by many who reach old age, endure frustrating physical limitations, or are

⁶² CPS (n6, ch1).

⁶³ *Washington v Glucksberg*, 521 US 702 (1997) and *Vacco v Quill*, 521 US 793 (1997).

afflicted with debilitating conditions. Elected leaders must address the many environmental barriers facing vulnerable people that might encourage despondent elderly and disabled people to choose death for unsound reasons. Attention to such problems as the prevalence of low-quality nursing care, the low pay of personal assistants, the current inadequacy of pain management and the unavailability of sufficient hospice care could improve the quality of life for severely disabled and terminally ill people, reducing the public's demand for AD.⁶⁴ It would be desirable for the SP to undertake further research into the provisions of such alternatives, especially since, as noted in the last chapter, their most recent study into palliative care, for example, was in 2008. Should the current Bill be rejected, inaction over the serious shortfall in care services will continue to disadvantage sick, dying and vulnerable people who currently would benefit from higher standards of care than presently provided.

4.6 Conclusion

There is an inherent difficulty in striking a balance which protects the vulnerable whilst allowing autonomous decisions to be made by mentally competent adults. One writer has argued, with reference to those with disabilities, that there has developed a *furor therapeuticus*, a drive to maintain life irrespective of the quality of life that is being maintained.⁶⁵ It has been shown that this may be true, through a consideration of current culture and the striving to remove imperfection from our lives. In fact a research-sponsored project to 'find a cure for human aging' sees 'no reason why death cannot be eradicated'.⁶⁶

The case for assisted suicide is a powerful one – appealing to our capacity for compassion and our obligation to support individual choice and self-determination. But it has been shown through the case study of interested parties that the case against assisted suicide is also powerful, for it speaks to us of a fundamental reverence for life and the risk of a slippery slope toward diminished respect for life, particularly where people with incapacities are concerned. It has been suggested, however, that AS is not an absolute and that AS and respect for life can co-exist. We can legalise AS for those who *need* the provisions of the legislation because of their disabilities, whilst still working to protect and improve the lives of vulnerable people. Again evidence examined from overseas proved that this is possible.

⁶⁴ S Stack Societal economic costs and benefits from death: another look. (2006).

⁶⁵ R Nicholson, 'Should the patient be allowed to die?' (1975) J.Medical Ethics 5.

⁶⁶ P Thiel (2012) Thiel Foundation.

Some counter arguments were provided in the hope of answering the concerns of the interested parties. Common concerns regarding palliative care and depression arise within this group and were given some consideration, but the main discussion focussed on the slippery slope, coercion and abuse. Concerns about how current proposals could affect vulnerable groups were outlined and suggestions given as to how these could be overcome by tightening terminology to find a middle ground. It was argued that if the politicians did more in the first instance to facilitate a better life for vulnerable people, as it was shown that many do not get the support they need, then they could justify their grounds for opposition. However this still does not eradicate the need for AS for the most vulnerable who are in a desperate state and want it. With proposed legislation currently under review, politicians will be obliged to choose which values are most important to them and their constituents, and to cast their vote.⁶⁷

The next chapter will focus on religious considerations in the assisted suicide debate.

⁶⁷C Andre and M Velasquez. 'Assisted Suicide: A Right or a Wrong'.
<http://www.scu.edu/ethics/publications/iie/v1n1/suicide.html#sthash.0AsL1I4C.dpuf>

Chapter 5: Religious Considerations

5.1 Introduction

This chapter aims to assess the views of religious people and bodies in the context of the AS debate. The majority of religious organisations are vociferously opposed to legalising AS in any form. Both organisations and individuals have expressed common concerns about slippery slopes and other issues, but in a wider context this chapter will focus primarily on philosophical arguments against legislation. This chapter argues that religious groups have a significant and disproportionate impact in preventing AS legislation from being passed.

In order to do this a faith-based contemporary approach will be offered to explain the context of religious opposition to assisted dying. Faith groups will be considered in the context of the recent evidence session at the Scottish Parliament on the AS bill. An analysis of arguments against AS will be analysed and acknowledged or discounted. Arguments will be developed based on analysis of the strategies employed by religious bodies in seeking to influence policy makers in their favour.

5.2 Background/History

In the western tradition, we find that in Greek and Roman times not all human life was regarded as inviolable and worthy of protection. Slaves and ‘barbarians’ did not have a full right to life, and human sacrifices and gladiatorial combat were acceptable at different times. Spartan law required that deformed infants be put to death; for Plato, infanticide is one of the regular institutions of the ideal state; Aristotle regards abortion as a desirable option¹ and the Stoic philosopher Seneca writes:

I shall not abandon old age, if old age preserves me intact as regards the better part of myself...I shall not avoid illness by seeking death, as long as the illness is curable and does not impede my soul...If I find out that pain must

¹ M Stauch, K Wheat and J Tingle *Text, Cases and Materials on Medical Law and Ethics*. 557, 12.1.2.1 Sanctity of life.

always be endured, I shall depart, not because of the pain, but because it will be a hindrance to me as regards all my reasons for living.²

Whilst there were deviations from these views, one being the Hippocratic Oath discussed in chapter three, it is argued that practices such as euthanasia and abortion were less proscribed in ancient times than they are today. There has been a gradual expansion of the circle of protected human life, outlawing much of what was described above. Many historians of western morals agree that the rise of Judaism and even more of Christianity contributed greatly to the general feeling that human life is valuable and worthy of respect.³ The parallel notion that life is not ours to take but instead is the concept of a 'gift' predominates.⁴

The traditional religious prohibition against suicide rested in the belief that deciding on the time of death was not for humans, but was God's prerogative. But McLean⁵ argues that this reasoning is out of place in any system of secular ethics, and notes that in many countries the legal prohibitions against suicide have been removed in recent years. Indeed, as outlined in chapter one, in Scots law it is generally agreed that there has never been any prohibition on suicide.⁶

It is often reported that churchgoing is in steady decline across Britain. Only 10 per cent of UK citizens attend church weekly.⁷ In the UK, in 2011, the average once-a-week attendance in Anglican churches went down by 0.3 per cent compared with 2012, thus exhibiting a stabilizing trend.⁸ Previously, starting from 2000, the rate of weekly church attendance in Britain was falling by 1 per cent annually and only 53 per cent of people identified themselves as Christian in a 2007 survey, compared with almost 75 per cent in the 2001 census.⁹

However, bearing in mind chapter two¹⁰ where we see how percentages do not always represent a true reflection of the situation and chapter three¹¹ where the same

² M Stauch, K Wheat and J Tingle *Sourcebook on Medical Law*, 2nd edition, 662.

³ H Kuhse, *Bioethics News*, July 1992. Background briefing (Vol.11 No. 4 July 1992 40)

⁴ A Britton and S McLean, *Sometimes a small victory*, 346.

⁵ S McLean and G Maher, *Medicine, Morals and the Law*, (1983) 46.

⁶ Unlike the position in England where suicide was illegal until the passing of the Suicide Act 1961.

⁷ Christian charity Tearfund's survey of 7,000 people in BBC news 'One in 10 attends church weekly', <http://news.bbc.co.uk/1/hi/uk/6520463.stm> Accessed on 18.03.15

⁸ *ibid*

⁹ *ibid*.

¹⁰ Chapter 2, section 2.3.3.

¹¹ (n22, ch3)

figures can be interpreted to favour the arguments of opposing parties, we see that 26 per cent say they attended a church service in 2008, which was up from 21 per cent the previous year.¹² In addition, the proportion of those who say they attend church every month has risen from 13 to 15 per cent, while 10 per cent claim they go at least once a week, which is up from 9 per cent.¹³ While acknowledging that the statistics can be contradictory, it is evident from all the figures that the UK is a society where the majority of people do not subscribe to religious affiliations.

Let us then consider why religious views opposing AS are still afforded significant weight in the AS debate, although culturally UK society is not predominantly religious and a majority of the public consistently wants to see a change in the law to allow AS.

5.2.1 Relevance of Religious Groups

Death is one of the most important things that religions encompass. Most faiths offer meaning and explanations for death and dying; all faiths recognise a place for death and dying within human experience. For those left behind, when someone dies, religious belief provides rituals to mark death, and ceremonies to remember those who have died. Religions provide understanding and comfort for those who are facing death and regard understanding death and dying as vital to finding meaning in human life. Dying is often seen as an occasion for receiving powerful spiritual insights as well as for preparing for whatever afterlife may be to come. So it is not surprising that all faiths have strong views on AS. As with the previous groups studied, we see that the views of religious bodies are held in high regard by parliamentarians, with them repeatedly being invited to give evidence to parliamentary committees.¹⁴ Religious bodies from all walks of life are included – Church of Scotland, the Catholic community, Muslims and the Jewish community. Parliamentarians view their opinions as worthy of serious consideration, as

¹² (n7)

¹³ (n7)

¹⁴ Church of Scotland Church and Society Committee, Catholic Bishops' Conference of Scotland, Free Church of Scotland, Faith and Order Board of the General Synod of the Scottish Episcopal Church, Muslim Council of Scotland, Scottish Council of Jewish Communities all gave evidence to the H&S committee on 27 Jan 2015.

evidenced by their repeated liaisons with them.¹⁵ It is suggested that this may be partly explained by the high number of MSPs who belong to a religious group.

It has been argued in chapter two that the Health and Sport Committee of the Scottish Parliament, is possibly biased in its viewpoints. This was shown through an analysis of the witnesses it chose to call upon to represent medical bodies, which reflected more of an opposing than a neutral stance.¹⁶ A similar pattern can be shown in relation to religious groups. All the witnesses called opposed AD. Perhaps consideration could have been given to the Humanist Society which is supportive¹⁷ or a supportive representative from the churches (which will be looked at later in this chapter) to give a more balanced representation. It is thus worthy of note at this point that a clear majority of the Health and Sport Committee members have strong religious roots and viewpoints, with the convener and deputy convener being regular churchgoers.

It is extraordinary that a country founded on religious freedom allows the most restrictive religions to influence policy, at the cost of others not being allowed the freedom to choose such things as when to end their own lives. This is especially so when a majority of the public are in favour of the legislation. One size definitely does not fit all in this highly contentious debate, and respect and consideration for differing viewpoints would allow a more constructive consideration of proposed legislation. The religious bodies seem reluctant to afford this to anyone whose views do not accord with their own. As Kuhse says:

People who approach ethics from different moral, cultural or religious perspectives will often arrive at different answers to morally controversial questions. These answers have their source in particular value systems and can therefore not be shown to be true or false, in the ordinary sense of those terms.¹⁸

Feelings and ideological commitments run deep and drive different conclusions. Many groups are willing to approach deliberations with a respect and consideration for the other stance. It is argued that religious bodies are unwavering in their opposition and often hostile in their approach, which does not aid ethical and moral consideration of this topic.

¹⁵ Lord Joffe's bill, Lord Falconers bill, Margo MacDonald's 2010 and current bill all considered evidence from religious groups.

¹⁶ (n72-74, ch 2).

¹⁷ See Humanist Society Scotland petition to support the AS (Scot) Bill. http://www.humanism-scotland.org.uk/content/assisted_suicide_consultation/.

¹⁸ H Kuhse 'Voluntary euthanasia and other medical end-of-life decisions: Doctors should be permitted to give death a helping hand' in M Charlesworth, (ed), *Bioethics in a Liberal Society*, 1993, 247-258, at 254.

This is further complicated by the fact that it is impossible either to prove or disprove the validity of religious belief and thought.

Previous chapters have argued that those being called to give evidence from diverse groups and organisations are well organised and articulate in expressing their views. These views, however, have tended to come from only one side of the argument – in this particular instance usually against AS. The official stances of the organisational hierarchies, however, are not necessarily representative of public opinion. This point will be developed further in relation to religious bodies.

5.2.2 Contrasting views

As was outlined in chapter four in relation to vulnerable groups, organisations representing minority groups, including religious groups, are generally portrayed as opposed.¹⁹ Every religious organisation invited to give evidence to the parliamentary committee on the AS Bill was opposed to it. However, studies show that 71 per cent of religious individuals are supportive of assisted dying for terminally ill people.²⁰ Let us then consider the stance of religious organisations in the context of research showing support amongst religious people for AS.

A major survey of religious opinion shows that large majorities of believers are in favour of legalising assisted dying. The poll, carried out by YouGov for the Westminster Faith Debates, involved nearly 4,500 people and revealed that only among Muslims and Baptists was there a majority against a change in the law that prohibits assisted suicide. Among Anglicans, Catholics, Jews, Hindus, Sikhs, Methodists and Pentecostals, a majority are in favour of changing the law.²¹

The poll shows that the proportion of believers who say they make up their minds with the help of ‘local or national religious leaders’ is 2 per cent among Anglicans and 9 per cent among Catholics. Most people rely on their own judgment or reasoning when making moral decisions, and among those groups there is overwhelming support for a change in the law, mirroring that of the general public.²²

¹⁹ (n8, ch 4).

²⁰ Clery (n16, Intro).

²¹ *The Guardian* Assisted suicide poll shows support among majority of religious people, <http://www.theguardian.com/society/2013/apr/30/assisted-suicide-poll-religious> Accessed on 16.02.15

²² *ibid.*

The organiser of the survey, Professor Linda Woodhead, said neither age nor gender nor church attendance significantly predicted opposition to assisted suicide. The only thing that did was a claim that God or the teachings of scripture supplied moral authority. These attitudes are held by a distinct minority of believers. She said:

For most people, death is no longer the last enemy; pain and loss of autonomy is... Add in the growing conviction that individuals have the right to choose when and how to end their lives – 82% in my poll, among them 75% of the Catholics who support change. Add the changing role of medical professionals. And that's where we are.²³

Muslims who opposed a change in the law did so on the grounds that death should take its natural course, and with reference to the sanctity of human life. Catholics were far more likely to cite concern for vulnerable people being exploited as a reason not to change the law.²⁴

5.2.3 Official Stances – A true reflection?

We have seen that the official stance taken by professional medical bodies and representatives of disabled people do not wholly represent the views of those they are intended to.²⁵ A 2013 survey²⁶ on assisted suicide found that the attitudes of members of certain religious groups were significantly out of step with the official position of that religion. The survey found that 61 per cent of Presbyterians (such as the Church of Scotland) were in favour of assisted suicide; 56 per cent of Catholics and 72 per cent of Anglicans also supported a change in the law to allow terminally ill people to end their own lives. In the same survey, it was found that less than 0.02 per cent of respondents said that they look to religious leaders for guidance on assisted suicide, versus 65 per cent who said they look to science and their own reason and intuition.

During the Health and Sport Committee evidence sessions, it was apparent that things were not as black and white as they seem. Ephraim Borowski, director of the Scottish Council of Jewish Communities whose official stance is against, recognised a denominational split within the Jewish community. The orthodox community is steadfastly opposed to the proposals; the liberal community is by and large in favour, with caveats; and the reform

²³ *ibid.*

²⁴ *ibid.*

²⁵ See 2.3.3.

²⁶ BMJ 2013;346:f2897

community is making its mind up.²⁷ The Scottish Council of Jewish Communities noted that many members of the Liberal and Reform Jewish communities would welcome a change in Scottish law to legalise assisted dying. This is most interesting: as outlined in the opening paragraphs of this chapter, it was initially the rise of Judaism amongst other factors which contributed greatly to the general feeling that human life is valuable and worthy of respect.²⁸

The Scottish Episcopal Church (Faith and Order Board) also tried to reflect a range of views from its members and generally was less hostile than other groups. The Rev Dr MacDonald²⁹ from the Free Church of Scotland highlighted in particular that some people will place a lot of importance on opinion polls and others say that ‘loaded’ questions tend to lead respondents one way or the other or that people have not considered the question in depth. This is a concern shared by the Christian medical professional Saunders as we have seen in chapter four.³⁰ Nonetheless there is very little evidence to suggest that the imbalance of views between the governing bodies and the people they represent is particularly different from the imbalance between the views of the population at large and the major denominations.

5.2.4 Going against the grain

It is clear that, although not among the witnesses who were invited to speak to the Committee, a range of views exist on the issues surrounding AS among the religious communities, including among people who are very committed and involved in their religious organisations. The Rev Scott McKenna spoke at the launch of the 2013 Bill. He talked about the Bill as ‘an attempt to bring peace of mind’ and said that he regarded it as ‘an act of Christian compassion’. We have also heard, elsewhere in the UK, from a former Archbishop of Canterbury, Lord Carey, who said: ‘those arguments that persuaded me in the past’ not to support a change in the law ‘seem to lack power and authority now when confronted with the experiences of those suffering a painful death ... there is nothing anti-Christian about embracing the reforms that Lord Falconer’s Bill offers.’³¹

²⁷ Health and Sport Committee 27 January 2015

<http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9750#sthash.e9YKu4Vo.dpuf>

²⁸ Kuhse (n3)

²⁹ Former surgeon and retired Professor of Theology and Ethics, Free Church of Scotland.

³⁰ Saunders (n31, ch4).

³¹ Carey ‘I’ve changed my mind on right to die: On eve of Lords debate, ex-Archbishop dramatically backs assisted death law.’ <http://www.dailymail.co.uk/news/article-2689295/Carey-Ive-changed-mind-right-die-On-eve-Lords-debate-ex-Archbishop-dramatically-backs-assisted-death-law.html#ixzz3VV4TAxuP>.

Rabbi Dr Jonathan Romain said:

the debate is not—as is often thought—a battle between the religious and secular camps, but is within the religious community too. There are many who have both a deep faith and a desire to see assisted dying legalised in Britain as a voluntary option for the terminally ill ... There are also a growing number of clergy like myself who are only too familiar with those dying in pain, and want to see them allowed the option of assisted death if they so wish.³²

It can therefore be seen that, whilst traditional views predominate, there are some high profile religious representatives who do hold more liberal views whilst not discarding traditional religious belief. In other words, they have managed to find compatibility between accommodating their religion whilst understanding that there may be circumstances where other considerations should take priority.

At a global level, perhaps one of the most famous religious figures in the world, Desmond Tutu, has also written about the issue. He states: ‘I revere the sanctity of life—but not at any cost.’³³ He acknowledges many of the issues raised in the context of these discussions and states: ‘I think a lot of people would be upset if I said I wanted assisted dying. I would say I wouldn’t mind actually.’ This view represents an emerging theme that, whilst the sanctity of life is still held in the highest regard, it is not an absolute.

Considering the evidence of the number of public and religious people in favour, it seems apparent that historical theology is reluctant to evolve from a view that was open to question some time ago. Instead of acknowledging the diversity of opinion and approaching debates with an open mind, some choose to use scaremongering in an attempt to influence parliamentarians to vote against proposals.

Ephraim Borowski, director of the Scottish Council of Jewish Communities, referred to Holocaust Memorial Day to make ‘a point about practicalities rather than principles’. He said: ‘It’s now a well-known cliché that the Holocaust didn’t begin in Auschwitz, it ended in Auschwitz. In terms of principle, it began with the belief that some lives are not worth as much as others, and that is precisely what we are faced with here.’ Dr Peter

³² *Mirror* Newspaper, July 2014. ‘Former Archbishop of Canterbury George Carey now supports right to die’ See: <http://www.mirror.co.uk/news/uk-news/former-archbishop-canterbury-george-carey-3846463>

³³ *Guardian* newspaper ‘Desmond Tutu: a dignified death is our right – I am in favour of assisted dying’, <http://www.theguardian.com/commentisfree/2014/jul/12/desmond-tutu-in-favour-of-assisted-dying> Accessed on 31/03/15

Saunders states ‘I don't see anything in this Bill to stop a Shipman³⁴ who gets a taste for killing and authorising, (from abusing) this situation’ and stated he is aware that some doctors would become ‘enthusiasts’ for it.³⁵ It was argued in chapter four that doctors already have such power; they can act legally to relieve suffering, at the same time bringing about a more speedy death for their patient, as is justifiable by the doctrine of double effect.³⁶

This type of hyperbole adds little to the democratic debate. The use of who used this tactic before a parliamentary committee reflects very poorly upon the witnesses, showing a narrowness of thought and ignorance of the argument as a whole. Dr Shipman’s actions were indefensible under any circumstances, and drawing comparisons between Shipman and what the Bill proposes simply clouds the whole issue. Any proposed legislation should be debated through a cool, clear, pragmatic discussion looking at the evidence, taking into account the statistics and, importantly, reflecting on public opinion.

5.3 Reasons for Opposition

The religious bodies share the same concerns already mentioned in previous chapters, such as distrust in the doctor–patient relationship, the impact of depression, lack of the opportunity for conscientious objections for medical staff and the slippery slope.

Dr Salah Beltagui, a member of the Muslim Council of Scotland's standing committee on parliamentary affairs, told MSPs that the legislation would create a ‘culture of suicide’. He said:

When I looked at the Bill, and other people looked at it, we found that it will do a lot of things which are not to the benefit of society as a whole. It will create mistrust between the medical profession and the general public. It will create a culture of suicide as one option of treatment for any person and if that's an option, that will be a very attractive one to many young people especially who are in depression or in a very bad way.³⁷

The Archbishop of Canterbury, in discussing literature on the proposals to legalise AS said: ‘The warnings given in these books seem to me to be so weighty as to make

³⁴ Shipman was convicted in 2000 for killing 15 patients with lethal injections, and an inquiry later concluded that he had in fact killed about 250 patients between 1971 and 1998.

³⁵ H&S committee evidence session on AS (Scot) Bill, 3rd Feb 2015.

³⁶ Chapter 4, section 4.4.1.

³⁷ (n27).

the case very strong indeed for leaving the issues much as they now are in the hands of doctors'.³⁸ However the Archbishop argues that the law does not leave the issue in the hands of doctors; it treats assisting a death as murder or a lesser charge. McLean³⁹ confirms this, adding that the current situation is far from satisfactory. For one thing, it does not provide doctors with immunity from prosecution when using the double effect doctrine, for example.⁴⁰ It could be argued that this is a refusal to face moral problems directly, and that if we do in fact allow certain cases of assisted dying such as non-voluntary euthanasia in cases of severely handicapped babies, then why do we allow these morally improper types of euthanasia to avoid prosecution in our society.

The Catholic Bishops' Conference of Scotland cite a reason for opposition as the Council of Europe's Recommendation which prohibits intentionally taking the life of a terminally ill or dying person⁴¹ – although that surely refers to euthanasia, which the Scottish Bill expressly prohibits, and does not cover a terminally ill person intentionally taking his/her own life. If helpful discussions are to be had and consideration given to the views of these bodies then objective and accurate information is required.

While religious organisations share a number of concerns with other bodies, one argument that from a solely religious perspective is that of the sanctity of life, and this will now be considered.

5.3.1 Sanctity of Life

The sanctity of life principle works to prevent the unauthorised or unwanted removal of life, and is breached permissibly only in certain situations, such as acts of self-defence, in war, or in states where judicial killing is permitted. In the past, its tenets were also imposed on those who took their own lives, as we have seen, but this is now legally irrelevant. Again what this shows is that most philosophical stances are not absolute. What is critical here is the idea that people should continue to have their lives protected, for example, by the terms of Article 2 of the European Convention on Human Rights, which was

³⁸ Cited by Williams, Textbook of criminal law, 512n.

³⁹ McLean and Maher (n5).

⁴⁰ *ibid.*

⁴¹ (n27)

incorporated into UK law by the passing of the Human Rights Act 1998.⁴² This modern statement on sanctity of life in the Convention is clearly subject to some caveats.⁴³

The Church of Scotland (Church and Society Committee) makes clear its fundamental opposition to the Bill, primarily on the principle that it breaches a societal prohibition on the taking of human life. The Muslim Council of Scotland believes that: 'life is the greatest gift from God and to tamper with it or interfere to end it is the most serious sin and an act of ingratitude against the creator'. The Free Church of Scotland's general driving principle for its opposition to the Bill is the sanctity of human life.⁴⁴

In its consultation response on the issue of the right to die, the Church of Scotland said: 'We believe that any legislation which endorses the deliberate ending of a human life undermines us as a society'. The Catholic Church has said the legislation would 'cross a moral boundary' and again states the sanctity of human life as a reason to oppose the Bill.

The Reverend Scott McKenna of the Church of Scotland believes that the religious arguments put forward by opposing faith groups, including his own church, 'do not stand up' and believes voluntary euthanasia can 'sit comfortably' within the Christian faith.⁴⁵

McKenna suggests that the church's main argument, that life is a gift from God and only God can choose the moment of death, is 'deeply flawed'. He said:

We are told that we shouldn't interfere with God's plan by shortening human life. This is bad and unsubstantiated theology. It portrays God as brutal and less loving than we are to our pets. When the Church speaks of compassion, it means to 'stand in someone else's shoes' – yet too often the church seem distant, cold and paternalistic.

⁴² This states that Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally

⁴³ Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
(c) in action lawfully.

⁴⁴ SP Written evidence submission on AS (Scot) Bill.

⁴⁵ 'My church seeks to deny a compassionate death ... a good death ... to those crying out for it' 7th Nov 2012, <http://theamateursguide.com/?p=883>.

Badham and Tullet are amongst other churchmen who concur that the church appears to be lacking in compassion in the face of suffering.⁴⁶ ‘They know best and, based on a flawed theology, seek to deny a compassionate death, a good death, to those crying out for it.’⁴⁷

McKenna also said his position was supported by some Catholic theologians. ‘Anecdotally there are significant Roman Catholic theologians who are in favour but you won't hear that from the hierarchy. The churches can continue to have their own view but they shouldn't be allowed to impose it.’⁴⁸ We have seen in chapter 3 that palliative care specialists are the people most likely to be dealing with people in their final days, and also the most likely to oppose AS. Comparisons can be drawn again here with priests who come to the aid of the sick and dying in their final days, either to comfort them and their families or to read them their last rites. It is interesting to see that those who have such a personal experience with the dying, having been at their bedsides, are opposed to measures which may provide an element of self-determination and relief.

5.4 Conclusion

This chapter began by considering religion, how prominent it is in British culture historically and at present via church statistics, and the motivations behind the lack of support for AS. In 2002, when the Netherlands legalised voluntary euthanasia, more than 40 per cent of the Dutch denied any religious allegiance and only half claimed to be Christians. Oregon, the first US state to allow assisted suicide, claimed that its lack of status as a ‘church state’ meant that it had a unique moral flexibility.⁴⁹ There is a discord between political consideration for religion and the reality of its influence throughout society as a whole; the weight given to those of religious affiliations giving evidence to UK parliamentary committees may not be reflective of general societal views. We have again seen in this chapter that the official stances of the organisational hierarchies are not representative of the people they are supposed to represent. Perhaps the UK needs to continue its move from organised religion to atheism or more liberal beliefs, to reflect the position as it really is rather than how the religious groups would like it to be.

There is hope that compassion will triumph over religious dogma and the decision to die not be seen as life-defeating but as life-enhancing and an act of immense faith. If a

⁴⁶ The Reverend Professor Paul Badham is a patron of Dignity in Dying and has spoken widely on his support for AS. See: ‘Is there a Christian case for Assisted Dying?’ SPCK 2009. The Revd Peter Tullett wrote in the *Church Times* in 2006 ‘Opposition to Joffe Bill doesn't reflect churchgoers' views’. See also the views of Revd Dr Leslie Weatherhead.

⁴⁷ *ibid.*

⁴⁸ (n44).

⁴⁹ ‘The American debate about medically assisted dying’, <http://www.dyingwithdignity.ca/2012/04/11/why-do-americans-balk-at-euthanasia-laws.php> Accessed on 29/03/15

majority of the population is in favour of AS, they, including atheists, agnostics and those who do not believe in a vengeful God, should not be denied legalisation by vocal minority interest groups. As legal AS would be a matter of choice for those that met all legal requirements, it would not be impossible for very religious people simply not to avail themselves of services that may exist, instead of trying to ban everything that offends their moral beliefs.

Persistence of the ‘sanctity of life’ argument can be challenged when one explores the original Hebrew text of the Sixth Commandment ‘Thou shall not kill unlawfully’ and Christianity’s history of endorsing the ‘lawful’ killing of enemies in war. Although the Church says, ‘You must not kill, you must not take human life. God has forbidden it’, the commandment is not absolute and condones lawful killing. The Bible gives examples in which killing is legally and morally acceptable, such as in battle or executing a death sentence. Although the scope of this thesis does not extend to considering theology and philosophy in depth in this context, these examples illustrate why the sanctity of life doctrine can be open to interpretation by politicians.

We can conclude that there is a disconnect between the hierarchy of the church’s teaching and what the majority of people want. This is shown through statistics and the discord highlighted with many high profile public churchmen speaking out.⁵⁰ Any commentary should acknowledge the right of a religion to believe AS would be wrong, but make it clear that a religion has no right to impose its beliefs and ethics on others, especially when these are not truly representative.

The final chapter will now reflect on the discussions in the preceding chapters. These discussions will be tied in to the views of politicians, for it is this group which will take the ultimate responsibility for whether or not legislation will be passed.

⁵⁰ (n29, ch 4) referred to high profile public figures such as Stephen Hawking and others speaking out in favour of AS, and how this could be influencing the public to support AS. Parallels can be drawn here as we have seen in this chapter prominent figures such as Desmond Tutu and ex-archbishop of Canterbury George Carey among other religious authorities speaking out in favour of AS.

Conclusion

The aim of the thesis was to address the following question:

For the last 30 years 69–82 per cent of the British population has consistently stated support for a change in the legislation to allow a choice of an assisted death for the terminally ill, mentally competent adult. Given these statistics, are politicians being constrained by lobby groups?

It has done this by examining the influence of three diverse lobby groups: professional medical bodies, vulnerable people and religious organisations.

First, however, the thesis set out the development of the AS debate in the UK generally, before analysing the historical and current legal position as it relates to AS in the UK. It was concluded after an analysis of statutory provision and case law that the debate on AS has drawn attention to an alarming lack of clarity, particularly in Scots law. The absence of either case law or legislative authority in Scotland is generally recognised as wholly unsatisfactory, although the current petition for judicial review may provide some clarification. It is also suggested that the Lord Advocate ought to adopt specific guidance similar to that for the DPP in England. Alternatively the best resolution would be for Parliament to bring in legislative measures to correct the ambiguous situation.

Chapter two addressed the position regarding professional medical bodies. This chapter investigated specific organisations, namely the BMA and the royal colleges, and considered the validity and reputability of their official stances. It was contended that these particular professional bodies should adopt a more neutral stance, given the influence they have on public and parliamentarians perceptions on AS. It was concluded that it should be possible to reach a successful co-existence between the medical communities and AS after an informative analysis of international laws.

Chapter three considered arguments for and against AD in a medical context. It was suggested that justifications for opposition are somewhat exaggerated and outdated and it was concluded in this instance that physicians' concerns regarding AD could be resolved within a legislative context. The opportunities healthcare has brought are immeasurably positive, but realism and limitations have to be present in any discussions concerning AS. Between our desire for personal autonomy and the outmoded paternalism of the medical

profession, a void has been created. If it is not addressed, it is inevitable that inconsistencies will develop with decisions being taken in a vacuum.

The BMA recently announced a major new research project on end-of-life care and physician-assisted dying. Beginning in 2015, they will hold a number of events across the UK with the public and doctors in order to compile the most comprehensive body of qualitative research carried out on the subject in the UK. This will look at the provision of palliative care and the practical and ethical issues around physician-assisted dying. This research is very welcome, given that this thesis illustrated how the grounds for opposition to the legalisation of AS was very poorly informed. The outcome of this research will be particularly interesting, and one wonders whether a reversion to the BMA's neutral stance will follow the research project.

Chapter four moved on to consider the impact vulnerable groups have on the AS debate. Particular consideration was given to the concerns about a slippery slope and regarding levels of uptake and potential abuse. Whilst some jurisdictions have moved to expand the eligibility criteria for AS, most have not. It is suggested that a robust legal framework could be adopted so the vulnerable can be protected whilst allowing mentally competent adults to make autonomous decisions about their own deaths. It is argued that the culture of Britain would allow AS laws to co-exist with continued palliative care, investment and research. Moreover, it is paramount that politicians address the current proposals realistically, accepting that they cannot foretell with complete accuracy how any new legislative provisions will be used in practice. In the absence of more research, investment in and development of quality of life for vulnerable people, politicians should not shield behind excuses for not allowing AS laws to pass.

The final chapter is concerned with religious influences. It is particularly interesting to see that politicians repeatedly give considerable weight and importance to religious objections, despite operating in a society which does not readily affiliate itself with religion. It is suggested that the reasons religious considerations are allowed to enter this debate is because many politicians may themselves still subscribe to religious beliefs. A move away from these particular considerations would be beneficial to allow a more realistic, moral, ethical and legal discussion to take place. Philosophical arguments could add substance to the debate in terms of their teachings about compassion. It was shown, however, that the religious bodies' arguments for opposition to AS did not in the main tend to focus on such arguments. Again, it is argued that it should be possible for arguments of compassion to

co-exist with support for AS. Given the international and other examples, it is clear that people with religious beliefs can find an equilibrium between their beliefs and AS.

This thesis did not intend to quantify numerically the impact that the groups studied had on politicians individually, but to provide a succinct reference point for considerations of the validity and stability of arguments presented.

The AS debate has provided a particularly interesting study with regards to stakeholder influence and motivations in a debate and this is set to continue. The challenge for politicians is to work out whether the suffering of those at the end of their lives is better able to be resolved by prohibition of AS or by legislating for it. As has been illustrated, there are medical, social, religious, political and many other reasons why society now needs to take a step away from ambiguity, uncertainty and deference and some of these reasons are more principled than others.

Members of parliament with constituencies in which medical establishments such as hospices are sited or in which religious and vulnerable groups are particularly strongly represented may perhaps base their approach to law reform on a fear of losing political support. But with opinion polls consistently showing the UK public's overwhelming support for AS, it may be of electoral benefit if they were to support the proposals. Whatever politicians' reasoning, the democratic deficit that results from failure to adequately regulate this area results in many people having to face the most troubling and anxious times with unnecessary fear and uncertainty. As we have seen, there are many difficult considerations to take into account; however, these are not sound enough reasons for continuing to allow the UK to retain the *status quo*. The situation has to be rectified, and politicians should be obliged to do *something* rather than nothing.

Bibliography

Back A L, J I Wallace, H E Starks, R A Pearlman, 'Physician assisted suicide and euthanasia in Washington State: patient requests and physician responses' (1996) *JAMA* 275(12): 919–925.

Battin M P, van der Heide A, Ganzini L, *et al.* 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups' (2007) *JME* 33: 591-597.

Bilsen J, Cohen J, Chambaere K, *et al.* 'Medical end-of-life practices under the euthanasia law in Belgium' (2009) *NEJM* 361(11) 1119–1121.

Brinkman A 'NPTN: palliative care comes under the spotlight in the Netherlands' (2009) *EJPC* 16(3): 151–153.

Britton A and McLean S *Sometimes a Small Victory* (1997) Institute of Law and Ethics in Medicine, University of Glasgow.

Catto G and I G Finlay 'Assisted death: a basic right or a threat to the principal purpose of medicine?' (2014) *J R Coll Physicians Edin* 44: 134–138.

Centeno *et al* 'Facts and indicators on palliative care development in 52 countries of the WHO European region: results of an EAPC task force' (2007) *Palliative Medicine* 21: 463–471.

Central Board of the Royal Dutch Medical Association. 'Vision on euthanasia' (1984) *Medisch Contact* 39: 990–997. [in Dutch].

Chalmers J 'Assisted suicide in Scotland: (not) clarifying the law' (2015) Available from: <http://schooloflaw.academicblogs.co.uk/2015/02/10/assisted-suicide-in-scotland-not-clarifying-the-law/>

Chalmers J 'Assisted Suicide: Jurisdiction and Discretion' (2010) *ELR* 14, 295.

Chapple A, Ziebland, S, McPherson, A, Herxheimer, A 'What people close to death say about euthanasia and assisted suicide: a qualitative study' (2006) *JME* 32 706–710.

Christakis N A, Lamont E B 'Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study' (2000) *BMJ* 320:469–472.

Clery E, S McLean, and M Phillips 'Quickening death: the euthanasia debate', in A Parks, J Curtice, K Thomson, M Phillips and M Johnson (eds) *British Social Attitudes: the 23rd report: perspectives on a changing society* (2007) Sage: London, 35–54.

Curlin Farr A, Chinyere Nwodim, Jennifer L. Vance, Marshall H. Chin, and John D. Lantos, 'To Die, to Sleep: US Physicians' Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support' (2008) *AJHPM* 25(2) 112–120.

Davies M, V English, R Mussell and J Sheather *The BMA's Handbook of Ethics and Law*, 3rd edition (2012) John Wiley.

Dworkin R. *Life's Dominion. An Argument about Abortion, Euthanasia, and Individual Freedom* (1993) Harper Collins, 208–213.

Emanuel E J, E R Daniels, D L Fairclough and B R Clarridge (1996) 'Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public' *The Lancet* Vol 347, No. 9018, 1805–1810, 29 June 1996.

Finlay I G and R George 'Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon's data' (2011) *JME*;37:171–174.

Freeman G and J Hughes. *Continuity of care and the patient experience. An Inquiry into the Quality of General Practice in England*. Kings Fund 2010.

Ganzini L, T A Harvath, A Jackson, E R Goy, L L Miller, and M A Delorit 'Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide' (2002) *NEJM* 347(8): 582–588. PMID: 12192019.

Ganzini L, Nelson H D, Lee M A *et al.* 'Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act' (2001) *JAMA.*; 285:2363-9.

Ganzini L, Goy E and Dobscha S 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey' (2008) *BMJ* 2008;337:a1682.

Gripp S, Moeller S, Bolke E *et al* ('Survival prediction in terminally ill cancer patients by clinical estimates, laboratory tests, and self-rated anxiety and depression' 2007) *JCO* 25:3313–3320

Hoppe, N and Jose Miola, *Medical Law and Ethics* (2014) Cambridge University Press,

Hurst, S A and Alex Mauro 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians' (2003) *BMJ*. Feb 1; 326(7383): 271–273.

Hurst, R DAA The International Disability and Human Rights Network. 'Assisted suicide and disabled people – a briefing paper' Available from: <http://www.daa.org.uk/uploads/pdf/Assisted%20Suicide.pdf>.

Illich I. *Limits to medicine: medical nemesis. The expropriation of health.* (1977) Penguin books

Johnson D 'Legalized Euthanasia. Dutch legalization of assisted suicide sparks international debate' Available from: <http://www.infoplease.com/spot/euthanasia1.html#ixzz3V6QX9SRZ>

Jones W H S 'Epidemics 1:11', in *Hippocrates*, vol 1, (1923) Harvard University Press: Cambridge, MA.

Judd M. and C Seale 'Joining a right-to-die society: Motivation, beliefs and experiences' *Mortality*, Vol. 16, No. 3, August 2011. Routledge Publishing.

Kerridge I H and Mitchell K R. 'The legislation of active voluntary euthanasia in Australia: will the slippery slope prove fatal?' (1996) *JME*;22:273–278.

Kmietovicz Z 'R.E.S.P.E.C.T. - why doctors are still getting enough of it' (2002) *BMJ* 324 (7328): 11-14.

Kure, J 'Good Death Within Its Historical Context and as a Contemporary Challenge: A Philosophical Clarification of the Concept of Euthanasia' in *Euthanasia - The 'Good Death' Controversy in Humans and Animals* (2011).

Kuhse H 'Background briefing' *Bioethics News*, Vol.11 No. 4 July 1992.

Kuhse H 'Voluntary euthanasia and other medical end-of-life decisions: Doctors should be permitted to give death a helping hand' in Charlesworth M (ed), *Bioethics in a Liberal Society*, (1993) Cambridge University Press.

Lien Foundation 'The Quality of death: Ranking end-of-life care across the world'. A report from the Economist Intelligence Unit. (2010)

McAndrew S 'Religious faith and contemporary attitudes' in Park A, Curtice J, Thomson K *et al.*, eds. 'British social attitudes 2009–2010: the 26th report' (2010) London: Sage.

McLean S, C Connelly and J K Mason, 'Purdy in Scotland: we hear, but should we listen?' (2009) JR 265 at 276

McLean S and G Maher *Medicine, Morals and the Law* (1983) Gower Ltd.

McPherson C J, Wilson K G, and Murray M A, 'Feeling like a burden: Exploring the perspectives of patients at the end of life' (2007) SSM, 64, 417–427

Meier D E, Carol-Ann Emmons, S Wallenstein, T Quill, R S Morrison and C K Cassel 'A National Survey of Physician-Assisted Suicide and Euthanasia in the United States' (1998) NEJM; 338:1193–1201.

Meisel A, L Snyder, T Quill for the American College of Physicians-American Society of Internal Medicine End-of-Life Care Consensus Panel, 'Seven Legal Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth' (2000) JAMA;284(19):2495-2501.

'Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995' (1996) NEJM; 335:1699-1705 November 28, 1996.

Nicholson R 'Should the patient be allowed to die?' (1975) JME 5.

Otlowski M 'Voluntary Euthanasia and the Common Law' in M Stauch and K Wheat with J Tingle *Text, Cases and Materials on Medical Law and Ethics*. 4th edition. (2012) Routledge.

Paris J J and M P Moreland 'A Catholic perspective on physician-assisted suicide' in M Pabst Battin, R Rhodes and A Silvers (eds) *Physician Assisted Suicide: Expanding the Debate*.

Price C 'More than two-thirds of GPs think RCGP should change its stance on assisted dying' *Pulse*, (2013) <http://www.pulsetoday.co.uk/clinical/therapy-areas/elderly-care/more-than-two-thirds-of-gps-think-rcgp-should-change-stance-on-assisted-dying/20005114.article>.

Seale C 'End-of-life decisions in the UK involving medical practitioners' *Palliative Medicine* (2009) 23: 198–204.

Seale C 'Hastening death in end-of-life care: A survey of doctors' (2009) SSM 69(11): 1659–1666.

Sheldon T 'Obituary: Andries Postma' (2007) BMJ 334: 320.

Snyder L, Sulmasy D P, for the Ethics and Human Rights Committee, American College of Physicians–American Society of Internal Medicine ‘Physician-assisted suicide’ (2001) *Ann Intern Med.* 135:209–216.216 [PubMed]

Stack S *From death: another look* (2006) Routledge.

Stauch M, Wheat K, Tingle J, *Text, Cases and Materials on Medical Law and Ethics* (2006) OUP.

Stauch M, Wheat K, Tingle J, *Sourcebook on Medical Law*, 2nd edition (2002) Cavendish Publishing.

Stark F ‘Necessity and policy in ‘*R (Nicklinson and Others) v Ministry of Justice*’ (2014) *ELR* 18 1 104–109.

Stiel *et al.* ‘Evaluation and comparison of two prognostic scores and the physicians’ estimate of survival in terminally ill patients’ (2010) *Supportive Cancer Care* 18: 43–49.

Thompson R E ‘I Swear by Apollo, the Hippocratic Oath is Obsolete’ Apr. 2004 *The Physician Executive*.

Van Beek K and Menten J ‘The Organisation of Palliative Care in Belgium’ (2010) in Ahmedzai S, Gomez-Batiste X, Engels Y *et al.* (eds.) (2010) *Assessing Organisations to Improve Palliative Care in Europe* (2010) Vantilt Publishers, Netherlands.

Van der Heide A, Rurup M, Hanssen-de Wolf J *et al.* ‘End-of-life practices in the Netherlands under the Euthanasia Act’ (2007) *NEJM* 356(19): 1957–1965.

Warnock M ‘A duty to die?’ (2008) Available from: <http://fagbokforlaget.no/filarkiv/Mary%20Warnock.pdf>.

Woitha K, Engels Y, Hasselaar J, Vissers K ‘The Organisation of Palliative care in the Netherlands’ (2010) in Ahmedzai S, Gomez-Batiste X, Engels Y *et al.* (eds.) *Assessing Organisations to Improve Palliative Care in Europe* (2010) Vantilt Publishers, Netherlands.

