

# **Dignity in Dying: The Report**

***February 2006***



**A statement by Diane Pretty (2002): who sought and failed to have an assisted death through the English legal system and the European Court of Human Rights**

<http://www.justice4diane.org.uk/story.asp>

*"I am only 43 years old. I desperately want a doctor to help me to die. Motor neurone disease has left my mind as sharp as ever, but it has gradually destroyed my muscles, making it hard for me to communicate with my family. It has left me in a wheelchair, catheterised and fed through a tube. I have fought against the disease for the last 2 years and had every possible medical treatment.*

*I am fully aware of what the future holds and have decided to refuse artificial ventilation. Rather than die by choking or suffocation, I want a doctor to help me die when I am no longer able to communicate with my family and friends. I have discussed this with my husband of 25 years, Brian, who has come to terms with what I want and respects my decision. He says that losing me will be devastating for him and our two children but he would be pleased to know I had had the good death I want. I want to have a quick death without suffering, at home surrounded by my family so that I can say good-bye to them.*

*If I were physically able I could take my own life. That's not illegal. But because of the terrible nature of my illness I cannot take my own life - to carry out my wish I will need assistance. Should a doctor give me the assistance I need, he or she will be guilty of a crime that carries a lengthy prison sentence. As the law stands it makes no sense. The law needs changing so that I, and people like me, can choose how and when we die and not be forced to endure untold suffering for no reason."*



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## Foreword

Dignity in Dying campaigns to put patient choice at the heart of all end-of-life medical treatment decisions. Our foremost campaign is to change the law in England and Wales so that a terminally ill, competent adult who is suffering unbearably can request and receive medical assistance to die. To this end we have worked very closely with Lord Joffe on the Assisted Dying for the Terminally Ill (ADTI) Bill, which will give patients that right within strict safeguards. In addition, Dignity in Dying leads the debate and helps shape the law on other end-of-life decisions, such as refusal of, or request for, life-sustaining treatment. We were also involved in drafting the Mental Capacity Act 2005.

In the past 5 years, what happens at the end of life has been a hotly debated topic in the media, in court, and in Parliament. A number of high-profile developments have helped spread the message of greater patient choice at the end of life:

- **Diane Pretty** took her fight for the right to die to the European Court of Human Rights in 2002, bringing the debate on assisted dying into the spotlight.
- **Miss B** brought her case to be allowed to refuse treatment to the High Court in 2002. Miss B's request was granted and her NHS trust was ordered to pay damages for their "unlawful trespass" in keeping her alive against her wishes.
- **Reginald Crew's** decision to travel to Dignitas in Switzerland for an assisted suicide in 2003 illustrated the need for a review of our own laws.
- **Lord Joel Joffe** introduced what would eventually become the Assisted Dying for the Terminally Ill (ADTI) Bill to the House of Lords in 2003.
- **A House of Lords Select Committee** was established in 2004 to consider the ADTI Bill, and recommended that it be fast-tracked through the House.
- **Mrs Z**, who suffered from an incurable brain condition, found herself in the High Court in 2004 when she attempted to make plans to go to Dignitas for an assisted death. The court ruled that Mrs Z's local authority did **not** have a duty to prevent her from going, and the Crown Prosecution Service did not intervene.
- **Leslie Burke** won a High Court ruling against the **General Medical Council**, securing his right to artificial hydration and nutrition. The ruling was later overturned in the Court of Appeal.
- **The Mental Capacity Act** was passed in 2005, coming into force in 2007, giving Living Wills statutory underpinning.
- **The Assisted Dying for the Terminally Ill Bill** was reintroduced to the House of Lords by Lord Joffe on 9th November 2005, with some key changes.
- **The Law Commission's review of the law of murder** began in December 2005, and will consider the treatment of mercy killings under the law of murder.

Because of the importance of the House of Lords Select Committee, our work in recent times has focused on the campaign to legalise medically assisted dying. We are now closer than ever to changing the law. This report will therefore concentrate primarily on this issue.

**Deborah Annetts,**  
*Chief Executive, Dignity in Dying, February 2006*

## Chapter 1: The law needs to change

*"I, John Close, being of sound mind but failing body, have decided to make this statement about my wishes, so there can be no ambiguity in the future. I wish to die. I am now prepared to actively seek an end to my life. I have been in contact with Dignitas in Switzerland: if possible I will take that controlled, caring way out. I have Motor Neurone Disease. I have had it two years now since diagnosis. It has taken its own course in that time but since late last year it became complicated by bowel problems. This has forced me to think hard about my future. I have been aware since day one of my diagnosis of the need to adapt to the progress of my disease. I have done so. I was forced to give up playing the guitar, to give up walking, to give up eating, to give up normal conversation, now I would like the choice to give up living, but this is against the law in the UK."*

**John Close, who received an assisted death at Dignitas on 26th May 2003**

## The law needs to change

Dignity in Dying, formerly the Voluntary Euthanasia Society, believes that the legal prohibition on doctors helping terminally ill competent adults to die at their request is untenable. We are not alone in our view - polls have consistently found that at least 80% of the public believe the same. Our argument is unequivocal: regulating end-of-life decision-making via the criminal law is not ethically, medically or legally sound. Legislation enabling terminally ill competent adults to request medical assistance to die is a far better response to people's concerns at the end of life.

### 1. The law is uncertain and arbitrarily applied

Assisting another's suicide is prohibited in England and Wales under the Suicide Act 1961, and ending somebody's life at their own request constitutes murder. Our law is the most inflexible and restrictive law in Europe: Switzerland, Belgium, and the Netherlands (as well as Oregon in the USA), permit assisted dying in certain, strictly defined circumstances, and in Portugal, Italy, Poland, Austria, Denmark, Spain, and Norway, the law distinguishes between the ending of a person's life who has asked for help to die, and the ending of a life without any such request (see appendix 3). Our law makes no such distinction.

#### 1.1 The Suicide Act 1961

Under the Suicide Act, anybody who helps another person commit suicide shall be liable to imprisonment for up to 14 years. This is so even if the person is dying and has asked for assistance in his or her suicide. However application of this law is unpredictable and arbitrary.

The confusion surrounding the Suicide Act is evident in the December 2004 case of Mrs Z.<sup>1</sup> Mrs Z's husband wanted to help his terminally ill wife travel to Dignitas, a Swiss organisation that helps people to die (see section 2.3). The High Court was asked to determine whether or not Mrs Z's local authority was required to prevent her from travelling overseas to end her life. The court ruled that she was free to go but added that, *"In making these [travel] arrangements, Mr Z has arguably committed an offence under Section 2 of the Suicide Act 1961."* The ruling went on to conclude, *"The court should not frustrate indirectly the rights of Mrs Z. The role of Mr Z is now a matter for the criminal justice agencies."*

The Crown Prosecution Service decided not to prevent Mr Z from travelling to Switzerland with his wife, despite the illegality of his actions. It is not clear on what ground this decision was made. Dignity in Dying has repeatedly requested that the Director of Public Prosecutions publish guidelines setting out the types of cases he will not prosecute, but to no avail. What is clear, however, is that a criminal law that is enforced arbitrarily does not offer clarity or certainty and fails to protect the vulnerable.

Graham Lawson was arrested for assisting his sister Sue's suicide; his experience was devastating. In December 2003 Sue, who had suffered from Multiple Sclerosis for 14 years, chose to take her life. Graham sat with Sue throughout her horrific 26-hour struggle to die:

*"The tablets meant she was drifting in and out of consciousness, yet still her body's urge to survive was stronger than her will to die. Her hands went up, she removed the bag and, in tears, gasped for air. When she came round sufficiently, she tried again - and again, and again - pulling the plastic over her face, desperate to die, only to resurface like a bobbing cork."<sup>2</sup>*

After Sue's death Graham was arrested and taken to the police station, strip-searched, and held in a cell. He was told he was facing up to 14 years in prison. Graham wasn't given the chance to tell his parents that Sue had died; the police did that for him. He was released the next day but it was five months until his solicitor informed him he would not be facing charges. It was only then that Sue's body was released for burial and the family could finally lay her to rest.

Speaking to the press about his experience, Graham said, *"I was arrested, stripped of my clothes, photographed, and made to feel like some kind of murderer. As far as I knew I was just being compassionate."*<sup>3</sup>

## 1.2 The law of murder and the Homicide Act 1957

Under the current law anybody who ends the life of another can be convicted of murder and receive a life sentence - even if the act is a compassionate response to a dying person's request for help to die (a 'mercy killing').

However, as with the Suicide Act, there is a confusing discrepancy between what the law says and does, as the 2005 trial of Mr Brian Blackburn (a retired policeman) demonstrates. Mr Blackburn's wife (a Macmillan Cancer nurse) was in agonising pain with advanced stomach cancer and asked her husband to end her life. Placing a flannel over her face so she could not see what was happening, Blackburn slit his wife's wrists. He then attempted to take his own life but failed, and called the police to confess. Mr Blackburn was charged with murder and spent three months in prison awaiting trial.

He pleaded guilty to manslaughter, a plea which is often entered in the case of a mercy killer. At the end of his trial, Judge Hawkins told Mr Blackburn that he had acted as a *"loving husband"* when his wife had begged him to kill her *"as the last loving thing you could do for her"*. Mrs Blackburn's sons from a previous marriage told the court that, *"the act that Dad undertook was totally unselfish and we have no bad feelings whatsoever"*.<sup>4</sup> Mr Blackburn received a nine month suspended sentence.

## 1.3 The Law Commission review of the law of murder

At the request of the Home Secretary in 2004, the Law Commission undertook a review of the law of murder, and concluded, *"The present law of murder in England and Wales is a mess"*.<sup>5</sup>

The Law Commission asked members of the public to comment on various scenarios where a life was ended. Predictably, the scenario in which *"a man had nursed his terminally ill wife for several years but eventually gave into her regular requests that he should 'put her out of it' and he smothered her with a pillow"* was *"generally regarded as the least serious"* by members of the public. 56% of respondents thought the husband should not be prosecuted.

The Law Commission's report stated, *"at present, in such cases, a conviction for murder, with consequent mandatory life sentence, can only be avoided by a 'benign conspiracy' between psychiatrists, defence, prosecution and the court, to bring them within diminished responsibility... It is however a blight on our law that such an outcome has to be connived at rather than arising openly and directly from the law."* The Blackburn case is a clear example of this.

In December 2005 the Law Commission announced that it would be looking critically at how the law of murder applies to mercy killers. Dignity in Dying welcomes this decision. However we believe simply downgrading the offence of mercy killing from murder would not address the real problem, which is that people who are dying and suffering unbearably want the option of medical help to die.

They want that help to be given to them by their doctor within a properly regulated framework, rather than their loved one having to run the gauntlet of the criminal legal system. In 2004, NOP asked the public whom they would ask to help them die if this were a legal option. 55% said they would ask a doctor whereas only 19% would ask a relative.<sup>6</sup> We believe that the proper response to the problem of mercy killing is to provide the option of medically assisted dying in a safe and regulated manner, as formulated in the ADTI Bill.

#### 1.4 The principle of 'double effect'

The principle of double effect distinguishes what is intended from what is unintended but foreseen. In the legal-medical context, the principle permits a doctor to administer potentially fatal medication such as opioids (pain-killers), provided that his intention is purely to control pain and symptoms - even if he foresees that his action will hasten death. This principle is unworkable, as recent high-profile criminal cases demonstrate.

In December 2005, following an eight week trial, Dr Howard Martin was cleared of murdering three of his patients with morphine overdoses. The prosecution alleged Dr Martin had administered huge doses of the drug with the intention of killing his patients; Doctor Martin maintained that he was trying to relieve the suffering of these patients.

This case exposed three serious flaws in the double effect principle as applied to the use of opioids at the end of life. Firstly, how appropriate is it to regulate end-of-life decisions on the basis of the doctor's intentions, rather than the patient's wishes? The law is inexplicably inconsistent in this area: on the one hand, a doctor who, at the patient's request, supplies life-ending medication is criminalised, despite the fact that it is the patient's intention and action that brings about death. On the other, a doctor who shortens a patient's life by administering high doses of opioids - regardless of the patient's wishes - may be justified under the principal of double effect, even if he foresaw that death would occur. The House of Lords has ruled in other (non-medical) cases that foresight of virtually certain consequences either amounts to intention or at least provides evidence of intention, from which a jury may infer that the guilty intention was present.<sup>7</sup> Why then should a doctor's foresight of death in these circumstances be innocent?

Dignity in Dying commented on the Martin case as follows:

*"It shows the lack of clarity in the law surrounding decision-making at the end of life. It was all about what the doctor intended. People may be surprised to discover that it makes no difference what the patients wanted. Bad practice is not being properly exposed and good doctors are not being properly supported or protected. The sooner we move to a system that allows a patient's wishes to be respected, with proper safeguards, the better-protected patients will be."*

Secondly, the Martin case uncovered the confusion that surrounds the use of morphine in terminal illness. Dr Martin was cleared because the Crown failed to prove he knew exactly what effects the doses of morphine would have on his patients. The prosecution could not prove that the drugs had killed the patients because expert defence witnesses described how patients could develop a resistance to morphine and need higher doses to relieve their pain. Disagreement and confusion as to the effects of opioids exists right across the medical profession.

Thirdly, the case highlighted the difficulties in determining the doctor's intentions. Richard Huxtable, lecturer in medical law and ethics, notes,

*"The...danger is that impermissible 'directly' intended deaths may too readily be assumed innocent by the various legal officials (primarily prosecutors and judges)...A wealth of anecdotal evidence suggests that covert euthanasia occurs under the guise of double effect."*<sup>8</sup>

Worryingly, polls reveal that the majority of doctors believe their colleagues sometimes administer pain-relieving drugs with the intention of hastening death:

**Table 1: Do doctors intentionally hasten death with pain-relieving medication?<sup>9</sup>**

	Yes	No	Don't Know
<b>GP NET (NOP) 2005:</b> Do you think that doctors ever administer pain relief medication to a terminally ill patient knowing that it may hasten death? (202 GP respondents)	<b>62%</b>	20%	18%
<b>Medix-UK 2004:</b> Do you believe there are circumstances where some health professionals in the UK currently give pain relief to terminally ill patients with the intention of shortening their life? (1,000 doctor respondents)	<b>51%</b>	15%	27%  6% 'would rather not say'

This covert medical practice goes on unseen and unregulated. New research finds it to be a widespread practice, and from this research we estimate that 192,000 patients per annum have their lives ended in this way (see appendix 2).<sup>10</sup> While doctors are no doubt acting out of compassion, how much better if the practice were properly regulated and transparent? Until it is the patient rather than the doctor who makes these decisions, there will always be the risk of abuse, and the law around the use of opioids, double effect and murder will continue to be "a mess" (see page 7).

## 2. The current law has terrible consequences

*"Our language does not have a term to adequately describe the wish for death when one's personhood is being destroyed by the relentless progression of disease...the consequences of misperceiving the significance for requests for aid-in-dying under such circumstances can be devastating..."*

Professor Timothy Quill, Palliative Care Consultant<sup>11</sup>

### 2.1 Covert medically assisted dying

Because it is illegal, it is difficult to measure the extent to which medically assisted dying is already occurring in the UK. However it is clear that requests are being made and, in some cases, acted upon:

**Table 2: UK healthcare professionals' experiences with medically assisted dying:<sup>12</sup>**

Survey/poll	Have received requests for help to die	Admit taking active steps to help patients die	Believe colleagues have assisted patients to die
Annual Conference Neuroscientists 2005			80% doctors (approx)
Medix-UK 2004	27% doctors		45% doctors (further 4% would rather not say)
Nursing Times Survey 2003	1 in 4 nurses		
Sunday Times 1998		1 in 7 doctors	
McLean 1996	28% doctors	4% doctors (provided patient with means to end life)	12% doctors
BMA News Review 1996	20% doctors		
Doctor Magazine 1995	62% doctors		
Ward and Tate 1994		12% doctors	

New research finds that nearly 3,000 patients were deliberately helped to die by doctors in 2004 - either with or without the patient's explicit request.<sup>13</sup> Because England and Wales has the harshest assisted dying law in all of Europe, doctors are unlikely to be open about having helped a patient to die. For this very reason it is difficult to be certain that the figure of 3,000 deaths is accurate. It could well be higher.

The heavy penalties which are imposed on those who help a patient to die in this country does not mean that the dying die better in the UK. Far from it. Where assisted dying is a legal option in places like the Netherlands and Oregon, the evidence has shown that the dying process becomes more patient focused, and there is better communication between the patient and the doctor. The patient is able to voice all his fears and wishes and the doctor is able to act on them without fear of being criminalised for his compassion.

Dignity in Dying agrees with academics such as Dr Tom Shakespeare, a leading disability activist, who stated, *"there is already evidence in many countries in the world of what would be called underground euthanasia, of illegal acts performed by doctors on behalf of people who wish to die. That is unregulated, it is unknown and it may involve all sorts of abuse. I think there is a strong argument that careful regulation would reduce the abuse"*.<sup>14</sup> With regulation comes transparency, accountability and safeguards, ensuring that patients suffering from depression, or patients who perceive themselves as a burden on their family and carers, will not receive a medically assisted death.

## 2.2 Mercy killings

*"She said, 'You have got to do something. You have got to cut my wrists and then do yours and we will meet each other on the other side'. I said, 'I can't'. She said, 'You have got to. I can't go to hospital. It's the last loving thing you can do for me'."*

[Mr Brian Blackburn, who helped his wife to die in October 2004](#)

The law is not preventing cases like Mr Blackburn's:

**Table 3: NOP 2004 - Percentage who would be willing to break the law and help a loved one die if they were terminally ill, suffering unbearably, and asked for help.<sup>15</sup>**

	Yes
Total	47%
Protestants	40%
Catholics	49%
Not religious	56%

Mercy killers can experience overwhelming feelings of guilt. Home Office statistics indicate that nearly 30% of those who help loved ones to die subsequently end their own lives.<sup>16</sup> Others develop psychological problems and drug dependency, or self-mutilate. In 1997 David Hainsworth attempted to smother his 82-year-old father who was suffering from cancer. Mr Hainsworth was so riddled with guilt that he punished himself by cutting off one of his own testicles.<sup>17</sup>

Legalisation of medically assisted dying would give real choice to people who are suffering unbearably from a terminal illness and prevent family members and friends risking their freedom and mental wellbeing.

## 2.3 Dignitas

Dignity in Dying receives hundreds of calls each year from people wanting information on Dignitas, a Swiss organisation which helps terminally ill people to die. Because we seek to change the law within the law we do not provide this information. Nevertheless, since Reg Crew's death at the clinic in January 2003 around 40 British people have ended their lives in this way, and Dignitas' British membership has increased by 710%.<sup>18</sup> 50% of respondents to the 2004 NOP poll said that they would consider going abroad for an assisted death if it remains illegal in this country.

## 2.4 Secret suicides

*"I have never had any inclination towards suicide. However, MND is a relentless disease. If I stick it out, I could finish totally paralysed and unable to speak...It is necessary to take action while I can still swallow..."*

[Suicide note of a 74-year-old MND sufferer, The Guardian, 5th July 1997](#)

Some dying patients who wish to end their suffering without incriminating loved ones take their own lives in secret, sometimes violently. 7% of doctors questioned in the Medix-UK 2004 survey reported that at least one of their terminally ill patients had committed or attempted to commit suicide in the last two years.

In 1993, Guardian journalist Jill Tweedie, who had been suffering from motor neurone disease, ended her life. Colleague and friend Polly Toynbee wrote of her death:

*“As she grew weaker, she told me she had already acquired pills which if taken together would be lethal. I thought the time was still far off, for although she could barely walk she seemed still so full of life. I was to see her the next day, but there was no next day. A friend who saw her just before noticed her breathing was getting slightly wheezy, the first sign of what she feared most – slow asphyxiation. Left briefly alone, without telling anyone she quietly checked herself into a clinic and died that night. There was no doubt in our minds that she committed suicide, not waiting for the final ravages.”<sup>19</sup>*

### 3. Palliative care is not always the answer

Dignity in Dying endorses the 2003-04 House of Commons Health Select Committee recommendations on improving palliative care, and agrees that *“the right to a good death should be fundamental.”*<sup>20</sup> Yet even with the very best palliative care some patients still suffer unbearably at the end of life and want help to die. No amount of palliative care can address their concerns regarding their loss of autonomy and dignity, loss of control over bodily functions, and their inability to engage in activities that make their lives enjoyable. This has been recognised by the British Medical Association, Macmillan Cancer Care, the National Council for Palliative Care, and the House of Lords Select Committee that considered the ADTI Bill.<sup>21</sup>

This type of suffering is illustrated by the experience of Dr Kade (a pseudonym), an Oregonian doctor who agreed to help his 29-year-old terminally ill patient die by providing her with a lethal prescription under the Oregon Death with Dignity Act (ODDA) 1997 – despite his initial opposition to the Act. Dr Kade said,

*“She had the right to choose and the Oregon statute allowed her to act on her decision. Her family and her fiancé were willing to displace their own need to have her with them with her need to be gone. I must do the same. And I have also redefined intolerable suffering. I now believe that it may occur in ways quite different from those which we as physicians normally consider and that intolerable suffering is best defined by the patient. My patient was suffering at the core of her being... Her dignity, her self esteem had been stripped away. The vitality of her life had passed. Her life as she defined it had become futile.”<sup>22</sup>*

Dignity in Dying endorses the view of Sir Graeme Catto, President of the General Medical Council, who stated in evidence to the House of Lords Select Committee in 2004, *“It would seem to me that it would be perfectly possible to proceed along the lines considered on the Assisted Dying Bill without in any way impeding the progress and desirable developments in palliative care”.*<sup>23</sup> Far from undermining it, assisted dying legislation is likely to bring about improvements to end of life care in the UK. All of the evidence from Oregon and the Netherlands (where assisted dying is legal) confirms this.

### 3.1 Palliative care in Oregon

*“Our hospice utilisation is very high, hospice access is very high, palliative care is very high... We were the leader before the Death with Dignity Act and we are still the leader.”*

Ann Jackson, Executive Director, Oregon Hospice Association.<sup>24</sup>

Palliative care and medically assisted dying work well together in Oregon. Although not all hospices allow assisted dying to take place on their premises, research has found that 95% of hospice workers support policies that allow them to continue to care for patients who use the ODDA, regardless of whether they themselves support or oppose the Act. Patients do not face an ‘either/or’ choice – patients who choose an assisted death are still entitled to receive hospice care. In fact access to hospice and palliative care in Oregon has improved since the ODDA came into effect: 22% of Oregonians who died in 1994 were enrolled in hospice programmes; in 2003, this figure was closer to 50%.<sup>25</sup>

Doctors’ knowledge and skills have also improved. In 2004 research carried out with Oregonian doctors who had received requests for help to die concluded:

*“...Involvement in the process had a positive effect on [doctors]. Requests frequently facilitated discussion of important issues. Such discussions were considered a valuable patient-centred activity, a hallmark of good end-of-life care. Many physicians felt that they became better doctors and were able to generalise lessons learned to other patients. They felt more confident in discussing end-of-life options, and were more proactive in bringing up end of life issues. Physicians also spoke about being emotionally moved, expanding professionally or spiritually, or growing on some personal level.”<sup>26</sup>*

### 3.2 Palliative care in the Netherlands

The debate surrounding the introduction of the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002, stimulated developments in palliative care. As with Oregon, knowledge and interest in the area has greatly improved since legislation. Ms Irene Keiser, Dutch Ministry of Health stated, *“One of the things we have noticed since the law came into force is that even more people have become interested in palliative care. We see more hospices and more doctors educating themselves in palliative care...”<sup>27</sup>*

Since legislation an extra 50 million Euros has been put into palliative care. Because the majority of Dutch people die in their own homes, this money has been used to provide extra training for GPs and carers who provide palliative care in the home.

## 4. The public wants the law to change

*“My sister had breast cancer and bone cancer. Although she received hospice care she suffered unnecessarily and I believe that people like her should be able to have the choice to be helped to die if this is what they desire.”*

Jo, London: <http://www.ukactnow.org/stories.asp>

The British public believes legislation giving terminally ill patients the right to request medical assistance to die is long overdue:

**Table 4: Percentage of people supporting and opposing medically assisted dying legislation (where know, number of respondents is given in brackets)<sup>28</sup>**

	Support	Oppose	Don't know
British Social Attitudes Survey (BSA) 1984 (1,562)	75	24	-
MORI 1987 (1,808)	72	19	9
BSA 1989 (1,274)	79	20	-
NOP 1993 (2,000)	79	10	11
BSA 1994 (1,000)	82	15	-
Independent on Sunday 2001	85	15	-
Sky Interactive 2001 (3,563)	84.5	15.5	-
NOP 2002 (1,000)	81	12	7
NOP 2004 (790)	82	11	7
YouGov 2004 (2,091)	80	10	10
YouGov/Telegraph 2005 (2,432)	87	8	6

Even those with religious faith believe the current law needs to be changed, suggesting that religious leaders are out of touch with the members of their churches:

**Table 5: NOP 2004, percentage of religious respondents supporting and opposing medically assisted dying:<sup>29</sup>**

	Support	Oppose	Don't know
All respondents (790)	82	11	7
Catholic respondents (163)	81	14	5
Protestant respondents (220)	81	13	6
Jewish (4)*	100	-	-
Muslim (22)	42	49	9
No Religion respondents (219)	95	3	2

\*NOP have stated that the low number of Jewish respondents renders this finding inapplicable.

Despite the fact that there is nothing in the ADTI Bill that refers to disabled or elderly people, some organisations representing these groups have interpreted the Bill as a direct threat to them. However, as with the leaders of faith groups, these organisations are out of step with the people they represent, because disabled and elderly members of the public are no less likely than anybody else to support medically assisted dying.

The 2004 NOP poll found that 78% of people aged 65 or over supported medically assisted dying legislation. Similarly, 80% respondents to a YouGov 2004 poll who were aged 50 or over supported legislation.<sup>30</sup> The poll also found that 80% of disabled respondents support legislation, compared with 79% of able-bodied respondents. And 91% of respondents to an online poll in 2005 by RADAR (an umbrella organisation for disability rights groups) thought terminally ill people should be allowed to ask for assistance to die.<sup>31</sup> This is particularly significant given that RADAR opposes medically assisted dying.

Perhaps most importantly, terminally ill people themselves would like the law to change. Many terminally ill people have said they would be comforted by the knowledge that should their suffering become unbearable, they would have the option of medical help to die.

## 5. Healthcare professionals' attitudes to a change in the law

*"Unfortunately current medical ethics and the law often make it dangerous to respond openly to patients in such dire circumstances. The safest thing for doctors to do is to minimise and ignore their desperate requests thereby abandoning them to act on their own or to continue suffering."*

Dr Timothy Quill, Palliative Care Consultant<sup>32</sup>

Because it is against the law, medically assisted dying has always been a taboo subject amongst healthcare professionals. However the discussion around the ADTI Bill has given them an opportunity to talk openly about this hidden area of their professional lives – and it is now clear that many believe regulating medically assisted dying via the law of murder and the Suicide Act does not serve the best interests of patients or doctors.

The law allows patients to refuse life-sustaining treatment, or to request that it is removed, even if their doctors do not believe this is a rational decision. As many as 177,000 patients die each year from 'non-treatment decisions'.<sup>33</sup> Dr Michael Wilks, Chair of the British Medical Association's Ethics Committee, recently asked, *"If competent people can now make legally binding decisions to refuse life-saving treatment knowing that treatment will lead to their death, to then go a little further where people could make competent decisions to determine the time and the way they die, how big a step is that?"*<sup>34</sup> Many doctors share this view.

**Table 6: UK healthcare professionals' views on medically assisted dying<sup>35</sup>**

Survey/event	Finding
General Practitioner 2005	51% GPs supported physician assisted suicide
Annual Conference of the Multiple Sclerosis Trust, November 2005	82.4% voted 'yes' or 'under certain circumstances' to the question, "should the terminally ill person have the right to ask for medical help to die?"
Annual Neurosciences Conference, September 2005	65% doctors (approx) stated that they were in favour of medically assisted dying for terminally ill patients within a legislative framework.
The British Medical Association Annual Conference, June 2005	53% doctors voted yes to the motion, "The BMA should not oppose legislation which alters the criminal law but should press for robust safeguards for both patients and for doctors who do not wish to be involved in such procedures."
Medix-UK 2004	56% doctors chose legislation for PAS over criminal prohibition
Nursing Times 2003	2 in 3 (66%) nurses believed assisted dying should be legalised
McLean 1996	65% medical practitioners in favour of a change in the law

The British Medical Association has now adopted a position of neutrality towards the ADTI Bill, as has the Royal College of Physicians.<sup>36</sup> Both organisations have stated that this is a matter for society to decide.

The National Council for Palliative Care, the Motor Neurone Disease Association and the Association of British Neurologists have also taken neutral positions.<sup>37</sup> The British Association of Social Workers and the Terrence Higgins Trust have publicly stated that they support a change in the law,<sup>38</sup> and the General Medical Council has stated, "Were this Bill to become law, it would present no insurmountable problems for the General Medical Council"<sup>39</sup>

Despite the finding of the Nursing Times Survey finding that two-thirds of nurses think the law should change, the Royal College of Nursing remains opposed to the ADTI Bill.<sup>40</sup> This appears to be yet another example of a membership organisation being out of step with the members it represents.

Chapter 2:

**The Assisted Dying  
for the Terminally Ill Bill**

*"I feel very strongly about assisted dying. It seems to me to be a human right to make a decision in relation not only to how you run your life, but how and when you die. Some terminally-ill patients suffer terrible deaths and the Bill is all about preventing unnecessary suffering."*

**Lord Joffe<sup>41</sup>**

## The Assisted Dying for the Terminally Ill (ADTI) Bill

Lord Joel Joffe first introduced the ADTI Bill to the House of Lords in January 2004. The Bill would enable an adult in England or Wales who has capacity and is suffering unbearably as a result of a terminal illness to receive medical assistance to die, at his own considered and persistent request. Because Parliamentary time ran out, a new version of the Bill was introduced in November 2005 (see section 2).

The Bill has over 20 interrelated safeguards - more than any of the assisted dying laws used in other countries:

The Parliamentary Joint Committee on Human Rights 2003-04 determined that, *“The safeguards in the current Bill would be adequate to protect the interests and rights of vulnerable patients, ensuring that nobody could lawfully be subjected to assisted dying without his or her fully formed consent.”*<sup>42</sup>

No legislative safeguards exist for any other end-of-life practice which may result in the patient's death (e.g. withdrawing or withholding treatment).

### 1. The House of Lords Select Committee on the ADTI Bill, 2004-05

In March 2004 a House of Lords Select Committee was established to examine the ADTI Bill. The Committee undertook the most comprehensive investigation into medically assisted dying ever carried out anywhere in the world.

The Committee of 13 Lords, including Lord Joffe, received over 14,000 letters and emails from individuals who wished to comment on the Bill, as well as nearly 70,000 petitioning cards and emails. Over 140 expert witnesses in the UK, Oregon, the Netherlands and Switzerland gave oral evidence. The Committee published a Report of its findings in April 2005.

**Please note that the Committee examined the 2004 version of the ADTI Bill. Since then the Bill has been redrafted, as detailed in section 2.**

#### 1.1 The Committee's recommendations

The Committee recommended that:

- An early opportunity should be taken in the next session of Parliament for a debate on their Report;
- Should a new Bill be introduced, it should be referred, following a formal Second Reading, to a Committee of the whole House for detailed examination in the light of the Report;
- Those responsible for any new Bill should give serious consideration to a number of key issues which emerged during the Committee's enquiry.

Dignity in Dying welcomed the report of the Select Committee. We recognise the hard work undertaken by the Committee to tackle the issue so comprehensively. The report made a number of helpful suggestions on how the safeguards in the Bill could be improved, and when Lord Joffe reintroduced the Bill in November 2005 it was clear that he had taken many of them on board.

## 1.2 Themes of the enquiry

A number of key themes came forward during the course of the Committee's enquiry, all of which we had addressed in our submission to the Committee. We believe the debate around medically assisted dying must be informed by the experience and data of countries and states which permit medically assisted dying - most notably, the Netherlands and Oregon. All of our arguments are founded in objective evidence and research. On this basis we argued that:

- **There is no slippery slope:** There has been no 'avalanche' of medically assisted deaths the Netherlands or Oregon; the percentage of people receiving assisted deaths has remained low and stable in both places. Medically assisted deaths comprise only 0.14% of all deaths in Oregon and 2.8% of all deaths in the Netherlands.<sup>43</sup>

Nevertheless opponents of the Bill claim that legislation will inevitably be loosely interpreted so that more patients can 'qualify' for a medically assisted death. They point to the Abortion Act 1967 as an example of legislation intended for a small number of people becoming available 'on demand'. However the Select Committee believed that, *"There are... dissimilarities between the Bill and the Abortion Act. The latter, for example, allows abortion in cases where there is considered to be risk to the physical or mental health of the mother or her other children as well as to her own life. There is also a difference from the ADTI Bill in the nature of what is on offer. Whereas it was, perhaps, to be expected that there would be growing pressures to apply the Abortion Act with growing elasticity in an age of increasing secularity, most people have a natural desire to remain alive and in consequence there is unlikely to be the same degree of pressure to exploit loopholes in a law permitting assisted suicide and voluntary euthanasia."*<sup>44</sup>

- **The doctor-patient relationship will not be damaged:** Assisted dying legislation facilitates open and honest discussion between doctors and patients. Conversely, the current law prevents doctors engaging in conversations with patients who request help to die, as Sir Graeme Catto, President of the GMC, pointed out: *"you come immediately into a conflict here where some patients may be requesting something that at the present time is unlawful and that precludes further conversation."*<sup>45</sup>

Perhaps because of their honest approach, research conducted across six European countries found doctors in the Netherlands to be the best at communicating and discussing end-of-life decisions with their patients.<sup>46</sup>

There is no evidence to support the claim that patients would not trust doctors if medically assisted dying were legal. A survey of 11 countries (including Britain), found that the Dutch have the highest regard and trust for their doctors, and a 2004 YouGov poll found that 79% of the public would trust their doctor the same amount or more if assisted dying were legal.<sup>47</sup> The Committee's report recognised that *"Opinion polls do not suggest any significant anxiety on this score from the point of view of patients"*.<sup>48</sup>

- **Vulnerable people will not be threatened by legislation:** We agree with researchers such as Emanuel, Lee and Brock who have concluded that legislation would ensure that doctors adhere to strict safeguards and thus protect vulnerable people such as the elderly and the disabled.<sup>49</sup>

Abundant research confirms that disabled and elderly people in Oregon and the Netherlands are actually less likely to receive an assisted death than able-bodied, younger people. Dr van der Heide, a lead researcher in end-of-life decisions in the Netherlands, has stated, *"We repeatedly*

*find, from 1990 onwards, that [voluntary] euthanasia and especially assisted suicide are not typical for the elderly age groups but rather for people who die at a somewhat younger age...We did not encounter in our death certificate study or our interview study any indication or evidence that disabled groups are involved more than other groups in end-of-life issues – not in euthanasia but also not in other end-of-life decisions”<sup>50</sup>*

The Committee’s report does not draw any conclusions on whether or not legislation will pose a threat to vulnerable people. However, it does note the arguments of Dr Tom Shakespeare, winner of the RADAR People of the Year Award 2003 for furthering the rights of UK disabled people, who said *“I do not think disabled people are dupes...I do not think they are going to be trotted off to die against the will”*.<sup>51</sup> With regards to elderly patients, the report cites evidence from Professor Raymond Tallis, Consultant Geriatrician, who stated, *“the older the age of death the less need in general there is likely to be for assisted dying. Younger people die harder than very old people”*.<sup>52</sup>

- **Depression is not an issue:** There is a wealth of evidence showing that patients who receive assistance to die are not depressed. One example is Dr Ganzini’s work in Oregon in 2002, which asked hospice nurses and social workers to rate in order of importance 21 reasons why their patients had chosen an assisted death. Depression was rated the 19th most important reason.<sup>53</sup>

Dr Lloyd of the Royal College of Psychiatrists told the Select Committee, *“everything we learn from the literature about this area does suggest that there is a small group who have received good care in terms of palliative care, symptom relief; they are not depressed, or if they were depressed, their depression has been treated to the best of our ability, and it does seem that there is a small group who, despite all that treatment, still wish to end their life.”*<sup>54</sup>

Dignity in Dying agrees with researchers such as Bharucha who argue that it is patronising and “reductionistic” to consider those who seriously pursue a medically assisted death as “simply depressed”.<sup>55</sup>

- **‘Burden’ is not an issue:** Research from Oregon finds the issue of ‘burden’ is related to the loss of autonomy, and it is this loss of autonomy that underlies a request for assistance to die in the vast majority of cases. The Third Annual Report into the ODDA observed that, *“Oregon patients almost always discussed concern about becoming a burden in conjunction with losing autonomy (and this) suggests that it might be part of patients’ ideas about independence.”* This reported concluded, *“No evidence suggests that such a pressure has been a primary motivating influence among the 70 Oregon patients participating to date...”*<sup>56</sup>
- **Palliative care is not always the answer:** Even with the very best palliative care, some terminally ill patients would still like the right to medical assistance to die. The Select Committee agreed that there is a group of patients who are *“unlikely to be deflected from their wish to end their lives by more or better palliative care.”*

However medically assisted dying legislation and palliative care should not be seen in opposition to each other. Rather than be undermined by it, there is every reason to believe that palliative care would develop and improve alongside assisted dying legislation. Oregon’s high standard of and high access to palliative care is recognised in the Committee’s report.

- **The public must decide:** Dignity in Dying shares the view expressed by the General Medical Council and the British Medical Association that it is for society as a whole, through the

democratic process, to determine whether, and on what basis, assisted dying should be made lawful.

We welcome the Select Committee's unanimous decision that *"while the most careful account must be taken of expert evidence, at the end of the day the acceptability of assisted suicide or voluntary euthanasia is an issue for society to decide through its legislators in Parliament."*

This is a significant change from the conclusion of the last Select Committee to consider the issue, the Select Committee on Medical Ethics 1993-94.<sup>57</sup> That Committee unanimously agreed that the law must not be changed.

## 2. The new Assisted Dying for the Terminally Ill Bill, 2005

Lord Joffe introduced a new version of the Bill to the House of Lords in November 2005. Having taken note of the recommendations of the Select Committee, Lord Joffe made some significant amendments to the new Bill:

**Assisted suicide:** Most importantly the new Bill is limited to assisted suicide, whereby the doctor prescribes medication which the patient must then self-administer to end his life. The doctor is not permitted to directly administer the medication (this would be voluntary euthanasia).

The ODDA works in the same way. Having heard evidence in Oregon that their law is working safely and without abuse, a majority of Select Committee members said that they would support Oregonian-type legislation in the UK.<sup>58</sup>

Lord Joffe told the British Medical Journal, *"I have listened to the views in Parliament and among medical professionals and believe there is more support for a law which requires the patient to take the final act. This seems to reassure doctors that the patient is exercising a choice and is less difficult to them on a personal level."*<sup>59</sup>

**Capacity:** The definition of capacity is now more stringent and takes account of the need to identify psychological or psychiatric disorders.

The Bill stipulates that if either the attending or the consulting physicians doubt the patient's capacity, he shall be referred to a psychiatrist or psychologist for an independent assessment.

**Terminal illness:** In recognition of the clinical realities of prognosis, the definition of terminal illness has been changed and is now modelled on Oregon's definition of terminal illness. It is now defined as *"an illness which in the opinion of both the attending and the consulting physician is inevitably progressive; cannot be reversed by treatment (although treatment may be successful in relieving symptoms temporarily), and will be likely to result in the patient's death within six months."*

**Conscientious objection:** This clause has been widened. It is now explicitly states that no doctor or any other person will be under any duty to participate in any diagnosis, treatment or other action authorised by the Bill. Further, no hospice, hospital, nursing home, clinic or other health care establishment shall be under any obligation to permit an assisted death on its premises.

### 3. Safeguards in the new Bill

**Table 7: Comparison of safeguards in medically assisted dying legislation: UK, Oregon, Netherlands and Belgium**

	<b>ADTI Bill</b>	<b>Oregon</b>	<b>Netherlands</b>	<b>Belgium</b>
<b>Formal reporting procedure?</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>
<b>Second doctor opinion?</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>
<b>Unbearable suffering?</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>Yes</b>
<b>Residents only?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Conscientious objection clause?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Other witnesses needed?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Competent patients only?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Written and oral request?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>
<b>Terminal illness only?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Only for 18 years or older?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Waiting period?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>For non-terminal illness</b>
<b>Psychiatric/psychology referral if competency in doubt?</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>	<b>No</b>
<b>Meeting with palliative care specialist?</b>	<b>Yes</b>	<b>No</b>	<b>No</b>	<b>No</b>
<b>Physician-assisted suicide?</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>No</b>
<b>Voluntary euthanasia?</b>	<b>No</b>	<b>No</b>	<b>Yes</b>	<b>Yes</b>

## Conclusion

- Competent terminally ill adults who would like to receive medical help to die are currently prohibited from doing so under the Suicide Act and the law of murder. Regulating how a terminally ill person would like to die using the law of murder and the Suicide Act is inhumane. Further, criminal regulation has repeatedly been found to be ineffective and untenable.
- Irrespective of what the law says, health professionals are helping their patients to die. Up to 164,000 people may have their deaths hastened by pain-relieving medication every year, via the unworkable principle of double effect. This takes place without safeguards, accountability or transparency.
- Nearly 50% of the population have said that they would be prepared to break the law and help a loved one to die, risking their freedom and their mental well being. 30% of mercy killers go on to commit suicide themselves.
- Faced with no alternative, some terminally ill patients are prepared to travel abroad to receive an assisted death, and others take their own lives in deeply distressing circumstances.
- Two decades of polling consistently finds that over 80% of the public think the law should allow competent terminally ill adults to ask for and receive medical assistance to die, subject to strict safeguards.
- Between 50 and 80% of British doctors and nurses also believe terminally ill patients should have this right. Medical organisations are increasingly open to this idea.
- The Assisted Dying for the Terminally Ill Bill provides this option within a safe and properly regulated system. The Bill contains over 20 interrelated safeguards, ensuring that only competent terminally ill adults who have made considered, persistent and informed voluntary requests could receive assistance in dying.
- Evidence from abroad shows that this is a far better response to people's needs at the end of life. Legislation facilitates open and honest discussion of all the dying patient's desires and concerns, and gives terminally ill patients an 'insurance policy' of an assisted death, thereby enabling them to continue to live without so much anxiety about their future.
- By providing clear guidelines to the medical profession and introducing accountability and transparency, legislation better protects vulnerable members of society.
- The House of Lords Select Committee that examined the Bill acknowledged the strong demand for legislation amongst terminally ill patients who are unlikely to be deflected from their wish by more or better palliative care. The Committee recommended the Bill be fast-tracked through the House of Lords. Dignity in Dying fully endorses these recommendations.

## Appendix 1: Key dates

### **1993-1994:**

The House of Lords Select Committee on Medical Ethics concludes that the law on assisted dying should not be changed.

### **1997**

The Oregon under the Death with Dignity Act, permitting patient assisted suicide but not voluntary euthanasia, is passed.

### **2002**

The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, permitting medically assisted dying, is passed.

The Belgian Act on Euthanasia is passed, permitting medically assisted dying.

Diane Pretty dies shortly after losing her battle for the right to have her husband Brian help her die.

### **March-June 2003**

Parliament's Joint Committee on Human Rights find the safeguards in Lord Joffe's Patient (Assisted Dying) Bill would be adequate to protect the interests and rights of vulnerable patients.

Three members of the 1993 Select Committee announce they now believe the law should be changed at the Second Reading of the Bill. These are Baronesses Jay, Flather and Warnock.

### **March 2004**

A House of Lords Select Committee is set up to examine the Assisted Dying for the Terminally Ill Bill.

The Liberal Democrats debate medically assisted dying for terminal illness or severe, incurable and progressive physical illness without hope of recovery. The vote in favour passes three to one.

### **August 2004**

The Law Commission describes the law on murder a 'mess' and call for it to be reviewed.

### **October 2004**

The Royal College of Physicians drop their opposition to medically assisted dying legislation.

The Royal College of General Practitioners and the Academy of Royal Colleges also adopt a neutral position (the RCGP has since reverted to a position of opposition).

### **November 2004**

The High Court lifts an injunction obtained by a local authority, enabling Mrs Z, a woman suffering from an incurable brain disease, to travel to Dignitas in Switzerland for an assisted suicide.

### **January 2005**

Brian Blackburn, who helped his terminally ill wife to die, receives a nine month suspended sentence.

The Judge tells Blackburn he had acted as a "loving husband" when his wife had begged him to kill her.

### **4th April 2005**

The Report of the Select Committee on the ADTI Bill is published. It recognises the demand for legislation and concludes that the acceptability of assisted dying is for society to decide through Parliament.

### **June 2005**

The British Medical Association adopts a position of neutrality towards the ADTI Bill.

### **November 2005**

Lord Joffe introduces a new draft of the ADTI Bill, with some significant changes. The Bill is now limited to patient-assisted dying; voluntary euthanasia is not permitted.

### **December 2005**

Following a consultation paper by the Law Commission, the Home Office's review of the law of Murder commences.

After an 8 week trial, Dr Howard Martin is found not guilty of killing three patients with morphine overdoses, because the prosecution fails to prove that the doses of morphine had killed the three men, or that Martin knew exactly what effects the drugs would have on his patients.

## Appendix 2: Frequency of end-of-life decisions in the UK, Europe and Australia (%)

	UK (2004)	Belgium (2001-2)	Denmark (2001-2)	Italy (2001-2)	Netherlands (2001-2)	Sweden (2001-2)	Switzerland (2001-2)	Australia 1996)
Total end-of-life decisions	70.2	<u>59.0</u>	<u>61.1</u>	<u>32.5</u>	65.4	<u>50.9</u>	75.0	64.8
Doctor-assisted dying	0.54	<b>2.78</b>	1.17	0.16	<b>5.12</b>	0.31	1.53	<b>5.4</b>
Euthanasia (voluntary)	0.17	0.46	0.10	0.05	<b>3.89</b>	-	0.39	1.8
Physician-assisted suicide	0.00	0.05	0.10	0.00	<b>0.31</b>	-	<b>0.52</b>	0.1
Ending life without an explicit request from patient	0.36	<b>2.26</b>	1.02	0.11	0.90	0.31	0.61	<b>3.5</b>
Alleviation of symptoms with possible life-shortening effect	36.3	33.4	38.9	26.7	30.1	30.3	32.3	30.9
Non-treatment decisions	33.4	<u>22.8</u>	<u>20.9</u>	<u>5.6</u>	30.1	<u>20.2</u>	41.1	28.6

Figures where the UK is significantly lower are marked in **bold**; figures where the UK is significantly higher than that country are *italicised and underscored*.

Figures for Australia taken from Kuhse, H., Singer P., Baume P., Clark, P., and Rickard, M., "End-of-life decisions in Australian medical practice", MJA 1997; **166**: 191-197

All other figures taken from Seale, C. "National survey of end-of life decisions made by the UK medical practitioners", *Palliative Medicine* 2006; **20**: 1-8. Figures based on 584,791 deaths per annum.

### Appendix 3: Comparative table of European law

Appendix 3	Suicide	Assisted suicide	Assisted suicide in case of terminal illness	Treatment of voluntary euthanasia in the case of a terminally ill person
England and Wales	Not a crime	Up to 14 years imprisonment	Up to 14 years imprisonment	Treated as murder resulting in life imprisonment
Ireland	Not a crime	Up to 14 years imprisonment	Up to 14 years imprisonment	Treated as murder resulting in life imprisonment
Scotland	Not a crime	Not specifically a crime	Not specifically a crime	
The Netherlands	Not a crime	Up to 3 years in prison unless it comes within the assisted dying legislation	Up to 3 years unless it falls under the assisted dying legislation	Law allows VE for a terminally ill person within strict safeguards
Belgium	Not a crime	Not a crime	Not a crime	Law allows VE for a terminally ill person within strict safeguards
Switzerland	Not a crime	Not a crime unless assistant benefits in some way	Not a crime unless assistant benefits in some way	Treated leniently. Subject to 3 years imprisonment if done from honourable motives
Finland	Not a crime	Not a crime	Not a crime	
Denmark	Not a crime	If done for personal interest, up to 3 years, otherwise limited penalties	See previous entry	Treated leniently - considered as homicide in mitigating circumstances - penalty up to 3 years
Sweden	Not a crime	Not a crime	Not a crime	Treated as murder
Norway	Not a crime	Penalty considerably less than 6 years	1992 case suggests no prosecutions will be brought	Treated leniently under Art 235 - penalty considerably less than 6 years

<b>Appendix 3</b>	<b>Suicide</b>	<b>Assisted suicide</b>	<b>Assisted suicide in case of terminal illness</b>	<b>Treatment of voluntary euthanasia in the case of a terminally ill person</b>
Spain	Not a crime	6 to 10 years	Less than 2 years imprisonment	VE for a terminally ill person unlikely to be subject to a prison term
Portugal	Not a crime	Up to 3 years	See previous entry	Treated leniently. Subject to up to 3 years in prison
Italy	Not a crime	5 to 12 years	See previous entry	Subject to 6 to 15 years in prison
France	Not a crime	Assisted suicide is not a crime	See previous entry	Treated as murder
Germany	Not a crime	Not a crime if the person can exercise control over his actions	See previous entry	Treated leniently. Subject to 6 months to 5 years in prison
Austria	Not a crime	Assistance carries 6 months to 5 years		Treated leniently. Subject to 6 months to 5 years punishment

## References

Dignity in Dying is happy to provide further information and references on any of the points raised in this report. Please contact our research department on 020 7361 0170

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- <sup>2</sup> ["I let go of her hand"](http://www.guardian.co.uk/g2/story/0,,1453639,00.html), *The Guardian Online*, 7th April 2005 <http://www.guardian.co.uk/g2/story/0,,1453639,00.html>
- <sup>3</sup> ["Peers focus on euthanasia changes"](http://news.bbc.co.uk/1/hi/uk_politics/4190621.stm), *BBC News Online*, 20th January 2005 [http://news.bbc.co.uk/1/hi/uk\\_politics/4190621.stm](http://news.bbc.co.uk/1/hi/uk_politics/4190621.stm)
- <sup>4</sup> ["Suicide pact husband spared jail"](http://news.bbc.co.uk/1/hi/england/4174155.stm), *BBC News online* Friday 14th Jan 2005: <http://news.bbc.co.uk/1/hi/england/4174155.stm>
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- <sup>15</sup> NOP 2004, *ibid*.
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- <sup>18</sup> ["Swiss suicide clinic sees number of British clients rise by 700%"](http://news.independent.co.uk/uk/health_medical/article9229.ece), *Independent Online*, 4th April, 2005: [http://news.independent.co.uk/uk/health\\_medical/article9229.ece](http://news.independent.co.uk/uk/health_medical/article9229.ece)
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## NOTES

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