The law looks at assisted dying

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The ethical and legal aspects of suicide and assisted suicide have been the subject of vigorous debate in the recent past but the controversy is not new. This paper, loosely based on an invited lecture to the 2010 summer meeting of the British Thoracic Society, seeks to explore the dilemma by tracing the attitude of English law to medical involvement in death and dying over the last 75 years.

THE CONTROVERSY IGNITES

The Society for the Legalisation of Voluntary Euthanasia was founded in 1935 by a group of eminent medical and clerical practitioners and held its first meeting in BMA House. These origins seem improbable in the light of the current attitude of both professions to assisted dying, but the new Society was enthusiastic and introduced its first Private Member's Bill in the House of Lords in 1936. It was defeated, one of those voting against being Lord Dawson of Penn, then Physician to the Royal Household. He defended his opposition on the grounds that legislation to permit intervention intended to hasten death is unnecessary because as soon as a medical practitioner is satisfied a patient's death is inevitable, there is a duty to minimise distress and act accordingly. This opinion was expressed in his management of the death of King George V in January of that year.[1] The King suffered from chronic obstructive pulmonary disease and had developed an exacerbation shortly before Christmas 1935. His condition deteriorated until he was bed-bound, comatose and had developed pleurisy. By the end of the third week in January, Lord Dawson was satisfied the King would not recover and, late one evening, administered a large dose of morphine followed by cocaine. About an hour later the King fell into a deep sleep and thereafter died peacefully at ten to midnight without regaining consciousness. Two reasons are recorded in the diaries published years later: his belief that the family (sic) had suffered enough, and that constitutional propriety would be facilitated if news of the King's death reached Fleet Street before the midnight deadline for appearing in the first edition of the morrow's newspapers.

Lord Dawson's management was not challenged, but it seems unlikely that such reticence would have ensued had any other member of the clinical team, or anyone from the royal household, given the injection of morphine. This suggests that at the time doctors were considered, to some unspecified degree, to be above the law.

THE COMMON LAW EVOLVES

Reliance on the existence of medical privilege is attributed to Dr John Bodkin Adams who, when arrested in 1956 on suspicion of murder arising from his practice, is said to have protested 'She wanted to die. That cannot be murder. It is impossible to accuse a doctor'.[2] Unfortunately for the practitioner, his opinion was erroneous and he was prosecuted, albeit unsuccessfully. However, the legal importance of the case is that it endorsed the validity of the ethical doctrine of double effect at English law. Dr Bodkin Adams prescribed large and rapidly increasing doses of opiates to relieve disturbed sleep in a number of elderly carehome residents, many of whom had made bequests to the doctor in their Will. The case attracted huge publicity, and a detailed account of the trial was published later by the trial judge—Devlin J (as he then was)—who thereby breached legal convention to a degree comparable to Lord Moran's account of Winston Churchill's medical history.[2 3] Devlin J is critical of the prosecution team but also intimates personal unease at the outcome which was that the practitioner had acted with good intent to relieve suffering and even had he thereby shortened life and known or believed this to be likely, such action did not constitute a criminal offence. What was not explored then or since is whether or not a practitioner can act with double intent as distinct from double effect. In the general context of the administration of opiates to patients with terminal illnes, is it possible that in some instances the practitioner does intend to hasten death as well as relieve symptoms?

The crucial importance of intention was re-emphased in the 1992 case of *R v Cox*.[4] Consultant rheumatologist Dr Cox had managed the severe, destructive rheumatoid arthritis of Mrs Lillian Boyes for 17 years and had an excellent therapeutic relationship with both her and her family. Elderly, emaciated, bed-bound and suffering from pressure sores, she was in severe and constant pain resistant even to opiates and, supported by her family, she begged and pleaded for assistance to die. Without discussing his decision with nursing staff from whom he obtained the medication, Dr Cox administered intravenous potassium chloride to Mrs Boyes who then died. Her body was cremated and it was a fortnight or so later before the matter was reported to the police. By then it was no longer possible to prove beyond reasonable doubt that this very sick woman had died as a result of the practitioner's actions and, nominally for this reason, the lesser charge of attempted murder was brought, so introducing the enormous legal advantage of a sentence amenable to judicial discretion. Dr Cox was convicted but given only a 1 year suspended sentence. After a disciplinary hearing by the General Medical Council he was allowed to continue in practice, subject to some retraining.

The distinction between the cases of Dr Bodkin Adams and Dr Cox rests on 'intention'. Both were

motivated to act by the benevolent wish to relieve symptoms but Dr Cox intended to kill (albeit only to secure symptom relief), whereas Dr Bodkin Adams—in the opinion of the law—intended only to relieve distress. Criminal offences are defined in terms of act and intent. Motive can be an exonerating factor, as it was for Dr Cox, but traditionally it only influences sentence, the end of the judicial process.

Intent, motive and causation of death in a medical context were explored again in the 1992 case of *Tony Bland* who had been in a persistent vegetative state after asphyxiation during the Hillsborough stadium disaster.[5] A consensual application from the hospital authority and family sought a declaration that withdrawing hydration and nutrition would not be unlawful despite the expectation that death would follow. In other words, neither civil suit nor criminal prosecution would ensue even though the patient's condition was stable and likely to remain so indefinitely if hydration, nutrition and good nursing care continued. Judicial opinion at all levels favoured the application, but the case was appealed as far as the House of Lords specifically because of the ethical importance of the decision. There it was held that nutrition and hydration provided other than by natural means did constitute medical treatment and that its withdrawal would not be unlawful. Opinion was divided on whether such a policy was justified because it was in the best interests or not against the patient's best interests or because his degree of obtundation was so extreme that he had no best interests. Despite the fact that the proximate or physiological cause of death would be dehydration and starvation, the legal cause of death was deemed to be the ultimate factor—the asphyxial incident, not the actions of the clinical team. Following the principles of this decision, the subsequent inquest returned a verdict of accident and cited traumatic asphyxia as the cause of death.[6]

This landmark case made one other contribution to the evolution of English law. Despite the authority of a decision at the highest level, their Lordships considered that the ethical implications went beyond their remit and so placed a specific prohibition on using the decision as a precedent. Any similar case should be referred to the Attorney-General until parliament—the voice of the people—had considered the ethical principle. A subsequent Select Committee report failed to change the law[7] and, in practice, not all subsequent cases of withdrawal of hydration and nutrition from patients in persistent vegetative state were referred for legal consideration. However, without further parliamentary debate on the 'principle' of whether or not it is lawful to withdraw hydration and nutrition from a mentally incapacited patient in these circumstances, the Mental Capacity Act 2005 has created a statutory requirement to apply to the courts before taking such action.[8]

Conflict over a competent patient's request for withdrawal of life-sustaining treatment arose in the case of *Ms B*, a 43-year-old quadriplegic and ventilator dependent after spontaneous haemorrhage from a congenital vascular anomaly in the cervical cord.[9] Her wishes were over-ruled and so she took her case to court. Butler-Sloss, President of the Family Division, relied upon the well-established legal principle that competent adults can refuse even life-sustaining treatment and directed the enquiry to assessment of competence. Current evidence was wholly in Ms B's favour and so her wish for treatment withdrawal was sanctioned and nominal damages were awarded against the hospital authority for treating her without consent. Reviewing other options, Butler-Sloss P commented 'with some sadness, that the one-way weaning process appears to have been designed to help the treating clinicians and other carers' and rejected the view expressed by some clinicians that discontinuing mechanical ventilation would be killing the patient or assisting her to die. Yet the practicalities are less clear. Expert opinion was that Ms B had a less than 1% chance of surviving while breathing spontaneously, presumably using her accessory muscles. Cessation of ventilation was expected to lead to death. The proximate cause, asphyxia, would be distressing for some minutes at least. Medication such as midazolam given to sedate and relieve distress would be expected to impair the tone and function of accessory respiratory muscles and so might hasten death. However, this could not be criticised because the duty to relieve distress, even though created by the patient's rejection of treatment, justified coincident life-shortening consequences through the doctrine of double effect.

THE ROLE OF STATUTE

In another case from 2002 the European Court of Human Rights upheld the decision of the English courts at all levels that the human rights of *Diane Pretty* were not contravened by the refusal to grant a declaration that her husband would not be prosecuted were he to help her to die, at a time of her choosing, to avoid further distress from her profoundly disabling motor neurone disease.[10] Her predicament prompted Lord Joel Joffe, former human rights lawyer who had conduct as solicitor in South Africa in the Rivonia trial of Nelson Mandela and colleagues,[11] to introduce a Private Members's Bill in the House of Lords seeking to legalise medical assistance to die in carefully defined circumstances and with many safeguards. A Select Committee explored the evidence thoroughly and on an international basis. The proposal was neither supported nor rejected, but suggestions were made for further consideration.[12] A modified Bill followed but was defeated on procedural grounds in a manner contrary to parliamentary convention.

The debate generated by this attempt to liberalise English law and by contemporaneous developments in other jurisdictions prompted renewed pleas for clarification of the terms of the Suicide Act 1961. The Act decriminalised suicide but it remained an offence to aid, abet, counsel or procure the suicide or attempted suicide of another. Conviction can result in imprisonment for up to 14 years, but prosecution can only be brought with the authority of the Director of Public Prosecution (DPP). The origins of this requirement are unclear. Criminal prosecution for any offence is only initiated when the prosecuting authorities consider there is sufficient factual evidence and that it is in the public interest to proceed. The Suicide Act adds the requirement to seek specific endorsement from the DPP, perhaps indicating, even as long ago as 1961, an awareness that sometimes the criminality of such an act is offset—perhaps negated—by a benevolent motive. This conclusion is strengthened by the fact that prosecutions for assisting suicide have been notable for their rarity and for the lenience of sentence in the case of conviction.

However, the law has not remained static, and three developments have occurred at or about the same time, leading to both change and clarification of the Suicide Act. A series of adolescent suicides concentrated in South Wales prompted concern that covert assistance through information sharing on the internet was responsible for this otherwise unexplained cluster of cases. As a result the Suicide Act was amended by the Coroners and Justice Act 2009 with effect from 1 February 2010.[13] Section 2 of the Act now defines the offence as assisting or encouraging the suicide or atempted suicide of another with the intent to secure that outcome. A number of additional

criteria tighten the provisions—for example, the offence is made out whether or not there is direct contact between the parties, even if the assistance provided could not in the specific circumstances be effective or even if the recipient does not act on it. At the same time, parliament rejected an attempt to create a statutory exception for the provision of assistance to suicide motivated by compassion.

Clarification of the Suicide Act has been achieved through further case law. In 2004 a local authority sought judicial determination on whether or not it had any obligation to seek to prevent a patient to whom it provided social services from travelling to Zurich where the commercial organisation Dignitas offers assistance to die to non-Swiss nationals in a jurisdiction where assisted suicide is not unlawful provided no personal gain is involved.[14] The judge was unequivocal in confirming that the local authority had neither right nor obligation to interfere in the lawful decision of a competent citizen to travel abroad, but also commented that the patient's husband, who was preparing to assist his disabled wife to travel, would be guilty of an offence. Nevertheless the husband was not prosecuted, nor has prosecution been brought against any of more than a hundred persons assisting another to reach Dignitas in similar circumstances. The case led to renewed calls for the DPP to clarify the criteria used to determine whether or not to prosecute under the terms of the Suicide Act 1961 and not merely respond by stating that prosecution was 'not in the public interest'. The dispute was resolved by the ultimately successful appeal of *Debbie Purdie* who suffers from multiple sclerosis and claimed her human rights were infringed if she did not know whether her husband would be prosecuted were he to assist her to travel abroad to seek an assisted death.[15] Despite failing at first instance and in the Court of Appeal, her application was upheld by the unanimous decision of five Law Lords, delivered in a blaze of publicity as their last decision before the judicial functions of the House of Lords were relocated and renamed the English Supreme Court.

The decision required the DPP to publish guidelines and this he did, amplifying criteria he had enumerated when justifying his decision not to prosecute the parents of *Daniel James*, a young man effectively quadriplegic after an injury to the cervical spine sustained while playing rugby, who had tried repeatedly and unsuccessfully to commit suicide and finally persuaded his parents to assist him to travel to Dignitas.[16] The DPP's guidelines were put out for consultation, considerably modified in response to comments received and finally brought into effect on 25 February 2010, almost contemporaneous therefore with the amended terms of the Suicide Act but wholly opposite in their implications. The details are easily accessible,[17] but they are only guidelines—they are not rules of law and no one factor is determinative. The emphasis is, very properly for a criminal offence, on the state of mind of the potential defendant, not on the predicament of the person seeking or receiving assistance to die. There are no antecedent qualifying criteria such as 'terminal illness' or 'unbearable suffering': each case is to be determined on its facts. Prosecution is unlikely if the assistance provided is prompted by compassion—in other words motive is considered here at the outset of the judicial process, not at its end as in the case of *Cox*.[4] Prosecution is more likely 'if the suspect was acting in his or her capacity as a medical doctor, nurse or other health healthcare professional … and the victim was in his or her care'. No prosecution has followed investigations into two former general practitioners who provided assistance either financially or by practical advice, one of whom had been investigated but not prosecuted previously for the same offence.[18 19]

A LOOK TO THE FUTURE

Nationally and internationally there is a growing demand for access to assisted dying, and public opinion in England and Wales is generally supportive.[20] Opposition is founded on both moral grounds and a perception that assisted dying is unnecessary and/or potentially detrimental to either society as a whole or to vulnerable subsections within it.[21] It is unlikely that the moral argument can ever be resolved because morality is a set of beliefs of uncertain origin which change with time and are not set out authoritatively in any universally acknowledged source. The perceived value of human life is of such moment to most people that the concept of foreshortening it in any way places such an act among those considerations which, in the words of Dame Mary Warnock, are 'matters of ultimate value which are not susceptible to proof'.[22] Thus only regulation, not resolution, is possible. Society endows its law-makers with the power to regulate, to determine whether an act is or is not to be permitted. Often this entails balancing the interests of the individual against those of society—for example, regulation of sexual conduct, or restraint of those with mental illness or who are suspected of as yet unproven terrorist activity. A prime consideration in the context of assisted dying is whether it does, in fact, create detriment to society or any subsection thereof. A number of potential hazards have been widely publicised, but such evidence as has been collected does not support these contentions. Most importantly, there is no evidence that vulnerable individuals are more likely than others to seek an assisted death because of some misguided sense of duty, a wish to avoid being a burden to others or perceived denial of self-worth.[23]

Publication of the DPP's guidelines on criteria in favour of or against prosecution under the terms of the amended Suicide Act provides welcome acknowledgement that society, through its laws, perceives the provision of assistance to die as an act not requiring punishment in all circumstances. Some might argue that this goes far enough and that no further legislative change is either necessary or desirable. Yet anomalies remain. Competent adults wishing to die who are dependent upon life-sustaining treatment are entitled to demand its withdrawal and are deemed to have died from the antecedent condition. Competent adults wishing to die who are not dependent upon life-sustaining treatment are liable to criticism if they seek to fulfil their wishes and those assisting them face investigation, albeit possibly not prosecution, for a criminal offence. If a person succeeds in securing an assisted death and their body remains within, or is returned to the jurisdiction of an English coroner, then an inquest is a virtual certainty, a verdict of suicide likely and death will be attributed to the method chosen by the individual, not the underlying condition prompting the decision. Thus Ms B with a high cervical cord lesion was entitled to demand withdrawal of mechanical ventilation and was deemed to have died from natural causes, whereas Daniel James, with a spinal cord lesion only a few segments lower and so able to breathe spontaneously, ended his life at Dignitas and a subsequent inquest recorded a verdict of suicide, with poisoning given as the cause of death.[24] A coroner resorted to a narrative verdict in the 1995 case of *David Rogers*,[25] another young man quadriplegic and ventilator dependent after a rugby accident who was coincidentally an insulin-dependent diabetic and who refused to permit its further administration. Such inconsistencies are inequitable. So too is the timing of legal evaluation. Decisions to withdraw life-sustaining treatment which require application to the court are considered before the event. Determining whether

prosecution is warranted when someone provides another with assistance to die only takes place after the event. Thus although the DPP guidelines provide reasonable certainty, those electing to die with the assistance of another must do so without absolute conviction that their assistant will avoid prosecution and will know that delay in the decision is inevitable.

There is a clear analogy between competent adults wishing to end their lives, competent adults wishing to forego or discontinue life-sustaining treatment, and decisions by the courts on the propriety of withholding or withdrawing life-sustaining treatment from those who are incompetent through age or mental infirmity. The courts have been used to resolve conflicts and define permitted boundaries in the last two categories, so it is logical to seek a possible legal solution to the first. Three questions would need to be considered by the court:

- Is the applicant adult, competent and fully informed?
- Is the applicant acting voluntarily and consistently?
- What evidence is offered to explain the wish for assistance to die?

If deemed to lie within the current guidelines against prosecution of an assistant, the applicant would then be entitled to seek help from whoever is most suited to provide it. To avoid exposing the seriously ill or enfeebled to the rigours of a court hearing, a two-stage procedure might be preferable such as is used to secure lasting power of attorney.[26] A number of advantages would follow. The requirement for a court-based procedure sets a fairly high threshold and preserves the almost inevitable individuality of the circumstances of each applicant. No person averse to assisted dying on moral grounds would be pressurised to become involved: those willing to participate would 'opt-in' rather than 'opt-out'. The Court of Protection as reconstituted by the Mental Capacity Act 2005 might prove a suitable forum because although its primary function is to protect the interests of the mentally incompetent, its first duty is to determine whether an individual does or does not have capacity.[27] Furthermore the Court has a remit to consider applications relating to serious medial treatment which includes, at paragraph 6(e), an ethical dilemma in an untested area.

Tribunals to consider such applications have been proposed[28] but, although perhaps less expensive and easier to access than the formal court service, can only apply existing law. The courts are more likely to act consistently and also have the power to make and extend the law. At present the provision of assistance to another to end their life remains a criminal offence at English law; there are merely circumstances, now more clearly defined, in which prosecution is deemed unnecessary.

The courts could therefore play an important part in cautiously allowing the law to respond to public concern and evolve in a liberal direction. However, it is unreasonable to charge the judiciary with responsibility for resolving moral conflict or determining ethical propriety. Lawyers do not have the training or entitlement to do so any more than medical practitioners. In the words of Holman J in the case of *MB*, a very young child totally paralysed by spinal muscular atrophy in whom consideration was being given to the withdrawal of mechanical ventilation[29]:

> 'I wish to stress and make clear, however, that I myself am not concerned with any ethical issues which may surround this case. My task … is to decide, and only to decide, where the objective balance of best interest of M lies. If I decide that it is not in his overall best interest to continue with a given form of treatment … then I must say so; and it will follow as a matter of law … that it is lawful to withdraw or withhold that form of treatment. The ethical decision whether actually to withdraw or withhold it must be made by the doctors concerned. Judges are neither qualified to make, nor required, nor entitled to make ethical judgements or decisions'.

His words were directed to the healthcare professionals responsible for MB but they can be applied more generally to any circumstance where a proposed course of action arouses moral controversy. Ultimately it is up to the conscience of those intending to participate—be it in homosexual activity, procreation outside marriage or the withholding or withdrawing of life-sustaining treatment. It is the function of the law to define and enforce the boundaries of permitted behaviour. Within those limits—which may need individual definition—it is a matter for each of us to determine what position to adopt while at the same time respecting the differing views of others.[30]

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REFERENCES

1. **Ramsay JH.** A king, a doctor, and a convenient death. *BMJ* 1994;**308**:1445.
2. **Devlin P.** *Easing the Passing*. London: The Bodley Head, 1985.
3. **Moran L.** *Churchill: The Struggle For Survival*. London: Constable, 1966. Reviewed in an Editorial: A Question of Confidence. *Lancet* 1966;**1**:920.
4. **Cox RV.** *12 BMLR 38*, 1992. And see *BMJ* 1992;**305**:731.
5. Airedale Hospital Trustees v Bland [1992] UKHL 5.
6. Hillsborough Victim Died Accidentally. Inquest report 22 Dec 1993, 1993. http://www.independent.co.uk/News/UK.
7. *Select Committee Report on Medical Ethics, House of Lords Report*. London: The Stationery Office Ltd, 1994.
8. Mental Capacity Act 2005 Part I s37;Part II s52. http://www.legislation.gov.uk/.
9. Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam).
10. Pretty v United Kingdom - 2346/02 [2002] ECHR 427 (29 April 2002).
11. **Joffe J.** *The State vs Nelson Mandela: The Trial That Changed South Africa*. Oxford: Oneworld Publications, 2007.
12. *House of Lords Select Committee Report on the Assisted Dying for the Terminally Ill Bill Volume I*. London: The Stationery Office Ltd, 2005.
13. The National Archives Coroners and Justice Act 2009 s59. http://www.legislation.gov.uk/.
14. *Re Z: A Local Authority v Mr Z and the Official Solicitor (Advocate to the Court)*, 2004, EWHC 2817 (Fam).
15. *Purdy, R (on the application of) v Director of Public Prosecutions*, 2009, UKHL 45.
16. No charges following death by suicide of Daniel James, 2008. http://www.cps.gov.uk/news/press_releases/179_08/index.html.
17. Policy for prosecutors in respect of cases encouraging or assisting suicide. http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf.
18. *'Dr Death' Won't be Charged over Assisted Suicide*. *The Independent* 25 Jun 2010.
19. *Doctor Won't Face Charges after Helping Woman to Die*. The Scotsman 2010. http://www.thescotsman.scotsman.com/euthanasia/Doctor-won39t-face-charges-after.6477909.jp.
20. **McAndrew S.** Religious faith and contemporary attitudes. In: Park A, Curtice J, Thomson K, *et al*, eds. British Social Attitudes 26th Report. London: Sage, 2009.
21. **George RJ,** Finlay IG, Jeffrey D. Legalised euthanasia will violate the rights of vulnerable patients. *BMJ* 2005;**331**:684—5.
22. **Warnock M.** In foreword to The Warnock Report 1984, 11 para 3. http://www.hfea.gov.uk/2068.html.
23. **Battin MP,** 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. *J Med Ethics* 2007;**33**:591—7.
24. Coroner records suicide verdict on Daniel James. *Times Online* 10 Dec 2008. http://www.timesonline.co.uk/tol/news/uk/article5318956.ece.
25. Inquest report, David Rogers. *Western Mail* 16 Dec 1995.
26. Mental Capacity Act 2005. Schedule 1. Lasting Powers of Attorney: formalities. 2005. http://www.legislation.gov.uk/.
27. Office of Public Guardian Court of Protection. http://www.publicguardian.gov.uk/about/court-of-protection.htm and see Practice directions and rule 9E: applications relating to serious medical treatment. http://www.hmcourts-service.gov.uk/cms/14705.htm.
28. **Pratchett T.** 34th Dimbleby lecture, Feb 2010. http://www.bbc.co.uk/i/qmfgn.
29. Re MB An NHS Trust v MB [2006] EWHC 507 (Fam) at para 24.
30. **Bernheim JL,** Deschepper R, Mullie A, *et al*. Development of palliative care and legalisation of euthanasia: antagonism or synergy? *BMJ* 2008;**336**:864.