

Proposals to introduce a Tribunal for Assisted Suicide in the UK

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It is time that Parliament took the brave and audacious move to publically debate legalising assisted suicide in the UK. Even though a Private Members Bill has recently been introduced in Parliament, it has little hope of success without Government backing. The continual underlying objection of the fear of the slippery slope and the effect of legalising assisted suicide would have on the elderly and the vulnerable is a justifiable one; however, the patient's autonomy must be respected and it will be argued it is possible to legislate in favour of assisted suicide whilst protecting the vulnerable. It will be argued that the introduction of a Tribunal style system to speedily and sympathetically consider each and every patient's plea to end their lives should be introduced. This would enable a panel, comprising representatives from both the judiciary and the medical profession an opportunity to assess each case on its merits. It would seek to confirm whether the patient has a terminal condition from which they will die within 9-12 months and each patient will be given a cooling off period to explore options of palliative care. Each case will be recorded and each death reported. The Panel will ensure that the patient is not being unduly pressurised and the person who will assist has nothing to gain. Each case will be closely monitored and each patient treated as an individual. Society should temper paternalism with respect for a patient's autonomy in order to end the imbalance between the right of a patient to refuse medical treatment where they will surely die as a result and the lack of respect for the self determination of a patient who is clear they wish to end their life.

2. Introduction

The issue of assisted dying has been the subject of high profile cases since 2002 and the ethical and legal debates have remained in the forefront of the media's spotlight. There have been a number of Parliamentary Bills introduced by Lord Joffe to legalise assisted dying and most recently a Private Members Bill was introduced by the former Lord Chief Justice, Lord Falconer. Moreover, assisted dying has the vocal support of the high profile author, Terry Pratchett, himself an Alzheimer's sufferer and Stephen Hawking, the world famous theoretical physicist and cosmologist who suffers from motor neurone disease.

This paper will examine the approach taken by the courts in cases where the applicant has sought a declaration to end their life by way of assisted dying and examine the justification of their decisions. The paper will then embark on a proposal which could respect a person's self determination to decide for themselves the stage at which they wish to end their life whilst seeking to ensure

the protection of the vulnerable. This proposal does not purport to be able to address every hurdle in its proposals to legalise assisted suicide but it hopes to take a more robust and adventurous approach to reach an end which permits those who suffer from a terminal condition to die with dignity.

2. The Law

In 1961, the Suicide Act decriminalised the offence of suicide, although to date assisting or encouraging a suicide remains a criminal offence in the UK which, upon conviction can impose a maximum sentence of 14 years imprisonment. In 2009, section 59 of the Coroners and Justice Act amended section 2(1) of the Suicide Act by inserting a new section 2A which states that a person commits an offence if the defendant 'does an act capable of encouraging or assisting the suicide or attempted suicide of another person'.

For many years, the courts have recognised the fundamental principle of patient autonomy. In the 1972 case of *S v McC: W v W*¹ Lord Reid said, '... English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty.' The view was reaffirmed in *re T (Adult: Refusal of Treatment)*², where Lord Donaldson said '.... . the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent'. These cases demonstrate that the wishes of a competent patient to refuse medical treatment even where it will lead to the patient's death must be respected and a patient's autonomy clearly outweighs the principle of sanctity of life. Perhaps one of the best known cases is *Ms B v An NHS Hospital Trust*³. Ms B was entirely dependent on a ventilator to breathe and was paralysed from the neck down. She sought a declaration from the courts that artificial ventilation be withdrawn and any continuing ventilation would be an unlawful trespass. There was no question of a lack of competency and the court upheld her wishes, permitting her to die in the manner she wanted and at a time of her choosing. In the same year, the courts were hearing the case of Diane Pretty, who suffering from motor neurone disease, wanted to die at a time of her choosing. Most importantly, she sought an assurance from the DPP that her husband would not be prosecuted if her were to help her to die. The House of Lords and later the ECHR were at pains to point out that Article 2 of the ECHR was not incompatible with Section 2 of the Suicide Act 1961 and could not

'be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on the entitlement to choose death rather than life'.

Moreover, as far as having the right to end her life at a time of her choosing and whether this fell into the scope of Article 8, the court held that it was justifiable and not a disproportionate measure under Article 8(2)⁴ to impose a blanket ban. The contrast between the case of *Pretty* and *Ms B* is subtle but relevant as the courts recognised *Ms B*'s right, as a competent patient to refuse medical treatment even where it would lead to her death. She was choosing death over life. In *Pretty*, the courts went to lengths to reject personal autonomy where the scope was suddenly extended to involve another person or the possible effects on other sections of society. The rejection of the Article 8 argument was based upon the courts desire to balance competing interests. However, a balance could not be achieved between a person's right to self-determination to be able to die at the time they wished and the protection of both the vulnerable and the disabled who could be influenced or pressurised to end their life for fear of being a burden on others. Whilst it is indisputably right to protect the vulnerable, it is oppressive to force those who wish to die, to remain living in pain and suffering.

The case of *Purdy v DPP*⁵ brought the issue of assisted dying once more to the attention of the media and public debate. *Ms Purdy* successfully challenged the DPP's failure to establish a specific policy setting out the circumstances in which a person would be prosecuted for encouraging or assisting another's suicide contrary to Section 2A Suicide Act 1961 as amended. Following *Purdy*, the DPP set out guidelines purporting to be a 'clear framework' including 16 public interest factors in favour of prosecution and 6 public interests factors against prosecution. The guidelines are however about the motive of the person suspected of encouraging or assisting suicide not about the patient or 'victim' themselves. The most recent high profile case is *R (on the application of Nicklinson) v MOJ and others; R (on the application of AM) v DPP and others*⁶ where the two applicants suffering from 'locked in syndrome' wished to be able to end their lives at a time of their choosing. It was acknowledged by Lord Justice Toulson that they 'present society with legal and ethical questions of the most difficult kind'⁷ but the applicants unsuccessfully argued that the common law defence of necessity to a charge of murder should be available in cases of assisted dying and argued that the Suicide Act 1961 was incompatible with Article 8. In practical terms, the cases referred to above are asking the courts to recognise their rights under Article 8 so they can determine for themselves the time at which they wish to die. The courts are sympathetic and whilst the judiciary can and do change law, they refuse to do so in an area which 'raises profoundly sensitive questions about the nature of our society, and its value and standards on which passionate but contradictory opinions are held'⁸.

The blanket ban on assisted dying and the courts reliance on Article 8(2) are entirely correct; assisted dying is a matter for Parliament to debate and legislate on, if appropriate and not for the courts to judicially determine by extending the margin of appreciation.

‘...the law relating to assisted suicide cannot be changed by judicial decision. The repeated mantra that, if the law is to be changed, it must be changed by Parliament, does not demonstrate judicial abnegation of our responsibilities, but rather highlights fundamental constitutional principles’⁹.

3. Autonomy

Throughout a person’s life, one has free will and autonomy to decide how to live their life. The law however, refuses to allow a person who has been diagnosed from a terminal and incurable disease to end their life at the time of their choosing. It lacks logical application to be refused the right to die at a time when that person feels their life lacks a quality they would wish to enjoy and when they feel that all dignity has been removed from their life. The irony is that if a patient with an incurable and terminal disease required lifesaving hospital treatment, even for an unrelated condition, they could refuse treatment and seek certain death. Moreover, the only avenue open to a person who wishes to end their life is to travel to Dignitas in Switzerland which will assist a person to end their life. It is oppressive that a person should have to embark on this journey when they should be ending their life in the place of their choice, more than likely their own home, surrounded by their family and friends. Furthermore, although there has never been a prosecution of those returning from accompanying their loved one to Dignitas to die, concern has led the person wishing to die to travel at an earlier time than they otherwise would and when they are still able to travel independently.

4. A call to legislate

Thus, it is for Parliament to legislate to enable those who wish to do so, have a dignified death and at the same time protect the vulnerable. The Assisted Dying Bill 2013, introduced by Lord Falconer as a Private Member’s Bill¹⁰ comes as a direct result of the Report from the Commission on Assisted Dying which Lord Falconer chaired. The Commission set up in November 2010 examined both the legal and ethical policy position of assisted dying in the UK, concluding that it was both ‘inadequate and incoherent’. It recommended legalisation in favour of assisted suicide through a structured framework of criteria and safeguards.

It comes therefore as a surprise to see that the latest Bill on assisted dying contains few of the recommended safeguards and criteria but in fact, differs little from the four previous Bills that have failed to progress effectively through Parliament in the past 10 years. The Bill recommends that a person can receive assistance in dying if that person has capacity, has made a clear and informed intention to end their life and is suffering from an ‘inevitably progressive condition which cannot be reversed by treatment’ from which they expected to die within six

months.

The Bill fails to address the one aspect fundamental stumbling block; the protection of the vulnerable. If the law is to permit the vociferous minority who are self-motivated and determined to end their life then the Bill has to address the vulnerability of those who might also be affected and if it fails to do so, it is doomed to failure.

It is for this reason that any proposed legislation should establish an Assisted Dying Tribunal. The aims of proposed legislation would be largely similar to the existing Bill, that is, to permit a competent patient suffering from a terminal illness from which they will die within 6 months, the right to die with assistance either from the medical professional or from family. A tightly regulated Code of Practice would be introduced with stringent reporting requirements.

The purpose of any Tribunal would be to examine each and every request for assisted suicide on its merits. It is envisaged that a Tribunal would compose of a panel of 5 members (rather than the normal 3 members), including two lawyers, two doctors (one psychiatrist and one a specialist in the terminal condition from which the applicant suffers) and a lay person.

Membership should be carefully considered and be by appointment. No members of the Panel should have any affiliation either directly or indirectly with any organisation that either promote or condemns assisted suicide. The purpose of the Tribunal would be to examine with dignity and respect the person's wish to end their life in a transparent, sensitive and open environment.

The applicant to the Tribunal should not be burdened by undue bureaucracy as evident in the court process and a hearing should take place expeditiously. Legal funding should be available. Any application to the Tribunal should entail two hearings, the first where the evidence is heard and a recommendation is made and then a second hearing after a 'cooling off' period, which would allow the applicant time to reflect and consider palliative care options.

The role of the lawyer and the psychiatrist would be to examine that the patient has capacity and has repeatedly expressed a settled wish to end their life. Evidence would be submitted directly by the applicant if possible in person or via video link.

The Mental Capacity Act 2005 is well equipped to serve this purpose and the principle contained in section 1 (4) that '*a person is not to be treated as unable to make a decision merely because he makes an unwise decision*' is pertinent as the Tribunal must subjectively rather than objectively consider the evidence before them. Mental capacity is a fundamental consideration in the same way that the courts consider capacity when a patient refuses medical treatment understanding that it will lead to their death. An applicant will lack capacity if

‘at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain’¹¹.

For the purposes of section 3(1) a person lacks capacity if they are unable

‘to understand the information relevant to the decision, to retain that information, and to use or weigh that information as part of the process of making the decision, or to communicate his decision (whether by talking, using sign language or any other means).

If they satisfy the requirement in the Mental Capacity Act, their capacity to make an informed decision will be satisfied.

Family and friends should be permitted to give evidence but this should be treated with caution as this could be the evidence of influence or undue pressure in the vulnerable. Nonetheless, for this very reason, it is also evidence that is important to hear.

Oral evidence combined with psychiatric evidence would also allow the Tribunal to examine whether the patient is suffering from a depressive condition which, if identified, may be an indication that their judgment may be affected and a signal that assisted suicide should not be an approved path. This examination of the patient’s mental capacity would address critics of the current Bill who express concern that there are no built in safeguards apart from the simple eligibility criteria. This proposal establishes not only that the patient has capacity (often not in doubt) but also goes to the crux of the objection – the protection of the vulnerable and disabled. It should be able to establish whether the applicant has been influenced or is subject to undue pressure as the inquisitorial nature of the Tribunal together with its expertise would have an opportunity to thoroughly investigate this avenue. The current Bill before parliament refers to terminal illness where the patient is ‘reasonably expected to die within six months’. Whilst a patient may be advised that they have a limited lifespan, the Royal College of Practitioners observed¹² that

‘it is possible to make reasonably accurate prognoses of death within minutes, hours or even a few days. When this stretches to months, then the scope for error can extend into years.’

A clinical ‘guesstimate’ of life expectancy, however well intended may be inaccurate and the effect of the patient may be devastatingly relevant. If a patient is told they have 18 months to live, they may have an entirely different perspective on ending their own life in contrast to where they have 6 months to live. This

problem raises a difficult issue to address. It is for this reason that it is proposed that one of the Panel members would be an expert in the condition from which the applicant is suffering in order to provide a further opinion on prognosis. This paper does not propose a fail-safe solution to this perhaps insurmountable issue but it is an area which would benefit from further medical expertise.

The current Bill before Parliament is likely to fail. Although unlikely, Parliament needs to engage in an extensive debate on assisted dying. Establishing a Tribunal may well be the only avenue in which can serve the autonomous wishes of the determined terminal patient whilst protecting the vulnerable of society.

Notes

¹ 1972 AC 25 at 43

² 1993 Fam 95 at page 113

³ 2002 EWHC 429

⁴ Article 8(2) states ‘There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others’.

⁵ 2009 UKHL 45

⁶ 2012 EWHC 2381

⁷ *ibid*

⁸ 2012 EWHC 2381

⁹ *Ibid*

¹⁰ *Assisted Dying Bill* (HL Bill 24) (session 2013-14)

¹¹ Section 2 (1) *Mental Capacity Act 2005*

¹² House of Lords Report Session 2004-2005 86-1, paragraph 118