The existing legal problem with assisted dying - and a review of the position in other countries written by Belinda Schwehr, Social Care and Health Lawyer, October 2024

Suicide used to be a crime, here, with survivors prosecuted and imprisoned and family members, assisting, potentially being prosecuted. Religious and moral objections regarded suicide as "self-murder".

There is now a range of moral and philosophical views held by different groups in society concerning the balance between the limits of personal autonomy, or whether there is a duty to continue life regardless. Nobody wants to see anyone's suffering lengthened, but how to prevent that, is the legal conundrum.

https://humanists.uk/2023/10/03/six-reasons-we-need-an-assisted-dying-law/ is an introduction as to why Humanists support Assisted Dying and https://humanists.uk/2023/07/11/the-assisted-dying-inquiry-everything-important-that-was-said/ is a precis of the most recent high level inquiry into the pros and cons of the topic by the Health and Care Select Committee, here. Over 350 million people across the world have access to assisted dying and in every country that has legalised it there is no call to criminalise it again.

Supporters contend that the practices preserve an individual's autonomy and self-determination during the end of life and allow people to choose a death with dignity; that euthanasia and assisted suicide are occasionally the only option to relieve unbearable suffering and that quality of life takes precedence over quantity of life; the option being an important aspect of the care for those who are dying, one in which physicians can facilitate death in a safe way that suicide by other methods cannot.

Conversely, opponents argue that euthanasia and physician-assisted suicide practices violate the medical code and the Hippocratic Oath, result in damage to the patient-physician relationship and undermining public trust in the health care system. They maintain that suffering, no matter how unbearable, can be relieved with adequate palliative care and/or terminal sedation and warn that vulnerable populations including the disadvantaged and disabled will be impelled toward premature death.

The "slippery slope" argument suggests that inevitable and undesired expansion will take place once euthanasia and/or physician-assisted suicide are legalised and the practices will result in error, abuse and infringement on the rights of vulnerable populations. As a percentage of all Medically Assisted deaths in Canada, those for whom their death was not reasonably foreseeable represented just 0.14% of all deaths in Canada in 2022 (compared to all MAID provisions, which represented 4.1% of all 2022 deaths in Canada).

The debate into the Leadbeater Private Members Bill is scheduled for 29th November on its Second Reading.

The current law

Section 2(1) of the Suicide Act 1961 provided as follows: *"A person who aids, abets, counsels or procures the suicide of another, or attempt by another to commit suicide shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years"*

Euthanasia refers to the act of intentionally ending the life of a patient by a health care practitioner through medical means at that patient's explicit request while 'physician assisted suicide or dying' involves the provision or prescribing of drugs by a health care practitioner for a patient to end their own life. Some physicians who already administer opiates with the intention of ending a person's life as well as reducing suffering and managing pain do not recognize their actions as euthanasia, because of the dual intention.

The drugs most often recommended where it is legal typically include a combination of (optional) benzodiazepine to relax the patient, followed by a high dose of a barbiturate such as phenobarbital, pentobarbital or secobarbital, which typically causes death, followed by a muscle relaxant, if required.

Following a series of cases, the courts and DPP have accepted that a person has a right to autonomy over their own body under Article 8, such that there is a legal right to end one's life at a point of one's own choosing. The Courts have, however, left it to Parliament to legislate and discuss these important ethical issues, not because they don't get involved in life or death decisions (they do, all the time regarding authority

to cease medical provision) but because any law we get must deal with checks and balances and requires careful thought and drafting, and underpinning through democratic support.

"It would not be beyond the wit of a legal system to devise a process for identifying those …few people, who should be allowed help to end their own lives. ***They would firstly have to have the capacity to make the decision for themselves****. They would secondly have to have reached the decision* ***freely without undue influence from any quarter.*** *They would thirdly have had to reach it with* ***full knowledge of their situation, the options available to them, and the consequences of their decision****: ... And they would fourthly have to be unable,* ***because of physical incapacity or frailty, to put that decision into effect without some help from others.*** *… the nature of the judgments involved would be no more difficult than those regularly required in the Court of Protection or the Family Division when cases such as* ***Aintree University Hospitals NHS Trust v James*** [2013] 3 WLR 1299 *or* ***Re B (Treatment)*** *come before them.*

…vulnerable people whom the present universal prohibition is designed to protect… would not meet the qualifications to be allowed help. The process would not be invoked and even if it were it would not succeed in securing them that help. It would be a more suitably targeted solution than any prosecution policy, however enlightened and humane, could ever be.

Following the Supreme Court decision in Tony Nicklinson's case, his partner took the case to the European Court of Human Rights. *That* Court held the case to be inadmissible, because the issue of assisted dying was within the state's "margin of appreciation". So it really is being left to our own Parliament to decide.

How has the law developed in other countries?

There are laws that permit assisted suicide, including physician-assisted suicide, worldwide, including Canada, Colombia, New Zealand, various states but not all, in the USA and Australia and across Europe. Several European countries permit it already: Switzerland, Netherlands, Belgium, Luxembourg, Spain, Portugal, Italy, and considering it are Scotland Isle of Man, Ireland and Jersey.

In some countries assisted dying is recognised as a constitutional right, whereas in others it is designed to protect doctors who practise euthanasia. Some countries do not distinguish between physical or mental illnesses when it comes to requesting assisted dying, eg in Spain, allowing anyone to make a request if they have a "severe, chronic and debilitating condition or illness" with no possibility of improvement. In Japan suicide is still a crime. The French Government introduced its end of life care bill in April, following a citizens' jury, which had overwhelming support for law change.

In Canada, where it was legalised in 2016 it was amended in 2021 to remove the need for there to be a "*reasonable foreseeability of natural death*" and again in 2024 to exclude those with a mental health condition *alone* from being able to use this law (not including neurocognitive conditions such as dementia).

In particular, the removal of the "*end of life*" condition in 2021 came about after hearing extensive expert and other evidence by a Canadian Parliamentary committee and a consultation involving over 300,000 people who had been involved in assisted dying since its introduction, about how that clause was working in practice.

The Assisted Dying Bill for the UK is likely to provide that, if statutorily defined procedures are followed, no offence of assisting a suicide under the 1961 Act will be committed. These are the issues worth considering:

1. What <u>conditions</u> will a person need to satisfy to gain the potential right to be assisted by a doctor (or anyone else) to die?

The Bill will provide that the right to a lawful physician-assisted death will only be available to someone with a **terminal illness**, namely someone who "*as a consequence… is* ***reasonably expected to die within six months***". Those with chronic diseases may suffer terrible and uncontrollable suffering from their condition but a doctor may not be able to say that the person would be "*reasonably expected to die within six months*".

There may be those who propose that Parliament should adopt the Canadian wording of "*advanced state of irreversible decline*".

2. What <u>procedures</u> will have to be followed by a potentially eligible person in order to gain the right to be assisted by a doctor (or anyone else) to die? A person will need to show that

(a) the individual has capacity to make the decision themselves, almost certainly using the capacity tests under the Mental Capacity Act 2005, and

(b) that the individual has made an informed, voluntary decision that he or she wants to die at a point of their choosing.

The assessment as to whether a person has capacity and has made such a decision will probably be **required to be made by a doctor, and that decision will have to be supported by a second doctor.**

That scheme leaves open the following issues: what type of **relationship** should the doctors or one of them, have with the person, to qualify? What procedures will the doctor(s) have to undertake? How is the doctor supposed to test the voluntariness of the patient's decision and/or whether the person is acting under pressure from anyone else? Would the doctors have to have had any special training?

There are well-established models for establishing consent for certain lifetime organ transplants under the Human Tissue Act 2004 - thorough and undertaken by specially trained staff, but not by doctors.

In Canada, before 2021, individuals had to wait 10 days prior to being able to have medical assisted dying. Canada now has two different ways of assessing eligibility depending on whether death is "reasonably foreseeable", or in a state of "irreversible decline". If the former, then a request must be made in writing and signed by an independent witness (either a paid professional or healthcare worker); two independent doctors or nurses must provide an assessment and confirm eligibility; the person must be informed that they can withdraw their request at any time; the person must be given an opportunity to withdraw consent and must expressly confirm their consent immediately before receiving medically assisted dying.

Where someone's death is not reasonably foreseeable, the criteria are different and a lot more meaningful regarding other options, and lengthy - unless the person is just about to lose capacity.

The Bill is likely to suggest that approval for each case of physician-assisted dying has to be given by a High Court Judge of the Family Division. This proposal potentially raises some difficult issues including: judicial numbers and capacity for handling many applications, would oral evidence be required, and due process issues for those whose capacity is declining. Will legal aid be available? It could be argued that it would be more appropriate for a separate, specialised adjudicative body with appropriate input from specialists in medical ethics, jurisprudence, palliative care, nursing, psychiatry and medicine and social care law, to be set up specifically to examine and give approval for such applications.

3. What protections will there be to prevent vulnerable elderly people from being persuaded to end their own lives prematurely?

It is unclear how, in practice, the Bill will lay down standards which have to be met in order to protect individuals against exploitation. There are several possibilities: creating a window or "pause" where the person has to consider matters without their family interfering /discussing; providing appropriate additional support to that person by way of care and palliative services so that they can see the alternative options; preventing dispersal of an estate where someone has died by way of physician-assisted suicide for a period of time to prevent pressure from being able to have an effect; and/or providing or requiring a course of counselling/therapy/oversight to ensure that someone is not being persuaded into doing so.

4. Will doctors be able to assist those who want a physician assisted death as part of NHS treatment?

Physician-assisted dying is available through public health services in Canada. This is a practical issue for NHS commissioners because, without NHS funding, this may only be an option for the relatively wealthy (and that

itself may represent a fresh breach of Article 8 for the severely disabled). There may also be concerns that having private clinics may encourage charlatans to operate in this area – although all doctors irrespective of how they undertake their work are regulated by the General Medical Council and the Care Quality Commission. There may be a need for specific GMC guidance to doctors who are undertaking work in this area or even a specialist regulatory body to provide specific rules and regulations and to provide the kind of multi-disciplinary oversight described above. If so, that will need to be set up and put into operation.

5. Will doctors be obliged to take part in such a procedure?

The Falconer Bill provided that doctors could not be required to take part in physician-assisted dying on the grounds that many doctors may legitimately conclude that this is not a professional service that, in all conscience, they are prepared to provide. The same provisions apply to abortion services but, in that case, the doctor is required to refer the patient to a medical colleague who may be able to assist.

There would either have to be specialist services under the NHS, or a national body which, at least for the first ten years, had specific and sole oversight over any such physician-assisted dying, in order to provide adequate ethical oversight as well as to provide a body of specialist knowledge and understanding of how the law is, or is not, working and creating a body of real expertise.

6. What should the doctor do if the doctor has concerns about the voluntariness of the patient's decision or is concerned about the case for any other reason?

The doctor should refuse to give the requested certificate. But there do not appear to be any present proposals to build in appropriate safeguards to prevent "*doctor shopping*". If a doctor has refused to provide a certificate because, for example, the doctor concluded that the person may lack capacity or is not someone with a terminal illness who is reasonably expected to die within six months, it seems important that any other doctor who is approached should be made aware of the concerns previously raised.

One way around this would be to require any doctor refusing a certificate to set out reasons for doing so and for such reasons to be included in the patient's GP notes; and that any doctor asking for a certificate should be required to be provided with full access to the patient's GP notes. That is not entirely straightforward because compulsory inclusion of material in a person's GP notes gives rise to other issues, particularly if the person profoundly disagrees with the conclusions in the statement of reasons.

Other features to consider

No major disability advocate groups in the UK – including Disability Rights UK, Scope and Not Dead Yet – support a change in the law to introduce assisted suicide or euthanasia. No doctors' groups in the UK support changing the law to introduce assisted suicide or euthanasia, including the British Medical Association, the Royal College of General Practitioners, the Royal College of Physicians, the British Geriatric Society, and the Association for Palliative Medicine. In particular, there is strong opposition to introducing assisted suicide from doctors who specialise in working with people with incurable conditions at the end of their life. A survey of palliative care doctors who are members of the Association for Palliative Medicine found that 82% oppose the introduction of assisted suicide.

A recent poll published in *The Telegraph* found that the general public placed legalising assisted dying as 22nd out of a list of 23 possible priorities for the new Government. Whereas if it is to BE a priority, the largest and most in-depth survey of public opinion on assisted dying, published in March this year, found 75% in Great Britain are in favour of change with a majority of support in every parliamentary constituency and across all ages, genders, socio-economic status and voting intention.

Wes Streeting, who voted in favour of changes to the law in 2015, is worried the state of end-of-life care in the UK meant it was not ready for assisted dying, raising concerns about people being coerced into exercising their right to die because of a lack of end-of-life care – or we might add, social care or free NHS Continuing Health Care services.